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Section on Person-centered Clinical Care

Person-centered clinical practice

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Background

In clinical care consultations are often doctor-centered. Patients are not seen as persons, but as cases or diagnoses. Doctors focus on symptoms and lack attention for context. The doctor does most of the talking and takes decisions on diagnosis and treatment, without shared responsibility and decision-making, and without a therapeutic alliance thus contributing to low compliance. And when meeting resistance persuasion and professional status are used [1].

In many cases better outcomes can be achieved with person-centered approaches.

Patient/person-centeredness

In patient-centered consultations there is more attention for context, taking into account social and psychological as well as biomedical factors. The patient is seen as a person and there is emphasis on a dialogue with that person. Engels biopsychosocial model is still used frequently to clarify various dimensions of the persons' context, and it is also used in medical education for this purpose [2].

Lack of time and knowing what is best for patients are reasons frequently mentioned for being doctor-centered.

Undeniably, patients usually present more than one problem in consultations in every-day (general) practice and the problem with the highest priority gets attention first. In trying to address as much as possible, psychological and social aspects are likely to get too little attention. To win time, physicians tend to interrupt patients fairly quickly and focus on their own agenda fearing that a patients' monologue will go on for too long [3]. Inhibiting behavior actually makes patients voice their perspective and concerns more often and is inefficient [4].

Life style

Life style related risk factors contribute negatively to outcomes of many chronic illnesses and avoidable deaths [5]. Physicians advising patients to change their lifestyle are disappointed so few take the advice seriously. But behavior changes are difficult to achieve. With only giving advise steps are skipped. One of the many theories underpinning (effective) life-style interventions is the 'Stages of Change' (Trans Theoretical) [6]. Five stages are identified: pre-contemplation, contemplation, preparation, action, and maintenance. Moving too quickly and trying to persuade a patient to change behavior too early, in fact impedes change. Motivational interviewing is an effective directive, person-centered counseling style to help individuals move through the stages, based on the theory that motivation is a state of readiness for change, fluctuating over time [7, 8]. When someone is motivated to make a change, intentions can be converted into actions and changes can be made.

Actions planned by physicians, are not as successful as actions planned by the individuals themselves. In 'Action-planning', a collaborative process, the person/patient chooses the goals, clinician and patient negotiate a specific plan. Changes can sometimes be achieved quickly and some patients even convert directly from the pre-contemplative to the action stage [9].

Solution focused and problem solving strategies can also be used to plan actions [10, 11]. Problem solving is used with success as brief psychological treatment but also in various management programs for chronic illnesses, for instance in diabetes care [12–14]. Key point is empowerment, helping a person to (re)exert control over practical problems and increase confidence about the own ability to solve problems. An unhealthy behavior can be seen as a problem, which needs to be solved. The physician guides the person through the process but the person finds the solutions and solves the problem.

A sequence of the above-mentioned effective person-centered techniques is practical for every-day clinical practice.

Treatment

Studies from a broad range of clinical contexts demonstrate better outcomes of person-centered care in clinical practice [15]. A systematic review on pain for instance, concluded that the quality of the interaction between physician and patient could be extremely influential on pain outcomes and lead to more relief of pain [16].

Bad news

Studies in oncology and various other specialties showed that most patients receiving bad news preferred a patient to a doctor-centered style when discussing diagnosis, treatment and prognosis [17]. Most people prefer full disclosure, but not all. With a person-centered style, knowing that not all patients want to know everything, the information can be adjusted to the individuals' preferences and cultural context [18].

Medically Unexplained Symptoms and depression

In Medically Unexplained Symptoms (MUS) difficulties in the doctor—patient relationship arise because doctors are the one to choose the direction [19–21]. These patients value GPs who provide convincing, legitimating and empowering explanations for their symptoms, but their concerns are less likely to be explored than in patients presenting explained symptoms, and reassurance is provided without a symptom explanation [22–24]. Recent research pointed out that GPs typically disregard patients' psychological cues and assert a somatic agenda and help maintain or even cause the problem of MUS [15].

Another example from mental health refers to 'the doctor knowing what is best for patients'. Even when doctors in theory know better than patients what the 'diagnosis' is and what the options for treatment are, they are no expert on every persons' life and context. Van Os, looked at guideline concordant treatment for depression. GP's were most effective when they used the guideline together with empathetic person-centered communication. Using guidelines in a dry technical way was less effective, even though the treatment was protocollarily correct [25].

Conclusion

There are many examples in favor of a person-centered approach but physicians often have not been trained in patient-centered communication. Fortunately in modern medical education patient-centered communication is considered important and so is teaching of additional patient-centered techniques in residency programs and continuous medical education. Hopefully this will impact positively on the health of many in the future.

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