

Becoming 'patient-centred': A review

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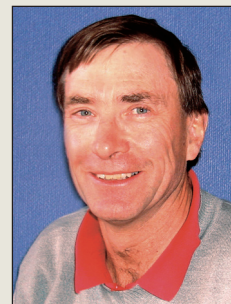
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ABSTRACT

Patient-centredness is becoming established as the main approach to medical care in general practice. While possibly illustrative of a new 'paradigm' of clinical care, it is more helpfully viewed as a better method of delivering biomedicine than a competing model of practice. This method appears to confer a number of benefits for both patient and doctor without compromising modern advances in biomedical science. However, there are persistent barriers that prevent further uptake of patient-centredness in both general practice and other settings. This review outlines these barriers, discusses some limitations of patient-centred medicine, and briefly suggests further ideas to improve the effectiveness of this clinical method.

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Introduction

Learning how to become 'patient-centred' is a feature of general practice training schemes in New Zealand, Australia, and the UK. It is also emphasised in undergraduate communication skills throughout the Western world. However, the uptake of patient-centredness is poor in the specialties and in hospital practice. This difference is explained in part by the historical development of patient-

centredness (initiated first in primary care), and by the ongoing barriers that inhibit wider use of the model.

This article firstly outlines the historical development of patient-centredness and its benefits, then identifies some ongoing complex barriers. Current limitations include problems with teaching and learning, and the approach to medically unexplained symptoms. These problems will be discussed and solutions suggested.

History

The last few hundred years of Western medicine have been characterised by many spectacular discoveries and advances (Box 1) that collectively developed the modern model of medical practice, now known as biomedicine. While these advances have been further refined in the last 50 years or so, another emerging focus has been how biomedicine can be better delivered.

For example, there is now a growing awareness of the importance of the interaction between doctors and their patients and how this is structured. In all settings, however, medicine continues to be delivered prima-

Box 1. 'The most important developments in medicine in the last 1000 years'

1. Elucidation of human anatomy and physiology
2. Discovery of cells and their substructures
3. Elucidation of the chemistry of life
4. Application of statistics to medicine
5. Development of anaesthesia
6. Discovery of the relation of microbes to disease
7. Elucidation of inheritance and genetics
8. Knowledge of the immune system
9. Development of body imaging
10. Discovery of antimicrobial agents
11. Development of molecular pharmacology.

From: Looking back on the millennium in medicine. NEJM 2000; 342(1):42-49 (Jan 6)

rily by way of a 'consultation'; the unwell person meets with a doctor who listens to his or her story. The doctor does an examination and/or some tests, then offers advice or provides treatment. Since the 1970s there have been many proposals for better ways to conduct this all-important consultation, the aim being more accurate history taking and improved agreement about the nature of the problem and what to do about it. The intention has been to make better use of biomedical advances to improve the patient's health in some way.

The majority of these proposals to heighten awareness of the more hidden processes within each consultation have taken place in general practice. Here, a consultation is mainly a discrete event between one doctor and one patient, with the same doctor providing continuity of care over long periods. General practice has been ideally placed for research into communication skills, the structure of the consultation, and the outcomes of care.¹

For example, Bryne and Long in the 1970s differentiated between 'doctor-centred' consultations (directed and controlled by the doctor) and patient-centred ones (allowing patients to set the agenda).² They noticed how individual doctors tended to use a particular style, regardless of the patient's needs or background. Pendleton and others developed seven 'teachable tasks',³ while Neighbour produced his five 'check points'.⁴ Drs Michael and Enid Balint were the first to use the term 'patient-centred'; they invited groups of GPs to discuss their more problematic or 'heartsink' patients.⁵ While not designing a new model of consulting, they ensured a better understanding of transference and counter-transference within the doctor-patient relationship and how these affect the encounter and the quality of clinical care.*

Box 2. Definitions of patient-centred care

'Patients want patient centred care which (a) explores patients' main reasons for the visit, concerns, and need for information; (b) seeks an integrated understanding of patients' worlds – that is, their whole person, emotional needs, and life issues; (c) finds common ground on what the patient's problem is and mutually agrees on management; (d) enhances prevention and health promotion; and (e) enhances the continuing relationship between the patient and the doctor.'

From: Stewart M. Towards a global definition of patient centred care. BMJ 2001; 322:444-5.

Mead and Bower also provided a thorough analysis of the concept of patient-centredness; their review of the conceptual and research literature identified several key dimensions; the biopsychosocial perspective,⁸ patient-as-person, sharing power and responsibility, therapeutic alliance, and doctor-as-person.

