Patient-Centered Care in Medicine and Surgery

Guidelines for Achieving Patient-Centered Subspecialty Care

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KEYWORDS

• Patient-centered care • Evidence-based medicine • Shared decision making • Hand surgery

KEY POINTS

- Patient-centered care is based on the principle that equality between physician and patient is mutually advantageous, and is a model of patient care commonly favored by patients over a traditional paternalistic model.
- Patient-centered care has 5 main components: the biopsychosocial perspective, the patient as person, sharing power and responsibility, the therapeutic alliance, and the doctor as person.
- Some aspects of patient-centered care are at odds with the disease-centered principles of evidence-based medicine; however, these two models of care are not mutually exclusive.
- By maximizing quality face-to-face time in patient interactions, devoting visit time to nonmedical aspects of the patient's life, empathizing with the patient, being mindful of one's self as a physician during the physician-patient encounter, and by involving patients in decisions about their care, patient-centered care can be achieved by hand surgeons.

INTRODUCTION

> *In many instances knowing the person who has the disease is as important as knowing the disease that person has.*
>
> —*James McCormick, 1996.*[1]

The physician-patient relationship has evolved from a paternalistic one to a patient-centered one over the past 2 decades. Though regarded as a valuable tenet of primary care, little has been written on patient-centered care in hand surgery or other surgical subspecialties.

Evidence-based medicine, on the other hand, has become an important aspect of the modern hand surgeon's practice. Though often mentioned in the same context as patient-centered care as a model of practice to which one should ascribe, evidence-based medicine may often be at odds with patient-centered care.[2] An appropriate balance of evidence-based and patient-centered care is necessary for optimal patient care in both general practice and surgical subspecialties.

THE PROGRESSION FROM PATERNALISM TO PATIENT-CENTERED CARE

Throughout history, the physician-patient relationship has depended on the medical situation (the physician's and patient's ability to communicate) and the social scene (the sociopolitical and intellectual-scientific climate) at the time.[3] Eras in

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which there was a focus on the religious and supernatural, such as ancient Egypt and medieval Europe, resulted in a more activity-passivity, parent-infant type model of physician-patient interaction.[3,4] Times of enlightenment and democratic thought, such as the Greek enlightenment and the Renaissance era, often resulted in a more guidance-cooperation, parent-adolescent type model of care with some participation by the patient.[3,4] Although there have been instances when more egalitarian, mutual-participation models of care were accepted throughout history, a paternalistic model has always been present to some degree.

Patient-centered care, with a stress on mutual participation by the doctor and the patient, was proposed by Szasz and Hollender[4] in the 1950s and further expanded on by Balint[5] in the 1960s. These theories stressed the belief that equality between persons is mutually advantageous and that the physician-patient relationship itself can have great inherent therapeutic value.[3–6]

THE 5 CORE COMPONENTS OF PATIENT-CENTERED CARE

Building on the foundation laid by Balint,[5] leaders in the field have determined that there are 5 components central to patient-centered care[2,6]: the biopsychosocial perspective, the "patient as person," sharing power and responsibility, the therapeutic alliance, and the "doctor as person."[6,7]

The Biopsychosocial Perspective

The biopsychosocial perspective refers to including general biological, psychological, and social factors when considering and treating a patient's condition. This perspective is in contradistinction to the traditional biomedical model of patient care whereby the patient's signs and symptoms are presented to allow for an accurate diagnosis and then treatment. The biopsychosocial perspective requires the physician to have a "willingness to become involved in the full range of difficulties patients bring to doctors, and not just their biomedical problems."[8]

The Patient As Person

Although the biopsychosocial perspective involves understanding the patient's illness in a broad framework, the patient-as-person principle requires understanding the individual patient's experience of illness. The generalizations of the biopsychosocial perspective lay a solid groundwork for patient-centered care, but using the patient-as-person principle the physician understands the meaning of the illness or condition with respect to an individual patient.[6]

Sharing Power and Responsibility

A key aspect to patient-centered care is the sharing of power and responsibility between the physician and patient. An egalitarian physician-patient relationship differs from the traditional paternalistic approach to medical care espoused in the 1950s, and encourages mutual participation by the physician and the patient in medical care and decision making.[3,4] This branch of patient-centered care has been the focus of much study of shared decision making, which has been championed by some as the central pillar of patient-centered care.[9]

The Therapeutic Alliance

Patient-centered care places value on the physician-patient relationship on the premise that a positive relationship between physician and patient can, in its own right, lead to more positive patient outcomes.[6] The therapeutic alliance focuses on the perception of the patient that the doctor is caring, sensitive, and sympathetic. Positive interactions with a physician undoubtedly improve patients' satisfaction with physician encounters, and may help to improve a patient's results through the placebo effect.[6,10]

The Doctor As Person

The doctor-as-person component of patient-centered care stresses the importance of the personal qualities of the physician on patient interactions. It regards the patient-physician interaction as a fluid one in which each party influences the other.[6] The physician's mannerisms, conscious or unconscious (body language, tone of voice), can engender either positive or negative responses and behaviors in the patient. From the physician's perspective, practicing the doctor-as-person aspect of patient-centered care involves self-awareness of emotional responses during the patient interaction.[11]

DISEASE-CENTERED VERSUS PATIENT-CENTERED: THE DIFFERENCE BETWEEN EVIDENCE-BASED MEDICINE AND PATIENT-CENTERED CARE

Although both evidence-based medicine and patient-centered care are stressed as medical practice models to strive toward, the two philosophies are fundamentally different. Evidence-based medicine is disease-oriented as opposed to the patient-oriented approach of patient-centered care.[2] Clinical trials, which are a mainstay of evidence-based medicine, focus on the evaluation