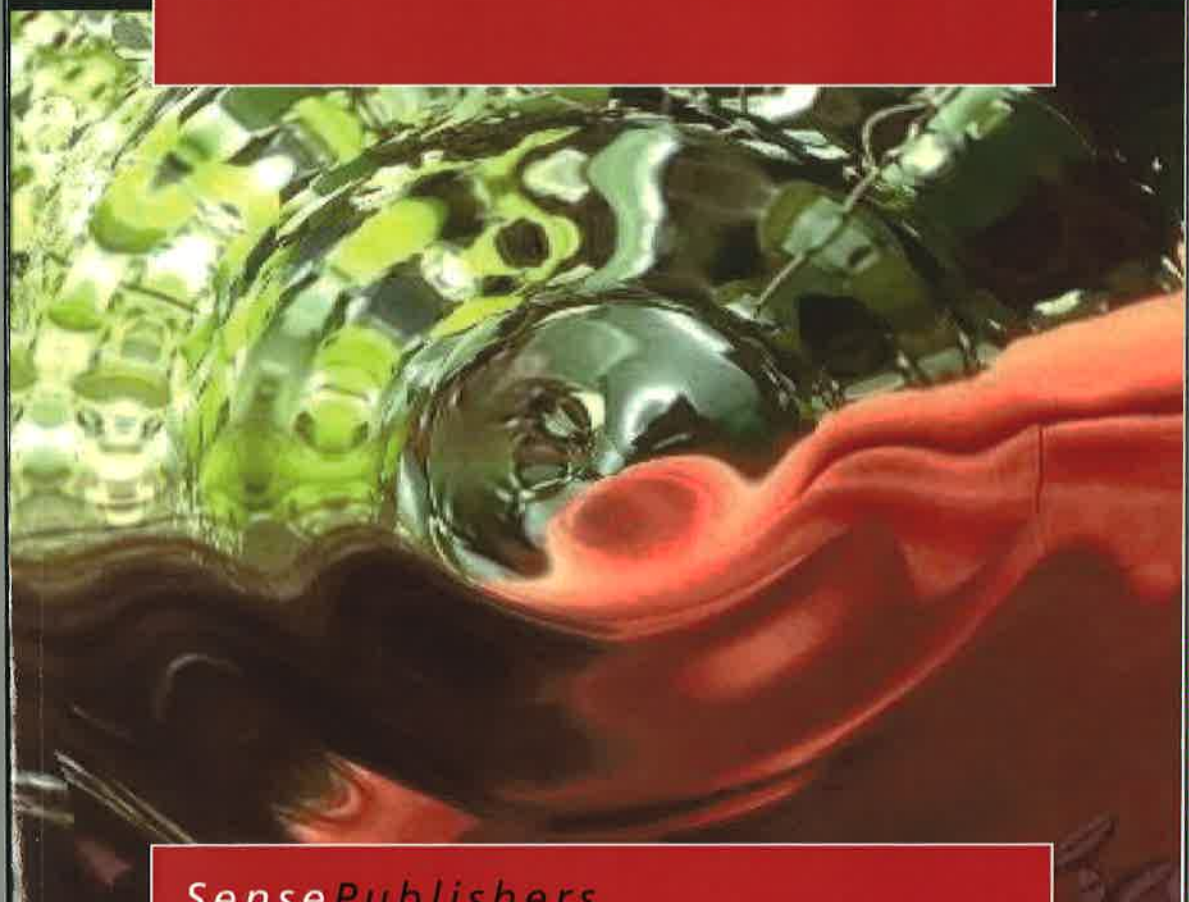
PRACTICE, EDUCATION, WORK AND SOCIETY

Health Practice Relationships

Joy Higgs, Anne Croker, Diane Tasker,
Jill Hummell and Narelle Patton (Eds.)



