Patient-Centred Care: A Review of the Concept

– R J Henbest

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Curriculum vitae

Ronald J Henbest was born in Edmonton, Alberta (Canada) where he qualified in 1974 with a BSc in Maths and Psychology and in 1978 with an MD from the University of Alberta. He then completed two years postgraduate study (residency) in Family Medicine with the Department of Family Medicine at the University of Western Ontario (Canada) and obtained his CCFP from the College of Family Physicians of Canada. Ron joined the Department of Family Medicine at Medunsa in 1980. He has a particular interest in the doctor-patient interaction and its importance for healing. He returned to the University of Western Ontario in 1984 to take their Master of Clinical Science Degree in Family Medicine (MCISc), which emphasizes patient care, teaching and learning, and research. His thesis on Patient-Centred Care involved the development of a method for measuring patient-centredness and testing it against patient outcomes.

Summary

The author reviews the development of the concept of patient-care and how doctors are changing their thinking about the type of care they render to their patients. He starts with a historical perspective, followed by a description of a parallel development, then, how this concept was re-discovered during this century, and finally how it is now used in medical literature. The old medical model of specific responses and specific cures is just no longer adequate; there is a need for a patient-centred approach where the patient as a unique person in his complete environment is cared for.

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In 1967 the following statement appeared in an editorial in the Lancet: "Care of the doctor-patient relation has for too long been left to chance; because of its importance to general practice it must now be examined, defined, and taught for only then can it be practised effectively."[1]

Indeed, during the two decades that have followed this editorial, much examination and definition of the doctor-patient relationship has occured, and one of the key concepts to emerge has been that of patient-centred care. This paper reviews the development of this concept beginning with an introduction to the term patient-centred, an historical perspective, and a description of a parallel development, followed by a review of the rediscovery of the concept during this century and the subsequent use of the term in the medical literature.

Introduction of the Term

The term, patient-centred medicine, was introduced by Michael Balint in 1970 in order to give a name to a particular way of thinking. Patient-centred medicine referred to the attempt to, "... understand the complaints offered by the patient, and the symptoms and signs found by the doctor, not only in terms of illnesses, but also as expressions of the patient's unique individuality, his tensions, his conflicts and problems".[2]

This was in contrast to the illness-centred or scientific way of thinking which considered the human being to be a complex biomedical machine and thus attempted to, "... understand the patient's complaints in terms of illnesses, that is, in terms of a pathologically changed part of the body or of a part-function of the body".[2]

These two ways of thinking led to different understandings of the patient and his problems. The understanding based on illness-centred thinking Balint called traditional diagnosis; the understanding based on patient-centred medicine, he called the overall diagnosis.

Historical Perspective

Jan Smuts, the legendary South African warrior, scholar, and prime minister, is generally believed to have been the first to use the term holism in his attempt to counter the reductionistic philosophy of science and medicine when his book, *Holism*

and Evolution[3], was published in 1926. Smuts argued that an entire, whole organism constitutes an entity that is more and different from the sum of its individual parts and further, that, "The whole in each individual case is the centre and creative source of reality; ... a hitherto neglected factor of a very important character".[3] According to Smuts's theory of holism it would have been impossible for the doctor to understand a person's illness apart from understanding the whole in which the illness was present, namely the person, himself. Nor could the person be understood without knowledge of the broader context of his family, work and society.

Unfortunately, the term, holistic medicine, has fallen somewhat into disrepute because of its use by a wide variety of unorthodox healers to mean very different things. However, the holistic approach, itself, has a long and distinguished history.

Capra[4], a prominent physicist who has written extensively about the philosophical implications of modern

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The person, not the problem ...

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science, has described in some detail how the practice of medicine in many cultures throughout the ages, has oscillated between reductionism and holism in accord with changing value systems. He gives an account of three holistic traditions: 1) the phenomenon of shamanism that is so prevalent in nonliterate cultures even today, 2) the system of classical Chinese medicine that forms the basis of most Eastern medical traditions, and 3) the tradition of Hippocratic medicine that lies at the roots of Western medical science.

