Patient-centeredness in the 21st century

Instrumentalization or improved communication?

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Abstract

Objective: The objective of the current study was to investigate the contemporary concept of patient-centeredness compared to the original notion of patient-centeredness in practice and politics.

Methods: This is accomplished through a concept-analysis of patient-centeredness on the basis of the original publications by Michael and Enid Balint as well as policy documents regarding patient-centeredness in the Danish health-care system in the period 2014-2016. A case-study was conducted on patient-centeredness in the Danish health-care system using interviews with doctor and patient before and after the consultation and video-observation of the consultation. The interviews and observations were transcribed and analysed using a framework derived from Pragmatics of human communication (Watzlavick, Beavin & Jackson, 1968).

Results: Substantial differences between the original patient-centeredness and contemporary patient-centeredness was identified. Both types of patient-centeredness were practiced. However, contemporary patient-centeredness was only realised in the patient performing the doctor's role-obligations of prescribing and monitoring treatment, resulting in a break-down of the doctor-patient relationship that was only restored by the doctor's practice of original patient-centeredness.

Conclusion: Contemporary patient-centeredness over-emphasises content-aspects of doctor-patient encounter in favour of relationship-aspects. Original patient-centeredness emphasises the relationship-aspects of the encounter and support addressing existential concerns that might have important implications for treatment.
1. Introduction

Contemporary health-care systems are shaped by two concurrent but different philosophical approaches: Evidence-based medicine and patient-centeredness [1]. Evidence-based medicine forms the foundation of Western health-care systems, fuelling an increase in specialised knowledge by focusing on effectively investigating, disseminating, and performing ‘best practice’ in biomedical treatment of diseases [2]. On the other hand, patient-centeredness emphasises the social and psychological aspects of doctor-patient relationships for the provision of effective care [3].

Integrating these approaches have been suggested by evidence-basing patient-centeredness, which has demonstrated a significant ability to improve treatment-outcomes, patient-adherence, patient-satisfaction [4, 5], and the ethical ‘best practice’ of medicine [6]. Consequently, the aim of evidence-based patient-centeredness is to identify and prescribe the effective component of the doctor-patient-relationship to improve patient outcomes [7, 8].

A review of research on the relationship between patient-centeredness and health-related outcomes concluded with an overall 5-component operationalisation of patient-centeredness: The bio-psycho-social perspective on disease, the ‘patient-as-person’, the ‘doctor-as-person’, the sharing of power and responsibility, and the therapeutic alliance [9]. Subsequent delineations of best practice of patient-centeredness include (but are not limited to) shared decision-making, addressing patient preferences, needs and characteristics, and sharing of information relevant to planning of care. Research has focused intensely on the ‘sharing of power and responsibilities’-dimension of patient-centeredness [9], and Danish political visionaries have pushed for the integration and promotion of this interpretation of patient-centeredness into current health-care systems.

“Contemporary patient-centeredness” thus refers to the current political interpretation and prescription of patient-centeredness that emphasises an equal relationship between doctor and an informed patient as well as consultations based on an open discussion of patient needs and expectations as the basis for treatment-related decisions [7, 10, 11, 12].

Contemporary patient-centeredness

Contemporary patient-centeredness in Danish political visions is evoked to improve health-outcomes and increase ability for self-management through doctors’ active inclusion of patients in treatment-related decisions and responsibilities [13]. Hence, patient-centeredness is increasingly operationalised as certain occurrences taking place during the doctor-patient encounter that may result in increased patient-independency [7]: The patient should be an active participant in decision-making and role-clarification and “(…) more patients should experience a care-trajectory in which they can themselves forward information about health and treatment” (authors’ own translation from Danish to English, [14]).

Consequently, contemporary patient-centeredness emphasise the active patient leading an independent life, who has certain preferences and needs that he is conscious of and can discuss. He can share power and responsibilities and is the master of his own care-trajectory under the guiding principle “my treatment, my decision” (cited from [15]) [11, 13].

However, the practical sufficiency and benign consequences of this emphasis on sharing power and responsibilities as the key to achieving patient-centered health-care remain
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unclear. It is the goal of this article to critically examine the prescription and practice of patient-centeredness in the Danish health-care system in light of the original conceptualisation of patient-centeredness.

