Patient-centered care and communication in primary care practice: what is involved?

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Abstract

Objective: This secondary, qualitative analysis examined physician-patient interaction and patient-centered care in a random sample of encounters of 44 physicians in 18 family practices.

Methods: Fieldworkers were trained in qualitative and quantitative data collection strategies including participatory observation, narrative description, interviewing techniques and note-taking regarding practice observations, patient encounters and community assessment. Fieldworkers spent 4–8 weeks in each practice. Data included descriptions of practices, personnel, office systems, patient encounters, chart audits and physician, practice personnel and community informant interviews. Data analysis included comparison of results with Stewart et al. patient-centered model.

Results: Results support and extend the work of Stewart et al. The content and expression of clinical discourse in the exam room springs from complex sources, including physician and patient characteristics, practice and community cultures, and related medical care expectations.

Discussion: Patient-centered values often conflict with other competing values. Ideas drawn from complexity science helped make sense of how “attractors” identified in findings influenced outcomes of patient-centered care and communication.

Conclusion: Physician, patient, practice and community characteristics, values and expectations impact the effectiveness of patient-centered care and communication.

Implications: Medical students, residents and practicing physicians need opportunities to evaluate competing values affecting the delivery of patient care.

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1. Introduction

From Hippocratic times to the present, the physician–patient relationship has been a focus of attention because of its influence on therapeutic outcomes. The result is a large literature examining communication in the doctor–patient relationship. Therefore, in this paper we focus on the patient-centered model of communication that has been taught in US medical schools during the last two decades.

The patient-centered model of communication developed in response to the increased integration of medical science and technology into patient care during the mid-to-later 20th century that emphasized the biomedical aspects of disease. This resulted in a gradual shift away from patients’ existential concerns about illness with a corresponding alteration in the power structure in the physician–patient relationship with the physician becoming the “expert” [1]. In the 1960s and 1970s concerns about equity in civil and
human rights led to changes in ideas concerning patients’ participation in care and the promotion of a collaborative relationship between the physician and the patient. With this shift in the balance of power toward a collegial relationship between physician and patient, patient-centered models (PCMs) of care, such as the biopsychosocial model, began to appear [2–4]. Although the biopsychosocial model was a shift away from the biomedical model, it later came under criticism for its physician’s frame of Ref. [5]. As the PCM evolved, it increasingly focused on the need to understand patients’ stories within the context of their daily lives [6–15]. More recently, the patient-centered method has expanded to look at other contextual factors that may influence communication such as the importance of the cultural context in which communication takes place [16], systemic factors [17], and limited resources [18] and their impact on care.

While these perspectives have expanded our understanding of the physician–patient relationship, questions remain concerning the actual impact of philosophical, organizational and community factors on current practice and patient-centered care. Our interest in this area was heightened when data from a larger study (described below) uncovered a complex array of factors that influenced the delivery of preventive services in family practices. In this paper we present the results of a secondary analysis of those data in which we examine features of practice and identify the ways in which “patient-centeredness” was behaviorally defined in observed patient encounters. We asked ourselves, “What occurred during the encounter that differentiated a patient-centered physician from one who was not?”

2. Methods

This paper describes the results of a secondary analysis done on a large RO-1 study, “Prevention and Competing Demands in Primary Care” [1]. This study was an in-depth, multi-method, comparative case study examining the organization, structure and process of care of preventive service delivery in 18 purposefully sampled mid-western family practices. A full description of methods used in this study can be found elsewhere [19]. The study was approved by the University of Nebraska Institutional Review Board.

2.1. Setting and subjects

We studied 18 purposefully sampled Nebraska family practices. Subjects included all practice personnel and 30 patients per provider who consented to have an observer present during encounters.

2.2. Data collection

Data were collected by highly trained fieldworkers and included dictated fieldnotes describing 1500 patient encounters, dictated field notes describing practice activities and the community, interviews with physicians, key personnel and community informants, practice genograms, patient pathways through office visits, and chart audits.

Patient encounter fieldnotes consisted of descriptions of the patient(s), the presenting problem(s), a description of the provider and patient interaction, including the provider’s style and relationship with the patient(s), provider management of the patient’s care, including prevention, health promotion, patient education, and referral to other providers.

