REFLECTION

Looking Within: Intentions of Practice for Person-Centered Care

William B. Ventres, MD, MA[1,2]

[1]Institute for Studies in History, Anthropology and Archeology, University of El Salvador, San Salvador

[2]Department of Family Medicine, Oregon Health & Science University, Portland, Oregon

Conflicts of interest: author reports none.

CORRESPONDING AUTHOR

William Ventres, MD, MA
Urbanización Buenos Aires III
Block H, Calle Los Maquilishuat No. 3-A
San Salvador, El Salvador
wventres@gmail.com

ABSTRACT

In order to integrate the biological, psychological, social, and existential dimensions of care into my day-to-day clinical encounters with patients, I have worked to cultivate several intentions of practice. These intentions of practice—habits of mind that nurture my resolve to attend to patients as complex human beings—help me navigate my interactions with patients and families in ways that are simultaneously efficacious and therapeutic. When routinely recalled and adeptly implemented, they are what distinguish me as a competent and capable practitioner of person-centered care, when I am at my best, from when I am not. I present them here in hopes that others may find them useful as they progress down their ongoing paths as healing physicians.

Ann Fam Med 2017;15:171-174. https://doi.org/10.1370/afm.2037.

As a young physician, many years ago, I felt frustrated. I felt unfulfilled by the constraints of the strict biomedical model in which I had been trained, severely limited by the narrowness of its focus. Fortunately, several senior members of my chosen discipline—I am a family physician—explained to me the value of connecting with patients relationally through the expression of affinity, intimacy, and reciprocity in clinical encounters, over time.[1] They urged me to see patients as individuals in context of their families, their communities, and the social and built environments in which they lived.[2,3] They suggested I investigate and make use of the "unclaimed space" between reductionist medicine and public health.[4, p. 228]

Supported in their thinking by the written works of other clinician-scholars,[5-9] they fostered my nascent realization that both situational and emotional dimensions of life are crucial determinants of health and healing. They offered me a blueprint for practicing person-centered care. This blueprint has meant reorganizing how I think about the problems presented to me in clinical settings.[10] It has meant seeing people first as relational individuals—members of families, neighborhoods, and communities, influenced by cultural norms and social forces, and motivated more by hope and fear than by statistical probability or rational deliberation—prior to addressing their physical concerns, as appropriate to the situation at hand.[11] It has meant conceptualizing family as a metaphor for the many dimensions of care that are not strictly biomedical in nature, all in order to maximize the therapeutic value of my knowledge and skills.

It is not the simple fact of being a family doctor, however, that has sanctioned me to practice person-centered care. When I truly practice person-centered care—when I honestly integrate the biological, psychological, social, and existential dimensions of care into my daily work with patients—it is less because of my professional training and more because I have worked to cultivate several intentions of practice. In this essay I review these intentions, reflect on some challenges they present, and invite others to consider putting them to use in their practices.

INTENTIONS OF PRACTICE

The following 7 intentions of practice—habits of mind that nurture my resolve to attend to patients as complex human beings–help me navigate clinical encounters in ways that are simultaneously clinically efficacious and healing for patients. When routinely recalled and adeptly implemented, they are what distinguish me as a competent and capable practitioner of person-centered care, when I am at my best, from when I am not.

May I Recognize Patients as Whole People First and Foremost

My patients are not a compilation of the physiological pathways, organ systems, and neural connections that were the focus of my medical training (and are the direct target of the pharmaceutical therapies I have at ready in my professional armamentarium). Rather, they are human beings, complicated and complex, made complete (and occasionally confusing) by a range of assorted emotions, histories, and learned behavioral patterns, especially when made manifest in the form of wants and expectations. I, too, am a human being. It is in offering up a human connection—a shared presence—that I can potentially transform a visit focused on curing disease and managing illness into one from which might arise the kind of therapeutic milieu that leads to healing.[12]

May I Practice Honestly With Others and Myself

People rarely come to me to tell me all that is going well in their lives. The nature of my work is more commonly filled with complaints wrought full of frustrations, fears, anger, anxiety, and just plain ignorance. My job is not to "sugar coat" the truth for patients; neither, however, is it to unveil more than they can bear. It is, aware of how people's capacities to face bad news and make difficult choices can be mutually created, to balance reality and hope.[13] My job is also to step up when my skills are needed and, concomitantly, to know when situations are beyond my capabilities. It is simultaneously to acknowledge both my strengths and my limitations.