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Health Practice Relationships

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5. PATIENT-CENTRED CONTEXT OF HEALTH PRACTICE RELATIONSHIPS

Health practice might be informed by scientific knowledge but it is carried out with people and within social contexts. To this end, much has been written about patient-centred care. The virtues of listening to patients, respecting their health beliefs and behaviours and working with them as partners have been well documented. From the World Health Organization to government agencies to local community health centres, all subscribe and explicitly endorse patient-centred approaches through policies, missions and practice models (WHO, 2000; Kitson, Marshall, Bassett, & Zeitz, 2012). There is no lack of recognition of patient-centred care in strategic plans, professional value statements, codes of conduct and organisational policies. In this literature little attention has been devoted to explicitly integrating this approach with managerial imperatives for efficient patient flow underpinned by allotting a predetermined number of days in hospital for each patient based on diagnosis. Moreover, traditional biomedical beliefs about health, and the dominant imperative for privileging evidence-based practice as best practice, continue to prevail over other ways of knowing and practising healthcare.

In this chapter patient-centred contexts of health practice relationships are framed through historical, paradigmatic and social practice lenses. The interconnected roles of dialogue, critical questioning skills and learning that shape health practice relationships are explored. Technology and digital health are also discussed as emergent factors that radicalise possibilities for reconceptualising patient-centred practice contexts. Conclusions are offered that assert that healthcare practice models underpinned by patient-centred perspectives cannot thrive as an add-on thought or strategy; neither can they thrive on simply appealing to professionals' emotions and relying on their empathy. Conceptualising and realising patient-centred professional relationships requires distinctive practice settings. Such settings foster a respectful listening atmosphere that invites patients to tell their stories, simply starting off by saying what matters to them, including what are their worries, expectations and hopes. Establishing professional relationships by listening to patients places expert practice knowledge discreetly into the background and the desire for dialogical interactions and mutual understanding into the foreground. Within such a patient-centred context, professional interpersonal relationships are placed at the core of healthcare practice and practice knowledge is collaboratively developed, underpinned by values of social justice, wellbeing, rights and responsibility, and respect for diversity.

J. Higgs et al. (Eds.), Health Practice Relationships, 37–46.

THE ROLE OF PATIENTS IN PROFESSIONAL RELATIONSHIPS: AN HISTORICAL OVERVIEW

Until the 1960s, physicians were the authority, responsible for the diagnosis, treatment and healing of patients (Hoving, Visser, Mullen, & van den Borne, 2010). Even if they did supply health education information to their patients, this was frequently not part of a comprehensive healthcare plan. Patients were viewed as passive and were not expected to participate actively in diagnosis and treatment decisions or to ask any questions. In the early 1970s, the first communication courses for healthcare professionals were being developed. Nevertheless, the clinician-centric perspective still prevailed among healthcare professionals and patients were still not active players in the patient education field. In the 1980s, patient education developed parallel to an increasing societal emphasis on patients' rights and the growth of patient advocacy organisations. In the 1990s, patients were considered to be engaged in the promotion of their health and in making choices in treatment and treatment goals. In 21st century communication, patient stories and dialogue have strengthened a growing interest in "shared decision making", where patients are actively involved in decisions with their care providers on the basis of equality (Trede & Higgs, 2008). The influence of important people around the patient, such as partners, children and the broader social network, is recognised and even incorporated in behaviour change interventions such as buddy systems.

From this historical overview we can glean the slow shift from a preoccupation with medical experts curing diseases and telling patients what to do to healthcare teams caring for chronic conditions and collaborating with patients. With the increase of chronic, complex and co-morbid conditions, the need for sustained rehabilitation and working closely with patients has increased. These developments have also changed from an exclusive biomedical perspective of health to a broader and more complex perspective. The WHO (1946, p. 1) defines health as "a state of complete physical, mental and social well being and not merely the absence of disease or infirmity". This definition, from more than half a century ago, suggests that health is broader than the absence of physical disease and embraces social wellbeing. The definition of health as "being" suggests that it includes mind and body, individual and social, and that it is perceived subjectively. The domains of health are expanding to include social, cultural, economic, environmental and spiritual wellbeing (Marmot, 2005). A patient-centred context for professional relationships therefore needs to engage with the cultural, social, environmental and physical conditions that shape the perceptions of health.