2.3. Data analysis

Four of the authors (VA, HM, BC, EB) were involved in the analyses of these data and in the construction of case study summaries for each site. In this secondary analysis, we initially used only the narrative descriptions of physician–patient encounters. To provide a variety of visit types, encounters for each of the 44 physicians (total for the 18 sites) were stratified by type of visit (acute, chronic, health care maintenance). Ten encounters for each physician were then randomly selected. For each site the authors independently read and coded the narrative notes of the ten encounters for each physician, using a template derived from the work of Stewart et al. patient-centered model (PCM) (see Table 1) [15]. Then in site-specific group analysis sessions we discussed our individual conclusions about patient-centeredness for each encounter for each physician at that site. We paid particular attention to the operationalized definitions for 6 critical features of patient-centeredness provided by the Stewart et al. model.

In addition to the patient encounter data, we knew from the larger study analyses that the physician interviews contained information in the physicians’ own voices about contextual issues they saw as affecting their practices and the delivery of care. The fieldworkers’ fieldnotes also contained impressions and observations about practices and community contexts. Because these contextual features figured prominently in our discussions in this secondary analysis, we decided to include physician interviews and practice fieldnotes in our analysis of each physician. These data provided additional clues as to the motives and the context of values and beliefs held by physicians, patients and others who worked in or influenced the practices.

We also looked at physician personality and interaction style as defined in the case summaries. We categorized physicians into general, non-exclusive groups, including those who (a) were predominantly analytically minded in dealing with patients and their problems; (b) those who focused more on relationships with patients; (c) those who seemed most interested in working efficiently and staying on schedule to see as many patients as possible each day; (d)
those who were more relaxed and unhurried during patient interviews. We then compared and contrasted our assessments of each physician with his or her stated values and beliefs as recorded in interviews and fieldworker’s observations in the fieldnotes. This triangulation of data strengthened our faith in the conclusions we reached as to the practice values and beliefs that motivated the care observed during encounters. From these analyses, we constructed summary accounts of physician personality types, practice styles and beliefs with supporting evidence. Using this analytic approach generated a productive dialogue, with high inter-rater reliability, comparing the physician–patient relationships and patient-centered care upon which we now report.

3. Results

Our most important finding was that the content and expression of clinical discourse that occurs within the exam room varies markedly because of the complex and diverse factors that influence it. Most models of patient-centered care focus on the behaviors and discourse of interaction. To appreciate factors influencing physician–patient interaction (Fig. 1), we found it important to understand implicit characteristics represented on our model by the following four themes:

1. Physician characteristics including style, values and philosophy of medicine.
2. Patient characteristics including priorities, values and philosophy of health.
3. Practice organization, priorities and culture and their relationship to physician philosophy.
4. Community culture, priorities and their relationship to medical care expectations.

As shown in the above figure, we viewed patient-centered interaction holistically as a sphere with dynamic, fluid components. In this model, the categories we identified wash over and influence each other depending upon their intensity, creating varied patterns. We describe each set of characteristics and what they entail and provide illustrative excerpts drawn from physicians’ own words. We also provide three holistic practice examples, Tables 2–4, compiled from encounter and fieldnote data that illustrate variations in physician patient-centeredness, or lack thereof, within the context of factors that shape the expression of practitioner behavior.

3.1. Physician characteristics

We found that a variety of physician practice philosophies and preferences, i.e. desire to do academic or private medicine; choice of location, urban or rural; preferences regarding patient population, shape values and beliefs that influence patient interaction and care. Possibly the most important of our findings is that while the PCM recognizes infinite differences in patients, it does not actively recognize the impact of the infinite variety of personality types, values, beliefs, clinical interests, and practice contexts among physicians. The latter seem to play an important role in the type of interaction that we witnessed between physicians and patients.

We found that different personality types, whether analytical, relational, pragmatic, relaxed, or some combination thereof, could each be patient-centered when physicians adapted their personalities and ways of working to the temperaments of their patients. When we compared our assessments of physicians’ observed personality types as manifested in encounter interactions with physicians’ stated values and beliefs in interviews, we found that they went...
Table 2
Qualitative summary description of a Nebraska practice, 1996–1999 (example: practice A)

Community context
This three-physician practice is located in a small farming community in which the hospital is a major employer. The hospital owns the clinic building and recruits physicians when needed, guaranteeing their first year salary and benefits. The economy of the community is very poor. Most people within the community know one another personally. Members of the community demonstrate a conservative, pioneer spirit.

