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Patient-focused care

Effects of organisational change on the stress of community health professionals

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Abstract

A quantitative and qualitative study was conducted with 191 health professionals working in primary care during the initial stages of adopting a more patient-focused, multidisciplinary approach to care. Patient-focused care involves a radical analysis of the health professional's philosophy of care and a critical examination of current systems of practice by taking into account the holistic needs of patients. The community health professionals had a range of initial perceptions of what patient-focused care would mean to their practice or working environment. One in three of those surveyed believed that patient-focused care would be a threat to their status as professionals and 60% of the sample believed they were already providing a form of patient-focused care. There was resistance to working in a multidisciplinary team, with some health professionals commenting that they had little in common with staff belonging to other disciplines.

The significant change for many staff was the transition from being in a single disciplinary team to being part of a multidisciplinary team; this change may have a critical impact on the stress levels of the health professionals themselves. Almost half (49%) of the health professional sample said that they were either experiencing 'high' or 'very high' levels of job-related stress. Sixty-five per cent of staff attributed their stress to job-specific stressors. The most commonly reported stressors were difficulties with patients themselves (47%) and staffing problems (39%). The health professional sample tended to express the symptoms of stress in somatic terms, rather than describe the cognitive, emotional, or behavioural aspects of their stress. This finding has implications for the development of interventions to combat stress among health service employees who encounter significant changes to their organisation or to their systems of practice.

Occupational stress

There is significant research evidence to show that stress in the workplace can often have a substantial adverse effect on an organisation. Stress has been linked to sickness absence, poor productivity, high staff turnover, and poor employee health and well-being (e.g. Cooper & Payne 1988, Quick *et al* 1992). In England, a recent successful negligence claim (see Palmer 1995) was made by a public sector employee, in which the employer was deemed to have failed to protect a staff member from the adverse effects of work-related stress on his mental well-being. This case has demonstrated that all employers should take a proactive stance in ensuring that the demands of the job, and the arrangement of the work environment itself, should be relatively stress-free for employees.

One of the most significant work-related stressors for employees is organisational change. This can take many different forms and could involve any of the following: a change in workload or working practice; a change in line manager or the manager's style of supervising staff; a change in location of work base; a change in the relations with colleagues or a change in one's role or responsibilities. Organisational change can be embraced or rejected by workers but it is the employees' reaction, their perceived input towards the change itself, and their perceived locus of control of further organisational change, which helps to determine the employee stress that may accompany organisational change. In one study of a joint health and social services project (James & Dewhurst 1995), organisational change appeared to create such a sense of loss and grief among staff that their reactions were as acute as if they had been bereaved. For example, one nurse who experienced the organisational change said that she felt stripped naked as she had lost her uniform, ways of working and off-duty time all at once.

Several authors have referred to Kubler-Ross's (1978) work on death and dying when examining health professionals' reactions to organisational change (Perlman & Takacs 1990, Schoolfield & Orduna 1994). According to Perlman and Takacs (1990) employees may react in any of the following ways when faced with impending organisational change or with the actual change itself:

- Denial – they may deny to themselves and to others the fact that the change has taken place;
- Bargaining – they may attempt to obstruct the change or alter the change so that the change can be more easily sabotaged or discredited;

- Anger – they may recognise that the change has taken place, but may try to vent their anger about the change by resisting it;
- Openness and readiness – they may begin to identify with the change and adopt the change as part of their role.

These reactions have proliferated among staff in organisations that have experienced some form of operational or human resources restructuring. In the health care sector, the most revolutionary and current system of operational restructuring has been the shift towards a more patient-focused system of care.

What is patient-focused care?

Patient-focused care is an innovative and controversial way of delivering health care to the public. It was first introduced in hospital settings in America during the late 1980s (Lathrop 1990) and has since attracted a great deal of interest in the UK and the USA. It involves the restructuring of services around patient experiences in order to make health care more user-friendly. There are five main principles that could distinguish patient-focused care from conventional care:

1 Restructuring and decentralisation of services.
2 'Multiskilling' of staff and 'skills enrichment'.
3 Multidisciplinary integrated care pathways.
4 Multidisciplinary team work.
5 Empowerment of patients.

By restructuring services to meet the holistic needs of patients, patient-focused care is a system of bringing services closer to patients and aims to meet their cultural, religious and individual needs. Restructuring of services that are more client-centred could involve changes in clinical or clerical procedures and work routines. For example, provision of client-centred practice in the community could involve the arrangement of baby clinics in the evenings to cater for working mothers.

