

Editorial

The enigma of patient centredness, the therapeutic relationship and outcomes of the clinical encounter

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The increasingly ubiquitous notion of 'patient centredness' often causes confusion; indeed instruction received on this subject often left trainees with only the vaguest notion of how it could be put into practice, sometimes leading to bizarre interpretations of this idea. For example, one colleague described how he, in an attempt at 'real' patient centredness, had attempted a whole surgery without saying anything at all for as long as possible, presumably just nodding and gesticulating to compensate. Although we readily agree that non-verbal expression accounts for a considerable content of communication, this is perhaps taking things just too far. Patient centredness remains a central plank of clinical learning, teaching and assessment and nowadays is also central of policy development in the health service. But what do we mean by patient centredness? Is it really important? How important is it compared to other aspects of the consultation? Does it make a difference?

One problem with these questions is that the notion of patient centredness has developed over several decades before and since the pioneering work of Michael Balint¹ and others; in doing so it now means different things to different people. Just as ideas of evolution and creationism have changed and adapted to new scientific discoveries² so have our ideas of patient centredness. As practitioners and thinkers have mulled over these ideas and as studies have revealed that patient centredness is not always what patients see as most important or what leads to improvements in outcomes the concept has become more enigmatic. Consequently, some clinicians have developed antibodies to the very idea of patient centredness. As a result, patient centredness has become as PC and as pejorative a term as 'political correctness' in some quarters; patient centrists have become fervent believers whilst positive 'acentrists' to coin a term, equally firmly believe that the notion is positively harmful.

Most of us lie somewhere between these extreme positions with the result that real life consultations may not in fact have increased in terms of patient centredness over the past 20 years.³

Patient centredness, at one time thought to mean listening, and then active listening^{4,5} has over time evolved into a variety of clinical behavioural (intermediate or proxy),⁶ patient perceived⁷ and health (true) outcomes. Although the concept has even extended to include administrative and policy issues such as access,⁸ in its purest form it still relates most closely to the clinical consultation. Models of the clinical consultation have been traditionally divided into behaviour orientated and task orientated models, both usually focusing on what the doctor does rather than what the patient perceives within or as a result of the consultation.⁹ This includes attending to psychological and social as well as physical aspects of the consultation (the biopsychosocial perspective), sharing power and developing a therapeutic relationship.¹⁰ Consultation tasks that have been thought to relate to patient centredness include eliciting patients' health beliefs, ideas, concerns and expectations, exploring the impact of presenting problems on physical and social functioning, tailoring explanation to incorporate health beliefs and involving the patient in shared decision making. From the patient's point of view the experience of patient centredness may relate less to tasks that the doctor undertakes and more to feelings of empathy and trust or effects such as continuity, concordance, time and enablement.^{11,12} Individual elements have been developed into complex rating scales for self¹³, peer^{6,14} and patient¹⁵ evaluation and many of these aspects have been incorporated enthusiastically into teaching and assessment¹⁶ of practitioners.

In a recent study of one aspect of patient centredness, Saba and colleagues looked in detail, using stimulated recall of both patients and doctors experiences

of videotaped consultations, at 125 treatment decisions in follow up consultations of hypertension and diabetes involving ten doctors and 18 patients.¹⁷ What they found has begun to shed some light on the enigma of patient centredness. In the 62 (50%) treatment decisions in which there was a good degree of shared decision making they found four archetypes or patterns of engagement of clinicians and patients: full engagement, where shared decision making (SDM) was present and agreed to be present by both patient and clinician who both had a positive subjective experience of the consultation (1/5 of cases); simulated engagement where the clinician thought he had shared decision making but the patient disagreed (SDM present, subjective experience negative; 2/5); assumed engagement where the doctor did not feel that they involved the patient but the patient thought that they had (SDM absent, subjective experience positive; 1/5); and non-engagement where neither patient nor doctor thought that the patient had been involved in decision making. (SDM absent, subjective experience negative; 1/5). The study suggests this may be because patients reference the doctor's words and behaviour against a separate factor: the quality of rapport established between them. Without trust and true understanding, in other words, the language of sharing can seem hollow – hence the patient assessment of 'simulated' engagement in almost two-fifths of decision moments.

This could also partly explain why broad patient measures of patient satisfaction correlate poorly with clinical behaviours exhibited during the consultation.¹⁸ Of course, the study described above dealt with chronic problems which were more likely but not invariably to engender involvement. Consultations will vary considerably in their content and opportunity for involvement at various levels.¹⁹ In addition, patients²⁰ and their doctors²¹ vary in their wish for involvement according to a number of factors such as presenting problem,²² age and social class, albeit with wide variations within each category.²³ Clearly there is more to the concept of patient centredness than can simply be measured by practitioners using checklists and rating scales or perceived by patients through the use of questionnaires. Given the findings that the clinician orientated observation of 'involvement' and patient perception of 'engagement' are not synonymous then addressing both aspects together is likely to be more meaningful in understanding the consultation than each alone.¹⁸

A fundamental problem with the traditional notions of patient centredness whether from a clinical or

patient perspective is that they originate from research founded on one or other of these perspectives (and usually the former) which then attempts to reach truths that apply to both. A drawback of this approach is seen in assessment of consulting skills using videotaped encounters, which despite its many benefits can lead to an artificially constructed dialogue where the practitioner's competence is being judged on his skills relatively independent of the contribution by the patient. Heritage, Maynard and colleagues in their groundbreaking research on clinical communication using the technique of conversational analysis have broken away from this paradigm and advanced our understanding of patient centredness by focusing on the conversations between patients and clinicians, combining qualitative and quantitative techniques and adopting a truly postmodernist approach to not only describe the language occurring in the consultation but also to make inferences as to why a particular sequence of conversation is occurring.²⁴