Patient characteristics
Most patients pay for their health care and physician visits out-of-pocket. Patients seek medical care for acute and chronic illnesses, but do not want the expense of paying for preventive services.

Physician characteristics
Physician A is the senior male partner. He has an analytic style and a slower pace. He has established long term relationships with his patients who are extremely loyal. They consider him to be exceptionally patient-centered.

Physician B is a younger, male member of the practice. His easy-going personality makes him appear patient-centered, although he does mostly acute care. He tries to meet the needs of his patients as they present. He has adopted an “informative” approach with patients who seem disinterested in preventive care.

Physician C is a younger, energetic, female member of the practice, who works part-time. She is committed to trying to keep patients healthy and she stresses preventive and health maintenance care in her practice, serving mostly women and children. She is also committed to the population at large and frequently talks about health promotion within the community even though some patients are resistant to preventive care.

Practice culture
The distinctly different personality styles and ways of adapting of these physicians results in a practice that could be characterized as three solo physicians practicing under the same roof. There is little sense of a common mission within the practice. Patients seem to self-select to like-minded physicians.

Assessment of physician patient-centeredness.
Both male physicians are thought by their patients to be patient-centered because of the relationships they build with patients even though both emphasize biomedicine. The female physician who emphasizes prevention is thought by some to be “pushy”. Since the community expects and wants acute and chronic care and de-values preventive care, the first two physicians fulfill patients’ expectations while the latter does not.

Table 3
Qualitative summary description of a Nebraska practice, 1996–1999 (example: practice B)

Community characteristics
This three-physician practice is one of the original primary care clinics located in a suburban area of a larger, fast-growing urban area. It is part of a health system in a highly competitive health care market.

Patient characteristics
Patients are socio-economically diverse, primarily young, middle-aged, family-centered people who lead hectic lives. Three-fourths of the patient population is covered by employer health-insurance plans. These patients expect efficient medical service and care more about being seen in a timely manner than about continuity of care with the same physician.

Physician characteristics
Physician A seems to be the informal leader of the clinic. He has a fast-paced, directive, biomedically oriented style that focuses on solving the patient’s presenting problem efficiently. He seems to develop positive, affiliative relationships with patients.

Physician B is more relaxed in his approach to patients. He usually spends more time with patients and as a result is more likely to run behind. His patients accept this inconvenience, knowing he will spend as much time as needed with them. He is most likely to address psychosocial issues with patients as they come up within encounters. He also uses a directive style and is primarily biomedically focused.

Physician C is the novice member of the group and recently finished his residency training. He is problem-focused and continues to develop his own style of affiliation with patients. He sees fewer patients/day than his better-established partners.

Practice context
These physicians get along well both personally and professionally and share a common biomedical practice vision despite their varied styles of practice. These physicians strive to provide the best patient care they can on the patients’ terms-efficiently and in a timely manner, making them patient-centered in this particular context. The staff is cohesive, courteous, helpful and friendly.

Assessment of patient-centeredness.
If patient-centeredness is about meeting the patient’s expectations in terms of providing efficient and timely service, physicians A and B would qualify. Yet the definition of patient-centeredness that we used includes broader psychological and social aspects of care that only physician B provides. None of these physicians emphasized preventive care which is also an aspect of patient-centered care.
alter those, but it is my job to make patients aware of those . . .

More specifically, as we applied the Stewart et al. criteria to each physician’s practice, we found that physicians in our sample elicited some, but not all of the model’s information at any one time. For example, physicians often elicited some of the patient’s narrative story of illness pertinent to the chief complaint, but not all. As physicians’ knowledge of patients’ circumstances evolved gradually over time, it enabled physicians to know their patients as whole people, making it unnecessary to ask for the “whole story” each time. We could see this in physician statements assessing their approaches to preventive care:

I try to incorporate preventive medicine or health care maintenance into my acute visits, by talking about ‘[W]hat do you do for your occupation?’ You know, ‘[Y]ou are a farmer, running a tractor without a cab, do you wear any protection?’

