

## Patient centred care in interprofessional collaborative practice

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The aim of this study is to describe key-elements of patient-centred care and its relationship with interprofessional collaborative practice in Primary Health Care, in the context of Unified Health System. Based on national and international review. The outcomes show that as professionals shift their focus towards patient centred care and patient's needs, their scope of view is broadened beyond the limits of their own professional activities. This shift is an enabler for changes in the current health care model towards comprehensive care and potentially impacting the quality of services.

*Keywords:* Patient-centred care. Primary Health Care. Interprofessional relations.

## Introduction

The present study analyzes patient-centered care (PCC) in interprofessional collaborative practice (ICP) following two leads: the first is a consequence of the emphasis of the health policies and of the research centers that are devoted to ICP<sup>1-4</sup> in PCC, highlighting its essential role in interprofessional collaboration. The current literature is also in agreement in considering the PCC as a key element in teamwork and ICP<sup>5</sup>.

The second lead for this study comes from the fact that in spite of the agreement in the literature seeing the PCC as a competency domain of the ICP<sup>1,6</sup> and the existence of successful empirical outcomes related to PCC<sup>7,8</sup>, there is a lack of a consensual definition for PCC, hampering its implementation<sup>9</sup> and hindering the dialogue between national and international literature. This dialogue is central to understand how international contributions on PCC may be comparable to the user-centered approaches present in Brazilian literature.

The academic publications on the issue represent PCC as a central domain for interprofessional collaboration and a core element in teamwork and ICP<sup>5</sup>. A PCC-oriented team is an indicator for differentiating three increasing levels of collaboration<sup>5</sup> (potential collaboration, collaboration in development, active collaboration and in this classification the denomination of a group as a “team” is restricted to those presenting “active collaboration”, that guide their actions with the patients and their health needs in focus.

Analyzing the key elements of PCC and their linkages with ICP will open the way for more in-depth studies and interventions conducive to teamwork strengthening and ICP centered in the patient, thus impacting the quality of healthcare.

### **Objective**

The purpose of the present article is to describe the key elements of PCC and their linkages with ICP in Primary Health Care (PHC) within the context of the Brazilian National Health System (SUS in the Portuguese acronym).

### **Methods**

To identify the Brazilian contributions on this subject, a review was performed in BDNF, LILACS and SciELO, using as descriptor the Portuguese equivalent of “patient centered care” e.g. “*assistência centrada no paciente*” without timeline delimiters. The search was performed from September 2013 to February 2014, using as criteria: Studies dealing with PCC as main subject and freely available in full-text versions, excluding thesis, dissertations and books. From the search, a total of 14 articles were selected, adding later four more that came as references in the articles found in the search engines and that were previously known to the researchers<sup>10-14</sup>.

The international literature search was performed in Medline, Scopus and CINAHL in the same period of time, using as descriptors “client centered care OR client centred

care OR person centered care OR person centred care OR patient centered care OR patient centred care". For the selection, the same criteria used for the Brazilian literature was employed. In this case the search turned out more than 24.000 articles. Due to the shocking asymmetry between Brazilian and international literature results, resulting of a paucity of national production on the subject, compared with the copious literature resulting from the use of the international descriptors, a choice was made to limit the international analysis to four literature review articles dealing with evaluation, outcomes and core elements of PCC<sup>15-18</sup>.

### **National contributions on PCC**

The main findings were the scarcity of national literature directly referring to PCC and the fact that most of the selected articles came from the Nursing sciences area. These studies focused on PCC in connection with the following aspects: 1) Enlarged healthcare perspective, 2) Patients' participation in care and 3) Humane care. In regard to the Enlargement of the healthcare perspective there is a cluster of contributions on holistic care<sup>13,19-26</sup>, comprehensive care<sup>13,20,24-28</sup> and health needs oriented care<sup>13,19,21,22,24,25,28,29</sup>. In the Patients' participation perspective the contributions cluster around the concepts autonomy<sup>21,24-26,30</sup>, self-care<sup>12,19,21,22,29,31</sup>, valuing experience<sup>20,23</sup> and patients' participation<sup>13,21,28,32</sup>.