The Hippocratic tradition, in contrast to shamanism and classical Chinese medicine, holds firmly the conviction that illnesses are not caused by supernatural forces, but are natural phenomena that can be

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... to understand the patient's unique individuality, his tensions, his conflicts, his problems

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studied scientifically. However, an emphasis on the fundamental interrelations of body, mind, and environment is shared by all three traditions.

After reviewing the history of holism, Capra describes what he sees as the new holistic approach, one that not only recognizes the interrelatedness of all things, but one that also attaches importance to the subjective aspects of medicine. For, as stated by Capra: "The proper valuation of subjective knowledge is surely something we could learn from the East. Ever since Galileo, Descartes, and Newton, our culture has been so obsessed with rational knowledge, objectivity, and quantification, that we have become very insecure in dealing with human values and human experience".[4]

An historical perspective is also provided by Dr F G Crookshank in a scholarly paper delivered in 1926.[5] He traces two routes of knowing: that of the sensualist (or empiricist), and that of the Platonist (or rationalist). Two rival schools of ancient Greece are described. The school of Cnidus regarded the purpose of diagnosis as being to categorize the patient's illness according to a systematic classification of disease. The school of Cos believed that the aim of diagnosing was to describe the patient's illness in its relevant context. The classical description of this second point of view is to be found in the writing of Hippocrates where it is stated that Hippocrates: "... framed his judgements or diagnosed by paying attention to what was common to every and particular to each case; to the patient, the prescriber, and the prescription, to the epidemic constitution generally, and to its local mood; to the habits of life and occupation of each patient; to his speech, conduct, silences, thoughts, sleep, wakefulness and dreams ... to his tears ..."[5]

The interrelated themes of the centrality of the whole, of the importance of the subjective (as part of the whole), of everything having a

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Doctors used to think of their patients as complex bio-medical machines - with something gone wrong

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context, and of the interconnectedness of all things all stem from holistic thinking.

The Client-Centred Approach

The client-centred approach can be thought of as both a parallel and contributory development to the concept of patient-centred care.

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In his landmark book, *Counselling and Psychotherapy*[6], Carl Rogers introduced a "newer psychotherapy," one in which the focus was, ". . . the individual and not the problem".[6] Its goal was genuinely different from that of other approaches in that its aim was not to solve any particular problem, but to help the individual to grow such that he could cope not only with his present problems, but also with later problems in a better integrated fashion. Thus, this new psychotherapy was to be person-orientated as opposed to problem-orientated.

What is now most commonly referred to as the client-centred approach, started as a way of conducting one-to-one therapy. This way of therapy was first referred to as nondirective[6] and its emphasis was on technique. A decade later, Rogers changed the name to client-centred therapy[7] to indicate that the focus of therapy was on the internal phenomenology of the client. The 1960s saw a broadening of the approach to other fields and the terms student-centred teaching and group-centred leadership were introduced.[8,9]

The final label that Rogers gave to his approach to interpersonal relationships was simply that of the person-centred approach.[10-12] The central hypothesis of this approach

was that, "... 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."[12] Rogers' consistent belief remained that it is the quality of the relationship that is central to the therapeutic process.[6,7,10-15] The three key attitudinal elements or characteristics of the counselor described by Rogers as vitally important in providing a growth-promoting relationship are now very well known. They are: 1) genuineness, 2) unconditional positive regard, and 3) empathy.[15] Rogers especially drew attention to empathy. It was, in his words, "... one of the most delicate and one of the most powerful ways we have of using ourselves."[11] The impact of empathy has been captured beautifully in the following words: "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."[11]

In concluding this section, I would like to draw attention to three points recognized by the client-centred therapists that have significance for the concept of patient-centred care.