In general we concur with Stewart et al. that patient-centered physicians try to incorporate prevention into care, however, we found that patient and community expectations also determine how much prevention is actually performed. We also agree that patient-centered physicians consistently work toward building a positive relationship with patients while at the same time being realistic in delivering necessary care to which this physician alludes:

Um, probably because I’m a woman, I do a truckload of preventive medicine, which I like and I try to [do] on the ladies that are just coming [in] for like sinus infection or something... [I] look back and see when they had a mammogram or pelvic . . .

Physicians varied in their ability to seek and find common ground with patients in managing their illnesses, depending on the correspondence between physician and patient personality characteristics and the characteristics of the practice and community. Similarly, we found that the ability of a physician to adapt to the personality styles of practice partners influenced his/her ability to find common ground around goals within the practice setting.

Overall, patient-centered physicians have successfully integrated their personal and professional values and commitment to patient-centeredness with the biomedical aspects of medicine. One physician explained his commitment to helping patients stay healthy this way:

Well, I’m from a family . . . [D]ad and his folks and my brother are all pharmacists, so we have been in the health field so I kind of grew up in the drug store; and my folks are both very healthy and are health-conscious, and uh, so I think some of it is my upbringing.

This integration was manifest both in the examination room and within the community of care; in both situations physicians made choices that supported both patient health and patient-centered care. Physicians integrated biomedical care while considering patients’ social, psychological, emotional and sometimes spiritual needs through thoughtful and sensitive communication. In some cases, physicians were quite aware that their patient-centeredness contradicted the prevailing biomedical expectations of care within their practice settings as in this comment concerning pneumococcal vaccine:

Well, the problem [is] there is a pulmonologist that comes out of [a nearby city, who] doesn’t believe in it. He now feels that it’s probably worthless. So I know [my partner] is really vacillating between what he ought to do. [My other partner] has been immunizing some people twice. I have been doing it once . . .

In other cases, physicians seemed unaware that they had created a “buffer” of sorts between the patient-centered values in which they believed and the explicit pragmatic

| Table 4 |
| Qualitative summary description of a Nebraska practice, 1996–1999 (example: practice C) |
| Community context |
| This one-woman family practice is one of two family practices in a smaller rural community. The other practice has several male family physicians. There seems to be some tension between the two practices and strong preferences exist among community members for one or the other. |
| Patient characteristics |
| A diverse group of patients of all ages come to this practice—many suffer from complex, debilitating diseases of the immune system. They come from the local area as well as from all over the country to see this physician. |
| Physician characteristics |
| This physician is acutely sensitive to the needs of her patients. She is exceptionally caring and holistic in her approach to patients. She applies a true biopsychosocial approach to the care of her patients and as a patient advocate, goes beyond what some might consider to be the limits of serving patients. She has coached her office staff to treat patients with the same respect that she shows. This physician’s goal is to prevent disease. She will see patients no matter what their financial resources. Her commitment to patient education, preventive medicine, health promotion and disease prevention is genuine—she is exceptionally patient-centered. |
| Practice characteristics |
| The physician’s staff is cross-trained, flexible, and responsive to the daily demands of patients’ needs. Although the practice is exceptional in many ways, it has been troubled by a series of poor financial advisors. The physician feels that the bureaucracy of larger systems such as the local hospital, private insurers, Medicaid and Medicare programs have often failed to work with her to best serve patients’ interests. |

Assessment of patient-centeredness. The practice of this physician is possibly patient-centered to an extreme.
values of the health care system in which they worked as in this example:

Yeah, this system’s got some inherent problems but, you know, overall I don’t, we try to keep those problems out of the clinic. As hard as that is to do, you know, I think we’d all say the patient care doesn’t get affected—maybe our personalities and moods and things like that do, which could transfer to your patients, but I don’t think patient care has ever changed because of something the system does.

3.2. Patient characteristics

A number of patient characteristics influence not only what patients expect in regard to health care, but also how much they are willing or able to do in complying with physicians’ recommendations. Some important patient characteristics include the patient’s age, background and experience, social, educational and financial circumstances, including health insurance status. A physician paraphrases the way he perceives patients to think in this example:

Well, again it boils down to health care dollars, and I have $20,000 and I need to provide clothes for my kids or myself and food and rent or house payment—you know it can only go so far, and for me [the physician] to say you should have this test... done [seems burdensome].

