From patient-centred medicine to citizen-oriented Health Policy-making

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I.

The term “patient-centred medicine” was introduced by Michael Balint and his colleagues in the late sixties of the past century. Advocates of patient-centred medicine argue that doctors and patients live in different worlds: the world of the individual patient and her or his unique experience of ill health; and the biomedical world of clinical experts.

In the world of clinicians a disease can be dealt with and controlled independently of the patient concerned. Diagnosis and cure of biological defects are in the centre of this model. The personal and social dimensions of an illness are perceived as irrelevant for the performance of clinical processes. Communication with patients can be neglected because high quality health care depends on the qualification of the clinician and the skilful use of medical technology alone.

In contrast, the patient-centred model broadens this perspective to include psychological as well as social problems. Patients are supposed to play a more active role as partners in a more egalitarian relationship. Professional dominance is replaced by shared decision-making. Since doctors and patients may have widely divergent views on the nature of the problem, on priorities, goals and treatment options shared decision-making is seen as the key to move from doctor- or illness-centred to a patient-centred care.

Shared decision-making presupposes empowerment of patients. Patients should be motivated and informed about the available evidence and potential side-effects. To put it differently: Whereas traditional medical care is technology-intensive, patient-centred care is interaction-intensive. According to the patient-centred model good clinical care includes both: a skilful use of the available knowledge as well as a skilful use of human communication.

Some advocates of patient-centred medicine emphasize an additional point as essential: a different view on the human organism as having a great capacity for self-healing. The ultimate goal of clinical care is – according to this view – to support or assist nature’s capacity for self-healing instead of trying to control it.

The discussion concerning patient-centred medicine raised by Balint and his colleagues focuses on overcoming biomedical reductionism and on patient-empowerment. Looking back we might call patient-centred medicine the first important step towards the “emancipation of the patient in health care”.

II.

A second important contribution to the emancipation of the patient in health care comes form the ongoing discussion on the quality of care and from a growing interest in the role
of patients, their families, self-help groups and other helping networks as co-producers of care. Avedis Donabedian was among the first to stress that the effectiveness of treatment processes often depends on the co-operation and co-production of the patient and the members of her or his social network. The patient is rediscovered as part of the service production process being the third input-factor in addition to the input from the health care team and from medical technology. Especially in treating chronic illness contributions from patients, family and self-help groups are of crucial importance for the long-term success of what has been achieved by stationary and ambulatory services of the curing and caring professions. This was one main result of our own research on the effectiveness of cardiac treatment and rehabilitation.

In the scientific literature dealing with the upcoming service-economy the consumer as co-producer is a rather common issue. Donabedian first struggled with patients as co-producers of clinical care in dealing with the complex issue of “attributive validity” of clinical outcomes: that is whether or not there is a causal relationship between treatment processes and their biomedical end points. He came back to it in a later paper on “Quality assurance in health care: Consumer’s role” in which he states:

“In part, the performance of patients depends on what practitioners have permitted them to do and how well they have prepared them for the task” (Donabedian 1992).

Looking at the ever-growing number of chronically ill citizens, information, advice, motivation and training of patients and their relatives become a major challenge in our move towards a better integrated, more comprehensive and indeed more citizen-oriented health care system.

III.

The discussion on patient-centred medicine is now going on for more than 30 years: Numerous papers and books try to clarify the meaning of it, how it improves patient satisfaction and medical outcomes and how to implement it efficiently. Nevertheless, we are far away from a widespread adoption of this model. It may even be the case that today the gap between the quality of health care available in Europe and the quality we could have is larger than 30 years ago. Today we should accept that the model of patient-centred medicine itself has serious limitations, which may have contributed to this situation:

The model focuses on patients without taking into account that due to cultural, socioeconomic or gender differences patients enter the doctor-patient-interaction with rather different expectations and belief-systems. We need more empirical research on patient preferences and expectations depending on gender, age and on their social, educational, physical and psychological situation. High-quality clinical care from the point of view of a group of experts may not be perceived as high-quality care from the point of view of a group of patients.

- The model focuses on clinical medicine without sufficiently taking into account, whether it is applied in primary care, acute hospital care, rehabilitation or long-term care. It does not differentiate between different treatment situations and different treatment settings. The role of citizens or patients as co-producers is much more obvious for example in health promotion and rehabilitation than it is in intensive care.
- The model of patient-centred care does not take into account that today’s health care is provided by numerous different highly specialized experts. Complex treatment situations need a pooling of different types of knowledge and skills from different specialists and professions. And they need a better organization and management. This raises the very serious problems of teamwork, inter-professional communication, co-ordination, and guidelines.