



Being well and wellbeing: better understanding of patient priorities in primary care

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ABSTRACT

INTRODUCTION: Achieving desired health outcomes in primary care can be challenging because of dissonance between the theory and reality of medicine, inadequate understanding of patient perspectives and priorities regarding wellness, wellbeing and goals of treatment, and under-emphasis of the concept of whole-person care in the doctor–patient relationship.

ASSESSMENT OF PROBLEMS: Anticipated dissonance in the doctor–patient relationship was explored using a self-designed audit, which also functioned as an educational and engagement tool.

Over a 12-month period, 282 adult patients (aged 24–94 years) provided responses to a question asking them to describe their best day in the context of their current health status. These responses were then entered into the Classifications field of the practice's patient management system.

RESULTS OF ASSESSMENT: Most respondents appreciated the opportunity, with a small number commenting on the challenging nature of the question.

STRATEGIES FOR QUALITY IMPROVEMENT: Entering audit findings into the patient's clinical record in a format accessible to all clinical staff enables increased opportunity for patients to be valued and engaged with. Goal setting and therapeutic choices can be made in the light of a better understanding of what matters most to the patient.

LESSONS AND MESSAGES: This project provided valuable and, at times surprising, information to clinical consultations that had not previously been obtained from or offered by patients. Such information requires an intentional, engaged and collaborative interaction with the patient, and enhances patient-centric consultations with a focus on whole-person care and wellness in the journey to therapeutic goals and health outcomes.

KEYWORDS: Wellness; wellbeing; patient priorities; whole patient; primary care; treatment goals

Introduction

General practice in New Zealand (NZ) is facing increasing demands from funders, providers and users of its services.¹ The dynamic environment

is not unique internationally, but the NZ health system's limited resources and challenges of our particular patient demographic, including Māori and Pacific peoples' health-care access and

WHAT GAP THIS FILLS

What is already known: Goals of treatment often differ between treating clinicians and their patients, resulting in less-than-ideal health outcomes. Challenges exist in identifying and discussing these goals, and general practitioners are well placed to engage in this process.

What this study adds: This project identifies a strategy for engaging patients and clinicians in discussing the motivation for health-related goals. It highlights some trends in a small cohort of patients, which may be generalisable in a similar context.

inequality, make consideration of how best to care for our patients and achieve desired health outcomes a critical and perpetual issue.²

Doctors are trained in health, disease prevention and treatment, and survival for their patients, to fight the perceived failure that is death. They are monitored and measured against standards of good medical practice.³ However, they are seldom asked to consider what exactly they are fighting for in their relationships with patients.⁴ Wilson and Cunningham discuss the dissonance of the biomedical model,⁵ describing a mismatch between the theory and reality of medicine, where the biomedical model is insufficient to achieve whole-person care for patients and creates anomalies that leave both clinicians and patients dissatisfied. Kleinman identifies the dangers of the medical model in its denial of a person's moral significance through a technical process that only superficially touches on a person.⁶ Wilson and Cunningham describe the superiority of a biopsychosocial model of care, coupled with valuing emotional quotient (EQ, the capacity for engaging well with others). A functional doctor–patient relationship is highly dependent on making empathic and caring connections within this model.

As we get older and have to face the reality of illness, disease and death, doctors are not well equipped to consider what wellbeing is for our patients.⁷ The experience and meaning of illness and suffering is widely variable. Understanding a patient's personhood and the effect of a disturbance to this enables clinicians to better address the caring role.⁸ Furthermore, the complexity of

prioritisation in the context of increasing illness, disability and treatment options, presents important challenges.⁹

It is a sobering reality for most people that with aging comes loss of function and increasing risk of disease. However, at the same time and perhaps surprising for doctors whose work is largely in the context of illness, many people also experience an increasing sense of fulfilment and flourishing.¹⁰