During interviews, one physician characterized the impact of women’s and elderly patients’ financial and life circumstances on the delivery of health care services in this way:

They [women between 40–50 years of age] are most often unemployed. Their kids are gone from the home, so they don’t [get] Medicaid now, and [Medicare] doesn’t cover them now anyway... Now they don’t have anything...

I don’t see a large number of the elderly... getting routine mammograms. Maybe they should, but we are dealing with a different mentality as well. Those individuals weren’t exposed to this [in earlier years] ...

We also found that patients have varying expectations for types of care, acute vs. preventive, for example. We found that if patients believe that they should seek a physician’s care only when acutely ill, then they are less inclined to seek preventive care. One physician explained it this way:

I’ll tend to focus more on preventive medicine at a physical and try to intervene at that time. Usually when people are sick they don’t want to hear you harping on them about smoking or whatever, even though it probably should be done, especially if they are coming in with something that’s maybe related to that stuff.

Patients’ assumptions about the role of medicine in their lives seemed to influence priorities, values and personal philosophies of health that actively determined whether or not patients partnered with physicians by adhering to or accepting recommended plans of care such as preventive measures. Many physicians commented on their patients’ unwillingness to incorporate preventive recommendations such as smoking cessation and weight reduction into health maintenance plans. Physicians were thus discouraged from pursuing certain aspects of preventive care until patients showed that they were ready to accept it.

3.3. Practice culture

Another finding is that the physician’s philosophy, as described above, can influence or be restrained by the larger practice organization itself. During the analysis of data, team members discussed physicians’ relationships with patients as influenced by the context of practice organization. Practices varied by their composition, organization, values and affiliations all of which influenced expectations as to how practitioners would serve patients. Staff skills, resources and values, for example, are known to make or break a practice and can have a tremendous influence on patient-centeredness. When a health care organization managing a practice restricts staff resources, it makes the situation even more difficult as in this example:

It seems like we’re always trying to juggle tasks with... nursing to make our nursing staff more available to do the things that they normally do, the BP’s, putting the patients in [exam rooms] and things... that’s probably the most important thing at this point... we’re just real understaffed to do those things...

We’re... short staffed, especially on Tuesdays... so we... request... they give some consideration... [to] productivity of the clinic... I guess if we’d been private, you know, an independent situation, we’d do the same things, you know, look at the bottom line. The priorities are a little different with this system.

Practices appear to adopt their philosophical values and expectations in three predominant ways. They adopt the values and beliefs of practitioners working in the practice, assume the professed values of the practice administration or health system to which the practice belongs, or evolve through a historical process over time. In the latter case, expectations are handed down by older practitioners, administrators and/or staff leaders who may or may not still be actually present within the practice. Overall it seems important that past and present values be reconciled and negotiated over time among leaders within the practice for the practice to evolve successfully. We found that successful practice evolution leads to common goals. This does not mean that physician partners have to practice in the same ways as highlighted in this response to the interviewer’s question whether partners practiced in a similar manner:

No, we’re all different. We have the same goal in mind, but we get there 3 different ways. I don’t think we practice the
same type [of medicine] and people who are out there in the public realize that and they kind of migrate in the direction which... suits them also.

In another example a physician comments on the negative consequence of a lack of shared goals:

I think there is a total lack of respect for the physicians by the executives and the administrators [of the clinic.] Um, you know I think there are things that they do, that you couldn’t do anywhere else and get away with. Um, but as a physician it’s... very tough... to get organized and try to do something... you can’t go on strike because the only people who get hurt are your patients...

When a practice’s administrative and clinical goals are congruent and clearly communicated, they are usually implemented successfully by physicians and staff. When they are not, as illustrated above, physician and staff morale decline. Physicians and staff may try to protect patients from the ill effects of such organizational tension, but most patients, and people in general, are perceptive enough to recognize when those serving them are dissatisfied.

