

# **Integrating patient-centered care and evidence-based practices: What is the prognosis for healthcare?**

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Healthcare is a complex enterprise in practice and in theory. Some view it as a scientific endeavor while others see it as a service to individuals bounded in unique context (Sackett & Strauss, 1998). As it is a necessary system within our society, changes have been difficult to implement because of the interests of powerful organizations. However, for the past several decades, patient satisfaction has increasingly been recognized as an issue. Patient satisfaction has become a key quality indicator used by many hospitals (Walker, 2006) in an attempt to appear more patient-centered.

Much research has been conducted regarding possible determinants of patient satisfaction (Bauman, Fardy, & Harris, 2003; Epstein et al., 2005; Fleming & Cullum, 1997; Ford, Schofield, & Hope, 2002, 2003; Gertels, Edgman-Levitah, Daley, & Debanco, 1993; Haes, 2006; Hardy & West, 1994; Holman & Lorig, 2000; Michie, Miles, & Weinman, 2003; Shields, Pratt, & Hunter, 2006; Stewart et al., 1995; Wagner et al., 2005; Walker, 2006), either directly or indirectly, but results are inconsistent. One reason may be the lack of a standardized tool. Another may be the variety of disciplines and perspectives with which researchers are approaching the topic. Research of patient satisfaction requires both examination of context and explicitly defined and measurable concepts. Thus far, synthesis of these aspects of patient satisfaction research has been difficult due to little available evidence which uses the same measures. However, patient dissatisfaction with healthcare has led to increased promotion and adoption of patient-centered care.

The concept of patient-centered care has been around since the 1950s (Lewin, Skea, Entlistle, Zwarenstein, & Dick, 2001), but practitioners and researchers are still debating what it means and how it can be measured. Some describe patient/family-centered care (P/FCC) based on the effect of the patient, family, and healthcare providers (Shields et al., 2006; Stewart, 2001;

Stewart et al., 2000; Stewart et al., 1995), its various elements or principles (Bauman et al., 2003; Johnson, 1990; Michie et al., 2003; Shelton, Jepson, & Johnson, 1987; Sidani, Epstein, & Miranda, 2006), and by the processes involved (Bauman et al., 2003). The ambiguity with which the terms are used in both practice and research amplifies the difficult task of operationalizing and measuring the concept.

While there is much debate over the specifics, there are some areas of agreement. The focus of patient/family-centered care is to promote increased participation of the patient and family in the provision of healthcare. The degree to which this is done and how it can be accomplished form much of the debate. Many agree that providers need to recognize the preferences, values, knowledge, and abilities of the patient (Bauman et al., 2003; Lewin et al., 2001; Michie et al., 2003; Shields et al., 2006; Sidani et al., 2006; Stewart, 2001; Stewart et al., 2000; Stewart et al., 1995). Some recognize that the preference of the patient may lie along a participation spectrum (Haes, 2006; Lewin et al., 2001; Michie et al., 2003; Sidani et al., 2006), ranging from a traditional, doctor-centered relationship, to being informed but not actively involved in decision making, to collaborating with their providers in a patient-centered relationship. However, patient preference is not the only determinant of participation in decision-making.

The comprehensive review and meta-analysis conducted by Lewin et al. (2001) indicated that shared decision making may not be appropriate in all situations. The evidence suggests that shared decision-making is likely most appropriate when the patient does not view it as an added burden, possible in serious or potentially terminal conditions where “death anxiety” (Haes, 2006) may be a factor. Additionally, situations with equipoise, or treatment options that have different but equally acceptable outcomes, are optimal for collaborative decision-making between patient

and provider ([Haes, 2006](#)). Informing, communicating with, and empowering the patient/family along with developing “common ground” are the core of P/FCC. The extent to which this is possible given the complexities of the healthcare system and the ways in which it should be pursued cannot be further clarified until the concept of P/FCC is operationalized.

Despite the lack of agreement across studies, one is notable for its broad reach across patients, families, and healthcare providers. Gertels et al. (1993) examined more than 8,000 patients, families, physicians, and hospital staff to explore those things most important to patients by addressing four questions:

- 1) What do patients want?
- 2) What do patients value?
- 3) What helps or hinders their abilities to manage their health problems?
- 4) What aspects of care are most important to them and their families?

The results identified eight dimensions for patient-centered care to address: respect for patients’ values, preferences, and expressed needs; coordination and integration of care; information, communication, and education; physical comfort; emotional support; involvement of family and friends; transition and continuity of care; and access to care (Gertels et al., 1993). Walker (2006) suggested the key characteristics for a patient-centered healthcare environment are open communication, a no secrets environment, a sense of ownership, and no excuses allowed. However the elements of a patient-centered culture are described, arguments for greater patient involvement of patients in the provision of healthcare can be categorized into two domains: sociopolitical and clinical decision-making. Sociopolitical arguments are based on the view that doctors control communication and the patient-physician relationship, while clinical decision

making arguments pose that doctor-centered and controlled communication and decision making ignores the knowledge, preferences, abilities, and experiences of patients (Wagner et al., 2005).

Much of the P/FCC literature defines the concept as in complete opposition to that of evidence-based medicine (EBM) or evidence-based practices (EBP). Only recently have researchers become interested in the marriage of these styles of care. Practitioners need to consider the individuality of their patients in conjunction with clear methods and standards by which they can evaluate and apply research evidence. One benefit that P/FCC could offer to the practice of EBM is the broadening and loosening of the evidence pyramid, which celebrates most highly randomized-controlled trials (RCTs) and blatantly ignores qualitative evidence (Tickle-Degnen & Bedell, 2003) which may more address important patient characteristics, preferences, and values. As Bensing (2000) states so well, patient groups that seem homogeneous using public health criteria may be quite heterogeneous when considering individual characteristics. It is in addressing the needs, values, and preferences of the individual patient that P/FCC can balance the weaknesses of EBM.