Patients' participation in care is defined as an opportunity for the exercise of citizens' rights in the quest for autonomy (related to ideas of freedom, leading role,

respect for subjectivity<sup>33</sup> as an important condition for self-care<sup>19,20,33</sup>. The concept of self-care is understood as a way of managing the healthcare process, implying the collaboration of the health team and the users and not a merely prescriptive activity<sup>34,35</sup>.

The findings in the literature relate PCC with Humane care, mostly in the relational realm, of interactions between practitioners and patients. The need to improve the relationship patient-provider was cited as a basic condition to PCC<sup>19,21,24,25,30</sup>, both in the sense of valuing the human condition<sup>19,24</sup>, in the improvement of quality of care<sup>22,24,25,28,30,31</sup> or for therapeutic success<sup>26</sup>. Several values are underlined as crucial for PCC: empathy, respect, solidarity<sup>30</sup>, listening, psychosocial support<sup>27</sup>, sensitivity, affection, dialogue in healthcare<sup>25</sup>, receptivity and rapport<sup>20,24</sup>.

The three topics that were identified in the Brazilian specialized literature about PCC, i.e. Enlargement of the healthcare perspective, Patients' participation in their care and Humane care, are also expression of current proposals in the Brazilian health policies. In the national health policy context, there are several approaches that may be part of the PCC concept, according to the literature. Some of them are the user-centered work process<sup>11</sup>, the person-centered clinical method centered/ patient-centered medicine<sup>36</sup>, comprehensive care<sup>13</sup>, Expanded Clinical Approach (ECA)<sup>37</sup> and the National Policy for Humane Care (NPHC), all of them based on the principle of comprehensive care<sup>38,39</sup>.

The ECA is a part of the NPHC and has the aim of enlarging the focus of clinical work, involving the patients' subjectivity. It is also an approach that aims to include not only curative, but also prevention, rehabilitation and palliative care in the clinical activities as a contribution to the autonomy of users.

The ECA is centered in the comprehensiveness of care under the postulate of the active influence of each individual in his/her own process of illness and health, including the social determination of this process<sup>39</sup>. Comprehensiveness may be conceptualized as a principle in a quest for a PCC, as it is a critique to the fragmentation of actions that patients receive, and it proposes an array of practices that look beyond the biological limits, beyond the procedure-centered intervention and oblivious of the insertion of the individual in a collective environment<sup>40</sup>. Patient-centered care is therefore to see the patient as a singular individual inside a collective entity, that interact in their individual and collective dimensions as can be also conceptualized in comprehensive care.

Comprehensiveness is one of the principles of the Brazilian National Health System, reflecting one of the ideals that were defended by the Sanitary Movement <sup>41</sup> and since then it has oriented the direction of the practices of the SUS. We understand the Comprehensiveness principle as a polysemic term<sup>12,13</sup> encompassing: a response to needs beyond morphology and functionality of the body; integration of promotion, prevention and treatment; interdisciplinary, intersectoral and interprofessional synergy to improve outcomes in healthcare and the quest for quality interactions and dialogues among stakeholders in the process of care<sup>14</sup>.

### **International contributions regarding PCC**

In spite of a growing popularity, the term Patient-centered care has not a unanimous definition or consensus in its key elements.

The international papers describe PCC as linked to three concepts: 1) An expanded view of illness; 2) Patients' participation in care and 3) Provider-patient relationship.

The expanded view of illness can be studied through the contributions of Stewart et al.<sup>42</sup>, a well-known textbook detailing the principles of patient-centered medicine that embraces the social and psychological factors in the understanding of a disease<sup>15</sup>. The bio-psychosocial model is seen as a key element of the PCC<sup>16</sup> even if this model should be enlarged to understand the singular perspective of each patient<sup>16</sup> and the need of perceiving care as a whole<sup>17,42</sup>.

On Patients' participation in their care, there is an emphasis on the centrality of the doctor-patient involvement<sup>18,43</sup> through the sharing of information<sup>15</sup>, objectives, power and responsibilities<sup>18</sup>. Involving patients as partners-in-care is considered the cornerstone of PCC. It includes the understanding by the patients of their own situation<sup>16,17,44</sup> and the participation in the decision-making process<sup>17,44</sup>, reverting the paternalistic relationship between providers and patients as described by Parsons<sup>45</sup>. In this sense, shared decision-making can be considered one of the techniques of PCC, to be used in the path of consensual relations between practitioners and patients<sup>17</sup>.

