Clinical Medicine 2009, Vol 9, No 4: 303–4

From the Editor

What is the point of care?

The improvements in diagnosis, management and treatment in a single career lifetime are nothing short of extraordinary. The range of drugs has expanded from around twelve to a large book full. The specialties have each developed their own skills and investigative techniques to a point where almost anything seems possible. Facilities now accepted as normal, including intensive care, cardiac surgery, transplantation and advanced imaging, are really all recent additions. Colleges and specialty societies maintain and enhance high standards of care and academic units exist to develop new approaches to care. Undergraduate and postgraduate medical education help to ensure excellent training while regular evaluation and accreditation contribute to the maintenance of high standards. The NHS is highly rated and high levels of satisfaction are recorded in national surveys. All seems well.

That is until more careful surveys and detailed discussion with patients and their families reveal deep levels of mistrust and a feeling that personal care has been lost in an era of medical progress.[1]

Those working at the sharp end will appreciate some of these problems. The sheer number of patients and their families in the accident and emergency departments and the acute medical units make personal care difficult. More reasonable working hours make individual continuity of care impossible. High bed occupancy rates often result in patients being moved from one ward to another for practical, rather than clinical, reasons and the patients feel cut adrift from familiar faces among their carers. Are these changes with which we are all familiar inevitable and intractable or can they be defined more clearly and practical solutions developed?

Those working within the service know of the problems but have little time to consider possible solutions. Enter The King's Fund and their Point of Care programme. The King's Fund has a deep understanding of the health service, experienced personnel, skills, funding and time to consider these issues. Their first evidence-based review paper was published in 2008.[2] Section one examines the quality of patients' experience in English hospitals today based on large-scale surveys and extensive structured interviews. The particular issues explored include those defined by the Institute of Medicine – compassion, empathy and responsiveness to needs, values and expressed preferences, coordination and integration of care together with information, communication and education. Finally physical comfort, emotional support, the relief of fear and anxiety and involvement of friends and family are also included.[3]

Some of the important initial findings note the marked variation in patient care hour by hour, shift by shift, day by day and ward by ward. The 'person in the patient' was often overlooked and it was rarely clear who was in charge – doctor or nurse – to discuss their care. The patient 'posted like a parcel' from one ward to another was a frequent finding. Understanding the importance of variations in care between different wards in the same hospital and between individual hospitals seemed of central importance to seeking possible solutions.

The second section considers the available evidence for these aspects of clinical care and the sometimes confusing range of definitions used in such studies. Of all the various phrases used to encapsulate patient-centred care, the phrase 'seeing the person in the patient' resonated most strongly with those interviewed. Section three explores a framework for the analysis of factors which underlie the patients' experience and how these experiences might be improved. It is clear that staff are motivated by the desire to provide high-quality care.[4] The factors underlying a patient's experience have been grouped into four levels – national, regional, institutional and individual.

The individual interaction includes patient and staff member and the clinical microsystem – a department, ward or clinical pathway. At this level the key features are leadership, morale, communication, level of experience in the team, flexibility, team ethos and priorities. Several technical and human priorities have been identified.[2] There are good examples of how the patient's stories of their experiences transformed the way staff thought of care. Changes were made in wards and clinics and fragmented services were joined up.[5]

Cornwell and Goodrich develop the idea of leverage where by the smallest effort can make the biggest difference, a technique described by Senge.[6] They describe the Schwartz Centre at Massachusetts General Hospital founded by the family of a patient.[7] The centre carries out programmes to educate and support caregivers 'in the art of compassionate healthcare'. Similar constructive approaches have been taken by the

Planetree Association founded in 1978.[8] Apart from these and a small number of similar organisations there has been little analysis of the factors that shape a patient's experience of care together with design and implementation of interventions to improve that care.

Among the report's conclusions is the observation that the ambition to improve patients' experience of care will only be realised with the willing cooperation and effort of all staff in direct contact with patients and if the wider organisation provides support and encouragement.

For further details, please consult www.kingsfund.org.uk/research/projects/the_point_of_care_improving_patients_experience/

References

1 Gilbert D. *Stumbling on happiness*. New York: Knopf, 2006.
2 Goodrich J, Cornwell J. *Seeing the person in the patient: the Point of Care review paper*. London: The King's Fund, 2008.
3 Institute of Medicine. *Crossing the quality chasm: a new health system for the twenty first century*. Washington, DC: National Academic Press, 2001.
4 Department of Health. *What matters – what matters to our patients, public and staff*. London: DH, 2007.
5 Thomas H. Engaging patients to understand and improve their experience of attending hospital. *J Comm Health Care* 2008;1:78–87.
6 Senge PM. *The fifth discipline: the art and practice of the learning organisation*. New York: Doubleday, 1990.
7 Schwartz KB. A patient's story. *Boston Globe Magazine*, 16 July 1995.
8 Planetree Association. www.planetree.org

Middle East Travel Fellowship Awards

There are few more harrowing experiences than the loss of a son or daughter. Lord Leslie Turnberg (the former President of the Royal College of Physicians) and his wife Edna have responded to their own personal tragedy in a remarkably positive and constructive way. The Daniel Turnberg Trust Fund UK/Middle East Travel Fellowship scheme has been established in their son's memory and has already funded 20 successful candidates from among 44 applicants for support. Contributions to the fund from the RCP have helped to support six of the successful applicants. The scheme covers a wide variety of clinical and research interests and enables individuals from the UK and Middle East to gain additional experience, to learn new techniques and to develop collaborative links for the future. Furthermore the scheme fosters improved international understanding. Details of this imaginative and important scheme can be found below.

ROBERT ALLAN

Middle East Travel Fellowship Awards

In October 2008, the **Daniel Turnberg Trust Fund UK/Middle East Travel Fellowship Scheme** was launched with the aim of encouraging collaboration between medical researchers in the UK and the Middle East. The fund was set up by Edna and Leslie Turnberg in the name of Daniel, their late son, who was himself conducting research as a Lecturer in Renal Medicine at the Royal Free Hospital, London.

The scheme provides short-term fellowships for early and mid-career clinical academics and bioscientists, offering an opportunity for them to learn new techniques, gain additional experience and develop collaborative links for the future. At a recent meeting of the scientific panel, 44 applications were assessed and 20 successful candidates were awarded a grant. The geographical spread of the awardees was wide and included three from the UK, two from Egypt, seven from Israel, two from Jordan, five from the Palestinian Territories and one from Lebanon.

The scheme is administered by the Academy of Medical Sciences and the awards were funded by the Daniel Turnberg Trust with the very strong support of the Wellcome Trust, the Wolfson Foundation and the Royal College of Physicians (RCP). The RCP's support was sufficiently generous to fund no less than six of these fellowships.

Details of these awards are available on the Academy's website as is the information about applications for next year's awards (www.acmedsci.ac.uk).