3.4. Community culture

Variables within communities can also exert considerable influence upon medical practices, shaping expectations of patients and the medical services that physicians provide. The history of the community and its economic circumstances has important implications for relations between the practice and other entities such as the hospital and other stakeholders within the community. The vitality of the community and its financial health influence patient and physician expectations as in this example:

I don’t see that there’s a huge [issue] about preventive medicine other than it’s something that I personally desire cause certainly, financially it’s not rewarding... I struggle... with going from a[n] intermediate to an extended [visit charge] on people because people out here had a fit when we went from $20 to $25 on an office call, had a fit! I mean it had been at $20 for year[s] and it’s now been at $25 for 4 1/2 years, you know, we’ll just get harassed. So you know, it’s not like you can up their charge because you pass out preventive medicine... However, because I’m going to live with them [these people] for years and take care of them... hopefully, and a lot of them are my friends... I guess I want to see that they, that I’m teaching them what I know.

In a different community where many patients lacked health insurance, a physician stated:

[I]deally I would like to see more preventive medicine, but the health care dollar, I think, prevents that, in my setting particularly, and I don’t know whether that is across the nation or not, but you’re dealing with people with a low to moderate income situation and they aren’t willing to spend their health care dollars for preventative medicine, and so you end up, I end up incorporating it into whatever type of health care setting that I find myself in.

The importance of synchronicity between practice and community cannot be underestimated. For example, in smaller communities, the hospital institution, its administrator(s) and board of directors can exert considerable influence on a practice organization and its physicians. In some places, the hospital actively recruits physicians and guarantees their salaries in the early phases of practice thereby exerting considerable power as our fieldworker noted in her fieldnotes in this situation:

[T]his hospital has... donated the land on which our family practice site is located. They also guarantee the salaries for one year, for two of our site physicians to recruit them into this area until their practice could be self supporting. In return for these options, the family practice clinic is [expected]... to send all of their lab patients, respiratory therapy patients, minor surgery patients and emergency patients back into the hospital for services.

In other, often larger communities, health systems can exert a similar type of power as they compete for patient market share by hiring physicians, placing them in strategic locations, and designing office/business/personnel systems and healthcare delivery strategies.

Differing communities, therefore, can exert immense social and/or organizational pressure on practices to conform to their expectations. Physicians who showed skill in dealing with such pressure were (a) aware of the sources of community influence, (b) aware of assumptions and associated values motivating these forces, and (c) were in some cases willing to confront and negotiate with the organizational leaders, thereby exerting counter-pressure aimed at serving patients’ interests.

4. Discussion

This analysis built upon a large body of literature and quality research pertaining to physician–patient relationship and patient-centered communication studies. The importance of this area of research cannot be underestimated given the implications of physician–patient communication on patient outcomes and the physician’s own work satisfaction. We concur with our Canadian colleagues that patient-centered interactions are important for the delivery of quality care. We conclude that physicians who are successful in putting the patient-centered care model into practice have made an active commitment to professional values that are patient-focused despite the dominant biomedical philosophy of medicine. And finally, we found that physicians who have committed to the patient-centered philosophy of medicine may be faced with conflicting values found in their practices, organizational or community environments. What is new about these findings?
In making sense of these data, we used a complexity model to help us understand what we were seeing [20,21]. One of the key points of complexity theory is that systems contain “attractors” which significantly affect the behaviors of the system(s). Understanding these attractors and how they influence the system of care-giving and health outcomes is key. Individual physicians function within personal and professional value systems as well as within practice systems. In our sample of physicians’ practices, a key attractor was their ability to actualize patient-centered values within their practice systems by creating an environment that emphasized patient-centered values. Patients, existing within their own individual systems, respond to these patient-centered, physician system attractors, fostering or inhibiting their future occurrence. In the same way, both physician/practice and patient systems are enacted within community systems that foster or inhibit patient-centered care. As our diagram shows, each of these systems is dynamic, each one influencing the others. Any attractor in any one of these systems can foster or inhibit the physician’s ability to act out patient-centered values.

For example, in practice A, there were three physicians with differing interests in providing patient-centered care. Their patients, with limited resources and many lacking health insurance, generally came to their physicians expecting illness care. Both patient and physician systems functioned within a larger community system in which assumptions about health care were largely shaped by geography and limited resources. Within this system, the community hospital was the strongest attractor and shaper of community health values. A significant conflict between the physicians/practice system and the hospital/system undermined the influence of the physician/practice system on the patients’ attitudes toward health care within that community. Had the physicians been able to compromise and reach agreement with the leadership of the community hospital, they might have had more influence in providing patient-centered care.