The international literature looks at the provider-patient relationship as a core component of the conceptual model of PCC<sup>15</sup> due mainly to the need of acknowledging the subjectivity of both physicians and patients and the need of building a therapeutic coalition<sup>15,17,18</sup>. In the professional-patient interaction, a few key elements are cited in describing PCC<sup>15-18,42,43</sup>, such as respect for patients' choices and effective communication. Worth of mention are the need of open communication about the

professional and patient's expertise, creating an interchange of information and knowledge<sup>46</sup>. Kitson et al.<sup>43</sup> in a review of Nursing and health public policy publications agree with other authors that highlight the importance of the relation patient–practitioner, analyzing under an interprofessional lens a wider scope of professionals other than the physicians.

Adding to the four selected reviews, there are other publications on the subject that use PCC as a global example to be considered<sup>47</sup> as a consequence of the limitations of the conventional biomedical model.

Countries such as the USA and the UK have in place policies geared to the implementation of PCC. In the USA studies, PCC is discussed as part of the debate for reforming healthcare, under the name of Patient–centered Medical Home (PCMH)<sup>48</sup>, defined as a desirable model of care reform that stresses the importance of PHC and PCC. In the UK, PCC was considered as a basic ingredient to give high quality medical care and lower the rate of medical errors<sup>16,49</sup>. PCC is also highlighted as a ICP attribute linked to patient's safety and quality of care<sup>50–52</sup>.

### **Core components of PCC and ICP**

In the Brazilian context of the SUS, with its principles and guidelines, tending to comprehensive care, social participation, teamwork, the analysis of the core components of PCC that appear in the Brazilian literature may be synthetized as follows: the enlarged perspective of illness, that is present in the international literature, is widened to include



an expanded approach to healthcare; power and responsibility are shared between practitioners and patients, leading to the participation of users in the decision-making process of their own care, as well as the social participation and control of the population in planning and managing the healthcare network. This synthesis also includes the practitioners-patients relationship regarding communication and interaction with the background of the complexity of health needs and the network structure of the services affecting also the interprofessional interactions.

The national and international literature about the attributes of PCC points to a consensus around three core elements: 1) enlarged approach to care<sup>16-18,28-30,53</sup> as an answer to the need of acknowledging and responding in holistic way to users, families and communities' demands; 2) Patients' participation in their care<sup>27,42,43</sup> and the need of empowering and support for self care and autonomy<sup>15,19,21,22,24-27, 30,34,42,43</sup> and 3) Patient-provider relationship<sup>13,14,18-20,24,25,30,42,43</sup> integrating the subjectivity of the parties, as autonomous subjects.

Those core components give room for an analysis of the links between PCC and ICP that show their reciprocal relations, as evidenced in the literature<sup>1,6</sup>.

### **Enlarged approach to healthcare**

This core element of PCC implies a response to patients' needs escaping from the reductionism of the pathological and physiological dimensions. Healthcare should seek to integrate actions in the areas of promotion, prevention, cure, and rehabilitation,

articulating and respecting the interprofessional, interdisciplinary and intersectoral lenses within the health network. There are differences between the Brazilian and international literature on this regard, as the latter speaks more to the comprehensive bio-psychosocial perspective, while the Brazilian sources shows the process of expanding the bio-psychosocial view from the beginning of the SUS debates, based in the historical-social practices framework<sup>54</sup> and integrating the social determinants of the health-illness process<sup>10</sup>.

The Enlarged approach to healthcare is linked to professional activities and concepts of health that acknowledge the need for a varied range of professionals, that attend to the multiple dimensions of health needs in users, families and communities. The complexity of health needs and healthcare organizations points to the substitution of the isolated, independent professional by the teamwork and professional collaboration and ICP<sup>1,6</sup>.

The analyzed literature shows imprecisions in terminology and lack of agreement regarding similarities and differences between teamwork and interprofessional collaboration. Several authors suggest that ICP may be used as a more wide-ranging term, encompassing the other: the ICP referred to the interprofessional collaboration as it is effectively implemented in practice settings, while teamwork is seen as a deeper level of integrated and interdependent work<sup>55</sup>. The ICP is interpreted as a shift from the “uni/multiprofessional” to the “interprofessional”<sup>55</sup>, and from cooperation (joint work structured around labor division and common goals) to collaboration, involving the setting

and seeking to achieve a single objective<sup>55</sup> for the mutual benefit of users and practitioners.

