Guest Editorial

The clinical encounter – the focal point of patient-centred care

Central to the UK Government's health-care modernization agenda, is the notion of patient-centred care. A plethora of initiatives have been spawned over the past few years with the objective of involving and empowering users of our health services in a more democratic, equitable and fair way. In parallel with this, the Government is introducing a raft of initiatives related to the need for accountability and for evidence-based medicine (EBM).

However, issues of volume and velocity continue to defy any rational solutions and the difficulties experienced in the management of clinical risk, as well as the incorporation of individual preferences, attest to the complexity, uncertainty and fragility of our current health-care system. It sometimes feels as if the National Health Service (NHS) is overheating through frantic attempts to evaluate the effectiveness and efficiency of its activity, practice EBM and accommodate the concept of patient-centred care. Furthermore, some people view the different initiatives alluded to above as potentially contradictory. For example, Bensing has suggested that EBM may make it more difficult to deliver patient-centred care[1] and there is a risk that the drive towards accountability will reduce morale and disempower professionals to such an extent that they will be unable to respond to the demands for patient-centred care.

Most of the current initiatives seem to be directed either at the patient or at the professional. Few of them recognize the importance of the interaction between the two. And yet human interactions are the essential element of humanitarian caring and of all health-care delivery. It is the clinical encounter, in other words, that is the point at which transactions between patients and professionals take place; it is the point at which decisions about diagnosis and treatment are made, and during which caring takes place.[2]

We know that patients value clinical encounters highly, and see them as central to their health-care.[3] We also know that a good clinical encounter can have beneficial effects on health outcomes.[4,5] Although much work remains to be done to explore which components of the clinical encounter are of utmost importance, current data suggest that positive effects occur when people feel empowered and that they have been 'heard'. In contrast, if people feel they have not been listened to, or talked down to, health outcomes can be adversely affected.[6] In addition, bad clinical encounters can lead to poor compliance with treatment and unwillingness to access services in the future.[7]

Despite the centrality of the clinical encounter, its scope and nature have not been well articulated in current health-care policy or practice. We know surprisingly little about it and it has not been a research priority. Surely, as part of our pursuit of a greater understanding of patient-centred care we need to define more clearly the nature and determinants of the clinical encounter, and its effects on health outcomes.

To address this agenda a group was convened by the MRC's Health Services Research Collaboration and the Royal College of Nursing, to explore our understanding of what makes the clinical encounter effective.[8] In current health-care major features of the encounter, such as their length, are often dictated by health-care professionals rather than by patients or through negotiation. Our meetings of experts from clinical practice and research concluded that there are four key elements central to all clinical encounters:

- The *values and attitudes* of both professionals and patients (including expectations);
- The *time* spent and the ways in which this time is used (the balance of listening and talking for example);
- The *trust* that exists between professionals and patients, and;
- The *context*, clinical encounters take place within contexts and systems that may dictate their nature, as they affect both patients and professionals.

From this meeting, there was general acknowledgement that understanding and improving the effectiveness of the 'clinical encounter' was a priority, particularly in a policy context of promoting patient-centred care. The group argues that the expected benefits to service delivery from initiatives around patient-centred care will not be successful without parallel investment in exploring the dimensions of the clinical encounter. We conclude that we need to pursue empirical research, educational activities and changes in health-care policy to help put the clinical encounter back in its rightful place 'at the heart of health-care'.

Attempts to promote research, and to stimulate a greater educational emphasis on clinical encounters, are important long-term strategies, but they will have little immediate impact on UK health-care. But the problem is an urgent one. New Government initiatives appear with alarming regularity, while patient confidence in the NHS and health-care professionals seems to be diminishing at an equally fast rate. As in all walks of life, better communication could go a long way towards reducing the widening gap between those who dictate policy from above, and the patients and professionals who are at the front line of health-care delivery. It is quite simply a greater emphasis on good communication that we are arguing for. We do not need more government initiatives, we simply need to facilitate professionals and patients' ability to work together so that the time they spend together is appropriate in length and context, that trust between them can be nurtured, so that they can share their values and attitudes in a helpful (therapeutic) way. That is nothing more or less than good health-care delivery. But that cannot happen without changes in policy and management in health-care trusts.

We believe that we have identified a policy and research vacuum in an area that is central to the modernization agenda. The clinical encounter must not remain a 'black box' into which poorly articulated or understood phrases such as 'better communication', 'more time' and 'getting to know your patient' are thrown. We need to treat this construct with the respect it demands.

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