Clarity to this issue of wellbeing can come from questions such as 'What does a good day look like for you?', 'What are the reasons you are alive, what are you living for?' and 'What quality of life would you look for if you couldn't do everything you wanted?'. Such questions become particularly germane towards the end of life.¹¹

An adaptation of Tibetan Buddhist reflection on mortality is: 'Since death alone is certain and the time of death is uncertain, what should I do?'.¹² Used as a regular practice, this quote creates awareness that each day may be one's last. Such reflections on death are not intended to be gloomy or morbid. The paradox is that focusing on death brings a vivid sense of life through senses of wonder, possibility and responsibility.¹³

The primary purpose of this project was to improve health-care delivery for patients enrolled with the author in his general practice by collecting patients' responses to questions about wellbeing. This was expected to inform treatment goals focused on wellness and wellbeing, not just survival. Secondary objectives included raising awareness among patients of the importance of wellbeing discussions, and providing a platform for education of colleagues.

Assessment of problems

The problem being assessed was the anticipated dissonance between doctor and patient with regard to understanding priorities in patients' health and wellbeing. The project design was intentionally simple, reasonably non-directive and personal. It was performed as an audit, being a review of data collected from patients as part of their clinical record, with the purpose

of improving their health care. External ethics review was, therefore, not appropriate. The process of obtaining this information included all patients being handed a written invitation to engage with the author in answering questions about their wellbeing and an option for patients to prohibit use of their anonymised response in written or verbal presentations. During this audit, it became apparent to the author that the results were not only of value to him and his patients, but potentially of benefit to other clinicians.

All adult patients enrolled with the author as their primary care provider and encountered in a clinical consultation from November 2017 to November 2018 were invited to participate in this project. If they agreed, they were given a one-page document explaining the project and inviting a response. The invitation included the following statements:

‘As a doctor, I have been trained to focus on health, disease prevention and treatment, and survival for my patients. However, as we get older and have to face the reality of illness, disease and death, doctors are not well equipped to consider the wellbeing of our patients. We as doctors tend to fight against the process of dying without understanding what it is we are fighting for.’

‘The purpose of this brief survey is to seek to understand what it is for you that we should be fighting for in our therapeutic relationship. What is the quality of life you would look for if you couldn’t do everything you wanted? Another way of putting this is ‘What does a good day look like for you?’ ‘What are you living for?’

The invitation was non-directive: ‘Your response can be anything, and it may well change over time,’ and was framed in the form of describing their best day. Patients were asked to take the page away to reflect on their response, which could be emailed or written and returned in hard format.

The rationale for asking questions that did not specifically relate to health was to gain an understanding of patients’ priorities in the context of their personhood, their whole person, rather than limiting this to issues of health and illness. Responses were entered into the patient

management system (PMS) under a Classification heading ‘General well-being schedule,’ and highlighted so they could be referred to in subsequent visits to help frame the consultation.

One patient declined to participate. Another patient declined to have their response used in presentations or publications. Very few patients, estimated to be <2%, were happy to take the invitation away but did not respond. A further estimated 3% on subsequent consultations stated they had not yet found time or opportunity to respond, but intended to do so.

Results of assessment

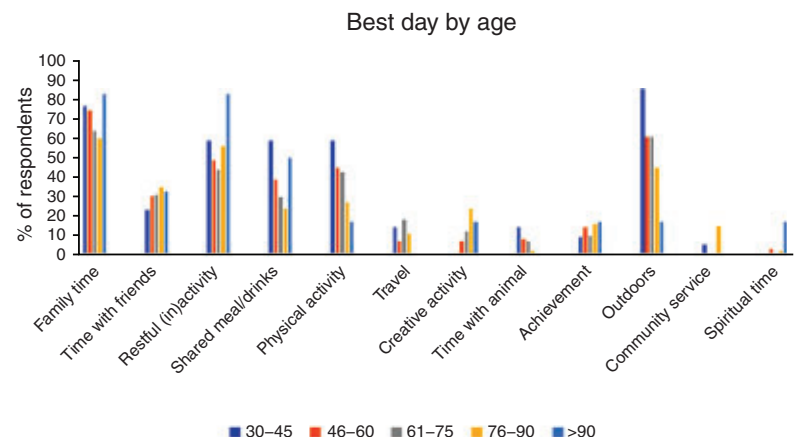
A total of 282 patients provided responses (Figure 1) that were recorded in their personal PMS Classifications. Most responses came from patients aged 61–75 years, which reflects the age demographic of the author’s practice.

