Patient-Centred Care – Do we really believe in it?

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Curriculum Vitae

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Introduction

The concept of patient-centred care has enjoyed much increased currency in recent years. It has found its way into postgraduate training programmes for family physicians, and has been the subject of many papers and seminars, as well as a small but growing body of research literature concerning its cost-effectiveness, effect on patient satisfaction etc. In fact such has been the momentum of this idea over the past few years that "patient-centredness" has fast become the current buzz-word of family practice.

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For all those of us who have long subscribed to patient-centredness as being central to the discipline of family medicine, this development must no doubt be welcomed as something long overdue. However, in our haste to do so, it would probably be wise, particularly in view of the implications for postgraduate training of family doctors, to do some stocktaking as to the state of the art of patient-centredness in our work at present. For the burgeoning popularity of patient-centredness in recent years seems also to have brought in its wake a number of major misconceptions which need to be recognised and addressed as soon as possible. Some of these misconceptions are of such a serious nature that they necessitate a

serious re-appraisal of what patient-centredness is and what it isn't.

What misconceptions am I referring to? For one thing many doctors including trainees (and even trainers) seem to regard patient-centredness as something you do when you have the time to ask a patient how he/she feels about their complaints in order to elicit their anxieties and/or expectations about their visit to their GP. Others seem to think that patient-centredness is all very well when patients have "psycho-somatic" problems but is of little or no use for organic or physical illnesses – "real medicine". "When I see a patient who is having a suspected heart attack, I'm certainly not going to waste time asking him how he feels about it", is one common comment. Other colleagues have argued that their patients are not particularly interested in discussing their fears about their health and simply want a quick and effective diagnosis and treatment for their ailments.

All the above perceptions, or rather mis-perceptions, betray a fundamental lack of understanding of what patient-centredness really is. Perhaps they are most useful in that they serve to illustrate what patient-centredness is not: ie patient-centredness is not an approach to patient care which focuses on the patient's mind to the exclusion of his body: such a fragmented approach is of course anathema to family practice with its emphasis on holistic care. Nor is patient-centredness dependent on the patient's socio-economic status or how verbal he/she is or in fact any other personality variables though these things may of course influence the form or expression the patient-centredness will take. In short, as the MCQ's would have it, patient-centredness is "none of the above".

"If that's what patient-centredness isn't" you may ask, "then what is it?" To attempt to answer this question we should perhaps begin by going back to the origin of the term "patient-centred-medicine" which was first coined by Michael Balint about a quarter of a century ago, in contradistinction to what he called "illness-centred medicine".[5] The latter referred to the attempt to fit patients into traditional diagnostic categories. "Patient-centred medicine" was the title of the publication of the proceedings of the lst International Balint Conference held in London in 1972. In his introduction to this volume, the editor Dr Philip Hopkins says: "It has been claimed that patients are sometimes considered as mere objects of medical treatment, in that diagnosis and treatment are determined solely by the doctor on the basis of his assessment. So often, this leads only to dissatisfaction and failure. The needs of the patient may not be expressed in words and have to be discovered by the doctor's investigation and even intuition. To satisfy such a patient does not mean simply to satisfy the patient's expressed wishes, but to fulfil deeper ... needs, the elucidation of which may be a complex (matter). The kind of medicine that takes into account these needs and satisfactions is well described as "patient-centred medicine ..."

"Patient-centredness" has become the buzz-word of family practice.

The GP needs to pre-scribe himself – the drug doctor.

A few points from this early description are worth noting. Firstly it is significant that Hopkins refers to a "kind of medicine" ie, it is not separate from any aspect of medical practice. Secondly there is reference to the patient's "deeper" needs which are not necessarily expressed in words (and indeed the patient may not even be aware of them at that time). And thirdly, the need for the doctor to be able to respond to this

deeper level of need on the part of the patient. This latter aspect relates to another of Balint's famous concepts viz "the drug doctor". Balint argued that of all the drugs prescribed in general practice the most commonly used, and yet least understood, was the doctor himself.

He suggested that in order to "prescribe himself" most effectively the doctor needed to understand his own indications, contra-indications, dosage, form of administration, unwanted side-effects, etc. The "drug doctor" needed to be individually titrated to meet the "deeper needs" of each patient which have been referred to. Much of the training in "Balint Groups" was (and still is) directed at optimising the effectiveness of the drug doctor. In this regard Balint referred to the need for doctors to undergo "a limited but significant change of personality" during their training in Balint Groups in order to be able to relate effectively to their patients, ie in order to practice patient-centred medicine.

