Nurse consultations: A person-centred approach

Florence Brown

Article points

1. Person-centredness in diabetes nursing consultations has not been well studied.
2. The process has two main ingredients: taking the patient perspective; and helping patients to think about their self-management and set goals.
3. The person-centred approach requires a paradigm shift.
4. Nurses (as well as people with diabetes) need knowledge, skills, attitudes and self-awareness in order to change their behaviour.

Key words

- Consultations
- Person-centredness
- Empowerment
- Nurse training

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In diabetes nursing, the consultation is the main place for nurse–patient interaction. Within that interaction will be a mixture of tasks for the nurse. Formal systematic training in consultation skills for nurses is non-existent and yet the literature recommends a person-centred approach (e.g. van Dulmen, 2003). This article discusses person-centred care and then examines the consultation process.

What a person-centred approach actually means is rarely defined and studies looking at person-centredness in diabetes nursing consultations are few and reflect negatively on outcomes (Kinmonth et al, 1998; Parkin and Skinner, 2003; Pill et al, 1998).

Defining person-centred care

A major component of the theory of the person-centred approach is that practitioners should hold the three core qualities of genuineness or congruence, empathy and being non-judgemental. Additionally, these qualities should be communicated by the use of active listening skills that elicit the patient perspective. Person-centred practitioners hold beliefs that underpin and communicate their practice. One such belief is that individuals do the best for themselves given their internal and external circumstances (Mearns and Thorne, 1988).

A concern about person-centred practice is that it can be seen as a passive activity. For example, communication of a non-judgemental attitude might mean that the practitioner will not challenge self-destructive behaviour but, instead, 'let it be' because it appears to be patient choice. However, both practitioners and patients bring their own expertise to the consultation, and neither should have a superior power base. It is therefore the responsibility of the person-centred practitioner to be congruent and enquire about what might be perceived as self-destructive behaviour, with a view to eliciting underlying issues preventing optimal self-care practices. This would be done with the practitioner holding the belief stated above that people do the best for themselves, and there may be internal or external circumstances where the nurse can facilitate the patient to resolve, and then optimise, self-care.

Person-centred research

Michie et al (2003) noted that studies of person-centred care had mixed and inconsistent physical and psychological outcomes. Following a review of the literature, they identified that person-centredness can be defined in two distinct ways, with two distinct outcomes. From an original cohort of 550 studies, they examined 30 studies that met specific criteria. Twenty studies took 'the patient's perspective' and ten studies 'sought to activate' the patient. The studies taking the latter approach were more consistently associated with good physical outcomes. Based on examination of the studies, Michie et al describe taking the patient's perspective as the 'first ingredient' and activating patient self-management as the 'second ingredient'.

Where practitioners took the patient's perspective they found that: (1) there was a match between the illness perceptions of health professionals and patients; (2) this match included patients' perceptions about whether their psychosocial issues had been addressed; and (3) this also included

Table 1. Traditional medical model versus empowering person-centred model (Anderson and Funnell, 2005b).

Traditional medical model	Empowering person-centred model
1 Diabetes is a physical illness.	1 Diabetes is a biopsychosocial condition.
2 Relationship of provider and patient is authoritarian based on provider expertise.	2 Relationship of professional and patient is democratic and based on shared expertise.
3 Professional usually identifies problems and learning needs.	3 The patient usually identifies problems and learning needs.
4 Professional is viewed as problem solver and care-giver (i.e. professional is responsible for diagnosis and treatment).	4 Patient is viewed as a problem solver and care-giver (i.e. professional acts as a resource and both share responsibility for treatment and outcome).
5 Goal is compliance with recommendations. Behavioural strategies are used to increase compliance with recommended treatment. Lack of compliance is viewed as a failure of patient and professional.	5 Goal is enabling patients to make informed choices. Behavioural strategies are used to help patients change behaviours of their choosing. A lack of goal achievement is used as feedback to modify goals and strategies.
6 Behaviour changes are externally motivated.	6 Behaviour changes are internally motivated.
7 Patient is powerless; professional is powerful.	7 Patient and professional are powerful.

patients' perceptions about whether or not needs had been met within the consultation. These three indicators led to a high degree of patient satisfaction.

Where practitioners were seeking to activate the patient, Michie et al found that the interventions used included: coaching patients to ask questions and be involved in their care before a consultation; and encouraging patients to be actively involved in decision-making, to act as partners in the consultation process and to take initiatives in giving information to health professionals.

There may be times in the diabetes consultation when taking the patient's perspective is more appropriate, such as when a patient has received bad news. In these circumstances, time is required as the patient goes through a period of adjustment. The 'first ingredient' will offer the kind of nurturing that a psychologically traumatised person will need to make sense of, and come to terms with, a major life event such as diagnosis. The 'second ingredient' does not discount taking the patient's perspective, but moves on to the facilitation of patient-set goals and discussion on how these goals can be actioned.

Another systematic review of provider–patient interaction in diabetes care examined eight randomised controlled trials (van Dam et al, 2003). They gave a 'tentative conclusion that focussing on patient behaviour […] is more effective than focusing on provider behaviour to change their consulting style into a more patient centred one.'

There is a sense from this statement that facilitating patient activation is not a person-centred activity. However, it may be an example of the confusion acknowledged in the review by Michie et al (2003) over the definition of 'person-centred approach'. If provider behaviour is not person-centred then there is a likelihood that interventions to enhance patient participation may be more to do with the provider's agenda than what the person with diabetes needs or wants.