A PARADIGMATIC OVERVIEW OF PROFESSIONAL RELATIONSHIPS

In this section we provide a paradigmatic overview of professional relationships. Paradigms are belief systems that are shared among groups of people. Paradigmatic perspectives address questions of what counts as knowledge and what are the distinguishing attributes of professional relationships. In a patient-centred perspective of professional relationships there are multiple interpretations of lived

experiences and there is not one single reality or truth that is external to self. Paradigmatic beliefs about knowledge, health and professional relationships hang together interdependently; one shapes and is shaped by the others. Furthermore, these paradigmatic beliefs are grounded in values, interests and assumptions and influence behaviours. In a patient-centred paradigm, knowledge is a broad concept that embraces experiences and perceptions. A patient-centred context is one where people engage with more than one way of knowing. Knowledge is developed between people inter-subjectively through dialogues and shared understanding which lead to acting together.

To assist in understanding paradigmatic differences that underpin the nature of professional relationships we present in Table 5.1 a simplified overview that distinguishes clinician-centred from patient-centred professional relationships. We acknowledge that there are many more paradigmatic distinctions, such as gender perspectives.

Table 5.1. Paradigmatic overview of clinician- and patient-centred attributes

Attributes	Clinician-centred	Patient-centred
Philosophical paradigm	Positivism	Realism
Interests and values	Economic, efficient and short term	Humanist, effective and sustainable
Health definition	Reductionist, biophysical, technical	Holistic, sociocultural, practical
Model of health	Illness model, medical world	Wellness model, life world
Role of patient	Passive and obedient	Own expert, interactive, participative, self-determining
Action of patient	Comply	Participate
Role of clinician	Expert sole decision maker, helper to survive	Expert facilitator of shared decision making, helper to cope
Power relations	Clinician claims power, patient is disempowered	Patient and clinician share power
Expectations by clinicians of patients	Not encouraged to think for self	Encouraged to think for self
Nature of patient education	Out of context, objective facts	Within personal and social context, intersubjective values

Attributes shape the purpose, roles and the wider practice context for professional relationships. In this table we make an abstract and crude paradigmatic distinction of the nature of professional relationships without wanting to simplify it. These attributes are rarely actualised in their pure form and may be blurred to some extent in clinical reality. With this table we aim to illustrate that professional relationships are shaped by assumptions and beliefs about health and power. We contend that it is important to deeply understand the beliefs, interests, values and assumptions of clinicians because, purposefully or unknowingly, they set the scene for professional relationships. Clinicians who are aware of the wider practice contexts and the attributes that shape professional relationships are in a better position to make purposeful choices about the role they want or indeed need to play with each individual patient. Furthermore, the attributes not only highlight the skills and capabilities necessary to enact the intended roles but also claim a position and a stance about what kind of role clinicians and patients are willing to take on.

Clinician-centred professional relationships are based on the function of information transmission, or information translation. It can be described as a one-way communication system when health professionals take on the role of the expert who has specific professional knowledge and patients take on the role of the naive, ignorant lay person who lacks expert professional knowledge. This type of professional relationship is characterised by control and monologues based on closed questions that require short yes or no answers.

Patient-centred professional relationships are dialogical relationships underpinned by co-participation and respect for each other's ways of knowing. Such relationships are based on the assumption that scientific and cultural ways of knowing are intertwined in a complex way and that only by collaborating and listening can professionals provide appropriate information and effective services. We agree with Stewart's (2001) definition of patient-centredness which "actually means taking into account the patient's desire for information and for sharing decision making and responding appropriately". This notion of patient-centredness implies that rather than telling patients, clinicians should listen to patients with the aim of identifying what it is they still need to know.

Tensions between scientific and cultural ways of knowing persist and continue to be the focus for many philosophers, researchers and practitioners alike. We note here that professional relationships are not only shaped by individuals but are also the product of both individual and social agency.

