

273: Consumers, interns, and senior clinicians on barriers to consumer participation in hospitals: Implications for medical education and structural change

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Objective:

To understand and explore the barriers to consumer participation in hospital based services and to outline the implications for education, structural, and system changes.

Methods:

An exhaustive literature review on the determinants of doctor-patient communication led to a framework for considering barriers and enablers for consumer participation in decision-making in public hospitals in Australia. Using that framework, structured interviews were held with 123 young doctors in their first two intern years, and 30 experienced clinicians. We obtained input from 250 consumers and advocates through interviews and questionnaires about their recent hospital experiences. Two researchers independently completed a content analysis of each group's responses, and compared these ratings. The principal researcher then performed a content analysis by carefully re-reading all the answers from each group to find themes or categories of comments, and assigned key words to emergent themes and sorted them. If the themes accounted for all the responses, the classification was accepted as the most parsimonious interpretation of the data, and drew conclusions from those identified themes. Themes from each group were compared and implications were drawn for future research, medical education and structural issues.

Results:

Trainee doctors, experienced clinicians, and consumers cite many of the same barriers to consumer participation in hospitals. All groups relayed that key enablers of participation were communication skills and the capacity to understand the nature and importance of the doctor-patient relationship to information seeking, collaboration in decisions, and clinical outcomes. Among the key inhibitors were medico-legal concerns, how consent was taken and by whom, the pressure of time, social and professional distances between doctors and patients, and poor patient literacy and health literacy. Experienced clinicians, however, cited structural and financial practices and policies, as more potent than micro-interpersonal or relationship issues. The process of training and the experience of the early years in the hospital system affected the outlook and mental health of young doctors, and consequently doctor-patient communication. Junior and senior medical staff agreed that changes to undergraduate medical education were necessary, but not sufficient advances in improving the doctor patient relationship and participative decisions.

Conclusions:

Marked changes have taken place in the social context of doctor-patient communication. Generational changes in medicine reflect broader secular trends that have altered the dynamics of lay-professional communication, and the trend will continue. Medical education must keep pace with the task of supporting new generations of health professionals in attitudes and values that welcome and foster participative care and apply it effectively. Empirical findings establish that changes in the system can place the doctor patient relationship at risk. This in turn has significant impacts on health outcomes and therefore on costs. At present the relative influence of interpersonal and structural factors on communication and participation are largely balanced in the Australian system. International experience cautions the professions and health system managers to observe how apparently unconnected issues such as forms of reimbursement, or medical staffing structures, can affect adverse outcomes such as avoidable morbidity and mortality, especially for those patients most at risk and most disadvantaged. At least some of these impacts are mediated by constraints on the doctor-patient relationship, in the time allocated for consultations, third party interference in clinical decisions, lack of access to senior clinicians by junior staff, or a lack of medical input into hospital policies, procedures, and governance. The impact and importance of the human aspects of care and patients' capacity to be significant players in the system, suggests these aspects are an untapped source of efficiencies - the kind of efficiencies that will avoid the unintended negative consequences of the technical and budgetary solutions of the past. The role of participative style in improved management of chronic illness and prevention of avoidable hospital admissions; the impact of patient education and coaching in acute settings on length of stay, post-operative complications, and recovery; the central role of communication in complaints, which are costly in reputation, morale and time, and in avoidable distress to patients; the substantial role of communication in preventing adverse outcomes, and in the management of legal risk once it occurs - all of these offer a real opportunity for the professions and health care institutions to rebuild public trust and confidence, and at the same time maintain financial responsibility.