The first point is that Rogers realized that the illness-centred way of

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thinking was not sufficient for dealing with people as a whole, who needed help: "The single element that most sets client-centred therapy apart (from other schools of psychotherapy) is its insistence that the medical model, involving diagnosis of pathology, specificity of treatment and desirability of cure, is a totally inadequate model for dealing with psychologically distressed persons."[12] Dealing with distressed people is a major feature of medical practice[13] and this fact has certainly contributed to the recognition of the deficiencies of the medical model to be described below.

Second, the client-centred therapists apprehended the importance of focussing on the person, rather than on the problem.[12] In the description of client-centred therapy by Boy and Pine, we find the following statements: "It focuses on the client as a person rather than on the client's problem. It is person-centred rather than being technique-centred, process-centred, or counselor-centred."[14] This focussing on the person was later to become one of the key principles of family medicine[15] and as we shall see, is central to the concept of patient-centred care.

The final point is that by the early 1970's, Rogers began to think increasingly in holistic terms when he

spoke of a "formative tendency in the universe as a whole, "which was to become one of the foundation blocks of the person-centred approach.[11,16]

The Concept of the Patient-Centred Care as Described in the Medical Literature

The rediscovery of the concept of patient-centred care during this century, has been a most exciting process. It began with the recognition by general practitioners of a lack or deficiency in their medical training. Consider, for example, the reflections of Sir James Mackenzie, in 1919, about his experience of starting general practice many years earlier: After a year in hospital as a house physician, I entered a general practice in an industrial town of about 100,000 inhabitants. I started my work fairly confident that my teaching and hospital experience had amply furnished me with complete knowledge for the pursuit of my profession... I was not long engaged in my new sphere when I realized that I was unable to recognize the ailments in the great majority of my patients."[17]

Focus on the individual and not on the problem

Gradually, the need for a different perspective on patient care came to be recognized. A number of distinct, but interrelated aspects of this new perspective can be identified and these will be presented in the approximate order in which they have appeared over the decades. Illustrative quotations from the writings of the original authors will be used to help portray something of the meaning of each aspect as it was first expressed. From the references given, it will be seen that each theme has been taken up time and again as this new way of thinking about patient care unfolded.

Francis Peabody, in an article published in 1927, identified not only that there was a lack in the medical education of this day, but spelled out what that lack was. He stated: "The most common criticism made at present by older practitioners is that young graduates have been taught a great deal about the mechanism of disease, but very little about the practice of medicine - or, to put it more bluntly, they are too "scientific" and do not know how to take care of patients."[18] Peabody went on to say that the practice of medicine is an art which includes the whole relationship of the physician with his patient thereby making it an intensely personal matter. In a striking aphorism, Peabody has emphasized what many forget during their years of hospital training; namely, that: "the secret of the care of the patient is in caring for the patient."[18]

It is the quality of the relationship which is central to the therapeutic process

Thus, Peabody articulated what was to become the dominant theme of patient-centred care: the primacy of caring for the person. Many others have expressed this same idea when speaking of personal versus impersonal care or of caring for the person, rather than the disease.[15,19-26] Fox in 1960, spoke of the personal doctor whose, "essential characteristic, surely is that he is looking after people as people and not as problems..."[20] Later, McWhinney was to state the first principle of family medicine as being, "The Person, not the Problem: The family physician is committed to the person, rather than to a particular body of knowledge, group of diseases or special technique."[27]

A second, and closely related aspect of care to be described was the significance of the subjective.[15,19,28-37] Henderson, in 1935, pointed out that in any interaction, "... the sentiments and interaction of the sentiments are likely to be the most important phenomena."[28] Sir James Spence, in 1949, in a paper called, "The Need for Understanding the Individual as Part of the Training and Function of Doctors and Nurses", pointed out that, "... doctors and nurses, because of the intimate character of their professional work, need particularly to understand the individual and to consider his feelings."[29] Later, Blum, in 1960, noted that it is crucial for the doctor to, "... understand the significance of the illness to the patient, since the doctor-patient relationship owes its establishment to the belief of the patient that he is ill."[30] John Stevens chose the value of the subjective as the central theme of his 1973 James Mackenzie lecture and claimed that, "In the long run, contrary to current educational credo, subjective