Many patients expressed appreciation for my undertaking this project and indicated they felt challenged by it.

‘Thank you very much for this survey. I think it’s fantastic going away from being alive at any cost versus having a life worth living. A very interesting discussion, and no doubt this can be quite challenging for doctors at times.’

‘Many thanks for giving this opportunity to share what is important to me.’

Figure 1. Summary of patient responses describing their best day.



'It is stuck to my fridge reminding me to ask this big question every day.'

'Why haven't you asked me about this before?'

'I have found this a very hard question to answer and I have several answers to the question. My wife and I have talked about it a lot and it's a good question to bring focus back to what's important in life.'

A few really did not want to engage:

'It's too late for me to think about this.'

'It's sitting on my desk for when I have time.'

'When you really think about this topic, it makes you realise how blessed we are to be living in NZ.'

'This has been a somewhat thought provoking and difficult question to answer.'

Responses were arranged according to categories of response and age, gender, number of clinical

conditions and presence of terminal (less than 6 months) illness (Table 1).

Particular themes emerged below.

Family and friends

Family time and having access to the outdoors were two most prominent aspects of wellbeing, for both genders (Figure 2). Other relationships were also highly and similarly valued across all ages, with family being of greater importance than friends (Figure 3).

'My best day would be a long walk by a lake, river or the sea, followed by lunch (preferably outdoors under shade) with family and friends.'

'Having a coffee and a sensible (or not) conversation with friends. And as for why I am alive and what I am living for, that's the \$65 million question. Don't have a definitive answer to that any more.'

'My best day would be sitting on our front deck with family or friends, enjoying a glass of red wine,

Table 1. Total patient ($n = 282$) responses by categories

	Family time	Time with friends	Restful (in) activity	Sharing drinks/ meal	Physical activity	Travel	Creative activity	Time with pet/ animal	Achievement	Being outdoors	Spiritual time	Community service	Total
age <30													0
age 30-45	17	5	13	13	13	3		3	2	19		1	22
age 46-60	57	24	38	31	35	5	5	7	11	47	2	1	77
age 61-75	77	38	53	37	52	22	14	9	12	73	1	8	121
age 76-90	33	19	31	13	15	6	13	1	9	25	1	8	55
age >90	5	2	5	3	1		1		1	1	1		6
Male	91	40	65	45	59	18	17	6	25	87	1	7	139
Female	109	48	74	52	57	18	16	14	10	77	3	10	143
Chronic conditions nil	35	17	22	22	28	4	5	3	7	34	2	2	
one	54	19	31	22	30	10	3	6	10	44		4	
two - three	70	41	56	30	40	13	18	9	9	56	1	7	
four or more	33	11	31	21	18	9	7	2	9	24	2	3	
Terminal illness Yes	5	4	3	4	4	2				6			
No	183	81	134	93	113	35	33	20	35	157	5	17	

sharing stories; having a good laugh and listening to the meat sizzling on the BBQ!’

Outdoor activities

Being outdoors was of highest priority in younger adults, and this declined with age.

‘My best day would be a surf in the ocean followed by a good book on the sofa.’

‘My best day is harvesting the produce from my garden.’

Creative activity

Creative activity was seen as a greater priority in older age. Such creative activity ranged from simple daily hobbies to building legacies. This was of little importance in the younger age group (30–45 years) and peaked in the 76- to 90-year age group. Achievement of a goal and creativity were particularly important for males.

Time with a favourite animal was important in the younger cohort (30–45 years) and declined with age.

