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Defining elements of patient-centered care for therapeutic relationships: a literature review of common themes

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Abstract

Rationale and aims: Patient-centered care is a recognized clinical method and ideal for patient - health professional relationships. Many definitions have influenced its evolution. For this research, our aim was: (1) to assess definitions and descriptions of patient-centered care to draw out elements of patient-centered care that are considered to be important markers of successful patient-centered care in the patient - health professional relationship and (2) to propose a set of elements that collectively reflect the diversity of 'patient-centered' definitions that describe the patient-professional relationship in this literature. A secondary aim was (3) to provide elements that could be used for development of a quality assessment tool.

Methods: We conducted a critical interpretive review of patient-centered care and patient-centered communication literature, beginning with a critical synthesis that yielded 12 articles that introduced new theoretical and definitional work on patient-centered care and patient-centered communication. We used an inductive and iterative analysis process to identify and group common themes. We used operational language to describe these themes.

Results: We identified 6 elements (each with 2 or more sub-elements) of the patient - health professional relationship that are considered important markers of successful patient-centered care (as found in this literature). The 6 elements are: (1) Engaging the Patient as a Whole Person, (2) Recognizing and Responding to Emotions, (3) Fostering a Therapeutic Alliance, (4) Promoting an Exchange of Information, (5) Sharing Decision-Making and (6) Enabling Continuity of Care, Self-Management and Patient Navigation.

Conclusions: Comparable fundamental elements were common among most authors within this literature: we found that variation in theory was typically a matter of degree and language. This work contributes analyses towards greater theoretical consistency for conceptions of patient-centered care. It also provides avenues for future development of quality assurance benchmarks.

Keywords

Definitions, literature review, patient-centered care, patient centricity, patient-professional relationship, person-centered healthcare, quality assurance benchmarks, theoretical consistency, whole person care

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Introduction

By putting the particular patient, not the average patient, at the center of care planning, patient-centered care has demanded significant changes in healthcare provision. Initially focusing on structural and institution-level practices that contribute to quality individualized patient care, patient-centered care is now recognized as a clinical method and ideal model for patient - health professional relationships as well. Medical organizations such as the

Canadian Medical Association [1], College of Family Physicians of Canada [2], Institute of Medicine [3] and American College of Physicians [4] now endorse and advocate patient-centered care, as do healthcare institutions, policy-makers and educators of health professionals around the world [5]. Studies also show patients and families to be supportive of patient-centered care [6-9].

Several definitions have been influential in the evolution of patient-centered care theory. These include a

Cochrane Review that characterizes patient-centered care as “a philosophy of care that encourages: (a) shared control of the consultation, decisions about interventions or management of the health problems with the patient and/or (b) a focus in the consultation on the patient as a whole person who has individual preferences situated within social contexts (in contrast to a focus in the consultation on a body part or disease)” [10]. While this review achieves clarity in its definition of patient-centered care, its analysis is limited to outcomes published in clinical trials, excluding theoretical work that remains influential for patient-centered practice. The broader patient-centered care literature reveals a lack of consensus about patient-centered care, but identifies three common themes: (1) patient participation and involvement, (2) the relationship between the patient and the healthcare professional and (3) the setting where care is delivered [11]. While these findings represent a wide range of professional roles, suggestions for patient-centeredness tend to vary widely depending on the role in question (i.e., nursing, family medicine, or healthcare institutions). Clear, measurable standards require specificity to be precise. After decades of theoretical work, patient-centered care still lacks a common definition.

The patient-professional relationship is where questions of communication, partnership and the decision-making process intersect - the patient-professional relationship thus presents itself as an ideal area of focus for improving patient care. Indeed, the patient-centered literature consistently argues that managing the patient-professional relationship is central to providing care that accurately responds to the patient’s needs [12]. Unfortunately, little has been done to map the patient-centered care literature regarding the patient-professional relationship. Hudon *et al.* note that patient-centered care measurement tools have included almost no items for the evaluation of the patient-professional relationship [13]. Similarly, our preliminary research has not revealed any patient-centered care quality assurance benchmarks/tools at the patient - health professional relationship level. Yet all health professionals (as well as their professional associations and the institutions within which they work) should be concerned with knowing and realizing desirable, effective practice at the level of the therapeutic relationship.