2. Background: Paternalism and patient-centeredness

Doctor-patient relationships have been rigorously researched for decades [16]. Frequently, they have been deemed asymmetrical, paternalistic or ‘doctor-centered’, e.g. centered on the doctor’s biomedical task of treating the disease, evidenced by doctors asking more questions, interrupting more, and deciding the relevance of different subjects to the consultation [17, 18, 19, 20]. However, two decades of interventions targeting this disparity have failed in overturning the asymmetry of the doctor-patient relationship, suggesting that a fundamental inequality of power is inherently at its’ core [17]. If so, this is a fact largely overlooked in contemporary patient-centeredness. In the review by Mead & Bower [8], all studies reviewed addressed the ‘sharing power and responsibility’-dimension of patient-centeredness, whereas no studies had yet been conducted on the ‘doctor-as-a-person’ dimension of patient-centered care. The lack of emphasis on this dimension of patient-centeredness disagrees fundamentally with the original notion of the concept that emphasises the doctor as a curative factor in his/her own right and the doctor-patient-relationship as ‘two-person medicine’ which essentially includes the doctor’s subjectivity (doctor-as-a-person) along with the patient’s (patient-as-person, [3, 21].

The original notion of patient-centeredness

Patient-centeredness was first conceptualised by Hungarian and British psychoanalysts Michael and Enid Balint and assigned particular importance to the unconscious needs of the patient and the unconscious needs of the medical doctor [3, 21]. Patient-centered practice is characterised by an overall understanding of the patient as a unique human being confronted by illness sufficiently problematic for him to elicit the help of a professional [21]. This help may be biomedical or psychosocial: Accordingly, the doctor’s most important skill is not necessarily to cross-reference symptoms with possible diagnoses and provide an entailed treatment, but to listen and to respond to the patient’s need albeit these may not be explicitly stated [3, 21]. At the core of the original notion of patient-centeredness is therefore a cautiousness of rendering the symptoms complained about more important than the action of complaining itself [21]. Indeed, a patient might express a need during the consultation, but satisfying the patients expressed wishes is rarely enough to fulfil deeper or unconscious needs relevant to the patient’s health [4, 21, 22].

A similar cautiousness pertains to rendering the diagnosis and treatment of the disease more important than the doctor-patient-relationship. Hence, of equal importance to what the doctor might do for the patient in terms of diagnosis and treatment is the way the doctor allows the patient to use him, e.g. how the doctor relates to his patient [3]. This is especially important in the case of chronic health-problems where curation of the disease is not an option. Thus, when treating a chronic patient, part of the doctor’s task consists of educating the patient to adopt an attitude towards their disease that yield the best possibilities for therapeutic change. Preferably towards a mature responsibility towards their illness [21]. However, being a “patient” requires a person to be the recipient in a helping relationship with a health-related problem that one is unable to identify and overcome, meaning that dependency of the patient on the doctor is a necessary antecedent for the formation of the doctor-patient relationship. Of central importance in the patient-
centred doctor-patient relationship is thus also the question of how much maturity can be expected from the patient in dealing with his disease, and how much dependency on the doctor that can be tolerated [21].

The contemporary prescription of patient-centeredness therefore differs from the original notion of patient-centeredness on several important points. The original concept pertained primarily to the doctor’s responsibilities, namely understanding the patient as a unique human being and treating him accordingly, attending to unexpressed needs as well as educating the patient to attain a competent approach to his illness. Conversely, contemporary patient-centeredness focus to the role-obligations of the patient, emphasising an equal relationship between doctor and patient in decision-making and care-management. While the original approach recognises a degree of passivity in the patient-role in the form of the patient’s dependency on the doctor, contemporary patient-centeredness places central emphasis on the patient’s autonomy and self-dependence. This corresponds to an extreme degree of maturity in the words of the original conceptualisation, since a patient is asking for help with a health-related problem the one cannot overcome. Finally, the core focus on subconscious and/or unexpressed needs of the patient that are assumed to be both present and pivotal during every encounter, are disregarded at large in contemporary patient-centeredness.

The consequence of these differences, as well as the practice of patient-centeredness in the Danish health care system, is an empirical question that is addressed through the theoretical lenses of the Palo Alto school of communication in the subsequent sections [23, 24, 25, 26].

