Patient-centred care in primary health care

Our first obligation must be to serve the good of those persons who seek our help and trust us to provide it. **- Cranshaw[1]**

The most emotionally gratifying and enriching moments in my young professional life have been those in which I was able to permeate and connect with the patient as a person, and be able to strike an understanding with the patient of what disturbed his/her functional equilibrium. Further steps down this path the patient begins to yield forth contributions towards the solution of the mystery that has vexed him/her to a point of dysfunction. My task as a clinician then becomes that of tapping into the fund of knowledge bestowed upon me by training, modified by experience (personally and professionally) and being remodeled and perfected by the continued encounter with patients.

This knowledge then allows me to explain what has been perplexing to the patient; it allows me to explore the patients fears, anxieties, inhibitions and vulnerabilities; it gives the patient an opportune time to share in a conducive and nurturing environment what has been a vexation to self and loved ones; the patient also gets empowered not only to overcome the present illness but also gets equipped with skills on handling future vexations that hamper the prevalence of healthy living.

The level of professional engagement in patient-centred care warrants that adequate time be spent with the patient and it may take several consultations to achieve the favorable outcomes. Sometimes one would witness the manifestation of this person-to-person interaction of greater depth as momentary hypersecretion in the eyes of the patient. It is not, however, unheard of nor impossible to observe a similar phenomenon on the clinician. I believe that it was upon making these realizations that Rogers[2] wrote: "*Almost always, when a person realizes he has been deeply heard, his eyes moisten. I think in some real sense he is weeping for joy.*"

Following these experiences, the inclinations that Balint[3] had when he referred to a notion of "*understand[ing] the complaints offered by the patient, and the symptoms and signs found by the doctor, not only in terms of the illness, but also as expressions of the patient's unique individuality, his tensions, his conflicts*" were unraveled to me.

It is amazing to find how much bounteous resource to help oneself are, but the capacity to mobilize them is most often overwhelmed by the state of being ill. This adds testimony to the findings of Rogers[4]: "*the person has within himself or herself vast resources for self-understanding and for constructive changes in ways of being and behaving and that these resources can best be released and realized in a relationship with certain definable qualities.*" Mobilization of these resources requires assistance from a clinician who "*grasps the buried latent unity of the suffering soul . . . and this can only be attained in the person-to-person attitude of partner, not by the consideration and examination of an object.*"[5]

The successful implementation of the prescripts of patient-centredness in Primary Health care is as relevant today, if not more, as it was when they were introduced by its proponents decades ago. As early as 1927, Peabody[6] eloquently stated that: "*The significance of the intimate personal relationship between physician and patient cannot be too strongly emphasized, for in an extraordinarily large number of cases both diagnosis and treatment are directly dependent on it, and the failure of the young physician to establish this relationship accounts for much of his ineffectiveness in the care of patients.*"

Capturing the person-to-person interaction in the context of comprehensive primary health care Fehrsen[7] wrote: "*It is the person of the health worker that allows another person to leave his/her presence, feeling better, feeling more human.*" Reflected in the notations of the most famous physician of the nineteenth century, Sir William Osler, is understanding of these assertions: "*It is much more important to know what sort of patient has a disease than what sort of disease a patient has*"[8].

Central to the effective and successful application of patient-centredness is the clinician's commitment to self-discovery, knowledge of own limitations, being in touch as well as in control of own emotional vulnerabilities. Pelletier[9] highlighted this aspect of the qualities of a clinician rendered patient centred care: "*Anyone in healing profession must become acquainted with his own emotional nature, his personality conflicts, his strengths and weaknesses, and generally to engage in a process of self exploration.*"

Putting emphasis to the critical necessity of sound person-to-person relations in patient management Rakel[10] lists the skills required to relate well to patients: "*develop compassion*

and courtesy, the ability to establish rapport and communicate effectively, the ability to gather information rapidly and to organize it logically, the skills required to identify all significant patient problems and to manage these problems appropriately, the ability to listen, the skills necessary to motivate people, and the ability to observe and detect nonverbal cues."

Primary Health Care training should strive to groom clinicians with demonstrable skills in "*show[ing] genuine interest in the patient; thoroughly evaluat[ing] their problem; demonstrate[ing] compassion, understanding, and warmth; and providing clear insight into what is wrong and what must be done to correct it.*[11] Throughout training we should inculcate a culture that nurtures the development of compassion, understanding, and patience combined with a high degree of intellectual honesty.[10]

For every second of every minute in every hour of everyday, in a Primary Health Care clinician's professional life the care of the patient should be the ultimate objective. As an educator, my greatest challenge is to model the ideals of patient-centred care in Primary Health Care to the learners in the face of a tangible reality – the person who bestows trust on the proficiency I ought to have acquired from my mentors. I was touched, as well as, inspired by the writing of Fehrsen[7] that: "*.there are many for whom the last refuge is in Primary Health Care. If this last refuge is uncaring, it's the final isolation, the final rejection, and hell for them!*"

Let us, therefore, be catalysts to unleash the capacity for caring in the health care clinicians we train.

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RURAL Telemedicine IN AFRICA

To the editor: Most of health professionals in rural areas feel isolated from mentors, colleagues, and the information resources necessary to support them personally and professionally. The medical equipment at their disposal may be less up-to-date and other necessary facilities less than adequate. These conditions have made it difficult attracting and retaining health professionals in rural areas resulting in geographic and socio-economic isolation that have disenfranchised millions of people from the health care services they require.

The advent of telemedicine, which is the use of telecommunication and information technology to provide medical information and services, has brought an alternate solution to help address the problem of healthcare provider distribution. Rural telemedicine can be seen as the way to distribute the medical expertise out to remote and rural health professionals who need consults to help them manage their patients.

Rapid development in computer technology and easiness to purchase has led to more amenability to computer-based telemedicine technology and the growing use of telemedicine. There are two modes used in most of the today's telemedicine applications. The first one is called store-and-forward or asynchronous mode and is used for non-emergent situations, where the diagnosis or consultation may be made within the next 24 – 48 hours. The application of store-and-forward includes teleradiology (the sending of x-rays, CT scans, or MRI), telepathology and dermatology. The second mode is the interactive (real time) consultation or synchronous mode, which may involve two-way telephone conversation or two-way interactive videoconferencing that provides face-to-face consultation.

Telemedicine also requires the availability of quality telecommunication infrastructure. However, the advanced telecommunication infrastructure is usually unavailable or very expensive in rural areas. According to the Federal Communications Commission (FCC) telecommunication and health care advisory committee "… in most cases the telecommunication bandwidth available to urban health care providers and business is not available in rural areas. This poor quality or the lack of telecommunication infrastructure remains one of the major obstacles for introduction of telemedicine in most parts of Africa. Even though in other places telemedicine is being used, the services offered are limited due to the lack of sufficient bandwidth, especially for quality video transmission. So to make rural telemedicine a reality, there needs to be cooperation between the department of health and department of communication so as to make sure that the telecommunication infrastructure needed for telemedicine is there.

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