For this research project, we surveyed the patient-centered care and patient-centered communication literature to draw out elements of the patient-professional relationship that are considered important markers of success at the relationship level. Our goal is to assess the provided definitions and descriptions of patient-centered care and then propose a set of elements that collectively reflect the diversity of patient-centered care and patient-centered communication definitions in this literature that describe the patient-professional relationship. Our secondary goal is to provide elements and sub-elements of the patient-professional relationship that can be easily translated for the development of a measurement tool.

Methods

We conducted a critical interpretive review of the patient-centered care and patient-centered communication literature. Critical interpretive reviews are a type of review developed specifically for bioethics research. A critical interpretive review aims to guide theory explicitly, making it less introductory than a scoping review. However, research that incorporates a wide range of interdisciplinary results cannot fit within the rigidity of a systematic review. Thus, a critical interpretive review seeks to “capture the key ideas” in a body of literature to answer a specific research question, while simultaneously putting forward an argument meant to advance knowledge in the area of inquiry [14]. For our review, we were guided by the following question: “What are elements of the patient-professional relationship that reflect patient-centered care?” For this review, we understood the elements of the patient-professional relationship to be all necessary and sufficient conditions for maintaining a patient-centered relationship as revealed in this literature.

Our literature review required developing a search strategy for a concept that is notoriously inconsistent in its definition and terminology [10,15]. It is also a concept with multiple names and a variable scope that is often interchanged with (among others) patient-centered communication, patient-focused care and person-centered care [16,17]. We chose to include articles that explicitly informed definitions or descriptions of patient-centered care or patient-centered communication. We excluded articles that used patient satisfaction as a metric for defining patient-centered care or patient-centered communication. We excluded any organizational literature on patient-centered care, as our focus was on patient-centeredness in the patient-health professional relationship, as opposed to organizational design and practices. Similarly, we excluded work that focused on particular health professions (e.g., patient-centered nursing, patient-centered counseling). Finally, we excluded literature on the concept of person-centeredness or person-centered care developed for use in other disciplines (e.g., education), which may not capture unique aspects of the relationship between the patient and their health professional.

We performed our review of the patient-centered care literature by searching the databases CINAHL, MEDLINE and PUBMED up to 2014 using the following keywords: “patient-centered care”, “person-centered care”, “quality of care”, “quality assurance”, “patient feedback”, “definition”, “patient-centered communication”, “patient-physician communication”. We reviewed titles and abstracts of the articles identified by this search to assess whether unique definitions of patient-centered care were likely to be included in the text. When the review of an abstract was inconclusive, a team member read the complete text. Next, we searched the reference lists of all retained articles to identify additional texts that were relevant to the research question but were not identified through the initial database searches. Finally, we performed targeted web searches for more articles by authors who had been influential in the patient-centered

care literature. Using this search strategy, we found a total of 76 articles.

One team member (SC) read the set of 76 articles to provisionally identify which articles fit our inclusion criteria. The wide variety of interpretation and method in patient-centered care literature was a challenge. Critical reviews describe the review process as a critical synthesis: due to the variety of methods within a literature, quality assessments not only occur during initial abstract reviews but throughout the review process. We used critical synthesis during our review, first to determine an article's credibility as a source and then to determine its contribution to literature. Individual interpretation is limited by its potential for bias, but this limitation was necessary given the target literature. SC gathered the definitional portions of each article. SC and CE then reviewed the 76 articles together to determine that each had made a unique, high-quality contribution to patient-centered care literature (many articles had used former theories of patient-centered care *verbatim*, while others were too element-focused to be definitional). This process yielded 12 articles that introduced new theoretical and definitional work on patient-centered care and patient-centered communication. We combined these in a spreadsheet with each definition broken down into recognizable elements. We then looked for common themes and ideas and regrouped these into elements that are inclusive of the variety of work in this set of articles. Sub-themes were then developed when more than one article had described key components of achieving a broader element.