Travel

Travel was cited most often among people in the 61- to 75-year age group;

‘My best day would be cruising around the world, actively exploring the amazing sights and sounds, or working on the land...both very important to me.’

Other

When an analysis was performed on the description of a best day according to the number of long-term clinical conditions (Figure 4), some trends were clear. People who were terminally unwell evenly valued relationships, activity and being outdoors (although the numbers were low). Regardless of long-term condition experience, family time was a high priority among responding patients. With increasing long-term ill-health, there was a higher priority placed on restful activity and a lower preference for physical activity and being outdoors.

Figure 2. Assessing priorities for both genders.

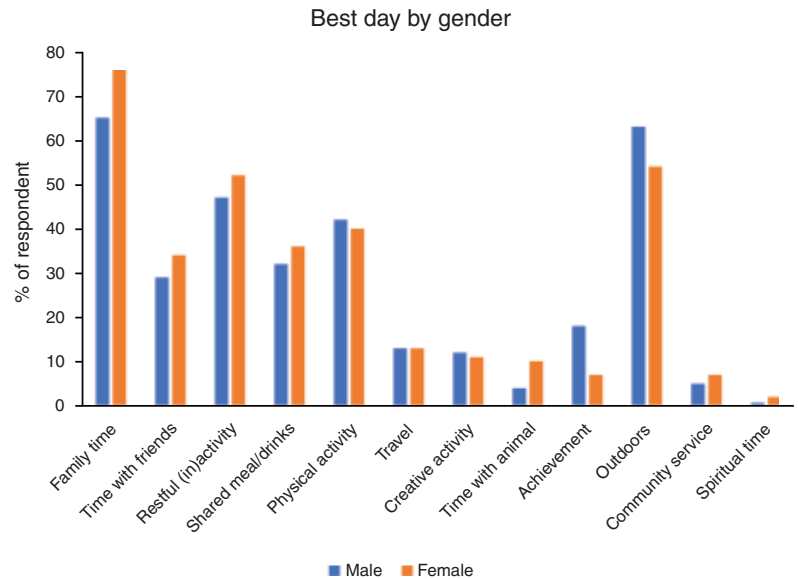
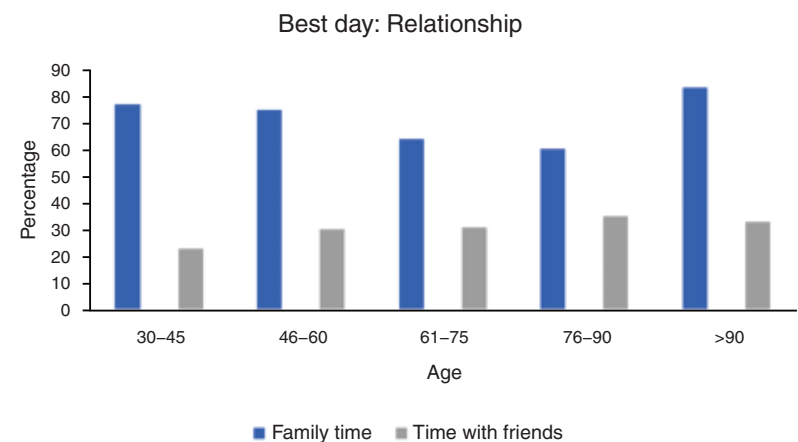