Paradigmatic perspectives often remain unnoticed because they are invisible and implicit. However, they can be exposed by the way people think about health. The question of who and what is responsible for improving wellbeing has a profound effect on what patients and clinicians expect from each other. Expectations set the scene for how patients and clinicians relate to each other and what role they are willing to play. People who believe that their body is a machine that simply needs fixing by an expert mechanic assume that there is no need for them to participate in their healthcare plan. They assign themselves a passive-submissive patient role. On the other hand, patients who believe that their physical health is closely related to their social, cultural and educational capital assign themselves a more proactive,

responsibility-sharing role. Patients who believe in their own responsibility for health will display agency and seek dialogues with clinicians.

Framing Health Practice Relationships Through a Sociocultural Practice Lens

Another way of exploring health practice relationships is through a social practice lens. Like other discipline-specific professional practices, health practice is foremost a social practice conducted by people fulfilling distinct roles in designated professional relationships (Schatzki, 2002). Practice in this sense comprises so much more than profession-specific knowledge and technical skills; it also includes dispositions, moral values and actions, decision making, professional judgement, relating to others, communicating with diverse groups and, last but not least, learning. All these practice features are interconnected and interdependent. Practice is situated because it occurs in a specific time and place and becomes alive in unique sociocultural practice contexts. Most of what is practised is routine and predictable, but there are aspects of practice that can never be fully predictable and where learning to respond in the moment is required (Zukas & Kilminster, 2012). Practising patient-centredness can be such a learning moment.

Exploring health practice relationships through a social practice lens brings the relational and dialogical aspects of health practice into focus. Attention is not on professional knowledge and expertise but on the doings, sayings and relatings (Kemmis & Grootenboer, 2008). The way patients and clinicians work and talk together and relate to each other shapes their interpersonal professional relationships. The focus is on interpersonal spaces that are immediately intersubjective and mutually construct practices. Observed through a relational and discursive lens, notions of detached objectivity and rational professionalism are contested as one-dimensional and incomplete notions of professional practice and practice relationships.

Practice relationships are nested within the workplace context and culture in each professional health setting, shaping the roles patients and clinicians assume. The workplace context and culture include physical layout, rosters and work shifts, technical instruments, and what counts as important and legitimate activity. The nature of social atmosphere and workplace culture, or what is valued and what is not, often remains invisible and implicit. The way people interact with each other and objects in space and time further shapes the context for professional relationships. Workplace cultures abound with symbols and routines (rituals). Clinicians who are oblivious to workplace culture and work atmospheres more often are shaped by them rather than shaping them. The interconnections between the physical and cultural dimensions of a workplace and how they influence health practice relationships remains under-researched (Trede, McEwen, & Sheehan, 2013). The spaces in a workplace are part of the contexts that shape professional relationships and, as Lyon (2004) suggests, workplace contexts are intersubjective and therefore can be transformed. In what follows we explore the role of dialogues in shaping interpersonal relations.

FRAMING HEALTH PRACTICE PROFESSIONAL RELATIONSHIPS THROUGH DIALOGUES AND STORIES

Dialogues enable engagement; however, they are fragile undertakings that can easily be hijacked by one dialogue partner. To simply conduct a conversation and appreciate how the "other" makes sense of situations is insufficient. Dialogue and meaning-making require close scrutiny by looking beneath the surface. What has been said needs to be followed by deeper questions such as "How important is this?", "Why did she say this?", "What are the ulterior motives and intentions?", "Is the dialogue privileged by a biomedical or sociocultural understanding of health?". Based on Habermas' theorising (1984) on what constitutes good communication there are three conditions we have extrapolated for patient-centred dialogues. These conditions are that both dialogue partners (1) disclose their bias and refrain from rhetoric and unsubstantiated claims that can mislead the other; (2) take a self-reflective stance; (3) articulate their reasoning rather than exerting power over the other. In other words, a patient-centred approach to dialogue is underpinned by a curiosity to establish what is needed from multiple perspectives. It requires insightfulness, perception and acknowledgement of both parties. Both emotions and logic play into patient-centredness. The ability to draw out what really matters to patients enables clinicians to work with patients in a patient-centred professional relationship.