In terms of 'multiskilling', models of patient-focused care have ensured that patients see only a limited number of health care workers when they come into contact with staff. In contrast, conventional care usually involves patients seeing a variety of different staff members and specialist clinicians for their health needs.

With regard to conventional care, documentation relating to patients are maintained by a variety of departments and staff groups. In contrast, patient-focused care emphasises the streamlining of documentation systems so that all departments and disciplines have the relevant information for holistic treatment of patients. Multidisciplinary Integrated Care Pathways map out the regime of patient care. They should be designed by all members of the multidisciplinary team, and often in collaboration with patients (Hurst 1995).

Multidisciplinary team work is also different from conventional systems of community health care, which is usually organised in teams of single disciplines (e.g. chiropodists in a chiropody team, district nurses in a district nursing team, etc.). Working as a team, and across disciplines, is a major feature of patient-focused care. Effective multidisciplinary team work would need the erosion of professional barriers and biases between disciplines and the encouragement of staff to work as part of a team, rather than as isolated specialist clinicians.

Most importantly, patient-focused care should entail increasing levels of patient involvement during the care process itself; patients should be allowed to become empowered and active in the planning and decision-making of any health care and advice that they receive. A personal account of Laungani's (1992a) experiences as a hospital patient, suffering from a degenerative disease, emphasises the merits and deficiencies of current systems of health care. This account epitomises why health professionals need to critically re-examine the ways in which they deliver care. Patient-focused care requires a radical shift away from health professionals viewing people as 'cases' to adopting a holistic perspective of each patient/user by recognising the idiosyncratic nature of each patient's cultural norms and values.

To illustrate why health professionals should recognise the impact of cultural factors on health and health care one could incorporate a conceptual model (Laungani 1990, 1991, 1992b, 1996) that analyses and compares Indian and British (Eastern versus Western) cultural beliefs, attitudes and behaviours. The model distinguishes between the value systems of Eastern and Western culture by examining the two cultures according to four sets of interrelated factors. The following hypothesised factors should be viewed as extending along a continuum, and not as dichotomous concepts:

Individualism ..... Communalism (Collectivism)
Cognitivism ..... Emotionalism
Free-will ..... Determinism
Materialism ..... Spiritualism

This model has been explained elsewhere (Laungani 1990; 1991, 1992b, 1996) and has been subjected to rigorous empirical testing. Research (e.g. Sachdev 1992, Laungani & Sookhoo 1995, Sookhoo 1995) has found that Western (British) cultural norms tend to lie at the left end of the continuum for each of the four factors and Eastern (Indian) cultural norms tend to emphasise values on the right side of the continuum. Such a model has been developed to understand, predict and explain how the dominant values of Caucasians and Indians interrelate with their beliefs about health, relationships and work. For example, at one end of the Cognitivism-Emotionalism continuum, Indian cultural norms emphasise the need to express emotions in which families may often quarrel, fight and swear at one another, although these outbursts are primarily symbolic and cathartic for those involved. Conversely, the mores for Western people is to repress one's emotions and to emphasise rationality and logic in one's relationships at a work and personal level. Even in a potentially emotive situation, such as a funeral, there appears to be a covert agreement among mourners in the Western world that to openly vent one's emotions would be undignified (Hockey 1993).

In terms of health and health care, the Cognitivism-Emotionalism continuum is useful in identifying problems that a health professional may encounter when practising in

a multi-cultural society such as Britain. One potential situation may arise in which an elderly Indian woman may complain of chest pains and express concern that her "heart is sore". However, the responsible health professional should not merely confine themselves to conducting a cardio-vascular check! Instead, the health professional could question the woman further to try to detect the root of her problem. It may be that, owing to the tendency of Indian cultures to emphasise emotional aspects of their existence, the elderly Indian woman in question may be presenting psychological difficulties such as stress or depression in somatic terms (Kakar 1982). This possibility may be likely, especially as Indian society does not have their equivalent expression for Western phrases such as 'feeling stressed' or 'burnout'. In essence, a patient-focused form of care would require the health professional to recognise, understand and respect culture-specific behaviour which may have an influential effect on a patient's health or health care.

