

## Patient-centred education: Time to reflect?



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*'There is something I don't know that I am supposed to know. I don't know what it is I don't know, and I feel I look stupid if I seem both not to know it and not to know what it is I don't know. Therefore I pretend I know it. This is nerve-racking since I don't know what I must pretend to know.'*

*(Laing, 1972)*

Patient-centred education in diabetes can no longer be viewed as the latest trendy soundbite in health care. There are few, if any, health policies and directives which are not punctuated with continual references relating to the importance of providing structured education in a patient-centred way. The National Institute for Clinical Excellence (NICE, 2003) and the National Service Framework (NSF; Department of Health, 2003) for diabetes recommend that structured patient education, based upon theoretical psychological models, is the most effective in improving health outcomes for those with diabetes. Patient education is arguably most effective when it is delivered in a tailored, structured and patient-centred manner. It is now a requirement for all health practitioners to provide structured, patient-centred care for patients with diabetes.

However, few of us involved in the management of patients with diabetic foot disease have received specific training with which to provide evidence-based patient-centred care. For those of us referring to the literature for guidance as to what constitutes patient-centredness, there are a variety of psychological models offered. For many of us, such diversity adds to our confusion as to the way forward (Anderson et al, 1997; Miller and Rollnick, 2002; Prochaska et al, 1992; Stewart et al, 1995).

Traditionally, healthcare practitioners have encouraged patients to make behavioural changes through the provision of advice – either passively through leaflets or more actively combining information provision with direct persuasion. However, there is a growing body of evidence which demonstrates that patients do not want advice if it is provided in a paternalistic or

parental style.

For many health professionals, making radical changes in our approach to patient education is problematic. Many practitioners have developed methods of delivering health education based on their own educational experiences and anecdotal evidence rooted in their practice. In particular, many have followed an educational journey where they have received a stereotyped traditional pedagogy, becoming submissively dependent on a teacher's directions.

Alternatively, patient-centred education is firmly rooted in principles of adult learning theory (Kinmouth et al, 1996). Such theory identifies that a person will only become ready to learn once they have experienced a need to know rather than as a response to education. The choice of advice giving as a strategy for encouraging behaviour change also has its origins in so many aspects of everyday life. Such established approaches are therefore difficult to change, but also as practitioners we often become frustrated when patients fail to take our advice on board.

We recently undertook a survey which aimed to explore practitioners knowledge and understanding of what is meant by the term 'patient-centred care'. In short we found that while there was widespread acceptance towards embracing the concept of patient-centred care, there were clear discrepancies when it came to translating such theory into practice (details of the survey have since been submitted to *The Diabetic Foot* for publication).

### Knowledge and skills

While embracing the philosophy of patient-centred care is important, its delivery will have limited impact without sufficient underpinning knowledge and skills. Despite the demand for us to deliver patient-centred education, few health professionals have received formal competency-based training and fewer still have been evaluated in their ability to deliver patient-centred care.

Currently, there is little, if any, practical guidance for practitioners attempting to appraise, modify or evaluate their approach to patient education. What is missing, therefore, is the ability to translate the wish list of successful educational approaches into clinical practice. If we take a close look at the NICE

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guidance on patient education in diabetes (NICE, 2003), there are potentially more questions than answers relating to patient-centred education. For example:

- What is structured education?
- How are we as healthcare professionals meant to embrace the adult learning approach in the context of our consultations?
- How do we begin to recognise the patient's agenda and to negotiate behaviour change during our consultations?
- How do we empower a patient?
- How do we recognise resistance and manage it?

The answers to such questions are fundamental to the delivery of patient-centred care if we are to base our approach on the existing evidence. However, if we were to identify the connecting thread between such models we can deduce that, at its most basic, there is a tangible anatomy or infrastructure which underpins a consultation delivered in a patient-centred style.

### Translating theory into practice

Little evidence exists as to which components of a patient-centred consultation lead to positive outcomes. If there is a specialist skill in the behaviour change field it is the artful handling of the interchange – whatever the health behaviour under discussion. There is much research on behaviour change, yet few attempts have been made to bridge the gap between theory and practice. Exciting concepts and methods are beginning to emerge focusing on the behaviour change consultation (Gambling and Long, 2004; Ismail et al, 2004). However, there is no magic bullet to take forward and follow in every consultation and there is no training course that will fit all.

The way ahead may not lie in the traditional PhD and Masters programmes. There is an urgent requirement for high quality practical multidisciplinary skill-based workshops that can be readily and regularly accessed to familiarise clinicians with the range of skills that are required. There are courses about, if you are lucky enough to go. One particular example is the well-established Northampton course, pioneered by the work of Charles Fox and Rosemary Walker. The course aims to develop the core communication skills that allow healthcare professionals to achieve true collaboration with patients with diabetes.

However, workshops in isolation provide little long-term feedback for diabetes educators and need to be subsequently followed up in practice. One such method could involve the use of a reflective tool to evaluate the delivery of patient-centred care.

### Consultation styles: time for reflection?

Reflection is the blue-eyed girl of continuing professional development (CPD) for healthcare professionals. Yet how many of us have ever reflected on our ability to communicate with our patients (*Figure 1*)?

We have chosen to focus on reflection as a method of improving communication skills in behaviour change consultations. Improved health practitioner communication is not a one-off event but requires ongoing development, support and evaluation. For practitioners to rise to the challenge of providing patient-centred care, much support is needed to embed the required specialist skills. Evidence suggests that high self-efficacy of practitioners is associated with them engaging in and delivering patient-centred care (Rollnick et al, 1999). Training therefore not only needs to focus on the theory but perhaps more importantly the continual monitoring and review of the process required to deliver patient-centred education.

Collaborative research between the University of Salford, the University of Cardiff and the University of Brighton will be utilised to develop training for behaviour change consultation in the diabetic foot. We are currently embarking on the development of a reflective tool which aims to support and enhance the facilitation of patient-centred care for practitioners providing care for patients with diabetes. This area of practice demands our attention, and arguably provides us with the greatest challenge of all. ■

**Figure 1: How we might reflect on our ability to communicate with patients.**

**At the end of your next consultation it may be useful to reflect on the following practical points:**

- How did I begin the consultation?
- To what extent did I identify the patient's agenda instead of imposing my own?
- Was I genuinely interested and curious in the patient's viewpoint, or did I specify the agenda?
- To what extent did I attempt to develop a rapport with the patient?
- After speaking to the patient, did I find out significantly more about their personal beliefs surrounding diabetes within their social and psychological context?
- To what extent did I genuinely listen to the patient, or did I interrupt the consultation?
- To what extent was I sensitive to the patient's non-verbal cues?
- How did I check that the patient had understood the information that I had given?
- To what extent were behavioural goals negotiated?
- How did I summarise the consultation with the patient?
- Did I arrange review and subsequent follow-up of advice that I had given?