Without shared expectations, participation and interactive dialogues, it is very likely that patients and clinicians live in two parallel worlds that do not intersect. A recent study of patients' perceptions of patient-centred care confirmed that key issues for patients had not been adequately addressed by hospital staff. Patient issues included respect, mutual trust, and clear and open communication (Ferguson, Ward, Card, Sheppard, & McMurtry, 2013). Respect meant that clinicians knew their patients as people beyond symptoms. Mutual trust meant that patients felt clinicians showed authentic empathy and interest which encouraged patients to get involved in their care process and participate in decision making. Open and clear communication was not only about access to information but an expectation by patients to engage in discussion about the information. Telling knowledge was not sufficient. Patients wanted to interpret information with their clinicians. Ferguson et al. found that almost half of their patient participants were not satisfied with their care experiences. They concluded that exposure to patient-centred experiences was needed. However, we question whether exposure without epistemological grounding is sufficient. Clinicians who conceive of themselves as biomedical experts who know best how to deliver efficient care can easily dismiss patient-centred approaches as fickle, time-wasting and emotionally draining.

Health agencies recognise that quality improvement in health services is connected to "good" patient experiences and effective dialogues. The various ways patient experiences are evaluated include patient satisfaction surveys and the collection of patient stories. Patient stories are part of the wider patient-centred movement and an increasingly popular approach to establishing meaningful patient-centred professional relationships (Charon, 2006). Patient stories are

immediately subjective, encourage active involvement, reveal the beliefs of the storyteller, provide distinct interpretations of situations, and create a space for discussing feelings and subjectivities; stories are an invitation to share experiences (Riessman, 2008). Stories can interrupt clinicians in their routine of getting things done (Frank, 2012). They can be a reminder of what is really important and what is really needed rather than diligently following task patterns. Patient stories can only be effective if they are responded to, which means that clinicians need to be willing to be interrupted in their routine. Charon (2006, p. 191) emphasised the importance of listening, claiming that the tasks of clinicians "include the duty to bear witness as others tell of trauma and loss". Through listening, patients talk and can convey their stories to professionals, which in turn is a reflective act that helps patients to make further sense of what matters to them. Charon (2012, p. 1880) succinctly described the reciprocal nature of patient-centredness in the following: "The contact between doctor and patient provides the ground for reciprocal recognition. Each comes to know things about the other that help the other, while being granted a view of self". Patients learn about clinicians and clinicians learn about patients and, at the same time, learn about themselves. This implies a reflexivity which goes beyond one-way listening and responding. Clinicians are learners and patients are teachers. This reciprocity and interdependence of listening, speaking and learning democratise and humanise professional relationships. Patient and clinician can meet at a human level. Storytelling, from this perspective, does not necessarily lead to more efficient care and does not work to economic or biomedical imperatives. What this approach enables is a cultural and truly people-centred way of being together which at the same time can transform health practice contexts. A patient-centred context is created through changing one's self (Aujoulat, d'Hoore, & Deccache, 2007). It requires thinking about the other and thinking about self in relation to the other.

Attention to detail and to personal circumstances are key features of patient-centredness. This attention is further underscored by compassion, empathy and an ability to consider "the other". These aspects all speak to humanity, diversity and complexity rather than to the application of universal rules and routine practices. Patient-centredness is based not on rhetoric, cognition and logical thought but on ethics, cultural awareness and interpersonal dialogue. To some extent patient-centredness is based on an optimistic outlook and a belief in human goodness. Patient-centredness cannot be captured from only one perspective or one party. Patient-centredness is built on dialogue, collective reflection on what is at stake and an awareness of the possible consequences of acting together that might be seen as a risk from a purely scientific perspective. Practices based on empirico-analytically derived evidence might not be the best practice in all situations. It is impossible and not sustainable to mandate compassion and moral deliberation, but it is possible to articulate the value of cultural contexts of professional relationships. Stories are a suitable vehicle for patient-centredness because they expose clinicians to cultural ways of knowing about health. Stories are engaging and immediately privilege subjective, cultural and individual points of view. Stories reveal what is important to the storytellers, how they live with a health

condition and its impact on their lives. Providing patients with opportunities to tell their story renders them some control, which can have enabling effects on them to take stronger responsibility for their recovery. The context in which questions are asked and the nature of dialogue that follows are essential in shaping health practice relationships and making judgements about their patient-centredness.