Overall, the primary principle of patient-focused care is to empower the people who use health care services. In effect, the empowerment of users may also involve a similar reduction in the power, status and 'expert' influence that the health professionals may exert over their patients or 'clients'. This process can be difficult for many health professionals to cope with. Patient-focused care involves more than *ad hoc* surveys of patient satisfaction or an analysis of the activities that clinicians undertake during the care process. It is a radical realignment of the health service culture to ensure that patients are no longer passive recipients of care and advice, but active informed participants who are involved to a greater extent in their care or the care of their loved ones. In essence, patient-focused care requires a radical change in the organisational culture within which nurses currently work and a regular analysis of the efficacy and efficiency of current working practices.

However, some health professionals may fear potential job losses, or feel threatened by perceptions of professional boundaries being blurred or feelings that their clinical skills are being 'diluted' or undermined. Likewise, some health professionals may feel reluctant to change their traditional ways of working and may view patient-focused care as doing additional work for little extra reward. Moreover, in terms of developing shared interdisciplinary records, health professionals may be reluctant to share information with other staff groups, even if they share a common case-load of patients. Overall, health professionals may experience significantly higher levels of stress and may require additional managerial and peer support during times of organisational change, especially the change required to effect a more patient-centred way of working.

The present study

A recent study of health professionals working in the community (Williams *et al* 1996) looked at staff and patient perceptions of the care process. The initial phase of the research also looked at the ways in which health professionals felt they had been affected by organisational change, their perceived levels of stress and their main ways of coping with stress. All of the community health workers were involved in the preliminary stage of implementing a more patient-centred way of working by changing from working in single disciplinary teams (e.g. district nurses in district nursing teams) to being in multidisciplinary teams (e.g. health visitors, chiropodists, physiotherapists, district nurses and occupational therapists in the same team).

The research focused on the effects of restructuring health services on the well-being of health care professionals by looking at employee perceptions of stress after their teams had been transformed from single-disciplinary teams into multidisciplinary care teams. It may have been desirable to have interviewed staff before the organisational change had occurred. However, owing to logistical reasons, the researchers had to adopt a retrospective research design.

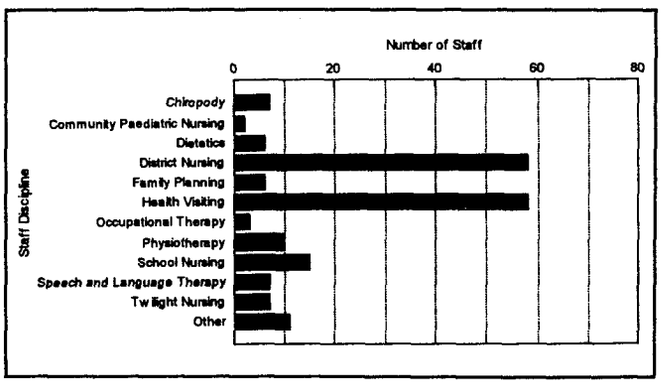
Method

Participants

A hundred and ninety-one community health professionals (177 females & 14 males) were interviewed and completed supplementary questionnaires. *Figure 1* outlines the range of staff groups who were contacted. Fifty-eight district nurses and 58 health visitors were interviewed. The views of allied health staff such as occupational therapists, physiotherapists and chiropodists were also obtained.

FIGURE 1

Participants by staff discipline



Materials

The sample of health professionals took part in a semi-structured interview and were asked about: their perceptions of patient-focused care; their overall feelings whilst at work; their relationship with patients and relations with management; and other factors such as what mainly motivated them when they were at work. The sample of health professionals were also asked about: their levels of stress; whether the stress levels had altered significantly since the organisational change; whether they had experienced any physical, emotional, cognitive, and behavioural effects from the stress; and the main strategies that they used to combat their stress.

Results

Perceptions of patient-focused care

Table 1 shows that a high proportion of the health professional sample (80%) thought that patient-focused care would need significant investment in training and

development. Over half of clinical staff sampled (57%) also felt that it could mean better use of existing staff. A lower proportion of staff voiced negative attitudes about the consequences of patient-focused care: only 16% thought it would mean 'de-skilling' of staff, and 14% thought that it would put jobs at risk. Thirty-one per cent of those sampled thought that adopting a more patient-focused practice would involve threats to professional status.

TABLE 1

Community health professional perceptions of patient-focused care

"In my opinion, patient-focused care will involve the following":	*% of staff sampled*
Some degree of staff re-training	80
Better use of existing staff	57
More time spent on patient care	40
An increase in staff workloads	39
Additional clerical support	38
Sharing each other's patients	38
More responsibility for clinicians	37
Cost-cutting measures	35
Doing other people's jobs	33
Threats to professional status	31
Additional clinical support	28
Untested changes to practice	19
'Deskilling' of staff	16
Putting our jobs at risk	14

Is current practice already patient-focused?