The paucity of empirical national studies about interprofessional collaboration and ICP is an additional obstacle in the understanding the links between teamwork and ICP issues. At the present moment we can observe that the effective teamwork characteristics (interaction, synergy, interdependence, reflexivity and common goals)<sup>56,57</sup> if limited to the team context, do not allow to deal with the growing complexity of care in the Enlarged care approach, as this perspective leads to the care network and the communicative practice.

The communicative practice, defined by seeking agreements, is a cornerstone for the interchange of arguments during teamwork in order to build a common project adequate to patients' needs<sup>57</sup>. This means that in the context of ICP and PCC, there is a need for a larger communicative practice, beyond the team itself, comprising also other teams and services.

In this sense, the communicative practice in healthcare integrates the perspective of users, families and communities' participation in building the aforementioned common project that is responsive to health needs and social participation.

### **Patients' participation in care and social participation**

Patients' participation and social participation in healthcare acknowledges the singularities of the patient as a unique human being, with moral competency, self-

conscious and a participant in care<sup>16</sup>. Social participation is seen as the relationship between the civil society and the State and is channeled through the Managing Councils and the Health Conferences within the structure of the SUS<sup>58</sup> and expands the ideas of shared decision-making to the managerial spheres of the health system.

PCC is emphatic in pointing to the need of fostering the users' participation and their families in healthcare decisions, as well as the social participation in the collective level, as a follow-up of the planning, decision and execution processes in health.

Findings in the literature regarding patients involvement confirm in Brazil the principles and guidelines of the National Policy for Primary Health Care<sup>59</sup> promoting the users' participation as a way to expand the capabilities of individuals and groups in dealing with the health determinants and conditions<sup>59</sup>.

On the other end of these conceptions referring to patients, families and communities' participation, there is still prevalent the clinical exercise under the Biomedicine hegemonic power<sup>60</sup>, the asymmetric relations among the professions and between practitioners and patients<sup>5,61</sup>.

PCC presumes the willingness of patients in being a part of the care team, as responsible for their own care. This type of care demands that information, reflection and investments need to be in the right place if the delegation of decision-making to patients is to become reality<sup>52</sup>.

### **Patient-practitioner and interprofessional relationships**

This component of PCC has to do with the interactions with users, families and communities as well as the interactions among professionals. This interplay between practitioners and users is key for the success (or failure) of the therapeutic behaviors. Rapport and trust are basic conditions that may potentially impact both quality and costs of health care.

The analysis of the patient–practitioner relationship shows the power ties that were enunciated by Foucault. This author examines the knowledge–power links, as the physician uses the knowledge as a way to control the “body” of the patient<sup>61</sup>. As a way to disperse the physicians’ power in contemporary societies, Foucault proposes to turn the citizens’ attention of authority to themselves and their behavior control<sup>62</sup>. Empowering citizens is tantamount to give them knowledge of their bodies and pathological conditions, to be able to make decisions in what may be understood as a citizens action<sup>63</sup>, in which patients in their right to advocate in their own behalf, at the same time become responsible for keeping themselves healthy<sup>52</sup>.

Fox and Reeves<sup>52</sup> examine the extension of the medical power to a range of professionals and patients/families and communities. The authors argue that social class, age and level of education are some of the factors influencing the patients’ capacity to search for information, raising concerns for a possible bias in favor of the more well–off in the society. In this view the underprivileged groups, in their intents to understand better about their health issues may be negatively burdened or reprimanded by the health professionals. Therefore, the degree of involvement and participation of patients in their care is linked to the extension to which they feel comfortable to question authority and

also to the quality of the rapport, in turn immersed in the sphere of interactions and communication among patients and practitioners. The interactions and communication level is also decisive in the interprofessional collaboration.

