When interprofessionalism also involves the patient: how to provide good healthcare beyond care

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ABSTRACT

The prevalence of aging-related chronic diseases makes it necessary to change organizational structures. In order to facilitate the transformation of health systems, interprofessional care teams, patient engagement, and collaborative practice will be necessary. Patient-centered interprofessional care is a process based on the collaborative relationship between healthcare professionals, patients and caregivers, as a useful strategy to "develop a shared understanding of the problem and generate a mutually acceptable assessment and management of the care plan". Everything must take place on a collaborative level, always respecting the different skills. Although the literature provides preliminary information to support the benefits of the patient-centered approach, transformational leadership and an organizational culture are needed to foster learning, research, and the implementation of innovative models to patient care. Furthermore, in the Italian healthcare reality, the aspects of practicability and "sustainability" of this model of care should be considered and the key elements, mechanisms and stages of development necessary for its possible implementation should be better defined.

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Introduction

Around 35% of Europeans are affected by a chronic condition and this number is expected to increase further.[1] The increasing prevalence of aging related chronic diseases is pushing Western health systems to change their organizational structures.[2] The elements of healthcare that could facilitate the transformation of health systems are interprofessional care teams, patient engagement, and collaborative practice.[3] In particular, the increase in chronic multisystem diseases will require a shift towards healthcare as a co-production of services and not simply as the provision of products and services.[4] The co-production of health care is based on the collaborative relationship between health professionals, patients and caregivers, as a useful strategy to "develop a shared understanding of the problem and generate a mutually acceptable evaluation and management of the care plan".[4] This approach makes it possible to focus on the life context of the patient/person and not exclusively on the disease,[3] and therefore requires greater clinical integration and coordination.[5] Patient engagement becomes the central and essential focus for health care, and the patients themselves become co-creators of the care process.[6-8]

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Interprofessionalism and patient-centered care

Interprofessional collaboration that includes the person being cared for, and therefore person-centred care, has been extensively studied, in terms of outcomes related to care, healthcare costs and perceived quality. A systematic review conducted in 2013 found that person-centred care leads to positive care outcomes. In this regard, the Institute for Health Improvement identifies the improvement of the care experience, the health of the population by *per capita* cost and the improvement of the working life of health professionals, as outcome indicators to measure the transformation of health systems.[4] The Institute for Patient and Family-Centered Care provides a definition of person-centered care as "an approach to health care planning, delivery, and evalua-

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tion based on mutually beneficial partnership between health care providers, patients, and families".[9]

Epstein and Street define patient-centered care as "deep respect for patients as unique living beings and an obligation to care for them on their own terms. Therefore, patients should be known as people in their social context, listened to, informed, respected and involved in their care. Their wishes are honored (but not senselessly implemented) during their health care".[10]

Eldh *et al*. emphasize that true participation is achieved when practitioners "recognize and respect each patient's unique knowledge and respect the description of their situation".[9] This new approach therefore requires a true partnership between patients, family and healthcare professionals, in which the needs and aspirations of individuals guide both clinical decisions and the way to measure the outcomes of the care pathway.[11] In patient-centered care, healthcare professionals inform, advise, and support patients, as they make decisions about their health and treatment. Patients do not receive "orders" from healthcare professionals, but actively participate in the management of their own care. Transparency and speed in providing health information, attention to physical needs and emotional well-being, a welcoming environment for families in care facilities, respect for the point of view of patients and their families, collaboration and inclusion in the decision-making process, are all fundamental elements in person-centred care.[11] According to this model, strict visiting hours and visitor restrictions belong to the past. Patients are given the authority to identify who can visit and when. Family members, as indicated by the patient, are invited to visit the patient during shifts and shift changes so that they can be part of the care team, participating in care discussions and decisions. The infrastructure of a hospital with patient-centered care encourages family collaboration through a home-like environment.[11]

The concept of patient-centered care also extends to pharmacological treatments and therapies. Patient-centered care therefore represents a shift in traditional roles from that of a "passive actor" to that of an "active team member." James Rickert, one of the leading theorists of patient-centered care, said that one of the fundamental principles is that "patients know best how health professionals can meet their needs".

According to Hood,[12] the treatment of diseases must become "personalized, predictive, preventive, and participatory". For this reason, 4P medicine represents a new way compared to systems focused on diagnostics and reacting to the disease after the fact.

The 4P approach includes the following 12 items: i) be heard (by healthcare professionals); ii) your experience is recognized; iii) have conditions for mutual communication; iv) share your symptoms/problems; v) have explanations for your symptoms/problems; vi) have explanations for what is being done (for oneself); vii) know the care plans; viii); collaborate in care/treatment planning; ix) express your goals; x) be able to manage your symptoms/problems; xi) autonomously manage health interventions (such as medications); xii) take care of yourself.

Therefore, the goal is to replace a "re-active" model with one oriented towards "pro-active", preventive medicine, also based, if possible, on a systemic and molecular approach. According to Hood,[12] the concept of the "standard patient" must change into the more correct point of view of the "genetically unique individual", to tailor the best approach to preserve health and adopt the right treatment of care.