Mead N, Bower P. Patient-centredness: a conceptual framework and review of the empirical literature. Soc Sci Med 2000; 51:1087-1110.

These innovations and analyses of the consultation were precursors for the most coherent and widely used model of patient-centredness, the 'patient-centred clinical method' (PCCM) developed by McWhinney and colleagues at the University of Western Ontario.⁶ They built on Helman's distinction between 'disease' and 'illness',⁷ developing six interactive components within each consultation (Box 2). This is the most common method used in general practice training.

A brief description

What would a 'patient-centred' consultation in primary care look like? Doctor and patient must first negotiate which issues or problems they will discuss in the consultation. Then, rather than simply asking closed questions, the doctor also elicits the patient's perspective of the illness: what it is like for the patient to be unwell; how illness affects their functioning; their ideas about cause and treatment. Indications for exploring

the patient's perspective include: when patient self-management is important; when providing motivational counselling is important; when the patient hints at significant thoughts or feelings; when family or cultural influences may significantly impact on treatment; and when symptoms are medically unexplainable.⁹

Learning about the patient's responses to previous illness, social supports, and stage in the life cycle will enable further discussion about any proposed plan of treatment leading to a mutual and openly agreed-upon decision. Rather than focusing on pathology-based questions, the doctor spends more time listening and responding to the patient's various 'cues and prompts' that indicate underlying issues. He or she can be observed 'tracking' the patient in their story so the patient feels more validated, recognised, and supported; a well-facilitated history can, in itself, be therapeutic.¹⁰

Such a consultation looks quite different from more old-fashioned,

* While formal Balint groups are still uncommon in medicine except perhaps in psychotherapy training, the subsequent use of peer groups in general practice since Balint testifies to the importance of groups of clinicians talking about their work and sharing problems.

paternalistic interactions, where the doctor was completely in charge. Instead, the doctor is more respectful and curious about who the patient is and why they have chosen to present. Investigation and management is tailored to the patient as a person, rather than reflexively testing to exclude disease and/or providing arbitrary treatment. This approach is designed to empower patients, rather than render them silent and submissive. It also implies that doctors need to become more aware of their own responses to each patient and how these influence the consultation¹¹ and outcomes of care.¹²

Overall, then, the focus is on the *person* rather than on a diseased organ or body; the advances in biomedical science have been, and are, very useful tools in service of the patient, but their use alone is not the primary goal of medicine. Particular issues such as personal suffering¹³ are more likely to be identified by a patient-centred approach to care, and the possibility of resolution or healing improved.¹⁴ Some of the benefits of a patient-centred approach are listed in Box 3.

Problems and barriers

Despite many enthusiastic adherents to patient-centredness,^{18,19} problems remain. The first is that the term is not immediately *obvious*. It does not accurately describe what the model intends to achieve or how. Critics of the model confuse the term with 'giving the patient what they want' or believe it is somehow a negation of science or current evidence. Some clinicians believe in a false dichotomy; one is *either* clinically competent *or* patient-centred, as if these skills are somehow mutually exclusive. Furthermore, the term has become less meaningful

over time; it is now more of a slogan than an accurate description.

The perception that being patient-centred will take more time²⁰ is also a major barrier. For clinicians already pressed for time, it would appear that asking about the patient's ideas and/or responses to their illness will simply extend the interview further; the doctor may feel he or she needs to proceed anyway regardless of the patient's own ideas. However, critics may not have recognised that time is being used ineffectively if the doctor discusses issues that are not priorities for that patient. Research indicates that taking slightly more time in the first consultation can pay considerable dividends in terms of patient satisfaction and compliance;²¹ others report that talking about all the immediate concerns does not take extra time.²²

Fear of opening 'a can of worms', or, in other words, allowing the patient to express their feelings and issues, can be a problem for many trainees who feel uncomfortable or do not know how to respond to affect. However, being empathic may actually shorten consultations as patients may keep talking until they are sure the doctor understands the nature of the problem.

Probably the biggest current barrier to more doctors using a patient-centred approach is clinician awareness. Given the model was developed

in the 1980s and the first major book published in 1995, many older clinicians have had little exposure to the idea of patient-centredness, either as under- or post-graduates.

In spite of this, however, many primary care and hospital physicians

trend towards patient-centredness over time, even if they do not call it so. Others do not make such a shift; perhaps the need to share responsibility between the doctor and patient

Box 3. Benefits of the doctor being more patient-centred

The patient:

1. Can more fully express to, and discuss with, their doctor, their ideas, concerns, and fears
2. Can better negotiate the proposed plan of management with their doctor, given the usual constraints of each person's situation
3. Will feel more known, validated, and supported as a person in their illness or disability
4. Is more likely to be adherent to treatment
5. Will have a better chance of recovery from their illness and have resolution of suffering
6. Can be understood even in cross-cultural consultations.