An additional issue resides in the fact that even though ICP and PCC acknowledge the importance of the different professions, the physicians are considered the “main providers of access of the patients to the other professionals and health services”<sup>52</sup> (p. 116). In the Brazilian PHC structure, doctors are the main responsible for prescriptions, request for tests and procedures and referrals to other professionals. This asymmetry in scope of professional practice is also mirrored in the salary scales differences between health professionals. Therefore there are reasons to propose that the shift to ICP and PCC should be supported with a genuine sharing of care among professions, co-responsibility of all the practitioners and the enlargement of the scopes of practice of non-medical professions. This shift is already in progress due to the complexity of health needs and services, and call for changes in the conventional power structures, including legal, political and economic aspects<sup>52</sup>.

### **Relations between PCC and ICP**

ICP and PCC are treated as different topics in the literature, or alternatively considering PCC as a subordinate theme of the ICP. The Canadian literature describes the interplay between the two topics and defines the Patient-centered ICP as continued interaction between two or more professionals or disciplines, organized around a common

effort to solve or explore a common issue, and including the patients' participation to its maximum extension<sup>64</sup>.

The Canadian authors D'Amour et al.<sup>5</sup>, and Orchard et al.<sup>1</sup> contributed to analyze the collaboration within the interprofessional practices in health. D'Amour et al.<sup>5</sup> shows how the collaboration rests in the premise of the willingness of the professionals to work together to improve healthcare, but they still have their own interests and they wish to keep their autonomy at work. The author explains that interprofessional collaboration allows through trade-offs and participation, to agree upon common objectives for the team, focused in answering to the health needs of the users.

Orchard et al.<sup>1</sup> state that the multiprofessional practice is still prevalent and in that practice every practitioner evaluate and plan their own treatment in an independent fashion and therefore the ICP is a challenge and change that must be faced by the different professions in a partnership with users. According to Orchard, this change is based in a set of attributes of the collaboration itself such as: participation, shared planning and decision-making, coordination and power-sharing, and above all partnership and participation with users.

In this aspect, ICP is built in the exercise of dialogue among professionals and users, families and communities, and includes the participation of all stakeholders in the decision process in healthcare, progressing towards more symmetric relationships.

As practitioners focus in the users and their needs throughout the work process, building the PCC in practice, they make a shift in their own focus towards an enlarged landscape beyond their own professional activity, up to that moment restricted to their

scopes or specialties. This shift is now directed towards the shared practice with professionals of other areas.

The change in focus from professions and services towards a focus in the patients and their health needs, thus moving towards PCC, is seen as a constituent of the transformation in the service model that may potentially improve the quality of care and at the same time to give rationality to the costs of the health system <sup>49</sup>. Literature shows that PCC generates good clinical outcomes, in costs and efficacy. Patients with chronic conditions (diabetes<sup>65,66</sup> cardiac diseases<sup>67,68</sup>, and dementia<sup>69</sup>), PCC influenced positively both the biological indicators (glycated hemoglobin, triglycerides and HDL) and other indicators such as hospital length of stay and institutionalization<sup>67,68,70</sup>.

System quality and costs are globally under pressure by the growth of technological incorporation and excessive and sometimes not adequate use of professional specialties, even though there are indicators showing that quality, costs and specially outcomes may be improved through ICP. The studies show the impact of interprofessional collaboration in the reduction of absenteeism, in the improvements in satisfaction at work, in patient safety and the quality of care<sup>71-74</sup>.

### **Final considerations**

On the one hand, the analysis of the Brazilian and international production allowed to the identification of three core elements of the PCC that crosscut the different professional groups in the context of public policies in health: the enlarged approach to care, patients'



and social participation in healthcare, and interprofessional and patient-provider relationships. On the other hand, those same key elements are present in the process of organizing the health services and the network for that purpose, through the teamwork modality and interprofessional practice, showing the reciprocal relationship of mutual influences between PCC and interprofessional practice.

To conclude, the changes in the context of the ICP will happen if the health practices are effectively shifted towards the users and their health needs in a comprehensive way, meaning that the daily work routines of the different professionals is organized in a collaborative fashion forging partnerships with users, their families and their communities.

#### **Collaborators**

Heloise Fernandes Agreli participated in the literature review, data analysis, discussion, writing and revision of the article. Marina Peduzzi participated in the analysis, discussion, writing and revision of the article. Charantola Mariana Silva participated in the discussion and revision of the article.

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