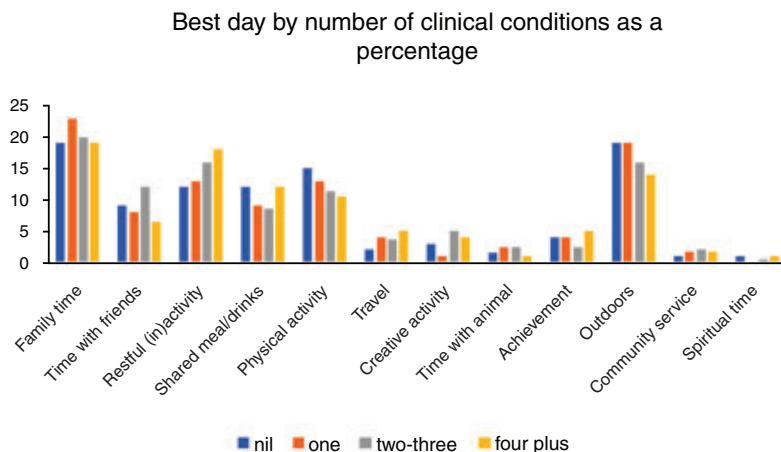
Figure 3. Assessing relationships valued across all ages, with family being of greater importance than friends.



Strategies for quality improvement

This audit project identified and confirmed the author’s concern regarding dissonance in the doctor–patient relationship with regard to understanding patients’ priorities in health and wellbeing. Patient priorities were identified as new and, at times, surprising information, and the process of articulating their priorities sometimes led to re-orientation of their lives for patients.

Figure 4. Analysis was performed on the description of a best day according to the number of long-term clinical conditions.



Adding this information to clinical records in a functional and visible way can be an important component of enhancing patient consultations. Such a process values a patient's whole-person context, enables doctors to better take a biopsychosocial approach to the health care they provide and forms empathic connections in the clinical relationship.

This information can then be available to all clinical staff, who have been informed of the purpose and value of such a record. The clinical team may then also use these records to further explore and enhance the whole-person care they deliver when engaging with patients.

Early responses to the reported process have been positive. Colleagues in the practice who also see the participating patients have been intrigued by the record and prompted to also explore these issues with patients. A hospital specialist colleague, on receipt of a referral and considering intervention options, rang the author on seeing the 'General well being schedule' entry to clarify this as it affected management decisions.

Lessons and messages

This project added valuable information to improve the clinical relationship between doctor and patient. It reinforced the patient-centric

paradigm of general practice when considering goals of investigation and treatment. It allowed the medical model to function collaboratively with whole people and empowered patients to (re)consider their goals and responsibilities in health and wellbeing.

On several occasions since undertaking this project, the author has had reason to refer to the 'Well-being schedule' in Classifications as a tool in treatment plan discussions with patients. The process of considering treatment risks and benefits, in the light of what the patient described as wellbeing for them, has enabled a focused and collaborative therapeutic outcome. This process also enabled the author to move towards being a whole-person doctor,⁵ one who engages and is cognisant of their patients' wider contexts – family, social and cultural settings.

Potential weaknesses of the project include the lack of a standardised structure for the responses and limitations to the recording fields (ethnicity, religious affiliation, education, socioeconomic status and functional status) and classification fields. However, the primary goal of the project was the collection of personalised responses from patients well known to the author, with the purpose of enhancing the quality of clinical consultations. A non-directive approach was chosen to empower the respondents to express themselves freely. Elements of the recording fields were kept to a basic level for reasons of practicality and to minimise the effect on patients who may be disclosing potentially sensitive information. Furthermore, the invitation to participate in the project used language that had potential framing effects, such as 'fight against the process of dying', 'what we should be fighting for in our therapeutic relationship', 'what does a good day look like' and 'what are you living for?' This language was influenced by the work by Gawande⁴ and used to create an emotional engagement with the patient.

Many responses were a surprise to the author even though I have known these patients for many years as their GP. This reinforced the need for discussion with patients and review of what wellbeing means and how this can be enhanced in clinical consultations. Too often, there is a distance between the priorities of the doctor and

those of the patient, and this may lead to poor health outcomes.^{14,15} However, with a simple, and yet robust, collaborative engagement in discussion about wellbeing, this distance can be minimised, the clinical relationship strengthened, and goals of wellness and wellbeing achieved. GPs have an enviable opportunity to contribute meaningfully to the journey of wellness with patients through their professional relationships that develop trust and care over time.

Conflicts of interest

The author declares no conflicts of interest.

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