From what has been said thus far, it must be clear that patient-centred care can only be understood in the wider context of the doctor-patient relationship. Furthermore, training in this area needs to be thorough and intensive. In 1972 Philip Hopkins[5] referred to the "growing awareness of the need everywhere for changes in the training of medical students, and for further training of doctors already in practice". He goes on to say that "perhaps, as Balint said often enough, the greatest need is to increase the awareness in our medical teachers of the importance of what he called, the overall diagnosis and its implications".

These were perhaps prophetic words for us to consider in a plenary session entitled "What kind of GP are we trying to produce?" being held over two decades later. For the truth is that in spite of the increased recognition of the importance of patient-centred care in recent years, the training in this area still falls very far short of the real needs of the situation. To be sure patient-centred care features prominently in the curricula of all self-respecting departments of Family Medicine and vocational training programmes worldwide. But if we were to consider the matter in terms of the quality control needed for the training for patient-centredness, we might say that it requires more than a well intentioned curriculum to reverse the acculturated illness-centred approach to patient care which family practice trainees have acquired during their undergraduate training. Balint groups are probably the longest established and arguably the most suitable vehicles for acquiring this training. But the truth is that there are relatively few such groups in family practice training programmes worldwide, and the situation is further hampered by the lack of suitably trained group leaders. In the absence of such a mode of training, trainees are given many inputs as to the principles and practice of patient-centred care. These sometimes extend to tuition on how to take up certain cues offered by the patient, and ways of eliciting the patient's concerns about his symptoms and the doctor's responses to them.

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This latter form of training can certainly be regarded as a step in the right direction. In my view, however, it still falls far short of the mark. I do not believe that patient-centredness can be taught as some kind of structure or grid which is superimposed on the consultation process. In fact I think it is probably true to say that patient-centredness cannot really be "taught" at all, but rather has to be

learnt in an experiential kind of way with the right kind of supervision. Otherwise, a highly artificial kind of situation tends to arise where trainees believe they have been patient-centred whenever they ask their patients what they think is wrong with them and elicit fears, expectations etc; and doctor-centred when they do not. Of course this amounts to a gross over-simplification and indeed a distortion of what patient-centredness is really about. For patient-centredness is not so much a technique for conducting consultations as it is an approach to patient care. In fact, it is even more than this: it is the very essence of the consultation in family practice. It is the process by which the doctor attempts to enter into his/her patient's world and tries to understand how she feels about her body and her soul by means of the obscure language system with which patients present to their doctors in the consulting room.

Thus seen, patient-centredness becomes not merely a tool of the consultation process, but the very *raison d'être* of family medicine. It is, in a sense, our most central article of faith. Yes, patient-centredness is our creed, without which we forfeit our claim to be a unique discipline practicing continuing personal patient care.

Seen from this point of view, the trainee who attempts to practice patient-centred medicine by implementing some rote formulae he has learnt, could be compared to a person who carries out religious rituals without any appreciation of their deeper significance and meaning. It easily becomes a hollow exercise, robbed of its richness and vitality. Surely this is not the kind of GP we are trying to train. But then, why has it taken so long for patient-centredness even to get properly on the map as far as training for family practice is concerned? Can it be that we have not truly believed in it? And if not, why not?

To answer this latter question, we first turn to our perennial bogeyman, the traditional disease-centred undergraduate medical training. Family practitioners are well aware that their undergraduate training has provided them with a good deal of much needed medical knowledge. However, as every newly-qualified doctor can testify, this mountain of information soon proves strangely inadequate in the face of ambulatory patients whose complaints defy the most assiduously memorised lists of differential diagnoses. Dismayed by the failure of the formulae he believed he could rely on, the general practitioner novice decides to fall back on the last line of defence, the laboratory. When this too repeatedly yields nothing but extra costs and anxiety for his patient, he becomes disillusioned with his medical school training, to which he now declares himself to be implacably opposed for all eternity.

The GP finds himself repeatedly lured away by the seductive glitter of high-tech disease-ology.