3. Theoretical framework: Pragmatics of human communication

The primary vehicle of establishing and maintaining any form of human relationship is verbal and non-verbal communication [26]. The verbal aspects of communication are well-represented in the research on doctor-patient communication since much of the research documenting its importance is based on audio-recordings [16, 27]. However, only 7% of the emotional communication that contributes to making the doctor-patient-relationship a curative factor in its’ own right [21] take place verbally [28], thus rendering research in doctor-patient relationships vulnerable to an obscuration and exaggeration of the importance of verbal communication.

Even so, when non-verbal aspects of communication are addressed (e.g. facial expressions and gestures), this is often done by quantifying body-movements to compute the statistical interrelation between kinesthetic and patient-outcomes [29, 30]. Consequently, a review identified 16 non-verbal physician-gestures associated with increased patient satisfaction and compliance, for example head-nodding, a forward lean, and arm symmetry (for an exhaustive list, see [31]). However, an additional review established pronounced ambiguity in the significance of specific non-verbal behaviour: head-nodding was positively associated with doctor-patient rapport in one study, but not another, and doctor’s gesturing is both positively and negatively associated with patient-satisfaction [29]. Moreover, integrating head-nodding into a larger behavioural complex signifying encouragement improved the predictability of patient satisfaction [30]. Combined, these findings suggest that any isolated consideration of communicative acts, be this verbal communication or single non-verbal gestures, provides an insufficient basis for investigating the quality of doctor-patient
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communication. Both representations on their own fail to account for the integrated verbal-and non-verbal communication that emerges to the conversation-partner and that one responds to when participating in human communication [26]. The doctor and patient continually influence each other and therefore cannot be considered separately [21], and it is this coherent presentation that is our focus. The interrelation of patient and doctor calls for an integrative model where attention is paid to the mutual negotiation of the characteristics of the relationship in which the doctor and patient take part as opposed to being the place of origin.

Hence, we understand communication as the observable manifestation of human relationships, a process of mutual influence through verbal and non-verbal channels simultaneously. This understanding is among others rooted in the five axioms of human communication [26], four of which are adapted below to analyse the practice of patient-centeredness:

One cannot not communicate
This means that all behaviour is informative through interpretation [22, 26]. Human relationships encompass both a psychological and behavioural aspect [26, 32, 33]. These aspects implicate each other in that every social act carries meaning as a symbol of the psychological interpretation and significance of the relationship. However, the behavioural aspect is not a transparent reflection of the psychological comprehension of the relationship, meaning that the relationship requires a continuous adjustment, definition, and negotiation through interpretation of the conversations-partners' behaviour as a simultaneous expression of their comprehension of themselves, the other, and their relationship [26, 34].

Every communicative act involves both a content and relationship-aspect, the latter defining the former, therefore being a meta-communication.
Take for example a doctor interrupting a patient’s account of his illness to ask an unrelated question, implicitly assuming the right to do so. The content-aspect would include the patient’s illness-narrative and the doctor’s question, whereas the relationship-aspect would be the implicitly conveyed interpretation and expectation of the nature of the relationship through the manner of addressing each other: the patient implicitly assuming the doctor to listen and the doctor implicitly assuming a superior position to the patient by presuming the right to interrupt and bring about a new subject.

Communication is both verbal and non-verbal.
The verbal aspect typically convey the content-aspects of communication, whereas non-verbal communication broadly understood (e.g. including the choice of words, the orator’s posture, gesturing, facial expressions, tone of voice, the sequence, cadence and rhythm of words and all other forms of non-verbal enablers and clues present in the context) implicitly conveys the conversation-partner’s comprehension of himself, the other, and the relationship [26]. Lastly,

A certain interactional pattern will evolve in communication that is either symmetric or complementary, depending on whether the relationship is based on difference or parity.
A symmetrical interaction strives to enhance or obtain equality, whereas a complementary interaction builds on differences and hence functional inequality in the relationship [26]. Taking the example above: if the patient implicitly accepts the doctor’s overturning of the
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subject by answering the question, they have co-created a complementary behavioural
gestalt. However, if the patient declines to answer the question either explicitly or by
continuing his own account, this would make for a symmetrical interaction since the doctor
and patient both attempt to control the content of the conversation.