Evidence-based medicine is still evolving. Despite its long history, practitioner and researcher are continuing to change the way they operationalize and implement it, as demonstrated below by three descriptions.

*“the conscientious, explicit and judicious use of current best evidence about the care of individual patients. The practice of evidence-based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research.” (Sackett, Rosenberg, Gray, Haynes, & Richardson, 1996)*

*“evidence-based health care involves using a combination of clinical expertise and the best available research evidence, together with patient preferences, to inform decision-making” (Fleming & Cullum, 1997)*

*“evidence-based medicine calls for the integration of our clinical expertise with the best available external evidence and patients’ values by translating our need for information into an answerable question and then tracking down the best information with which to answer the question” (Sackett & Strauss, 1998)*

EBM is actually implemented in a variety of ways, including clinical guidelines, protocols, and best practices, which may or may not be based on evidence. Sackett (Hasnain-Wynia, 2006) believes that EBM can promote patient-centered care by more explicitly stating the risks and benefits of acceptable treatment options. In contrast, it can be viewed as intrinsically biased in the direction of researchers and practitioners and towards research designs that fail to consider the context of the patient and family (i.e., RCTs) (Bensing, 2000; Ford et al., 2002; Sackett & Strauss, 1998; Tickle-Degnen & Bedell, 2003). In everyday practice, clinicians need more information than RCTs can offer (causality and probability), such as pattern and possibility (Tickle-Degnen & Bedell, 2003). Furthermore, the stringent exclusion criteria of many RCTs prevent patients with many issues dealt with by practitioners from participating in research (Bensing, 2000; Ford et al., 2002); thus, the outcomes of such research is applicable to a very small proportion of patients seen by the average practitioner.

The strengths of evidence-based medicine are that it does address practitioners' needs for high quality evidence regarding intervention efficacy and fosters the development of standardized methods of care. To the table of healthcare, EBM brings rigorousness and application of the scientific method while P/FCC offers a humane consideration of the reality of dealing with illness and daily life so that the patient is acknowledged as an active participant in their own healthcare.

Combining these approaches is no easy task, particularly given the ambiguity and conflicting evidence present in the research base for both. Factor in the political and financial interests, and the task seems nearly impossible. However, some researchers have bravely offered up their solutions for criticism and revision. Epstein (2005) describes one aspect of the solution as "rather than the number and type of a specific set of behaviors, responsiveness and informed

flexibility should be considered fundamental qualities of patient-centered communication.” Sidani et al. (2006) describes the best available evidence as “represents the synthesis of knowledge related to interventions...from various sources, such as: research, chart review, quality improvement projects, standards of care, and clinical experience.” However, this evidence is still heavily weighted towards information arising from researchers and practitioners. Many other clarifications and modifications unite aspects of EBM and P/FCC, but due to space constraints, they are not all described.

Two approaches more thoroughly integrate EBM and P/FCC. The first is the chronic care model (CCM) proposed by Wagner et al. (2005). The CCM takes a systems perspective and describes four areas of development that should exist within the healthcare system: self-management support, delivery system design, decision support, and clinical information systems. This model incorporates not only the patient and physician, but also the family, the practice team, and the healthcare organization. Of course, one difficulty in implementing this type of system would be measuring patient-centeredness across the system.

The second strategy describes the operationalization of the integrated patient-centered evidence-based approach, composed of three phases (Sidani et al., 2006). Phase I focuses on the synthesis of evidence, identifying the name, components, and associated activities. Evidence from the literature and practice setting are combined to better understand the applicability of the intervention in the specific situation and setting. Phase II is concerned with generation of an intervention description. Patients are informed of treatment options during this phase. Phase III represents the consultation with patients to draw out their preferences. This step should be characterized by shared decision making. Evidence-based patient choice (EBPC), first described by Hope (1996), is a similar approach to integration.

Despite the multitude of ideas, there are significant obstacles to be overcome. The challenge of integrating different types of information, such as empirical research, patient-physician interview, patient abilities and experiences, physician expertise, and patient values and preferences, is not an easy task. Furthermore, the complexity in addressing the individuality of patient characteristics and provider characteristics with possible conditions and complications within the natural setting is staggering. Nevertheless, the development of a system-wide culture to assist patients and providers in identifying important issues would greatly enhance the feasibility of practicing patient-centered evidence-based healthcare. As Wagner (2005) stated so succinctly, quality is a feature of systems, not people.

One thing does seem clear; while not all patients want to be actively involved in the provision of their healthcare, they do want the opportunity (Ford et al., 2002). Regardless of preferences, patient knowledge and literacy remains a barrier for some who might like to become more involved, but are not adequately equipped. If a physician or organization is going to promote patient-centered evidence-based care, they must be equipped also to inform and educate a wide range of patients. The burden this may place upon staff, resources, and finances remains unclear.

In the end, patient-centered evidence-based care may essentially be about the balance between individualization and standardization of healthcare. Of course, all of this research and debate is done with the noble goal of improving healthcare. Unfortunately, the relationships between patient satisfaction, implementation of P/FCC and EBM, and health outcomes remain unclear. Much more research is needed to understand the theoretical and practical links between these approaches to healthcare and their impact upon patient outcomes. If in fact, they do not



appear to affect patient outcomes, they should be discarded for new ideas with the potential to improve such outcomes.

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