May I Accept What Emerges in the Clinical Encounter

I am not my patients' keeper. Although I do make recommendations based on relevant understandings of risk, my patients lead their own lives. Some of the choices they make seem like inevitable responses to difficult circumstances, and others like inconceivable alternatives in the face of known hazardous outcomes. Still others seem like incontrovertible unhealthy choices, some occasionally coinciding with unavoidable bad luck. My work is to accept and address whatever comes up in my encounters with patients, so that I might better nudge people along toward health with respect, wherever they are on their path, rather than condemning them and the way they lead their lives.

May I Share the Responsibility of Care

I work with others. Even in the hospital, where I typically desire more control than when I am situated in the office, I do not work in isolation. Family members and loved ones, receptionists, medical assistants, nurses, social workers, psychologists, and medical colleagues (both generalists and subspecialists)—they are all part of my clinical household, each contributing in their own way to the process of attending to patients. That I may often take the lead does not mean that I cannot also follow and learn from others. In patient care, as in dancing, graceful movements are created relationally using experience, intuition, and awareness as guides to progress from one step to another.[14]

May I Be Calm in the Face of Uncertainty

Medicine is often messy work, regardless of where it is practiced. We may imagine that the next big scientific breakthrough will solve many of the physical problems from which people suffer. The reality is that given what we know about how social determinants, lifestyle choices, and normal aging affect illness outcomes,[15] a large proportion of us will experience setbacks in our health if not outright disability over time.[16] And, of course, all of us will eventually die. In the meantime, we have neither perfected science to a point where a normal laboratory result will guarantee clinical success, nor have we figured out, even in economically wealthy countries like the United States, how to provide equitable access to medical care for all people. In light of these realities, especially when working one-on-one with patients, I strive to hold in my consciousness an open awareness of the anxiety that comes from confronting suffering with imperfect tools and within a deeply flawed system. I try, in turn, to project a non-anxious presence and advocate for health in spite of the constant muddle in which we find ourselves situated.

May I Work to Protect Patients

Knowing that our current health system has significant problems, many of which I believe are predicated on models of scientific reductionism and corporate industrialization, I intentionally seek to safeguard my patients. I hope to provide for them a figurative refuge from all the advertisements, come-ons, and quick fixes that are part and parcel of our contemporary medical culture. It is not from the inevitability of death

that I try to protect them, but from illusions of inappropriate expectations and excesses of overtreatment. Moderation is my mantra. Education is my instrument. Patience is my virtue.

May I Be Authentic

Early on, regrettably trusting the informal curriculum that formed much of my professional identity formation, I questioned my place and worth—the power of medicine, I was convinced to believe, was in science, knowledge, and the application of highly technological skills. I was wrong. There certainly is power in science, knowledge, and advanced technology, and in certain critical situations they absolutely can be lifesaving; these situations, however, are the exception rather than the rule. Vastly more often than not, how I conduct my work is as important as what I actually do clinically, and I am confident that my interpersonal awareness contributes to my therapeutic efficacy. My confidence is supported by humility, respect for others, and resiliency in the face of failure.[17] I believe in the power of person-centered care.

FURTHER REFLECTIONS

As obvious to me that I can and do attend to these intentions of practice is the reality that there are many times I do not. I sometimes find myself sidetracked by the very science and technology that I consider fundamental to medical practice. I get caught up in the minutiae of laboratory results, misjudging their worth as a simulacrum for patient well-being. I fail to appropriately integrate the desktop computer seamlessly into the consultation. I cut corners in order to "get to the point" when I am running late (a tactic that invariably seems to fall flat and leaves me dropping further behind). I succumb to boredom and fatigue. Not infrequently a lack of communication is the biggest culprit when things go awry; somewhere along the line I have failed to grasp something the patient, a family member, a fellow staff member, or a clinical consultant has either subtly intimated or directly stated, and my own relational capabilities suffer.

Also clear to me is that some reading this will question (1) whether intentions can be taught, and (2) can their effects be measured? I respond, first, by pointing out I know they can be learned, as I have learned them and continue to grow my appreciation of their meaning and usefulness. I suspect that transformative teaching methods are much more likely to help learners explore such habits of mind than are ones commonly used in traditional settings of medical education.[18] Second, although the jury is still out, promising evidence exists as to the utility of mindfulness and self-awareness training among medical practitioners.[19-20] These innovations, as well as much broader attempts to bring cultures of compassion to whole institutions,[21,22] may help pave the way for developing the kind of personal professional perception the 7 intentions above promote.