Table 1: Differences between original and contemporary patient-centeredness

<table>
<thead>
<tr>
<th></th>
<th>Original patient-centeredness</th>
<th>Contemporary patient-centeredness</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Core values</strong></td>
<td>Patient-as-person, Doctor-as-person, therapeutic relationship</td>
<td>Patient autonomy, Shared power and responsibilities</td>
</tr>
<tr>
<td><strong>Primary focus</strong></td>
<td>The doctor’s responsibilities: Responding also to patient’s unexpressed needs</td>
<td>The patient’s responsibilities: Express expectations, wants and needs.</td>
</tr>
<tr>
<td></td>
<td>The relationship-level of interaction</td>
<td>The content-level of interaction</td>
</tr>
<tr>
<td>**Relationship-</td>
<td>Complementary relationship, Doctor superior to patient</td>
<td>Symmetrical relationship, Power is shared</td>
</tr>
<tr>
<td>characteristics**</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Conscious/Unconscious</strong></td>
<td>Emphasizing the unconscious and its’ implications for our interpersonal interactions</td>
<td>Emphasizing cognitive and conscious deliberations as the primary basis for interaction and decision-making</td>
</tr>
</tbody>
</table>

Table 1 summarises the main characteristics of original and contemporary patient-centeredness in lieu of the pragmatics of human communication. Notably, the original notion of patient-centeredness retains a basic complementarity in the doctor-patient-relationship, whereas contemporary patient-centeredness strives for symmetry and equality by asserting the sharing of power and responsibility between doctor and patient. The above presented axioms form the framework for the following exemplification of some of the key elements of original and contemporary patient-centeredness in a consultation regarding treatment of chronic arthritis.

### 4. Patient-centeredness in a practical case

The following case presents an analysis of a doctor-patient encounter focusing on examining the performance patient-centeredness in accordance with the original and contemporary conceptualisation. The encounter is part of a data-material from a year-long fieldwork including observations of a total of 56 consultations and 24 interviews with doctors and patients on three different hospital departments (rheumatology, chronic pain, neurology). Data was collected with separate interviews conducted with the patient and doctor before and after the consultation. The interview before the consultation explored expectations regarding treatment and consultation and the interview after the consultation explored satisfaction and experience of the encounter. The interviews were confined to ten minutes to accommodate the daily routines at the department.

**Background and before the consultation**
The patient is a single man in the fourties. He has been seeing his current doctor for the last five years and has been through extensive diagnosing-procedures involving several erroneous diagnoses followed by ineffective treatment. He has now been diagnosed with an arthritic condition of the spine, but despite the right diagnosis, he has not experienced relief from biological treatment. At the last consultation, he was much affected by the restraints caused by his illness. He usually spent towards 60 hours a week on his job, and it was agreed that he would give in a sick-note because of his back-pain. The restraints caused by his disease however strongly interfered with the patient’s sense of self, threatening his identity:

\[
\text{Patient: “I have been sitting with damned tears in my eyes in here because you simply can’t... in our days your work is your identity... if you can’t mind your work then all the negative thoughts start appearing... what happens next? Because the job you have is such a large part of you. And me, being (...) with great success and all, there is no way I could imagine if I had to start lying around at the couch at home doing nothing.”}
\]

Consequently, the doctor has in his own words 'been working well within the psychological half', because he was well aware of the threat posed by the disease and prompted the sick-note in accordance with his agenda to have the patient reduce his work-hours, e.g. to cope realistically with the implications of his illness.

\[
\text{Doctor: This whole uhm... this idea “who am I?” is threatened by the disease. And what posed a great challenge was to... accept... that “I am this unwell”... and to announce this to his employer. And we discussed that subject in the last consultation where he uhm... happily for me, also discussed the issue with his employer and has adapted his work-life so that it regards his needs based on his identity as a patient. I presume!”}
\]

The excerpts illustrate the conflict between the identity as a successful worker versus the identity as a patient, the former being what the patient counts as his identity as a person and the latter emphasised by the doctor. The latent threat posed by chronic illness towards important aspects of one’s identity poses an important topic that needs to be addressed and that often remains unexpressed during the doctor-patient encounter. Hence, up until the present consultation, the doctor has supported the patient in a psychosocial adaption informed by an understanding of the patient as a unique human being and the interference of the illness with the patient’s sense of self. Thus, the doctor uses his extensive knowledge of the patient’s life and strains to aid the patient in recognising and coping with the restraints posed by his illness. In short, developing an increasingly mature approach to his illness [3, 21].