COMMUNICATION, KNOWLEDGE AND THE INTERNET

The rapid developments of information technology have also begun to infiltrate healthcare delivery and how patients and clinicians communicate with each other. With the advent of the digital age, possibilities for participation, information exchange and support groups in the healthcare sector have expanded dramatically. In addition to health literacy, patients need to become increasingly more digitally literate. Through access to the Internet patients can inform themselves about diagnoses, symptoms, prognoses and the like. Blogs, wikis, and other social media (web 2) enable patients and carers to seek advice not only from professional experts but also from peers. Digital support groups are flourishing. The Internet has brought to our attention the changing role of clinicians in communicating and educating patients. Patients no longer need to depend only on their local clinician because they can also connect with people, whether lay or professional, around the globe. Danowski Smith (2013) labelled these patients "patient 2.0".

Today, health practice relationships can be seen in a three-way communication loop between patient, clinician and the world. This shift towards a globally connected patient community offers new possibilities for peer support, peer mentoring and giving voice to patients. It also provides challenges for clinicians in terms of how to engage with these digitally literate and connected health consumers. Knowledge no longer resides exclusively with health professionals, but interpreting and differentiating aspects of knowledge to social situations and individual experiences of patients becomes an important capability. In the digital age, clinicians more acutely than ever need to rethink their roles because they are no longer in exclusive possession of expert knowledge. Through digital access to information, clinicians are more needed as facilitators and moderators of health information and as coaches who help patients make sense of this information for their own needs and situations.

CONCLUSION

With this chapter we aimed to provide better understanding of the context for patient-centred professional relationships and a stronger stance to argue for it. We commenced by exploring the patient-centred context for health practice relationships. We provided a historical overview of the developments of health practice relationships from clinician-centred to patient-centred relationships. We discussed how health practice relationships can be understood through two broad paradigmatic lenses. Paradigmatic perspectives explain that professional relationships are products of world views where beliefs about what constitutes

knowledge and health are of prime influence. A social practice lens is a useful reminder that health practice is not conducted in isolation but is predominantly a social practice that involves people working together. As a social practice and with a focus on patients, health practice relationships need to be based on ethical, moral, compassionate and social justice values that embrace the life world and cultural ways of knowing. The expectations of all involved need to be articulated and attended to. Furthermore, a patient-centred context that invites engagement and active participation is crucial. Professional relationships that are privileged by instrumental, economic and efficiency stances would allocate patient-centredness a minor role at best, or undermine it as unprofessional and irrational at worst. Understanding the reasoning behind patient-centred relationships through social practice theory and communicative action theory provides clinicians with a deeper understanding of the nature of patient-centredness.

We propose to frame professional relationships within a perspective of reflective and self-critical communication and shared understanding by learning from each other to gain insights and new knowledge. We suggest using stories to evoke what it means to be human and to stimulate reflections on current notions of professional relationships. To be human means to think for self, make sense of experiences and, based on these deliberations, to act purposefully. Furthermore, to be human means to be able to question self, explore feelings and assumptions that shape the way people reason, and consider consequences of decisions and actions. Our perspective of patient-centredness goes beyond emotion and compassion. We argue that patient-centred contexts should be motivated by a sense of social justice. Patient-centredness cannot be an add-on to models that do not value cultural and social perspectives. Patient-centred contexts can only be created together with patients through reciprocal relationships where patients and clinicians listen to and learn from each other.

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SECTION 2: UNDERSTANDING PROFESSIONAL RELATIONSHIPS