Final thoughts and reflections

Patient-centered interprofessional care is a process of transforming the clinical approach. This is a change that could be defined as "philosophical" in the delivery of health care, which from an activity aimed at patients/families, is transformed into collaboration with patients/families.

As a general and preliminary reflection, however, it seems essential to consider, first of all, the geographical and social reality from which these proposals and the consequent considerations of welfare reform come. In a system such as that of the United States, in which the insurance organization and the private sector prevail, the setting of care modalities becomes a fundamental operational choice that also imprints the organization of care by the various providers (clinics, hospitals, insurance companies, medical centers, *etc*.). For this reason, the mode of provision and the intrinsic organization of health care strictly guide the patient's choice, who requests and seeks the most appropriate mode of assistance or that is considered most suitable, liveable, and enjoyable. This creates a competition between care providers correctly oriented towards the needs of the patient on a clinical and care level in a broad sense, but all under the perspective of a "commercial" and exclusively corporate and "for-profit" vision of the care system.

It is clear that in a universalistic "National Health Service" European style system, such as the one present in our Country (albeit in light of the possible implementation of the so called "differentiated autonomy of the Regions"), these new organizational methods should take into account the aspects of practicability and above all of "sustainability".

In our healthcare system, for many years we have been pursuing and working toward the objectives of humanizing care, improving quality, empowering the patient and the family network, empathic collaboration between doctor and patient, therapeutic alliance, and health pact. All this must necessarily take place, but the structure of hospitals and other health facilities should substantially change, but this does not seem entirely possible, in the light of the current rules and organization.

In this regard, there is a broad reflection on the appropriateness of single bed rooms in hospitals, already promoted at the time by Prof. Umberto Veronesi with an explicit request to the architect Renzo Piano to design a model hospital, with spaces on a human scale, single rooms, rooms for family members and green areas,[13] and recently re-proposed in a brilliant article by Laura Stabile.[14] It is necessary that any new structure should be built with only single rooms. However, the reality of Italian hospitals, often of ancient construction and partly obsolete, does not make it easy to completely renovate, except in a few cases, also in consideration of the need to maintain an adequate number of beds to what is required by the national reference standards, such as the well-known Ministerial Decree 70/2015.

Even the World Health Organization, in the recent document "Hospitals of the future-A technical brief on re-thinking the architecture of hospitals",[15] underlines the need to create single-bed rooms to be used flexibly, with the possibility of using the second bed in case of emergencies. If we

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think about the COVID 2020-22 pandemic, it is clear that a "ductile" hospital, with wards with mobile modules and single rooms, is the ideal solution to deal with any emergencies, not only for infectious and contagious diseases; however, this goal requires structural changes of enormous impact and, as mentioned, not always achievable.

As a general reflection, it seems appropriate to refer to the principles of value-based medicine,[16] according to which the model of care delivery within the centers must have the objective of providing high-quality services to patients and constantly measure the clinical outcome of the entire treatment path with annual benchmarks. If we refer to the Italian situation, benchmarks such as those represented by the *Programma Nazionale Esiti* and Prevale.

These principles also seem to inspire a further reflection on the already cited NEJM Catalyst article,[11] by the Institute of Medicine, which defines patient-centered care as "that form of care that respects and responds to the individual preferences, needs and values of the patient, ensuring that the values themselves guide all clinical decisions". In this regard, the approach to care needs to be rethought as a whole, with a new focus on active collaboration and shared decisions with patients. And in fact, the article introduces a new synthetic proposal, that of the Medicine of the 4 C: Culture, Care, Communication, Collaboration.[17] This is exactly what is strongly emphasized and discussed in our Country, on the need for informed consent, in particular consent to treatment, to be the result of communication and a therapeutic alliance that increasingly appears to be a fundamental element of care. Moreover, an Italian law also clearly states that "The time of communication between doctor and patient constitutes time of care" (Law 219/17, art. 1, paragraph 8).

In our opinion, with respect to these proposals and theoretical elaborations on interprofessional collaboration, a third approach is needed. Collaboration cannot be dependency, invasion of the field, or confusion of roles. We need equal rights, but we need a distinction between competences and weight in decision-making. The patient must be put in the best possible conditions to decide and to share the care provided. Quoting Epstein and Street again, "patients' wishes must be honored (but not senselessly implemented) during their health care".[10]

First of all, the collaborative relationship between the various health professionals, within hospitals in particular and in any case in all sectors, appears fundamental.

Secondly, overcoming the barriers between health departments and facilities and the divisions between the various operators can bring added value to the conduct of excellent care.

Thirdly, it is clear that the care of a complex patient, such as those followed by internal medicine, cannot fail to involve doctors, nurses, social workers and other figures in the social-health network who are deemed necessary from time to time, together with family members and/or proxies for a sharing of clinical decisions. Everything must take place on a collaborative level, but also guaranteeing respect of the various skills. The patient's interest and values come first, but conflicts or unnecessary arguments must be avoided.

Transformational leadership and an organizational culture are needed to support learning, research, and the implementation of new and innovative models of patient care. The literature provides preliminary information to support the benefits of the patient-centered approach, but it will be important in the future to clarify the key elements, characteristics and identification of its mechanisms and stages of development, for a more correct definition and possible implementation, particularly in our Country.

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