But the truth is actually more complex than this. For I believe that while family physicians fulminate against the specialist-orientated teaching hospitals, their true feelings towards them are really highly ambivalent. On the one hand there is genuine indignation at the fragmented, often impersonal way in which medicine is taught and practiced at these institutions. But at the same time there lingers in the deep or not-so-deep recesses of the family doctor's psyche, a naggingly persistent feeling of inferiority in relation to the specialist disciplines. The specialist medical school training has become internalised as a kind of parental authority figure which the GP feels

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compelled to try to satisfy and impress in spite of the feelings of anger and rebellion which may rise up within him. Somehow, though his reason tells him otherwise, his heart hankers after the "hard" medicine which was so proudly held up to him by his erstwhile teachers. Personal patient care feels vaguely too "soft", too *feminine* for the GP's comfort, in spite of himself.

And so it is that the commitment to patient-centred care amongst both trainers and trainees is less than total. We do not have complete faith in it. To use the religious analogy again, specialist medicine could be regarded as the idolatry of the family practitioner. Try as he might to remain true to patient-centred medicine, the GP finds himself repeatedly lured away by the seductive glitter of high-tech disease-ology. Specialist medicine may be seen to be the GP's golden calf, in more senses than one.

So, if we want to train GPs who are patient-centred in more than name and declaration only, we first have to address the malaise of faith in ourselves. And we need not be ashamed of this malaise, because behind all faith there always lurks the shadow of doubt, even amongst those whose faith is strongest. What needs to happen, however, is that we have to acknowledge these doubts openly amongst ourselves, and discuss and debate them constructively. It is not necessary, indeed it is counter-productive, for us to pretend that these doubts do not exist, in order not to appear vulnerable to our specialist colleagues, to each other, and to ourselves. And trainees should be encouraged to express their own reservations about patient-centred-ness which should be taken seriously and discussed fully, rather than simply being treated as mistaken notions which they will discard in due course. Otherwise they will graduate from training programmes as exponents of a liturgy which they recite dutifully, but without conviction.

It needs to be understood by trainees and trainers that our preference for patient-centredness is ultimately based on a value judgement on our part. This is not a case for which absolute proof can be found (if indeed such a thing as absolute proof really exists for everything). Various studies have and should continue to be conducted, but at the end of the day our penchant for patient-centredness still rests on our own perception that this is the mode of relating to our patients which is best suited to the needs of our work situation. Inevitably, some doctors will take to it more naturally than others, and some by dint of their own temperaments will be more sceptical or even hostile to it. In any case complete patient-centredness is an ideal to which we can only aspire, and is at best only approximate. In the course of the training process each individual needs to be helped to find the way of being patient-centred best suited to their own personalities. There is no single way to patient-centredness nor any one single way to be patient-centred. In the course of the training process, the validity and even the very meaning of patient-centredness itself should be constantly open for discussion and dialogue.

... the way of being patient-centred best suited to your own personality.

Believe in patient-centredness because this offers patients the best possible care.

Open discussion about doubts concerning patient-centredness can be a very fruitful exercise. I have encouraged the trainees in the Western Cape Vocational Training programme to do this and the results have been gratifying.

Trainees who have worked through

and resolved their questions and mixed feelings about their field of study are more likely to internalise its values in an enduring and meaningful way.

So, in answer to the question, "What kind of GP are we trying to train?", I would say it is one who is not merely clinically competent, but has learnt to listen to his patient in a special kind of way. He has learned to listen to the unique story each patient tells him, usually through his body, of the travails of his heart and spirit, past and present. In short, we need to train patient-centred doctors who believe in patient-centredness. They believe in patient-centredness because they have become convinced that this offers their patients the best possible care. They are also aware than in many cases they may be the only person to whom the patient can relate in this uniquely personal and intimate way. In a time of increasing social upheaval and rapid change, our trainees will know that they are offering their patients something extremely precious, something which no political system can provide, but which no health system can really afford to do without, whether it realises it or not.

Those of us who are responsible for training, carry the awesome responsiblilty of training a new generation of family practitioners who will take our discipline into the next century. They have the energy, ability and enthusiasm to meet the difficult challenges which lie ahead. Much will depend on our own ability to convey to them the abiding value of the work which we do. We can only succeed if we are prepared to do the necessary soul-searching to identify and overcome our own resistances to full belief in patient-centred care.

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