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Patient-centred care – is it possible?

EDITORIAL

NINA AASS

Nina Aass, Head of Section for Palliative Care, Department of Oncology, Oslo University Hospital, and professor at the Institute of Clinical Medicine, University of Oslo.
The author has completed the ICMJE form and declares no conflicts of interest.

STEIN KAASA

stein.kaasa@medisin.uio.no
Stein Kaasa, Head of Department of Oncology, Oslo University Hospital, and professor at the Institute of Clinical Medicine, University of Oslo.
The author has completed the ICMJE form and declares no conflicts of interest.

We need more than simply good results from clinical trials to provide patient-centred care.

'Reporting and treating oral cavity problems is not something we do as a part of routine clinical practice, unfortunately. We should do it – but there are so many other important things that need to be done in a hectic cancer ward.' We recently overheard this conversation between a nurse and doctor. It is probably representative of the prioritisation in many areas of the Norwegian specialist health service. A Norwegian study has shown that the situation is not much better at Norwegian nursing homes (1). Dry mouth is a subjective condition, like pain, anxiety, fatigue and nausea, and can be measured by asking the patients how it feels. It can cause considerable discomfort, but can be prevented and treated, as shown in the clinical overview by Kvalheim et al. in this issue of the Journal of the Norwegian Medical Association (2).

Symptoms must be systematically reported. This is an important part of the clinical consultation by GPs and in outpatient clinics, hospitals and nursing homes. When treating symptoms, a follow-up plan must also be drawn up for patients in order to assess treatment efficacy and to ensure rapid implementation of any adjustments that are needed. This is important for all patients, but particularly those with a short life expectancy.

One possible reason why subjective symptoms are not being systematically assessed, reported and treated in the Norwegian health service is that routine practices are considered adequate for this purpose. However, there are strong indications that this is not the case. Multiple high-quality randomised controlled trials have shown that troublesome symptoms and overall quality of life are significantly improved if the symptoms are systematically reported and treated according to guidelines, and further monitoring is provided where necessary.

More than 750 patients with solid tumours and metastatic cancer were included in a randomised controlled trial at an oncology outpatient clinic in the United States (3). All patients were receiving routine chemotherapy to treat their tumours. The patients were randomly assigned to receive routine symptom monitoring or to systematically report the 12 most common symptoms. Patients in the intervention arm reported their symptoms regularly on a tablet. Nurses at the outpatient clinic received email alerts when participants reported symptom intensity above a certain level. Doctors received printouts of the symptoms, and appropriate treatment was initiated. Significantly more of these patients reported improved quality of life after six months than the patients who received routine symptom monitoring. In addition, the lives of patients in the intervention group were extended by a median of five months, and fewer of them had emergency hospital admissions or received intensive care. We assume that this and several similar trials are transferable to Norwegian conditions both in cancer care and for other somatic conditions. The results of these trials were published many years ago, and there are clear national recommendations for systematically reporting symptoms (4). Unfortunately, there is little indication that clinical practice has changed in Norwegian hospitals and nursing homes.

> ***«The systematic reporting of symptoms and functions has been pushed down the priority list»***

In recent decades, various new imaging modalities and improved molecular biological diagnostics have meant that many patients can receive personalised treatment. Major investments have been made in research and new technology in somatic medicine. The established 'old method' of systematically reporting symptoms and functions has been pushed down the priority list. Old methods are quickly forgotten and brushed aside when new innovations are introduced. This is perhaps understandable, but it impacts on the overall provision of personalised treatment, which is not solely about biological parameters. In our view, a change of attitudes and systems is needed, in terms of medical education and the priorities of politicians and healthcare bureaucrats, health service managers and the doctors themselves.

There is a strong focus in today's health service on treating the disease, while *treating the patient with the disease* is given less attention. The latter is referred to as patient-centred care. Several good clinical studies have shown that when patient care is organised and implemented in a way that treats both the disease and the patient with the disease, patients with incurable diseases can spend more time at home, have a better quality of life and fewer troublesome symptoms, and live longer (5, 6). In order to incorporate this approach into the routine treatment, a broadly composed international panel has recommended developing and implementing care models that are adapted to the patient (7). These recommendations are also included in a Norwegian Official Report from 2017 (4).

It is not difficult to agree that good oral care for seriously ill patients should be offered as a minimum in today's Norwegian health service. Unfortunately, this is not really the case today. Many patients with a short life expectancy and their families are still finding that something 'as simple' as basic oral care is not being provided.

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