As *Figure 2* shows, the majority of health professionals surveyed agreed with the notion that they are already providing patient-focused care. Only 23% of the sample were neutral about whether or not they were currently practising in a patient-focused manner.

Conceptually, health professionals could move away from dichotomous perceptions of patient-focused care. Instead, a more useful analysis could involve examining patient-focused care along a continuum of care. Although a high proportion of staff felt that they were already providing a form of patient-focused care, it is important to obtain feedback from the patients themselves in order to gauge the extent to which care is patient-centred. Further details on the patient perspective of care are discussed elsewhere (Willliams 1996, Williams *et al* 1997).

Levels of stress

Figure 3 shows that, of the Community health clinical staff interviewed, almost half (49%) of them said they were either experiencing 'High' or 'Very High' levels of stress. A large proportion of the health professional sample (65%) attributed their stress levels to job-specific stressors. An Analysis of Variance (ANOVA) was conducted to examine whether there were any differences between staff groups and their reported stress levels. The analysis uncovered a significant effect for staff group on stress levels: $F(10,129)=2.11$, $p=.02$. However, a *post hoc* Tukey HSD test did not reveal significant differences between the means of any two of all staff groups studied.

FIGURE 2

Proportion of respondents who saw themselves as already providing patient-focused care

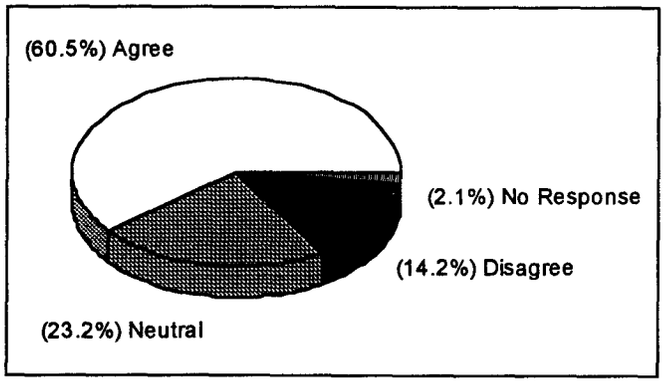
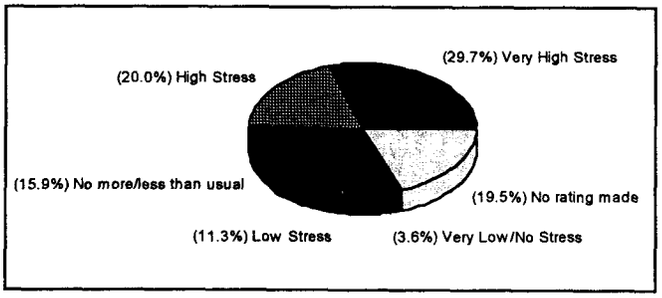


FIGURE 3

General reported levels of stress among community health professionals



Attitudes about patient-focused care and levels of work stress

Questionnaire data were also collected from staff regarding their attitudes towards introducing patient-focused care. Respondents were asked to rate on a 3-point scale whether they agreed or disagreed with 14 statements which included: "In principle, I am in favour of the idea of patient-focused care", "I am unsure about what patient-focused care is", "I don't see how patient-focused care affects me and my work", "I don't see why we need to do patient-focused care in the first place", and "Patient-focused care is just a fad". A multiple regression analysis was conducted in which each respondent's perceived level of stress was compared with their responses to the 14 attitude items about patient-focused care. There were non-significant findings for degree of stress and 13 of the items. However, the item "I don't see how patient-focused care affects me and my work" revealed a significant inverse correlation with respondent levels of stress ($r=-.2062$, $p=.017$). On a 5-point scale, 'very high stress' was rated as '1' and 'hardly any stress or no stress' was scored as a '5'. This finding means that respondents who

agreed that they did not see how patient-focused care would affect their work were more likely to report feeling 'hardly any stress or no stress'. Conversely, those staff members who felt that they had a clear idea of how patient-focused care would affect their working lives were more likely to report higher levels of stress.

Work-related stressors

During the semi-structured interview, staff were asked about whether they were experiencing any problems with their work-load or working practice. *Table 2* depicts the range of stressors that affected their work.