The doctor:

7. Is able to share more responsibility with their patient
8. Gains improved knowledge of, and relationships with, his or her patients
9. Does fewer tests (i.e. reduces costs) as knowing about the person improves diagnostic accuracy
10. Has fewer 'heartsink' or 'difficult' patients¹⁵
11. Has more job satisfaction, less anxiety, and reduced chances of complaints.^{16,17}

is difficult for clinicians trained in more hierarchical structures without the benefit of consultation skills training. Acknowledging that the patient has considerable power requires a substantial shift in one's approach to clinical medicine as well as in ideas about oneself and one's role as a doctor; flexibility of style is also required.

Some GPs in New Zealand have now studied for the Diploma of General Practice run by the University of Otago; their study includes critically reviewing their training, various models of clinical care, and their

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current mode of practice. An illustration of one doctor's change in perspective is provided in Box 4.

Structural issues in hospital practice

While there has been a significant shift then, in primary care towards patient-centredness (within registrar training, through postgraduate study, or even through personal experience of illness²³), the situation is different in hospital practice. Research indicates that younger students are taught to communicate along patient-centred lines as new students, yet rapidly lose their capacity for empathy as they enter hospital medicine and specialty training.^{24, 25} Students can also become more 'paternalistic and doctor-centered' as training progresses.²⁶

The comments below are not intended to be critical of the hard work of well-intentioned hospital clinicians who excel with seriously unwell patients. Instead, they are directed more at the teaching culture of hospital medicine, which arguably provides a significant barrier to learning how to become more patient-centred. As noted earlier, learning to become patient-centred implies that the doctor and patient are in a one-to-one relationship at the time of the consultation. This is much less the case in the team-based structure of health care delivery in major teaching hospitals.

Instead, students and junior staff are part of a wider team, responsibility is diffusely shared, but with the consultant at the head of a well-developed, well-enforced hierarchy. Patients do not have a 'consultation' as they would in primary care; instead, much of the history is taken by junior staff without responsibility for decision-making. Senior staff then check a few salient facts or confirm physical findings and eventually come to a consensus about what to do about the patient's presenting physical problems. How the patient feels, their current life issues, or how their social context contributed to those problems are largely subli-

mated to the pressing need for physical interventions.

Similarly, ward rounds are usually goal-driven towards identifying physical tasks; they are often dominated by discussion *about* the patient rather than *with* him or her. The group environment also makes personal disclosure by patients more difficult.

Medical students are also trained into making clinical notes in a particular way; the biomedical hospital chart is both a strange, yet remarkably similar document around the world, regardless of one's original training.²⁷ It is generally written in the passive voice ('the patient was admitted, IV lines were inserted,' etc.) by an effaced narrator, who represents the collective wisdom of his/her team or discipline. According to Charon,²⁸ students learn to '*suppress their own authorial voice, their own I.*' She asserts that the dominant discourse of the medical notes developed at a time when 'detachment' was considered to be the ideal clinical stance. Despite more understanding now that this stance causes considerable problems for both patients and doctors,²⁹ the predominant style of clinical notes remains substantially unaltered over the last century.

In practical terms, then, junior doctors are powerfully socialised into a working culture that focuses more on bodily processes than on persons, often makes decisions about patients rather than with them, and reinforces a stance of clinical detachment. With some exceptions,³⁰ there is little ongoing coaching of communication skills within clinical settings, and little acknowledgement of how clinicians' encounters will significantly affect the trajectory of patients' illnesses.³¹ Recent local research confirms how senior staff often inhibit students' attempts at taking a more person-centred history,³² and at times appear to be unaware of how their own role-modelling of 'being with' patients is critically important in establishing the values and norms of interpersonal behaviour in each clinical setting.³³

Box 4. A personal journey towards patient-centredness

'I graduated in the 1970s and in those days we had no such thing as communication skills, ethics training, or understanding of the consultation. We just had lectures on bodily processes for three years, then we were trained how to diagnose and treat. Hospital medicine in the 1980s was of course characterized by the scandal of Bonham and Green [research on patients without their consent] and by paternalism; doctor knew best. Asking patients for their own ideas about treatment was not even on the agenda, yet of course I eventually learned in my own practice that many patients had ideas of their own, and I had often been puzzled as to why so many of them didn't follow my advice! After several years in 'GP-land' I eventually enrolled in a communication skills course for GPs; this started me on a very interesting journey. Doing the Diploma then gave me a better idea of why my own undergraduate training was so deficient, and introduced me to patient centredness as a concept. It was something I was probably doing in private practice anyway but didn't have the words to really describe it. I am much more conscious now of what I am actually doing during a consultation and why it still sometimes turns to custard; now though, I have some methods of retrieving the situation with that patient.'

