Terminology, time and tension: the challenges of delivering person-centred care

My first edition as editor-in-chief of *Future Hospital Journal* (FHJ) presents a wide-ranging collection of articles on person-centred care. As a cardiologist who additionally practises general medicine and completed general practice training, the manuscripts in this edition provided much food for thought. This edition of FHJ articulates a series of demands from our patients: to rise to the challenge of being more co-productive in the delivery of their healthcare; to reflect honestly on how we practise with them; and to hear and acknowledge the clear message that there is always the opportunity to improve in the way we serve our patients' needs.

My predecessor stated at the first board meeting of FHJ that his overriding vision was for this journal to be high quality, but equally brave and unafraid to address the big issues that needed debating; no matter how hard they were and uncomfortable that made us feel. I wholeheartedly endorse that vision and will continue to deliver against it. I have no doubt that this edition will evoke strong emotions from some readers when considering one of the biggest issues we face in healthcare delivery.

As with the rest of society, we are a product of our time and, as clinicians, even more a product of our training and the hierarchical culture we work within. Neither patients nor clinicians are homogenous entities (as evidenced in the varying perspectives within this journal, and, possibly, uniquely in the associated patient's perspective on many of the articles) and both will vary in their responses to the issues brought to the fore within these pages.

I would argue that the relationship between individuals and their healthcare professionals is context specific and more nuanced than is often acknowledged. There is a difference between the routine consultation with the person living with a long-term condition (such as outlined in Simon Eaton's article[1]) and a patient being acutely admitted for a life-saving intervention. By the same measure, this means that there are times in medicine when a debate with a patient about the best course would be inappropriate, while at other times it is fundamental to the consultation that a person is able to determine what courses of medical action are available to them and which are most appropriate to their own lifestyle. The use of the terms 'patient' and 'person' in these scenarios are different and this edition challenges us to consider both. You may not agree with my use of the terms above, but the terminology is important and both are valuable and appropriate, while neither should be seen as singularly correct.

In the NHS, we must move with the times and accept that society in general has moved away from a deference to professionals, to a more questioning and informed population. However, some service users, particularly the large number of older patients that we care for, may be more comfortable with the old paradigm and genuinely wish to defer to their professional. However, we must be careful not to stereotype; some older users will be more IT savvy than their clinicians, fully informed and wish to drive their own healthcare, while some younger patients may not be so well informed and may also wish to be guided more directly. One area that is of particular challenge is ensuring we are equally able to deliver person-centred care to those with reduced mental capacity and learning difficulties. Culture also plays a significant part in this debate and the fascinating manuscript on cancer care in Albania sheds light on a developing country facing its challenges in this area.[2] In the NHS, we deliver healthcare to a culturally diverse society and again we should be careful not to assume a uni-dimensional approach to culture in healthcare.

The practicality of delivering person-centred healthcare may appear daunting, especially in a rigid, traditional system of new and follow-up appointments. Time is something we all lack, and as the complexity of healthcare and the increasing demand for it combine, one may feel unable to embrace a more person-centred approach to the consultation. However, we must remember medicine is for the benefit of patients and, in our own areas of practice, look to make both the process changes required to ensure we are delivering our mandate in the most appropriate way and challenge ourselves to benchmark our practice.

While the current financial position of the NHS and political direction (both big P and little p) will further challenge us,

as a clinical community we must be bold in our engagement with service design; spreading best practice and sharing our experiences of success and failure to the wider community. Future Hospital development sites and Vanguard sites[3] are a start, linking primary, secondary and social care to try and ensure a more holistic approach to healthcare delivery to the whole spectrum of health. Equally, as stated in the Future Hospital Commission report[4] we must embrace the concept that a hospital is more than just a physical building and acknowledge there are innovative ways of delivering hospital care outside its four walls.

We must question how we practise, especially in hospital medicine, where the specialist consultation is often perceived as more intimidating and patients potentially reluctant to take the initiative in addressing their own concerns. One of the seminal pieces of practice that has helped me in understanding my patients' wishes has been the use of Pendleton's rules, taught to me as a GP vocational trainee. The simple exploration of a patient's ideas, concerns and expectations[5] has allowed me, in a very simple way, to take this central tenet of the GP consultation into my various roles as a hospital physician. I recommend it to you as a simple, yet effective tool to ensure that you are on the same page as your patient and able to address the issues that are of most concern to them. It is often illuminating, surprising and empowering. It is possible to deliver person-centred care in a 10 minute consultation; however, the less we speak and the more we listen in those first few minutes is critical.

FHJ is a fundamental vehicle to share our successes and failures in this area and I would make a request to you to send us your experiences, with data to support your findings, so others can learn from your experiences (both good and bad) and we can help each other address this challenge.

Despite the tensions, it is a challenge we must embrace. ■

Wing Commander Edward Nicol

References

1 Eaton S. Delivering person-centred care in long-term conditions. *Future Hospital Journal* 2016;3:128–131.

2 Organ H, Rama R. Approaches to end-of-life care: a comparison between the UK and Albania. *Future Hospital Journal* 2016;3:134–135.

3 NHS England. *New care models: Vanguards – developing a blueprint for the future of NHS and care services*. London: NHS England; 2016. Available online at www.england.nhs.uk/wp-content/uploads/2015/11/new_care_models.pdf [Accessed 30 March 2016].

4 Future Hospital Commission. Future hospital: caring for medical patients. London: Royal College of Physicians, 2013. Available online at www.rcplondon.ac.uk/projects/outputs/future-hospital-commission [Accessed 30 March 2016].

5 Pendleton D, Schofield T, Tate P, Havelock P. *The Consultation: an approach to learning and teaching*. Oxford: Oxford University Press, 1984.