This review also identified a therapeutic process that relates to other models, including Egan's Helping Model (Egan, 1998), which consists of three stages: (1) 'the current state of affairs'; (2) 'the preferred scenario'; and (3) 'strategies for action: how can people get what they need and want?'. Clearly, stage 1 is about active listening and eliciting and exploring feelings and behaviours concerning an issue, while stages 2 and 3 start to help the individual to consider that his or her situation could be different and change is possible.

Anderson and Funnell (2005b) described the differences in consultation styles between the traditional medical model and the empowering person-centred model (*Table 1*). This table demonstrates that a change is required in not only philosophy but also knowledge, skills and self-awareness on the part of the practitioner to achieve an empowering style of consultation. Anderson and Funnell (2002) also studied a five-stage empowerment model of consultation (see *Table 2* on page 85).

Two of the studies cited in both reviews mentioned above are studies of outcomes following person-centred training of practice nurses (Kinmonth et al, 1998; Pill et al, 1998). In the first study, practice nurses assigned to the intervention group received 3 half-days' person-centred training. After 1 year, the patients who had received a person-centred approach had worsening biomedical outcomes (weight and lipid profiles both increased) and poorer knowledge, compared with those not

Page points

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2. If provider behaviour is not person-centred then there is a likelihood that interventions to enhance patient participation may be more to do with the provider's agenda than what the person with diabetes needs or wants.
3. Differences between the traditional medical model and the empowering person-centred model involve not only philosophy but also knowledge, skills and self-awareness on the part of the practitioner.

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receiving a person-centred approach. However, the intervention group did report increased patient satisfaction and improved self-care practices.

The second study (Pill et al, 1998) demonstrated that following person-centred training, 80% of practice nurses were unable to sustain a person-centred consultation style after a 3-year period, and patient biomedical outcomes again showed no improvements. Further analysis of these findings described the nurses as experiencing a 'basic dilemma'. At what point could they let go of personal responsibility for what the patient chooses to do, especially if biomedical outcomes were deteriorating (Pill et al, 1999)? A weakness in this study was, again, that the training was limited. While the authors acknowledged this, they stated that the main issue was the basic tension between nurse responsibility and patient self-responsibility. However, this issue could be resolved by practitioners who are secure in their person-centred approach.

In both studies, there was an assumption that 2 or 3 days' training is sufficient to change previous consultation styles, which presumably would be more disease-focused and didactic in nature. Adopting person-centred skills and integrating them successfully into the consultation would require practice, observation, supervision and experience. The Kinmonth et al (1998) study did not assess or measure whether the consultations in the intervention arm were person-centred or not. Additionally, and possibly more importantly, the person-centred approach may be opposed to the philosophy of practice previously held, of a more traditional, disease-centred approach. There is no indication that the nurses in either study were presented with the philosophical underpinning of person-centred practice, thus making adoption of a new set of skills without the practitioners holding person-centred beliefs somewhat alien.

How does the contrast in approaches to communication with patients arise? In part, it can be understood in the way that nurses were trained.

There is very little research into diabetes specialist nurse consultations. A recent study (Parkin and Skinner, 2003), however, videotaped 141 consultations with patients with diabetes carried out by seven diabetes specialist nurses and two diabetes specialist dietitians. Results showed significant disagreement between patients and health professionals on the content of the consultations. This discrepancy suggests that the consultations are not person-centred. It has implications for diabetes education and management because both the patient and the health professional will be working with separate agendas. These results suggest a disease focus on the part of the health professionals and possibly quality-of-life issues on the part of the patients.

Paradigm shift

The person-centred approach requires a paradigm shift (Anderson and Funnell, 2005a), but how can this be achieved in practice? In general practice, research has demonstrated that patients have 'unvoiced agendas' in the consultation, especially in relation to psychosocial issues (Barry et al, 2000). The key to an effective person-centred consultation is facilitating the expression of the agenda of the person with diabetes. Nurses (as well as people with diabetes) need knowledge, skills, attitudes and self-awareness in order to change their behaviour from a paternalistic (although very well-meaning) way of practising to a model that is fundamentally person-centred. Skills include asking open questions, paraphrasing and reflecting feelings that enable exploration of thoughts and behaviours around issues that the person with diabetes has stated to be important. The possibility that change is an option can be invited. Realistic patient-set goals (as opposed to nurse-set goals), with detail of how these goals can be actioned, can also be explored by open questions starting with 'what', 'when', 'where', 'how' and 'who'. Another technique that is gathering interest is that of motivational interviewing, which has a theoretical base of assessing readiness to change, importance of the change and confidence about changing (Rollnick, et al 1999).

Conclusion

The structure of the nurse consultation has been neglected in terms of understanding it as both a framework for delivering person-centred care and a vehicle for facilitating the partnership between the nurse and the person with diabetes. It is possible that nurses are relatively good at delivering the 'first ingredient' of patient-centred care: taking the patient perspective. This, however, is only the initial stage of the consultation process. There is now evidence that nurses need skills for the 'second ingredient' of a person-centred consultation: facilitating people with diabetes to state what they would like to be different about their self-management and supporting people with diabetes to consider in detail how to convert chosen goals to reality. ■