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In summary of this overview of hospital culture, students receive training that tends to undermine the dimensions of patient-centredness previously discussed, such as awareness of the biopsychosocial perspective, doctor-patient relationships, patient-as-person, and doctor-as-person.³⁴ Dr Pat Farry, a former regional

director of general practice registrars and one who has done much to promote patient-centredness in New Zealand, asserts that GP registrars need to *combine* their hospital learning about medical diseases with a wider knowledge about persons in order to work effectively in primary care [personal communication, 2008].

Critical reflection

There is yet another barrier to individual shifts towards patient-centredness, and this is in the realm of philosophy. To illustrate this, the Diploma of General Practice requires GPs to identify the implicit assumptions, beliefs, or foundational rules governing their work as doctors. What generally emerges is firstly, an understanding that their medical training has been profoundly reductionist and biological, and secondly, a better understanding of both the strengths and weaknesses of their 'received model', that of biomedicine.

An illustration of the materialist, essentialist, and reductionist assumptions of modern medicine is the list chosen by the editors of *NEJM* of the 'most important medical developments' of the last millennium in Box 1. These appear to be all based on a concept of 'body-as-machine'; there is no acknowledgment of persons, their volition, their culture and community, or how these affect health and/or individual responses to illness.^{35,36}

Again, these comments are not critical of the modern advances in biomedical science with their increasingly accurate understandings of bodily systems. They are intended instead to emphasise that uncritically accepting these underlying assumptions (Box 5) in all situations is a recipe for disillusionment on the part of the doctor, and disappointment, even poor medical care, on the part of the patient. In contrast, being aware of both the strengths and limitations of biomedicine helps practitioners become even more effective.

Box 5. The implicit assumptions of biomedicine (according to McWhinney)

'Patients suffer from diseases which can be characterized in the same way as other natural phenomena. The disease can be viewed independently from the person who is suffering from it. Each disease has a cause and it is a major objective of research to find the causes of disease. The physician's main task is to diagnose the disease and, where possible, to prescribe a specific remedy aimed at removing the cause or ameliorating the symptoms. To do this, the physician is provided with an intellectual tool – the clinical method known as differential diagnosis. Mind and body are considered separately, each with its own diseases. The patient is usually a passive recipient of the prescribed treatment'

Taken from: McWhinney IR. *Changing models: the impact of Kuhn's theory on medicine. Fam Prac* 1983;1(1): 3-8.

These comments on ontology (beliefs about the nature of the world) and epistemology (one's stance with respect to knowledge) acknowledge that patient-centredness calls for rethinking any hidden beliefs about how and why patients become unwell and the role of the doctor in relation to the patient and in providing help.

It can be difficult to identify one's deeply ingrained belief systems after the intense enculturation to biomedical norms and values that most doctors experience during medical training.^{37,38} The tensions of such self-examination and critical review are yet another barrier to patient-centredness; it is perhaps easier to continue the way one was taught than to re-evaluate and learn new ways of being and relating with patients. These issues perhaps illustrate 'competing paradigms' consistent with the work of the historian, Thomas Kuhn,³⁹ but will not be discussed further here.[†]

Limitations

The patient-centred clinical method is the most coherent of patient-centred models, but there appear to be two main limitations. Undergraduate medical students do not easily assimilate

the six components and it does not provide a model for better management of medically unexplained symptoms.⁴⁰ These limitations are discussed below.

Teaching patient-centred care is well theorised⁴¹ and is commonly taught within departments of general practice in many medical schools as a *method* of managing consultations for the many different patient presentations in primary care. However, students often struggle to understand the PCCM diagrams and have difficulty putting the patient's data into various arbitrary boxes. Their more immediate focus is usually on learning which symptoms are clues to which particular diseases, and so on. Furthermore, the model is not reinforced in other university departments, where clinicians usually teach the technical aspects of diagnosis and treatment within their own particular specialty. Theorising about particular models of consulting is not generally included.

To some extent, then, students learn to 'put on their patient-centred hat' while in general practice, then forget it in other clinical settings. At the University of Otago, for example, PCCM has been explicitly taught since the 1980s in the depart-

† Note that the list of advances in modern medicine could also be seen as the foundational research that established the current paradigm; consistent again with Kuhn, 'normal' science now continues to refine these advances rather than challenge the assumptions that underpin them.

ments of general practice, but its uptake by other departments has been at best minimal.

