The Patient Centred Approach – Urban CSA Myths

In this article I will look to demystify the fabled patient centred approach in the CSA. I have read several articles around this subject, the most recent one being where the author in question advocated a patient centred approach to the CSA to being like a waiter and to ultimately give the patient what they want. Perhaps we can agree to disagree in this respect. There is a significant difference between being patient driven, that is driven by the demands or agenda of the consumer or the customer in the restaurant, and to being patient centred. As a comic reminder, and for those of you who might appreciate it, do have a look at Monty Python's Mr. Creosole ordering in a restaurant and consider if there is any form of patient centredness that you can observe. I argue not.
http://www.youtube.com/watch?v=Y2Bs1ZZ-7b8
At all times as a doctor in the CSA you must be perceived to be in control of the consultation but in the same instance have a flexibility to able to negotiate a shared and informed choice which ultimately is perceived to be in the best interests of the patient.
In 2005 I practiced as a private GP for 18 months (http://www.pulsetoday.co.uk/story.asp?sectioncode=21&storycode=4012168) and was exposed to consultations which were best described as ethically challenging. To stick to one's ethical guns in situations where you are paid directly to make clients 'happy' can make for a moral battleground. Ultimately through one's actions you attract the patients that you ultimately deserve and this can be equally applicable to those of us who have been in NHS practice for some time. I enjoyed the challenge of private practice immensely but inevitably for me it was the patient driven nature of the practice which led me back to the NHS. This is by no means an article on the pros and cons of private practice but merely a personal reflection of my time within the private sector.
So back to the MRCGP – how do nervous, anxious and rigid GP registrars undertake a patient centred approach to the CSA? Let us start by looking at the urban myths which surround formative statements 15 and 16.

The Interpersonal Domain
Reasons for Failing

15. **Does not develop a shared management plan, demonstrating an ability to work in partnership with the patient**
16. **Does not use language and/or explanations that are relevant and understandable to the patient**

Urban Myth 1
Always offer options to a patient
This is simply not true or indeed applicable for certain situations in the CSA and in real life. I will give you an example – albeit an extreme one. You see a patient

with crushing chest pain which radiates down his left arm and into his neck. Would you offer him the option of:
1. Do nothing 2. Get an ECG 3. Blue light him to hospital asap.
So in this instance I am presuming most of us would not be saying to the patient, pick an option! The challenge is if the patient refuses to go to hospital, then how do we make such a consultation patient centred? Well consider first exploring and acknowledging what his fear and anxieties may be around being admitted to hospital. It is only then that you will be able to understand the patient's perspective and give the patient the opportunity to be involved in a shared and informed decision. An informed decision will rest upon the doctor's ability to explain in simple 'user-friendly' language the reason for an urgent admission. The key in passing is the way in which the doctor presents this message. A doctor centred registrar may bypass the patient completely, intent only on doing what they deem to be in the best interests of the patient. A patient driven registrar may well agree with a patient to let them go home without actually addressing the risk and benefit of such a decision, thereby failing also clinical management competencies

7. Does not develop a management plan (including prescribing and referral) reflecting knowledge of current best practice

and

9. Does not demonstrate an awareness of management of risk or make the patient aware of relative risks of different options.

Management options are certainly valid in many real life situations and in the CSA, but what is important is that sharing of options requires an informed choice that is to say weighing up the relative risk and benefit of the proposed management options. Your job in the CSA is to share that information and ultimately if a patient makes an unwise or unsafe decision, your job is to find out why before condoning or challenging it.

Urban Myth 2

Patients always want to share decision making

There is a subtle difference between involving a patient in a consultation and sharing decision making. Patient centred doctors will be responsive to patients, and move consultations forward as necessary taking on the responsibility for decision making when patients are unsure and do not wish to make a decision for themselves. If we have to make comparisons to the restaurateur then consider in this case the waiter who may decide for you what dish to order because you have asked for his advice and based on your preferences and their knowledge of the food, the waiter is able to choose the most appropriate option for you. Ultimately it is the doctor who has to be perceived to be in control of the consultation in moments of uncertainty.

Urban Myth 3

Give as much information as possible to patients.

The CSA is not about talking at patients, but talking with patients. You may know everything there is to know about atrial fibrillation, but how much do you know about the patient who has the atrial fibrillation? Can you tailor your language accordingly to the patient who does not understand the words 'cardiac' or 'arrhythmia'. Perhaps the patient has mentioned that he feels his heart is skipping a beat and feels that it does not beat regularly – use this to your advantage, re-iterate language that the patient will understand when explaining the diagnosis and it's implications. Keep it simple and relevant to the patient who is sitting opposite you!

To summarise, consider the following pointers in refining a patient centred approach:

INFORMED DECISION MAKING
NOT THE PICKING OF OPTIONS!
SHARING OF INFORMATION
BENEFICENCE VERSUS NON – MALEFICENCE
WORKING TOWARDS BEST INTERESTS OF THE PATIENT
HOLISTIC APPROACH
BE PREPARED TO NEGOTIATE

Finally remember that:
'Mutual assistance makes mutual success' – Traditional Chinese Proverb

In the next article I will re-direct the focus on the challenges of the Global and Data Gathering Domains.

About the author:
Dr Nigel Giam
MBBS MRCGP MRCP Bsc DRCOG DCH DFSRH PGCertMedEd

Dr Nigel Giam is the course director for Mentor MRCGP preparation courses– www.passmrcgp.com for more details.

He is a GP Programme Director for the St Marys VTS and works as a GP and a lecturer in medical education. He is a Senior OSCE Examiner and Tutor of General Practice at Kings College School of Medicine and Imperial College School of Medicine. He has worked as a RCGP and PACES course organizer.