Critical interpretive reviews allow thematic development to adapt to the literature in question. Through an inductive and iterative analysis process, we arrived at 6 major elements (each with 2 or more sub-elements) that collectively incorporated aspects of patient-centered care that apply to patient - health professional interactions (as found in this literature). To describe these themes, we used language that was operationalizable rather than vague and theoretical. To develop a rationale for these elements, we drew upon the work of McCormack *et al.* in their creation of domains for patient-centered communication in cancer care [18]. We found that the patient-centered communication literature was often more readily operationalizable than the seminal definitions of patient-centered care; thus, we endeavored to develop elements (and sub-elements) of patient-centered care that provided measurable outcomes. Finally, these themes were organized to better reflect the flow of a typical professional-patient interaction.

Results

The characterizations or definitions extracted from these articles are shown in Table 1. These formed the basis of our analysis. Our analysis resulted in 6 elements that characterized patient-centered care at the patient-health professional level. The 6 elements are: (1) Engaging the Patient as a Whole Person, (2) Recognizing and

Responding to Emotions, (3) Fostering a Therapeutic Alliance, (4) Promoting an Exchange of Information, (5) Sharing Decision-Making and (6) Enabling Continuity of Care, Self-Management and Patient Navigation. As shown in Table 2 and discussed below, each of these elements has sub-elements that expand upon their parent element. Table 3 shows the distribution of the 6 elements across the articles we reviewed, as well as additional items each found in only one of the articles in the set. Table 3 reveals much variation in how authors describe major elements of patient-centered care. Below, we present the results of our review, along with an elaboration on our reasons for including each element and sub-element.

Engaging the Patient as a Whole Person

From our review of the literature, the importance of seeing the patient as a person with a variety of needs, values and preferences was common to all definitions. This theme was expressed with 3 common elements. The first involved *adopting a biopsychosocial perspective*. The implications of this element were both philosophical and practical and used to justify the patient-centered care approach [10,15,27,28]. The biopsychosocial perspective is described as a focus on the aspects of patient care that extend beyond the illness in its biomedical structure, changing the way illness is perceived in both diagnosis and treatment.

The most consistent element of this theme was *respecting the individual, their needs and preferences*. This involves an appreciation of the uniqueness of the individual patient (including understanding the unique meaning an illness has for the individual) by offering care that is customized to a patient's individual needs and preferences [3,10,12,15,21,22,26,27]. The patient's web of relationships is foundational to understanding the patient as a whole person. *Acknowledging the relational patient* is sometimes described as including family members and friends in their care plans [20,21], while others considered the context of the care setting or even eco-system health as fundamental to understanding the whole patient [5,18,20].

Recognizing and Responding to Emotions

Seminal definitions of patient-centered care highlight the importance of handling and responding to patient emotions, but are unclear on strategies to address emotional needs [15,21]. Patient-centered communication addresses these concerns by highlighting the importance of *identifying and understanding emotional cues* [18,27]. While not every care visit is emotional in nature, patients may be less likely to participate when they feel their emotional needs are not considered, or that an emotional response would be considered unnatural or unwelcome [18].

A patient-centered response to emotions also requires *validating and reacting to emotional cues*. Patient-centered professionals should communicate their understanding of an emotional response and express acknowledgement by showing sympathy, empathy and reassurance. Another key