In example C the woman physician’s strong patient-centered values and sense of service attracted a vulnerable, underserved population within her community and from an expanded geographic area. However, her financial practice advisors did not provide a means of supporting her values for the long term by keeping her practice financially viable. Within the larger community, this physician’s eccentric style and patient population were viewed as outside the norm and marginalized from mainstream community healthcare. Had this physician been able to secure better practice management that monitored both financial and community trends, she may have been more successful in overcoming barriers to her worthy goals.

Our diagrammatic conceptualization provides this kind of a broader view of the complex factors that influence patient-centered care. By focusing on the physician/practice, the patient, and the community we are able to synthesize a picture of patient-centered interaction within the context of other important factors that the encounter alone does not provide. We are not saying that you cannot influence physician–patient interaction by only focusing on physician and/or patient systems. What we are saying is that if one fails to account for attractors that may exist in larger organizational or community systems, those attractors may inhibit or undermine the goals or changes desired.

### 4.1. Limitations of study

While we think that our findings are important and new to the literature, there are several potential limitations of our study. One limitation was that we did not have audio taped encounter data, but lengthy, descriptive narrative notes of physician–patient communication as recorded by fieldworkers during encounters. While we were careful to train fieldworkers to guard against bias and interpretation in their observations and descriptions, it is difficult to eliminate all bias. However, these narrative fieldnotes provided the rich contextual description that made this analysis possible.

A second limitation was that all data were collected within one mid-western state from a purposefully selected sample of practices. A third limitation, related to the second limitation, is that our qualitative findings by their very design are not intended to be generalized to other practices. At the same time, we feel confident that our new insights are important. Physician, patient, practice and community characteristics all influence physician–patient interaction and patient-centeredness. Since these characteristics are present in all practices, regardless of their variety, we would expect to see their influence in any practice situation where physician–patient interaction is examined.

### 4.2. Practice implications

Weston and Brown discussed the gap between the patient-centered care model and the dominant biomedical philosophy of medicine ([15] pp. 117–31). As discussed above, we believe this conceptualization has implications for medical practice as well as medical education. In practice, strategies to reconcile differences between physician patient-centered values and practice demands include making explicit one’s commitment to a patient-centered philosophy of care. In some cases, physicians overcame an organizational milieu at odds with their philosophy of medicine by finding ways to work within it. Thy paid attention to the importance of synchronicity of their values with those of their practice partners, practice organization and the community in explicitly shaping health care expectations within the examination room.

These implications have prospective implications for medical education. For example, learning objectives and curricula can highlight exploration of patient perspectives, both individual and cultural, and how they affect patient participation in biomedical scenarios. This type of teaching would stimulate not only increased awareness but also
value-centered adaptive behaviors in clinical problem-solving. Small group discussion of clinical issues during teaching rounds with medical students and residents could consider questions such as the following. What constitutes successful care from the patient’s point of view? How congruent are the culture and values of the patient and the health care institution? How do you thoughtfully bridge any differences? What difficulties will the patient have in adhering to the care plan within his or her community? Discussions such as these would be grounded in what is realistic as far as patient-centered goals are concerned and address the practical implications of carrying out such goals while also considering their cultural, economic and organizational implications. The implications of this analysis would caution educators that if teaching patient-centered care includes only attention to the physician–patient relationship within the encounter, students may not recognize or deal with contextual factors that can derail such care.

4.3. Potential for change

Since our results expand the notion of a patient-centered philosophy of care beyond the examination room and place the physician–patient relationship into the organizational and institutional contexts of both practice and community, it stands to reason that successful strategies for change should recognize and negotiate which among the competing values should shape the choices that impact patient care. Only by explicitly recognizing, facing and naming these competing values can the frustrations identified herein associated with providing patient-centered care be addressed, negotiated and overcome. While the task may seem daunting, physicians, patients, and communities who would work together to promote a common vision, on common ground, will find that they have a strong voice for change.

References