

# Patient-centred Care

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## Part I

### Benchmarks for Busy GPs

*This section is not a comprehensive review but a short selection of abstracts to help you focus on important aspects of the subject partly in the form of reminders and memory joggers.*

The concept of patient-centred care originated from many diverse sources such as the ancient Greek school of Cos, the writings of Hippocrates and the holism of Jan Smuts.

Patient-centred care has also been derived from client-centred therapy (Rogers, 1961) and a person-centred approach (Rogers, 1980) and is founded on the research of Carl Rogers and others from the 1940s onwards.

He said:

It is the creation of a climate to help individuals reach self-understanding and promote change and growth in a constructive manner.

It requires three elements or attitudes in the doctor:

- The first is genuineness, realness or congruence.
- The second is acceptance or caring or prizing. Rogers called this "unconditional positive regard".
- The third is empathetic understanding.

*Essential CME is a series involving a continuous self learning process in Family Practice for general practitioners, primary care physicians and generalist medical officers. With the introduction of the category "Family Physician" and the need for certification and recertification in the future, this series is aimed at the busy doctor to help him or her to update knowledge on broad issues in family practice by using different approaches. Some parts will be focused on helping the general practitioner to obtain certification as a "Family Physician" via postgraduate examinations.*

*There are five parts to the section.*

*Part One is called BENCHMARKS FOR THE BUSY GP. Instead of reading through a long article, a group of GPs will have extracted the important facts on the subject from a general practice perspective.*

*Part Two will be on SOUTH AFRICAN RURAL GENERAL PRACTICE. It will deal with the issues arising from practice in remote rural clinics. It will be context related to practising in poverty stricken communities and problem orientated to the specific conditions arising from this context.*

*Part Three is called TEACHING OLD DOCS NEW TRICKS and is a mock oral examination for a postgraduate degree in family medicine.*

*Part Four will be a self evaluation section by short MULTIPLE CHOICE QUESTIONS (MCQS).*

*Part Five is a selection of SOURCES OF INFORMATION and resources for further reading.*

*Throughout these sections family practice perspectives and theories will be integrated with the clinical aspects. Obviously this CME section cannot cover all that is "essential" in a prescriptive way but aims to help you revise, stimulate your interest and provide some guideposts.*

*This eighth one of the series is on PATIENT-CENTRED CARE.*

The foundation of person-centred care rests on a basic trust in human beings.

It is an attitude that helps release change and growth in the personality and behaviour of individuals. It helps persons have the freedom to choose and facilitates the creative, formative tendency of mankind. Its aim is to help persons move in the direction of wholeness, integration and a unified life.

Michael Balint used the term "patient-centred medicine" in contradistinction to what he called "illness-centred medicine" (Balint, 1970, Hopkins, 1972). Balint used the term "traditional diagnosis" to describe the understanding based on illness-centred medicine and the term "overall diagnosis" to describe the understanding reached by patient-centred medicine.

From these and other beginnings, the **Patient-Centred Clinical Method** was developed by the Department of Family Medicine at the University of Western Ontario, London, Canada.

The **Traditional or Conventional consultation** proceeds, in the main, by questions and answers by an objective and detached physician. The main purpose is to arrive at a physical diagnosis and exclude pathology. This is all well and good in the clinical sphere of malfunctioning body parts.

The **Patient-Centred Clinical Method** can be described as follows:

"The essence of the patient-centred method as it relates to the patient's agenda is that the physician tries to enter the patient's world, to see the illness through the patient's eyes. He does this by behaviour which invites and facilitates openness by the patient. The central objective in every

interaction is to allow the patient to express all the reasons for his attendance. The doctor's aim is to understand each patient's expectations, feelings and fears." (Levenstein et al, 1986 in references).

The key to the patient-centred method is to allow as much as possible to flow from the patient, in order to understand the patient's expectations, feelings and fears.

Feeling understood is perhaps one of the most powerful and positive feelings that one can experience.

