Mental Health in Family Medicine 2010;7:193–5

Editorial

Democratising and vitalising family practice by patient-centred medicine

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Keywords: Europe, family medicine, general practice, patient-centred medicine, shared decision making

Patient involvement and shared decision making is gaining more and more attention in primary healthcare services. Patients, family doctors (FD), health professionals, insurance companies and authorities all request more active involvement of patients in health care. The patient–health professional relationship is moving rapidly towards a more active patient-oriented relationship.[1]

The engagement of patients in management decisions has been shown to have positive outcomes. Enhanced knowledge of management options, better adherence to treatment procedures and reduced preference for expensive procedures are some of them.[2] Improvement of treatment intensity and quality of life, better understanding of the patient's problem, improved satisfaction with doctor–patient communication, improved patient confidence in sensitive matters, better treatment adherence and better integration of preventive and promotional care interventions have been shown to improve.[3] Despite this evidence, FDs seems not to be good at predicting the preferences of patients. FDs are expected to help patients choose from the different options offered by specialists, which might hide a danger for patients without a voice, risking the potential for inequality of access for vulnerable groups.[2]

From the patient's perspective good communication opportunities with FDs are seen as an indicator of quality. Patients expect more explanation, sufficient consultation time and more involvement in their own health problem decision process from their FD. Nevertheless the intensity of this expectation is dependent to the culture of the patient.[4]

Communication between FDs and patients may sometimes create conflict. Patients are upset when some of their wishes have not been fulfilled or a patient who has paternalistic expectations from their FD may perceive a shared decision-making approach from their FD as a source of low self-confidence and insecurity.[5]

Besides that, shared decision making may not be appropriate for all types of patients;[6,7] it is often difficult to achieve in practice,[8] and it seems like an ideal.

To overcome this problem further insight into this process is needed. Barriers like attitudes of health professionals, skills and time burden have been described,[9] while factors such as experience of shared decision making, personal preferences, relationships and others (i.e. social class, education, culture and ethnicity) need to be investigated.

A tension between empowerment and medicalisation is prevalent. This is created by the separation between biomedical and biopsychosocial medicine.[10]

Enriching the FD professional paradigm with a more patient oriented approach is a major challenge. Training is an important tool to overcome this. CME activities might not be sufficient, more intensive training might be needed. An early involvement in shared decision making in the early years of medical

study and delegating some duties to the nurse might help. Introducing patient oriented decisions in guidelines might also be of importance. An integration of professional guidelines with the decision-making tools of patients is needed.[11]

Family doctors often do not know the preferences of their patients concerning their treatment. Prescription decisions are generally guided by the perception of the FD and not by the expectations of the patient. Diverse expectations of patients have been observed. Some just want more information on their illness and their treatment; others desire more involvement in their treatment decisions. Problems that prevent shared decision making in the family practice context have been shown as lack of time, a threatening power relationship between FD and patient, lack of training and lack of information about risks and benefits.[1]

The Alma Ata Declaration has recently celebrated its 30th anniversary and primary health care remains the main benchmark for most member countries; more emphasis on health equity, social justice and the prevention of exclusion are needed. Oversimplification of primary care services in low-resourced settings has been a common problem.[3] It is expected that primary care is building enduring relationships between patients and family doctors, and participation in the decision-making process is expected as part of this relationship. The forming of a network between family members and healthcare staff is anticipated. A healthcare service devoted solely to a one-way delivery channel for priority selected interventions is not appropriate.

This observation provokes new questions. For example, if there is a need for democracy in healthcare services, if the decision-making process were totally left to the initiative of the patient could the direct interference of government policies, finance systems, insurance and social security companies, religious and cultural structures, the structures of law and exterior effects such as the social and economic situation of the nation and service fields to this system be ignored? How does education and the perception of service fields affect the progress of decision making? What kind of effect will this have on the medical profession and doctors? Such questions can be taken further, and even though democracy sounds well, questions still remain on its presence in health services.