Patients need to feel they have been *deeply heard* by their doctor

evaluation is of infinitely greater value than any so-called objective assessment."[33]

With the recognition of the primacy of the person and the significance of the subjective, came the realization that the doctor-patient relationship is of tremendous importance.[13,18,33,34,38-40] Peabody stated it very powerfully when he said: "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."[18] A fourth aspect of care that was identified early on was referred to as whole person medicine.[25,29,38,39,41,42] In the 1940s, Dr Paul Tournier of Switzerland, published his first and probably most influential book, *Medicine de la Personne,*[39] which means medicine of

Newly trained doctors know a lot about the mechanism of disease, and very little of how to care for the patient

the whole person. Tournier maintained that, "... in the name of scientific objectivity itself, we must take every factor into account, the spiritual and psychological as well as the material, in order to relate them to the symptoms which the patient is suffering."[41] Whole person medicine was later defined by Dr Michael Brennan as, "... care by a family practitioner who considers the person as an integrated biopsychosocial whole at a given stage of his life cycle..."[39] The theme of whole person medicine represents the application of holistic thinking to patient care. The recognition that all things are interrelated and especially that illness and people need to be understood in their respective contexts has found expression in the writings of Brennan,[38,39] Stevens,[33] McWhinney,[25,43] and Cassell[44,45] amongst others.

A fifth theme of this different perspective of patient care is that of a more comprehensive diagnosis that better expresses the doctor's understanding of the whole person. Spence taught students that, "... before explanation and advice can be given to a patient they must make three diagnoses: the diagnosis of the disease, the diagnosis of the concept or fears of the disease in the minds of the patients or parents, and thirdly, the diagnosis of the patient's capacity to understand the explanation and follow the advice."[29]

Balint,[19] as early as 1957, urged doctor's to aim for a deeper or an overall diagnosis that took into account the patient's emotions and life situation in addition to his signs and symptoms. Greco,[31] in 1966, spoke of a precise diagnosis that necessitated assessing all levels of disturbance. McWhinney[32] in 1969, described a three stage diagnosis that consisted of a clinical, an individual, and a contextual diagnosis. Ten years later, Wright and MacAdam[46] similarly defined a threefold diagnosis made up of physical, psychological, and social components. Others who have written on this theme include Blum,[30] a Working Party of The Royal College of General Practitioners,[47] Tait,[48] and Pendleton.[36]

As the concept of understanding the whole person in order to arrive at a deeper diagnosis became better understood, attention was focussed on ascertaining the real reason (or all of the reasons) for the patient's attendance.[34,36,49,52] For example, Hodson noted that, "Perhaps the most highly-developed, most rewarding and difficult art of which the experienced general practitioner is capable of, is that of discovering

The secret of the care of the patient is in *caring* for the patient

the real reasons why the patient came to consult him in the first place..."[53] The patient's reasons for coming to the doctor have been found to include his ideas and attitudes, his feelings, and his expectations.[35,36,46,50] The ascertainment of these reasons for coming, was in addition to the doctor's task of making a diagnosis. Thus it was seen that, "Two tasks lie at the very centre of a physician's life: understanding a patient's illness and understanding the patient,"[32] and the concept of two agendas (the patient's agenda and the doctor's agenda) was born.[54,55]

The last theme to be described is really a consequence of all the others: the recognition that the practice of the kind of medical care implied in the interrelated themes described above, requires certain personal qualities and interpersonal skills of the physician.[13,32-34,38,44,45,56,57] This recognition of the importance of the doctor's interpersonal abilities is exemplified by Brennan's statement that: "The basis of adequate total person care in family practice lies not

only in the physician's technical competence but also in his personal qualities of sensitivity and awareness. Especially important is the physician's sensitivity to the feelings of patients and his intellectual as well as his intuitive awareness of the inextricability of the psyche from the soma."[58]

The Use of the Term Patient-Centred in the Medical Literature

The purpose of this final section is to illustrate the use of the term "patient-centred" since its introduction in 1970. It will be seen that the naming of the concept helped to crystallize the thinking of others such that the different themes identified in the previous section could become integrated.