On the day of the consultation, the patient has achieved great relief from his primary nuisances: pain and stiffness of the back, albeit the reason is not that he has reduced his workload. Instead, he has discontinued the biological treatment without consulting the doctor in favor of self-medicating with medical cannabis-oil. The health-related relief is mirrored in the patient’s s mood by his own assertion as well as in his patient-reported
outcomes (PROs), which are the currently at their best compared to his entire care-trajectory. The doctor is unaware of the discontinuation of the biological treatment and the fact that the patient has begun self-medicating. Prior to the consultation, he assumes that the improvement is due to a reduction of work-hours. Hence, the consultation revolves around the patient’s disclosure of his discontinuation of the biological treatment and self-medication with medical cannabis to the doctor, who presumes a regular follow-up on the treatment-procedure and the sick-note.

The consultation
The consultation begins with the patient awaiting the doctor’s invitation to speak, thus inviting the doctor to take a superior position in a complementary relationship. Accepting this, the doctor starts of by framing his 1.5-minute-long account as a “list[ing] of some key facts” regarding the patient’s well-being and the course of his disease:

*Doctor:* “We have long been treating you for your disease. You have been very, very bad of. Massive pain, even pain resistant to treatment. We have never really landed in a situation where the treatment had a good effect (...) The fundament of the entire treatment of course involves a consideration of what your body can do and what you offer your body (...)*

From the point of view of contemporary patient-centeredness, one would focus on the content-level of the communication, e.g. the doctor defining the illness-trajectory of the patient, thus displaying an example of paternalistic medicine. However, from the perspective of original patient-centeredness, one would emphasise the relationship-level of communication from which the doctor’s account of the patient’s medical history and well-being is construed as recognising and bearing witness to the patient’s life, encountering the patient as a person and acknowledging the suffering derived from his illness, thus strengthening the therapeutic relationship.

The patient is hereafter invited by the doctor to tell how he has been and he states his use of medical cannabis early in the 20-minute-long consultation. The doctor responds by crossing his arms, lowering his chin, saying “yes?” in a hesitant and questioning manner, waiting for the patient to go on, non-verbally displaying an alertness to the content of his account. He remains in a listening position, inviting the patient to continue, thus preserving the therapeutic relationship even though the content of the account regarding the use of medical cannabis violates the formal boundaries of it.

The patient continues his account by stating the benefits he experiences from the treatment in a matter-of-fact way that non-verbally mimics the confidence of the doctor while he was giving the account of the patient’s disease-trajectory, assertively banging his finger on the table for every benefit listed. They co-create a reversed complementary gestalt with the patient in the superior position and the doctor as inferior by remaining in a listening position. However, the doctor proposes to reinstate himself in the superior position by interrupting the patient’s narrative in the following excerpt:
Patient: (...) I have been taking medical cannabis-oil for 4-5 weeks now (...)
Doctor (interrupting): Who controls that treatment?
Patient (firmly, staring the doctor in the eyes): No-one.
Doctor: No-one.
Patient (slowly, in a firm voice): I do. And I have been for five weeks, and 80 % of my (...) pain has gone. Some days, when I have been working for ten hours, it starts to hurt a little bit. (...).
Doctor (awaiting the end of the account, arms crossed, face displaying interest): Fine.
Patient (after a three-second break): That’s status on how I feel.
Patient (after a two-second break): Now I’ll try to take a break and see what happens if I don’t take it [the medical cannabis-oil, red.] to see how my body reacts. If I start relapsing, feeling weak again, I’ll resume the treatment without blinking. I will (maintaining firm eye-contact).
Doctor: How has the talk been regarding your work, what... uhm, what...

The patient declines the doctor’s suggestion for reinstating himself as the superior party in their interaction by refusing anyone control over his treatment-trajectory, equalising himself with the doctor in that the patient himself controls his treatment. By independently introducing an alternative treatment, the patient obtains a task that normally pertains to the doctor, thus indirectly proposing equality and consequently an overturning of the basic configuration of the doctor-patient relationship by breaking two unspoken rules of it: treatment options are the doctor’s area of expertise, and their collaboration must be within the realms of Danish law that includes legislation against medical cannabis. The patient seized the doctor’s tasks in the encounter and underlined this by his last statement proposing his own treatment-plan. The result of this is evident in the end of the excerpt by the doctor’s role disintegrating mid-sentence.