One of the first ways of understanding is by listening.

Carl Rogers also said "very early in my work, I discovered that simply listening to my client, very attentively, was an important way of being helpful. It seemed surprising to me that such a passive kind of interaction could be so useful." (A Way of Being, 1980, p137).



The commonest criticisms of the patient-centred approach are:

**"It all sounds very nice but it is too academic and I don't have the time. My practice would grind to a halt if I opened up each consultation into a chat session. We are clinicians not psychologists."**

Answers to this are:

What you say is may be correct but:

"Some doctors take to it more naturally than others, and some by dint of their own temperaments will be more sceptical or even hostile to it." (Levenstein, 1994)

"Complete patient-centredness is an

## The Cutting Edge of Family Practice Research

**How does one measure the doctor-patient relationship, patient-centredness and other dynamics of the consultation?**

**How do they affect outcomes and how effective are they in other ways (clinically, efficiently, cost effectively, meeting the patients' or society's needs and expectations etc etc)?**

**The assessment of the doctor-patient relationship and patient-centredness are some of the unique areas where research is being done in Family Medicine (Henbest, 1991).**

ideal to which we can only aspire, and is at best only approximate”.

## What about the time problem?

It is difficult to answer this. From research so far done patient-centred consultations take a little longer, but not much longer, than doctor-centred ones but time may be saved **in the long run** by an early and accurate identification of the patient's problems. (McWhinney, 1989, p123-124).

## Is it really necessary to address the patient's agenda?

The answer is: we do not know unless we ask. Patients have fears even about minor problems. In emergencies, the medical agenda must take precedence but when these needs have been met, no patient has a greater need of being listened to.

The patient-centred clinical model, on the other hand, does not mean giving the patients everything they want. Excessive demands and views in conflict with normal medical management need to be negotiated and reconciled.



Henbest (1989) highlights **seven themes** that pervade the concept of patient-centred care:

**The Primacy of Caring for the Person:** This focuses on personal versus impersonal care and caring for the person rather than only the disease.

**The Significance of the Subjective:** is the understanding of what the illness means to the patient.

**The Importance of the Doctor-Patient Relationship:** emphasises the effect the personal relationship between doctor and patient has on diagnosis and outcome.

**Whole Person Medicine:** which takes into account, amongst others, the patient's psychological, spiritual and social life.

**The Comprehensive Diagnosis:** is a “deeper” diagnosis such as the three stage diagnosis (clinical, individual and contextual) or the threefold diagnosis (physical, psychological and social).

**The Patient's Agenda:** refers to the aim of discovering the real reasons for the patient coming to see the doctor.

## COMMON MISCONCEPTIONS ABOUT PATIENT-CENTREDNESS

It is being a “nice guy”.

It is a good bedside manner.

It is meeting all the patient demands (as opposed to concerns).

It is only an academic exercise.

It takes more time.

**The Person of the Physician:** highlights the personal qualities and skills of sensitivity, awareness and intuition.



There are several other themes that are linked to patient-centred care:

**The Art of Healing** which not only addresses the physical body but also the social and spiritual aspects and the distress of the human spirit (see in references: *The Healing of Persons* by Tournier and *The Healer's Art* by Cassell).

**The Relief of Suffering** which includes physical pain but is by no means limited to it. The relief of suffering and the cure of disease is seen as twin obligations of a medical profession that is dedicated to the care of the sick. Little attention is explicitly given to the problem of suffering in medical education.

Suffering may be defined as the state of severe distress associated with events that threaten the intactness or personhood of the patient (see in references: *The Nature of Suffering* by Cassell).

**The Concept of the Humanist Physician** is the ideal of a clinically competent physician who is a compassionate and educated man. This doctor has a firm basis of technical competence and clinical craftsmanship and is also compassionate. This denotes that he has some understanding of what sickness means to other persons (not to be confused with pity or condescension). (Pellegrino, 1974).

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