Gill,[59] in 1972, described eight types of interviews in general practice, two of which are relevant here. The first type, which Gill called the traditional medical interview, utilized the illness-centred approach and was described as follows: "The doctor is the powerful purveyor of medical science.

Discovering the very real reasons why the patient came to you

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He observes the patient to find an illness, be it hypertension or depression, which he can treat. The patient's life and feelings are of secondary importance to the illness. The doctor's own feelings are denied existence altogether, as far as possible."[59] In contrast to this, was the patient-centred approach in which, "The doctor tunes in to what the patient is trying to say behind the presenting complaint, and sees any illness in terms of the whole patient... The doctor-patient relationship is often used explicitly in the interview... the keynote is awareness and tuning in to what the patient is bringing."[59] Byrne and Long's[50] detailed analysis of over 2,500 doctor-patient interviews, published in 1976, led to the observation that doctor behaviours stemmed from four sources: 1) a need to know (that is, to have a clear understanding of the patient's symptoms), 2) a need to control (that is, to limit the patient to a defined area), 3) a recognition of the patient's undeclared needs, and 4) a belief in the ability of the patient to make decisions and to be involved in his own treatment. The first two groups of behaviours, Byrne and Long categorized as doctor-centred; the third and fourth groups, they called patient-centred.

In 1979, Wright and MacAdam[46] described doctor-centred and patient-centred consultation styles as the opposite ends of a continuum. The doctor-centred style was seen to be highly directive and it restricted itself to the diagnosis of disease. The patient-centred style in contrast, provided, "... an insight into the patient's perception of, or response to, his problem," and helped the physician to, "... learn much about the person who had the disease, as well as (about) the disease itself..."[60]

Stanley Levenstein, in 1982, described the patient-centred doctor's role as that of a catalyst, "... facilitating the inherent growth potentials which exist within each patient and family, and helping them to find healthy solutions to their problems instead of illness."[61] For Levenstein, being patient-centred meant shifting the emphasis from the doctor to the patient: "To be maximally effective, that is to practice patient-centred medicine, we have to play down our own importance and stress that of our patients."[61]

More recently, a patient-centred clinical method for family practice has been described by Joseph Levenstein[52] and further expanded by the Department of Family Medicine

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Two tasks at the centre of a doctor's life: to understand the patient's illness and to understand the patient

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at the University of Western Ontario, London, Canada.[54,55,62] They described the method 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."[54]

Summary of the Concept of Patient-Centred Care

The concept of the patient-centred care can be seen to have a history, both ancient and modern. Its ancient history can be traced to its roots in holism; its modern history can be followed through its rediscovery during this century. This concept can also be seen to have a parallel in the

client-centred therapy described by Carl Rogers.

Perhaps most importantly, the concept of patient-centred care can be seen to have a number of interrelated aspects or themes including the following: the primacy of the person, the significance of the subjective, the importance of the interpersonal

To see the illness through the eyes of the patient

(doctor-patient) relationship, the wholeness of the person, the deeper (more comprehensive) diagnosis, the real reasons for coming (the patient's agenda), and the person (personal qualities and skills) of the physician.

In concluding this review, I would like to emphasize that what we are witnessing is a change in thinking about patient care, a shift in paradigms.[63] It began with the recognition that, "... an exclusive concern with the traditional medical model of specific agents, specific responses, and specific cures is no longer adequate to the doctor's practice."[60] Eventually, as the many aspects of this newly rediscovered perspective of care have come to be identified and expanded, both the need for and the recognition that a shift is occurring has been stated explicitly,[25,33,44,64] as evidenced in the following profession by Cassell: "I believe medicine is in the midst of fundamental and exciting changes; it is evolving toward a profession in which the primary concern of physicians is with sick (or well) persons rather than merely their diseases. Indeed, this is probably the most profound shift in medicine since the concept of disease as we know it, came into being in the 1830s."[44]

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