By the announcements above, the patient has made himself both the doctor and the patient, thus effectively stripping the doctor of power and purpose in the encounter. The doctor has used his power to frame the consultation, direct the conversation, and he has only taken an inferior position on his own initiative. By assuming both available roles in the doctor-patient encounter, thereby proposing an equal, symmetric relationship, the patient destabilises the doctor’s control on the relationship-level of their encounter, resulting in a neutralisation of the culturally mediated complementarity of the relationship and a subsequent break-down of the communication- and relationship-norms.

However, through his actions above, the patient embodies the desirable patient-characteristics within the paradigm of contemporary patient-centeredness: His preferences are clear; he will not accept any limitations to his functional level, and he actively takes responsibility for the decision-making in his care-trajectory, thus living the mantra “my treatment, my decision” [14]. Using the contemporary notion of patient-centeredness, he exemplifies the desired self-dependence, since he has already acted on his medical preferences on his own. The patient’s self-medication can be further understood via the conflicting emphasis on personal (successful worker) vs. patient-identity between the patient and the doctor: The identity as a patient including functional limitations is an unacceptable substitution of the patient’s identity as a successful worker, an identity around which the patient structures his existence and meaning. Acknowledging the unexpressed
need for meaning and addressing the dilemma posed by the conflicting identities as part of the treatment-process allows him an opportunity for therapeutic change in his relationship to his disease, thereby supporting the patient in taking best care of himself both as a patient and as a successful worker, e.g. to develop a mature approach to his disease as emphasised in the original notion of patient-centeredness.

After further discussing the patient’s use of medical cannabis in a symmetrical exchange where the patient and doctor equally contribute to the content of the conversation, the following exchange takes place:

\[\text{Doctor: “I would not be the person that I am if I didn’t say that (that the patient feels better, red.) justifies more or less everything”}.\]

\[\text{Patient: “But that was the largest of all my hopes that I could sit you down and tell you (...) and you would say: Wow, there’s something here and I’d like to... try and help you (...) if you know what I mean, right?”}\]

This exchange was followed by the doctor’s offer to contact clinics that he knows are working with medical cannabis-oil on a trial-basis, thus shifting his emphasis in the consultation towards the safety of the patient. Hereby, the doctor displays an accommodation of an unexpressed need for understanding and for preserving control and the patient’s identity. He accepts the patient’s choices and his way of stating them, extending a helping hand to the patient that he could not ask for. Hence, the doctor infers an unspoken wish and responds to this by expressing both personal and professional sympathy for the patient’s choice of medication under the circumstances. By doing so, he once again poses to resume the superior position as the helping party of the relationship that the patient can depend on. As evident in the end of the above excerpt, the patient accepts this proposition with relief. The rest of the consultation is performed as a complementary behavioural gestalt with the doctor holding a superior position, directing the conversation, and contextualising the benefits that the patient experiences with biomedical knowledge and the patient’s other lifestyle-changes of increased exercise and giving up smoking.

\textit{After the consultation:}

Referring back to the last-cited excerpt in the interview after the consultation, the patient states:

\[\text{Patient: “It was what I had hoped for, but it was not what I had expected. I know that it is a rather alternative way that I am behaving at the moment, that maybe... not all doctors had approved of. But I think because he knows me and has seen me the way he has, he would like to TRY to help me... It means a lot that... oh, but I feel so safe with him, I really do”}\]
Here, we see that the patient has more needs than expressed in the first part of the communication. Apart from the conscious need that is stated clearly in the consultation; his preference for medical cannabis-oil, he also has an unexpressed wish to have his choice understood and accepted by the doctor. This wish is however accompanied by an internal conflict between hoping for the doctor’s acceptance but not expecting it, effectively disallowing him from openly stating his hopes for the consultation. His refraining from doing so however allowed for the original notion of patient-centeredness to be realised in the doctor’s inference of this unexpressed need and subsequent response to it in a way that strengthened the therapeutic relationship by increasing the patient’s feeling of security in depending on his doctor as a person and his knowledge and recognition of patient as a human being.

5. Future directions: Do we have a problem with patient-centeredness?

Bensing [35] argued for the integration of evidence-based medicine and patient-centred medicine which has now been attempted for 18 years. This has largely been done by incorporating patient-centeredness into the epistemology and methodology pertaining to evidence-based medicine. This includes identifying and prescribing human communication guided by the overall misunderstanding that it is an individual act of communication (be this verbal or non-verbal), and not communication as an expression of a relational context that form the premises of a specific doctor-patient-relationship. The consequence of this is a break with some of the central philosophical notions of patient-centeredness, turning the end into a mean and thereby entailing an instrumentalization of patient-centeredness that contradicts the original notion of the concept in several important ways as illustrated in the current case.