TABLE 2

Most commonly reported stressors among community health staff

Type of Difficulty	*% of sample*
Patient-related difficulties (e.g. hostile/aggressive patients, attempting to contact patients in their homes)	47
Staffing difficulties (e.g. covering for absence; being short-staffed)	39
Administrative work	27
Problems with the computer system	26
Time management concerns	23
Change in work-load/working practice	18

Staffing difficulties were of considerable concern among respondents. They commented on high levels of staff turnover and the additional time needed to introduce new staff to clinical and administration practices. Another staffing problem for some respondents was staff absences, either brought on by holiday or staff sickness. This trend may inflict a great deal of stress on staff, especially if they feel that they have insufficient cover and if they perceive that the staff absences may be long-term.

Administrative work was also seen as a stressor. Many staff expressed concern about the volume of paper being circulated around the Trust, much of which was not seen as important to their work. Some of the staff sampled thought they had too much unnecessary administrative work to do.

Another concern for some clinical staff was operating or accessing the computer system that they used for recording their clinical work. At times, the system could not be accessed during 'shut-down' times or was slow in operation when many other staff were using the system. The problem of access was significant for part-time staff who often had limited time to input data onto the computer.

Difficulties with patients and clients was also reported by 47% of the clinical staff sample. Some district nursing staff had problems getting into contact with patients and obtaining access into some patient homes. Some staff complained about patients who did not attend clinics at the arranged appointment times, whereas some staff sampled felt that they needed additional training to cope with aggressive or 'difficult' patients. Another recurrent problem with patients and clients was linguistic difficulties. Many staff said that they had experienced problems in communicating effectively with those clients whose first language was not English.

Staff also commented on problems in managing their time. Many clinical staff wanted to spend more time with patients and clients. Forty per cent of all staff surveyed thought that patient-focused care practice would enable them to make better use of resources available and could help them to spend more time with patients. However, 38% of staff also thought that patient-focused care may involve an increase in their work-load.

Communication difficulties or relations with others was also seen by clinicians as problematic. Some staff members wanted to improve communications or relations with any of the following groups: staff belonging to the same discipline; colleagues from other disciplines; management; patients; GPs and GP staff; and Social Services.

These stressors were seen by employees as having an adverse impact on their health. The following reported effects of stress were drawn from semi-structured interviews in which interviewees volunteered the symptoms of stress that were most meaningful to them. A content analysis was conducted on the interview data and the main themes of the reported symptoms were categorised as being either physical, cognitive, emotional (or affective), or behavioural effects.

The effects of stress

Table 3 depicts the most commonly reported perceived physical effects of stress that staff tended to experience over a six-month period. The main physical impact of stress among staff was general fatigue (39%). Staff members also reported an increase in headaches or migraines from feeling stressed. It is notable that this health professional sample tended to express their stress in somatic, rather than psychological or behavioural, terms. This finding could be owing to the undergraduate training of many of these experienced health professionals, who were taught to mainly view health, and the health of others, in terms of physical symptomatology.

TABLE 3

Physical effects of stress among community health professionals

Symptom	*% of sample*
Feeling tired	39
Headaches	12
Sleeplessness	8
General sickness	7
Tenseness	7
Lethargy	4
Other physical symptoms	4
Exhaustion	3

Some health professionals said that they felt exhausted, lethargic, and physically tense. Some of them also complained of sleeping difficulties. Given the physically demanding nature of the work that the health care employees regularly carried out, it is unsurprising that almost half (49%) of those sampled felt overworked and over a third of them (36%) felt tired.

In contrast to the high percentage of reported physical symptoms, relatively lower levels of cognitive, affective, or behavioural symptoms were exhibited. Some of the primary cognitive effects of stress included: repeated self-doubting or self-critical thoughts (only 7% of the sample); an uncomfortable preoccupation with the source of their stress (5%); and poor concentration (3%). The main types of emotional effects of stress that health professionals experienced whilst at work included regular feelings of anger or irritability (14% of the sample). Staff who were under high levels of stress also complained of feelings of loneliness, boredom, bewilderment, and feelings of being emotionally drained and numb.