A new model which seeks to capture the essence of past and present, clinical and patient perspectives has recently been created (Figure 1). This two stage model has emerged from six years of close analysis of the GP consultation in both research and practice contexts. The model highlights the complex interaction between a seemingly sequential journey (the consultation) and the dynamic factors which so shape its quality and outcomes. In particular, it reminds us why consulting is rightly seen as both science and art: definable in terms of destination and signposts; indefinable in terms of the nature and quality of the ride. Described more specifically, the consultation has relatively clear stages and goals but is inevitably an iterative process, where the dialogue often moves back from decision-making to data gathering when new issues emerge (hence the dotted feedback loop). And the 'route' the consultation takes is also shaped in many different ways by three separate contributing factors: the doctor brings a set of characteristics which will impact variously on the discussion, the patient does the same, and their dialogue takes place within the context of a particular practice environment.

Arguably, the next phase of learning, teaching, research and assessment of the consultation should be grounded in a deeper understanding of how clinicians and patients co-construct their dialogue. The technique of conversation analysis could provide us with a truly patient centred way to do this which could ultimately lead to clinical conversations that will make a real difference to patients and clinicians.²⁵

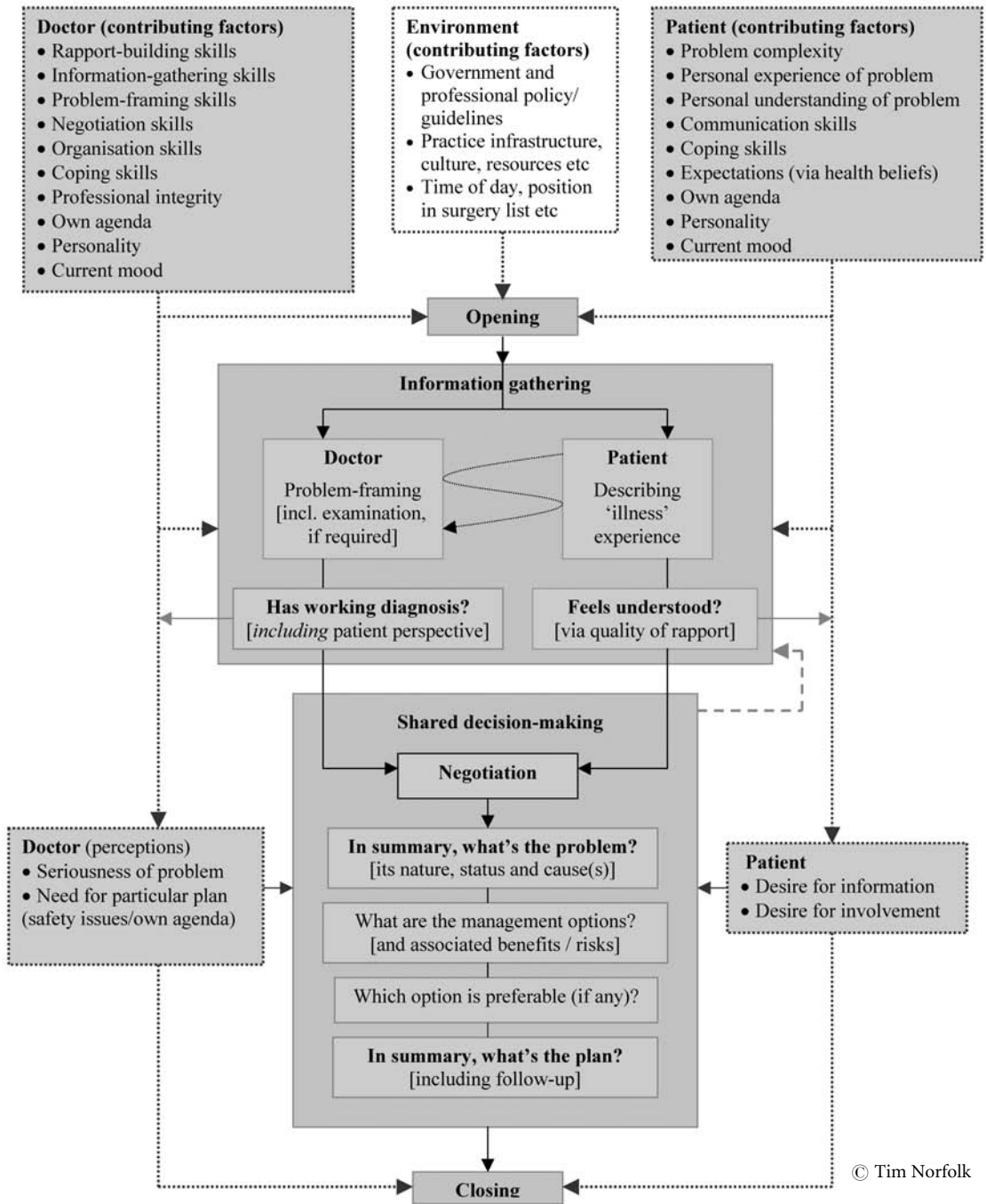


Figure 1 Patient-centred consulting: a comprehensive model

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