Moral Hazards of a New Patient Pathway: Varying Inter-professional Interests

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Background

Moral hazard suggests that those insulated from risk behave differently [1, 2]. Much has been made of this as regards patients. In our population, for example, it has been suggested nationally, that those who smoke should have their access to healthcare limited until they quit [3]. However, less focus has been placed on clinicians and allied health professionals as they develop practice, even that which will intimately affect patients. Introducing a new service prima fascia requires inter-professional collaboration. However without true communication between all parties changes are unlikely to be achieved successfully.

With a worldwide drive to reduce costs and iatrogenic illness, our Trust hopes to change its surgical pathway for patients with lung disease, which traditionally requires an in-patient stay.

Challenges

A working party was convened to develop and agree a proposed protocol. Where old systems do not have to be included there is a chance to design a system with patients rather than the staff at the centre. However, ensuring wide engagement can be challenging.

The group consisted of: surgeons, anaesthetists, ward nurses, specialist pain nurses and research staff. All wish the best for the patient but come with varying priorities:

Surgeons and ward staff are crucially aware of bed state issues.

Anaesthetists and nursing staff are focused upon acute pain issues.

Specialist pain nurses may focus more on chronic analgesic requirements.

Few are as aware of chronic care issues at home as the patient, their families and the general practitioners â€“ none of whom were available to meet with the group. This is particularly relevant given the tertiary referral nature of our Trust, with often long distances between the operating site and the patients’ homes.

Discussion

The current climate expects surgeons to provide optimal care in the shortest possible time with mortality outcomes freely published [4]. It is unsurprising therefore that they may feel insulated from
the effects of pain on both the patient and the wider healthcare community. Anaesthetists and nursing staff are less likely to feel pressure from list managers and may therefore focus more on “softer issues” including pain relief and anxiety, potentially ameliorated by interventions requiring hospital care.

Chronic pain is recognized to be more common where acute pain is poorly controlled, and multiple studies suggest that pain following day-case surgery is a problem in the community. Thus, engagement of patients, their families and their general practitioners, to provide routine, active feedback will be vital. Currently this is not widely performed on a regular basis in any surgical field. Rather, clinical nurse specialists hear about the particularly difficult problems, without access to data which might help elucidate risk factors for severe, chronic pain following surgery. It may be that our patients want to come in later and go home earlier after surgery, but unless we can provide them with not only mortality data, but important morbidity data (currently unavailable) we risk long term pain impacting on life and work outside the hospital [5, 6, 7].

Whether a more coherent approach to the inter-professional ethics and values will overcome the differences in moral hazards in our clinical practice remains to be seen. However, the impact of inter-professional education and collaboration on healthcare outcomes has been recognised and promoted [8]

Conclusions

We recognise that we represent only one component, pain management, of a larger patient pathway, where multiple stakeholders bring to the table their own values and desired outcomes. However, despite our inter-professional differences in values and skills, the anticipated outcomes should be:

a) Engagement and agreement amongst the inter-professional team on a pathway that provides enhanced patient centred care

b) Agreement on a finalised protocol to be shared across the wider multi-disciplinary team within the organisation

c) Data collection to facilitate review of outcomes and adaptation of protocol where needed. Additionally providing morbidity data that will benefit patient selection and enhance the consent process

References


