

Assessing patient-centred care through direct observation of clinical encounters

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Patient-centred care, defined as respecting and responding to the needs and preferences of patients, empowering them to make decisions that best fit their individual needs, has been identified by the Institute of Medicine as an essential element of high-quality care.¹ It can be thought of as respectfully involving the patient² in a way that helps practitioners provide care that is concordant with their patients' values, needs and preferences while better enabling patients to actively provide input and participate in their healthcare.³ Patients are more satisfied with their care when they feel that healthcare providers are understanding their needs, carefully listening and clearly providing information⁴; in addition, patient-centred care has been found to be associated with improved patient outcomes.⁵ In order to provide exemplary patient-centred care, one needs well developed communication skills, especially in the realm of active listening and responding to patient cues. The importance of physicians mastering the art of patient-centred communication skills can be seen as a theme in the educational objectives of medical school curricula as well as in the competencies of the Accreditation Council for Graduate Medical Education.²

Approaches to evaluating patient-centred communication skills include patient surveys that assess satisfaction with a healthcare provider⁶ and direct observation. Training programmes employ standardised patients to directly observe communication skills such as with Objective Structured Clinical Examinations.⁷ Direct observation can also occur in real time or through videotaped or audiotaped real patient encounters. When using audiotaped encounters, the 'Content Coding for Contextualization of Care' or 4C method

can be used to evaluate clinical care performance.⁸ With this method, audio recordings of patient–provider encounters are used to assess whether care planning has taken into account patients' contextual factors, individual needs or circumstances that are relevant to planning appropriate care. The coding takes into account whether or not there were clues of patient context relative to care, and if so, determines if the healthcare provider explored the context. If they did explore the context, the next step is to see if the patient provided confirmatory evidence of the contextual factors and whether the provider addressed the contextual factors in the care plan.

The paper by Schwartz *et al*⁹ identifies some success and opportunities for improvements in the area of contextualised care. The authors see patient-centred care as the 'provider elicitation and incorporation of patient contextual factors, individuating information which, is important to managing the patient's health'. Drawing from three datasets totalling 1392 patient–physician encounters and 96 client–health assistant telephone calls, this study used the 4C coding system to explore the impact of how the provider learned the contextual information by (1) probing (a provider behaviour that can be targeted for performance improvement) or (2) through spontaneous expression by the patient. They found patient contextual factors identified via probing were incorporated into the plan of care more frequently than those spontaneously revealed by patients (68% vs 46%, 71% vs 54%, and 93% vs 77%, respectively). In summary, the data demonstrated that providers are more accepting of contextual factors that they are able to elicit by probing and more dismissive of those factors revealed in spontaneous conversation by the

patient.⁹ Of note, these same authors in their early work using these data found that patient outcomes improved in significantly more cases when the physician had incorporated the patient's contextual information into the care plan than when the physician had not.¹⁰

A recent commentary noted that patient-centred care requires healthcare providers to not only elicit patients' wishes but also to recognise and respond to their needs and concerns.⁴ Notable in this statement is the 'respond to' action which is often under appreciated. From the Schwartz *et al* data, it would seem that the majority of providers minimised or disregarded what patients brought up on their own, which clearly is not in line with patient-centred communication. If patients care enough to spontaneously bring up issues on their own, they regard them as important. In bringing up issues, patients may want their providers to think about them, or at the very least listen and respond to them, if for no other reason than to validate their concerns and dispel any worries. By minimising or disregarding the issues raised by patients, providers miss an opportunity for patient-centred care. As Rollnick *et al*¹¹ point out, practising patient-centred care is more than just 'being nice' to patients. It also involves listening, clarifying, reflecting and bridging gaps.

Interestingly, in the Schwartz *et al* study, health assistants were able to provide more contextualisation of care across factors, whether probed or spontaneously. Despite the small sample size, one has to wonder what training or experience is provided to health assistants that allows for their contextualisation at a higher level. One has to also wonder if the health assistants contextualise at a higher level because they are 'closer in proximity' potentially, socioeconomically, and educationally, or without professional distance from the patient compared with physicians, and therefore can better relate to them.

Although many recognise that communication skills are vital in becoming a skilled healthcare provider, few recognise the need to continue to learn and refine these skills. Healthcare providers strive to instil the value and importance of communication to their trainees. Students learn about communication in medical school curricula and their skills are tested in observed structured clinical examinations. Unfortunately, students are rarely given feedback on their communication skills in their clerkships when they are immersed in patient care. This lack of attention continues during their postgraduate training.¹² This may be partially fuelled by faculty time constraints, but may also be due to lack of faculty development in the area of communication.

Ironically, although many physicians recognise the need for continuing medical education in the realm of medical knowledge, most physicians do not recognise the potential for improvement in their communication

skills, believing that they already do this well.⁴ Rather than assume that they are proficient in communication skills, physicians should embrace continued growth in this area and participate in training strategies that have been identified for teaching communication skills to physicians.¹³ One such strategy is through direct observation of physician communication skills. This can be a powerful tool to employ, as through direct observation and feedback, one can be coached and corrected. Through the use of direct observation and evidence-based communication competencies, one can have a window into the doctor-patient relationship. With this method, physicians can participate in quality improvement projects as they relate to patient-centred care approaches/techniques and can be motivated to pursue excellence in patient-centred communication.¹⁴ In addition, the approach of direct observation and evaluation may also have the benefit of the Hawthorne effect, becoming even more powerful at changing physician communication behaviour than patient surveys.⁶

Therefore, audiotaped (or videotaped) encounters such as those used in the Schwartz *et al* study could and should be used for the purposes of continuing education in communication skills. Perhaps if participants in the Schwartz *et al* study received feedback about their behaviour of not incorporating patient contextual clues, they would have been given the opportunity to self-reflect and correct their behaviour, therefore becoming more patient centred. One aspect not measured in the 4C method is how tone might affect the probing or spontaneity of the contextual factor. Johnson *et al*¹⁵ explored differences in the quality of medical visits among African American versus white patients. They looked at the overall communication process, the orientation of patient centeredness and the emotional tone. Physicians were more verbally dominant with African American patients than with white patients; they talked 43% more than African American patients and only 24% more than white patients. Physicians' affective tone was less positive during medical visits with African American patients than with white patients.

In summary, the paper by Schwartz *et al* provides another window into the conversations between healthcare providers and patients, with valuable insights into patient-centred care for providers and teachers of healthcare communication. Only direct observation (or recordings) of patient visits could have generated these data, underscoring the value of direct observation in medical education and quality improvement. We call on healthcare systems, accrediting bodies, and professional organisations to support, emphasise and even mandate continuous training and professional development through direct observation of the most common and complex procedure undertaken by healthcare providers—the medical interview.

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