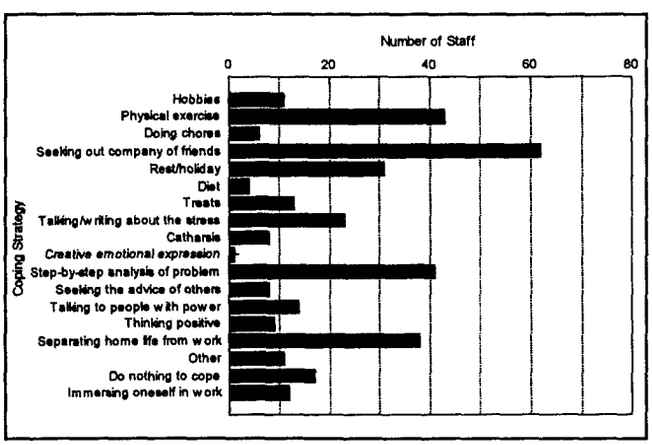
In terms of behavioural symptoms, 10% of all respondents admitted that they had to take time off work because of the severe levels of stress that they were experiencing. Only 5% of staff said that they had lost interest in their work and that they would like to leave their job. Also, only 5% of the sample said that had begun to take neglect their physical hygiene and appearance because of their preoccupation with their source of stress. Some staff members (3%) also felt concerned about the increasing amounts of work that they had taken on, since the organisational change.

Coping strategies of health professionals

As *Figure 4* shows, the main way that health professionals attempted to cope with stress was to seek out the company of friends or colleagues with whom they can discuss the situations that are causing stress and explore possible solutions.

FIGURE 4

Main coping strategies used to combat stress



Another popular active behavioural strategy used by staff respondents was to write down the main sources of stress, to analyse the problem in more detail and then decide on a solution to the problem. In addition, 22% of the health professional sample also adopted other active strategies such as physical exercise.

However, a relatively effective coping mechanism for health care workers would be to attempt to separate work considerations from home life. Respondents also said that they usually adopted a range of other strategies to distract their attention away from their work stress. These included: taking a vacation or a break away from the workplace; hobbies; and treats such as aromatherapy or going out to restaurants.

An area for concern is the minority of staff members who replied that they did not have any outlet for their stress and that they did not feel that they were doing anything constructive to cope with their stress. These individuals were experiencing high levels of stress after events such as a change in management, a change in working conditions or working practice. Their reactions ranged from tearfulness and sleeplessness to avoiding work itself and procrastination. This type of reaction mirrors the 'Chaos' phase outlined by Perlman and Takacs (1990) in which there is diffused energy, feelings of powerlessness and insecurity, a sense of disorientation, a loss of identity and direction. In this phase, employees need emotional support and time to re-establish their identity at work.

Discussion

This study has found that health professionals, at least those who work in the community, primarily tend to view the symptoms of their stress experiences in somatic terms. This finding has implications for interventions aimed at enabling community health staff to cope with their stress. By focusing mainly on the physiological effects of stress with interventions such as relaxation therapy or biofeedback techniques, the health professional could be neglecting the multi-dimensional nature of their stress and its effects on their well-being. Employee assistance programmes in the NHS need to be comprehensive in focusing on *all* aspects of a staff member's experiences of stress. The types of programme that have been offered so far "such as counselling, stress awareness sessions, and relaxation classes [tend to] address the symptoms of stress, and not its causes" (Cole 1996).

Although the main coping strategy employed by many respondents was to seek out the company of friends, colleagues or family, it is worrying that some respondents did nothing to cope with their stress. In addition, some health professionals used diversions such as exercise, hobbies, or by taking a holiday. However, such an approach may not be entirely satisfactory considering that the health professionals' job stressors are not being targeted and resolved. An alternative approach by some health professionals has been to conduct a step-by-step analysis of the main stressors that impinge on their job satisfaction. However, some of the causes of stress among health service staff could be deeply rooted and may require assessment by an independent researcher.

Although the research found a significant effect for perceived stress levels and staff group, no one discipline differed significantly from any other staff group. This trend

suggests that, although many health professionals may think that their stress is unique to their own discipline, there may be scope for investigation into stressors that are common to all health professionals. These common stressors could be uncovered by using a generic instrument, such as the Job Stress Survey (Spielberger & Reheiser 1994) rather than a more specific tool such as the Nurse Stress Index (Harris, Hingley, & Cooper 1988). It should be noted that use of a research instrument tailored solely to one, or several, professional groups could in fact limit the comparability of findings obtained, particularly if respondents belong to a variety of staff groups working in a *multidisciplinary* team.

Further research could examine inter-professional or intra-professional differences in terms of stressor frequency and stressor severity, and could evaluate the effectiveness of the coping strategies that they use. In this way, health professionals and managers will be better equipped to effect the most appropriate interventions to combat work-related stress among *all* levels of health service staff.

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