Indeed, in stating his preferences and making his own treatment-decisions, the patient acted out the autonomy that is the centre of contemporary patient-centeredness. By doing this, he however also effectively stripped the doctor of power in the encounter. The patient seized two of the doctor’s key tasks, namely monitoring and administering treatment, thereby becoming a prime example of the ideal patient of contemporary patient-centeredness solely by his refusal to be a patient.

Patient-centeredness may be realised as an open discussion of needs and preferences whenever the patient has explicated these in advance, and this may indeed take place in a symmetrical interaction. However, the symmetricity in the current case arose from the patient stripping the doctor of his role-obligations, thus threatening the doctor-patient-relationship, while simultaneously wishing to feel safe through the doctor’s acceptance of his decision. Hence, while a symmetrical interaction took place on the content-level of the interaction such as contemporary patient-centeredness prescribes, the interaction remained complementary at the relationship-level. The reunification of the therapeutic relationship was successfully accomplished on account of non-adherence to the desired norms of contemporary patient-centeredness, namely by the patient refraining from stating his significant wish for understanding and acceptance. This allowed the wish to be inferred and responded to by the doctor, thus enhancing the experience of a human encounter, of trust, and of being seen as a unique person, which is the basic foundation of the therapeutic relationship that also underlies original patient-centeredness.
Pending questions are thus whether the symmetry entailed in the contemporary notion of patient-centeredness is obtainable when the patient does not pose to be his own doctor, and whether this is a desirable development in doctor-patient relationships. In the current case, it is questionable whether the patient needs the encounter from the perspective of the contemporary notion of patient-centeredness as he is now fully in charge of his own care-trajectory, thus living the mantra “My treatment, my decision” [14]. The overall purpose of contemporary patient-centeredness is putting the needs of the patient at the centre of the consultation to enhance the quality of care. However, by expounding patient-centeredness through a minute explication of the obligations pertaining to the patient (e.g. stating needs and wants, sharing information), policy-makers might unintentionally violate this very aim by attempting an undue translation and operationalisation of relational aspects of communication into content-aspects that must be explicitly contained in the encounter (e.g. discussion of patient preferences and expectations), thus disregarding the occasional necessity of ambiguous communication of hopes and needs as in the current case. Realising patient-centeredness as an understanding of and regard for the patient as a human being sometimes entails not demanding explicit preferences, hopes, and needs to be expressed during the encounter, that is, to avoid making the patient the centre of the encounter in recognition of the fact that human relationships sometimes call for a necessary obscurity regarding the needs or expectations that one hopes to have met [24], precisely in order to enable their fulfilment.

Shared decision-making and open discussion of preferences and needs are appropriate parts of a patient-centred health-care system, but contemporary patient-centeredness risk overemphasising these aspects of patient-centeredness while underemphasising the interpersonal encounter and the therapeutic relationship. The encounter between doctor and patient demands mutual receptiveness. The doctor’s task of assessing, diagnosing, and treating the patient is of an essentially transgressive nature, making doctor-patient encounters fundamentally complementary. Accepting the inequality both interpersonally and politically enables the doctor-patient encounter to become a humanly equal encounter involving both the patient-as-a-person and the doctor-as-a-person as proposed by the original notion of patient-centeredness. The exaggerated emphasis on conscious, cognitive decision-making disallows both patient and doctor from entering the encounter carrying their unconscious and unexpressed needs in addition to their conscious wishes. In short, it runs the risk of precluding the human encounter of the doctor-as-a-person and the patient-as-a-person that is at the core of patient-centeredness.

The clinical implications of the original notion of patient-centeredness therefore include an emphasis on the relational aspects in doctor-patient encounters and an emphasis on addressing existential themes such as concerns regarding the loss of a valued identity as part of the treatment as exemplified in the current case. The limitations associated with the identity as a patient was unacceptable to the patient of the current case, entailing a sudden discontinuation of biological treatment in favour of alternative treatment-paradigms. Addressing the existential implications of the patient’s disease early in the treatment-process might mitigate the potential hazard associated with this through a gradual integration of disease-related limitations that allow the patient to adjust to his view of himself.
References


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