Democracy today is not only a concept of law and politics; it appears to be a need and necessity in the presentation of health services. In a democratic environment the provision of equitable health services to everyone is a basic principle, which has been ratified in the Universal Declaration of Human Rights: 'the achievement of highest level of health, without distinguishing between race, religion, politics, confession, economic and social status is a basic right'.[12] The utilisation of health and other rights at the highest level is only possible with democracy. The World Health Organization defines health as a 'physical, mental and social wellness, rather than being ill or disabled'.[2] There are now debates to add the 'political wellness' statement into the definition of health. The most important reasons for this debate are newly evolving diseases due to the presence of inequity, the insufficient practice of democracy or non-democratic conditions, which cause trauma and distress. Modern medical practice in the 21st century recommends considering health along with the environment of the individual and that healthy people, as well as those who are ill, should also be approached in a holistic, comprehensive, preventive, curative and rehabilitative way.

Today we experience a 'mixed' situation, which is more difficult. Some patients leave it to the FD; some prefer to intervene in their current situation. This is also the case for the FD. The expectations of patients increase with the development of human thought, improvement of technology, innovations in medicine and progress of communication. The diversity and choices of diagnostic and treatment opportunities is increasing life duration and quality of life, but is causing trouble during the decision process for the FD, patients and relatives. These decisions sometimes end in law suits.

Democracy is inevitable for medical practice and health services. Patient-centred medicine is democratising and vitalising clinical medicine, which gives validity to the patient's illness experience and healing potential. Patients' attitudes, values, perceptions, expectations, experiences and potential for promoting their health need to be considered.[13] This will improve the relationship between doctors and patients, provide patients with control over their own body and will safeguard doctors because of their practice. It will diminish the weight of the sword which is hanging over the doctor's head and will enhance the satisfaction of both patients and doctors.

ACKNOWLEDGEMENT

This editorial is supported by the Akdeniz University Research Projects Support Unit.

REFERENCES

1 Elwyn GJ, Edwards A and Kinnersley P. Shared decision-making in primary care: the neglected second half of the consultation. *British Journal of General Practice* 1999;49:477–82.

2 Bryant LD, Bown N, Bekker HL *et al*. The lure of 'patient choice'. *British Journal of General Practice* 2007;57:822–6.
3 *The World Health Report 2008: primary health care now more than ever*. Geneva: World Health Organization, 2009.
4 Coulter A and Jenkinson C. European patients' views on the responsiveness of health systems and healthcare providers. *European Journal of Public Health* 2005;15:355–60.
5 Rotar-Pavlič D, Švab I and Wetzels R. How do older patients and their GPs evaluate shared decision-making in healthcare? *BMC Geriatrics* 2008;8:9.
6 Brundage M, Feldman-Stewart D, Leis A *et al*. Communicating quality of life information to cancer patients: a study of six presentation formats. *Journal of Clinical Oncology* 2005;23:6949–56.
7 Edwards A, Elwyn G, Atwell C *et al*. Shared decision making and risk communication in practice: qualitative study of general practitioners' experiences. *British Journal of General Practice* 2005;55:6–13.
8 Berry D. *Communication Between Patients and Professionals*. New York: McGraw-Hill, Open University Press, 2007.
9 Gravel K, Legare F and Graham I. Barriers and facilitators to implementing shared decision-making in clinical practice: a systematic review of health professionals' perceptions. *Implementation Science* 2006;1:16.
10 Salmon P and Hall GM. Patient empowerment and control: a psychological discourse in the service of medicine. *Social Science and Medicine* 2003;57:1969–80.
11 van der Weijden T, van Veenendaal H and Timmermans DRM. Shared decision-making in the Netherlands: current state and future perspectives. *Zeitschrift für ärztliche Fortbildung und Qualität im Gesundheitswesen* 2007;101:241–6.
12 Stevenson FA, Barry CA, Britten N, Barber N and Bradley CP. Doctor–patient communication about drugs: the evidence for shared decision making. *Social Science and Medicine* 2000;50:829–40.
13 Fugelli P. The Zero-Vision: potential side effects of communicating health perfection and zero risk. *Patient Education and Counseling* 2006;60:267–71.

CONFLICTS OF INTEREST

None.

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Accepted July 2010