The second main limitation of patient-centredness is that, while it is helpful to identify patients who present with medically unexplained symptoms (as more of the patient's personal story, life issues, and context will emerge), it does not readily help with ongoing management. Medically unexplained symptoms (or somatisation) have been described as the 'black hole' of medical science. Doctors seem quite powerless to make effective interventions when their patient remains unwell despite no organ-disease being found. It is a source of frustration for doctors in both primary and secondary care, and is for patients the cause of much suffering, some of it iatrogenic.⁴² Patient-centredness enables much better delivery of biomedicine, but it does not resolve the mind-body split that so characterises the last 300 years of medical science (see again Box 5).

Future development

These two limitations are potentially resolved, however, by recent advances in undergraduate medical education, and by more effective approaches to somatisation.

Medical education has been under considerable scrutiny in the last few decades. In the UK, four new medical schools have opened since 2000, with curricula emphasising better integration of basic science and clinical skills, problem-based learning, independent study, community awareness, and more comprehensive approaches to achieving patient-centredness.⁴³ This latter point is achieved through a new method of communication skills and consultation training called the Calgary Cambridge guides.⁴⁴

Developed by Johnathon Silverman from Cambridge, UK, and Suzanne Kurtz from Calgary, Canada, these guides provide a revised format for the medical content of a consultation as well as identifying all the process activities within each encounter. Clinical notes include sec-

tions on the illness experience as well as the outcome of discussion with the patient about management. Process activities are: initiating each session; gathering information; providing structure; building relationship; explanation and planning; and closing the session. The authors have identified 71 skills or observable behaviours, which can be variably used within different consultations.

The benefits of using the Calgary Cambridge guides are considerable. Staff become more aware of a dual focus on both content and process, teachers and students develop a similar language for analysing each interaction, and micro-process skills become both teachable and examinable. The authors maintain the model is just as useful in hospital care as in general practice, as each doctor-patient interaction can be planned, delivered, and later reviewed. Over 60% of UK medical schools now use these training guides.⁴⁵

Overall, it appears that this more focused delivery of communication skills within the clinical setting (rather than just being confined to pre-clinical training) helps deliver a more patient-centred curriculum. The model is being used for the first time at Otago University in 2008; perhaps this new cohort of students will retain slightly more patient-centredness as they progress through their clinical years starting in 2010.

While patient-centredness is helpful in identifying the problem of medically unexplained symptoms, it is usually insufficient to achieve a resolution (this usually involves better awareness by the patient of their current issues, affect, or personal story, and how this relates to bodily symptoms). A better model has been offered by Broom,⁴⁶ who has consistently provided practical solutions based on extensive theory and technique.⁴⁷ Mann provided an accurate review in this journal of more effective approaches to somatisation;⁴⁸ arguably, these approaches should also be included in undergraduate training. Further work needs to be done

within the patient-centred model to incorporate these ideas and advances.

Summary

In general, patient-centredness appears to deliver biomedicine more effectively by providing a vehicle for more comprehensive assessment of both patient-as-person and their disease. Being patient-centred can help avoid over-treatment and over-investigation; it improves adherence as the clinician translates biomedical knowledge into a framework the patient can understand. It also helps identify clinical problems where biomedicine has no answers. The patient-centred clinical method from Ontario is the leading model of patient-centredness, being the most theorised and well-developed.

'Becoming patient-centred' applies to both individual clinicians who learn to use this approach, and to the profession as a whole. The spread of patient-centredness from primary care into the other clinical specialties has been slow so far. To some extent, this is explained by an understanding of the barriers to further uptake. These include the label, a perception of lack of time, lack of awareness, the structure of clinical teaching, and an uncritical acceptance of the foundational assumptions of biomedicine.

However, despite these problems, patient-centredness offers considerable benefits for both patient and doctor. New undergraduate curricula provide a diverse package of innovations including more accessible models of consultation training, all of which reinforce patient-centredness. More comprehensive approaches to somatisation need to be incorporated into undergraduate training, as well as into both primary and secondary care.

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Competing interests

None declared.

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Medical professionalism

'Medical professionalism cannot be imposed by governments or by a regulatory culture. It must emerge from and be sustained by doctors themselves. "Medicine is a vocation in which a doctor's knowledge, clinical skills, and judgement are put in the service of protecting and restoring human well-being. This purpose is realised through a partnership between patient and doctor, one based on mutual respect, individual responsibility and appropriate accountability"'

Black C. Still striving for utopia. BMJ 2006; 332:47-48.