CONCLUSION

The core of being able to provide person-centered care lies not "out there" with patients, families, other persons, or even the doctor-patient relationship. Instead, this core lies "within": within the vision of how we see the people who come to us as patients, within the understanding of our roles in their lives, and within our own intentions of practice. "Within" lies the fundamental mindset we bring to both reflecting upon and nurturing our work in clinical medicine. My own intentions of practice have helped me develop the knowledge, attitudes, and skills needed to become a healing physician. They have, for me, been sources of personal and professional enrichment. I invite you to consider what intentions of practice may help you along your professional paths. May they be of service as you learn and grow in your work of caring for patients.

To read or post commentaries in response to this article, see it online at http://www.annfammed.org/content/15/2/171.

Key words: bioethics; family practice; medical education; person-centered care; physician's role; professionalism

Submitted April 3, 2016; submitted, revised, September 13, 2016; accepted October 16, 2016

Funding support: This work was supported by a residential writing fellowship from the Fondation Brocher, Geneva, Switzerland.

Acknowledgement: I thank Richard Frankel, PhD, for his thoughtful comments and support. I thank, as well, the 3 anonymous reviewers for their helpful recommendations.

References

1. Carmichael L. Voices from family medicine: Lynn Carmichael. Interview by William B. Ventres and John J. Frey. *Fam Med.* 1992;24(1):53-57.
2. Farley E. Voices from family medicine: Eugene Farley. Interview by William B. Ventres and John J. Frey. *Fam Med.* 1992;24(2):152-155.
3. Zervanos N. Voices from family medicine: Nikitas Zervanos. Interview by William B. Ventres and John J. Frey. *Fam Med.* 1992;24(5):390-394.
4. Ransom DC. Voices from family medicine: Donald Ransom. Interview by William B. Ventres and John J. Frey. *Fam Med.* 1992;24(3):226-229.
5. Engel GL. The clinical application of the biopsychosocial model. *Am J Psychiatry.* 1980;137(5):535-544.
6. Kleinman A, Eisenberg L, Good B. Culture, illness, and care: clinical lessons from anthropologic and cross-cultural research. *Ann Intern Med.* 1978;88(2):251-258.

7. Balint M. *The Doctor, His Patient and the Illness*. London, UK: Tavistock Publications; 1957.
8. Frankl VE. *Man's Search for Meaning.* Boston, MA: Beacon Press; 1984.
9. Magraw RM. *Ferment in Medicine: A Study of the Essence of Medical Practice and Its New Dilemmas.* Philadelphia, PA: W. B. Saunders & Co.; 1966.
10. Ventres WB. How I think: perspectives on process, people, politics, and presence. *J Am Board Fam Med*. 2012;25(6):930-936.
11. Miller WL. Routine, ceremony, or drama: an exploratory field study of the primary care clinical encounter. *J Fam Pract*. 1992; 34(3):289-296.
12. Ventres WB, Frankel RM. Shared presence in physician-patient communication: A graphic representation. *Fam Syst Health*. 2015;33(3): 270-279.
13. Ventres WB. Building power between polarities: on the space-in-between. *Qual Health Res*. 2016;26(3):345-350.
14. Ventres W. The joy of family practice. *Ann Fam Med.* 2012;10(3): 264-268.
15. Health Affairs. Health Policy Brief: The Relative Contribution of Multiple Determinants to Health Outcomes. http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=123. Published Aug 21, 2014.
16. Council for Disability Awareness. Chances of disability: me, disabled? http://www.disabilitycanhappen.org/chances_disability/disability_stats.asp. Updated Jul 3, 2013.
17. Ventres WB. Healing. *Ann Fam Med*. 2016;14(1):76-78. https://vimeo.com/147882756.
18. Ambrose S, Bridges M, Lovett M, DiPietro M, Norman M. *How Learning Works: 7 Research-Based Principles For Smart Teaching.* San Francisco, CA: Jossey Bass; 2010.
19. Beckman HB, Wendland M, Mooney C, et al. The impact of a program in mindful communication on primary care physicians. *Acad Med*. 2012;87(6):815-819.
20. Beach MC, Roter D, Korthuis PT, et al. A multicenter study of physician mindfulness and health care quality. *Ann Fam Med*. 2013;11(5): 421-428.
21. Cottingham AH, Suchman AL, Litzelman DK, et al. Enhancing the informal curriculum of a medical school: a case study in organizational culture change. *J Gen Intern Med*. 2008;23(6):715-722.
22. Lown BA, McIntosh S, Gaines ME, McGuinn K, Hatem DS. Integrating compassionate, collaborative care (the "Triple C") into health professional education to advance the triple aim of health care. *Acad Med.* 2016;91(3):310-316.