Table 1 Definitions and Characterizations of Patient-Centered Care

Stewart <i>et al.</i> 2001, Brown <i>et al.</i> 2003, 2014 [5,12,19]	In 2001 [12]: "Patients want patient-centred care which (a) explores the patient's main reason for the visit, concerns and need for information; (b) seeks an integrated understanding of the patients' world - that is, their whole person, emotional needs and life issues; (c) finds common ground on what the 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." (445) In 2003 [19], the authors elaborate, arguing that understanding the whole person "includes an awareness of the multiple aspects of the patient's life ... including the ecosystem." (4, Brown <i>et al.</i>) In 2014 [5], they reduce these 5 elements to 4, removing section d: enhances prevention and health promotion and make changes to the language of the other 4 components. These become: (1) exploring health, disease and the illness experience; (2) understanding the whole person; (3) finding common ground; (4) enhancing the patient-clinician relationship.
Mead & Bower 2000 [15]	Mead and Bower suggest 5 dimensions of patient-centered care: (1) adopting the biopsychosocial perspective; (2) understanding the patient as a person; (3) sharing power and responsibility between the doctor and the patient; (4) building a therapeutic alliance; (5) understanding the doctor as a person.
Frampton & Charmel. 2009 [20]	Essential elements of patient-centered care discussed by Frampton & Charmel (2009) are: 1. Human interaction and relationship-centered care. 2. Access to health and medical information. 3. Healing partnerships involving patients, family and volunteers. 4. Nutrition. 5. Spiritual and cultural diversity. 6. Complementary and Alternative Medicine (CAM) and conventional care. 7. Healing art. 8. Healing environments. 9. Healthy communities.
Gerteis <i>et al.</i> 1993 [21]	Patient-centered care involves: Respect for the patient's values, preferences and expressed needs; coordinated and integrated care; clear, high-quality information and education for the patient and family; physical comfort, including pain management; emotional support and alleviation of fear and anxiety; involvement of family members and friends, as appropriate; continuity, including thorough care-site transitions and access to care.
Dwamena <i>et al.</i> 2012 [10]	Patient-centered care is defined as "a philosophy of care that encourages: (a) shared control of the consultation, decisions about interventions or management of the health problems with the patient and/or (b) a focus in the consultation on the patient as a whole person who has individual preferences situated within social contexts (in contrast to a focus in the consultation on a body part or disease)."
Ontario Medical Association 2010 [22]	For a healthcare system, being patient-centered allows patients to move "freely along a care pathway." For practitioners, 2 aspects of becoming more patient-centered are focusing on the patient as a whole person and improving patient-physician communication.
Davis, Schoenbaum & Audet 2005 [23]	The authors propose 7 aspects of patient-centered primary care to improve patient-centered care. These include "Superb access to care, patient engagement in care, Clinical information systems that support high-quality care, practice-based learning and quality improvement, care coordination, Integrated, comprehensive care and smooth information transfer across a fixed or virtual team of providers, Ongoing, routine patient feedback to a practice and publicly available information on practices."
Institute of Medicine 2001 [3]	Patient-centered is defined in the report as "providing care that is respectful of and responsive to individual patient preferences, needs and values and ensuring that patient values guide all clinical decisions."
Barry & Edgman-Levitan 2012 [24]	"Over time, advances in medical science have provided new options that, although often improving outcomes, have inadvertently distanced physicians from their patients." "In shared decision making, both parties share information: the clinician offers options and describes their risks and benefits, and the patient expresses his or her preferences and values." "Experience has shown that when patients know they have options for the best treatment, screening test, or diagnostic procedure, most of them will want to participate with their clinicians in making the choice." "Patients should be educated about the essential role they play in decision making and be given effective tools to help them understand their options and the consequences of their decisions." "Clinicians, in turn, need to relinquish their role as the single, paternalistic authority."
Van Berckelaer <i>et al.</i> 2012 [25]	In this study, researchers developed their definition of patient-centered care by asking patient focus groups what patient-centeredness meant to them. "The 3 broad codes identified to varying degrees in all focus groups were communication, structure of the practice and health system, and responsibility for or ownership of care." "The themes related to communication can be broadly summarized as a desire for clear, timely, and courteous communication." "With respect to practice structure, respondents valued a system designed to facilitate provider continuity and contact." "Finally, themes associated with 'ownership' of or responsibility for care suggest a relationship and practice style that allows the patient both to trust the provider's guidance and to engage more fully in his or her own care."

Fredericks <i>et al.</i> 2012 [26]	"In this article, we use a theoretical lens of critical social theory and its underpinnings of power." "At the organizational level, patient-centered care has been described as a merging of patient education, self-care, and evidence-based models of practice." Patient-centered care consists of 4 aspects that include communication, partnerships, health promotion and physical care. "This approach to care requires an appreciation of patients' expectations, beliefs, and concerns regarding their illness and/or disease; an understanding of their personal circumstances; the ability to find a common ground on what the problem is and agreeing on the management; and the knowledge to use the best evidence to inform treatment decisions."
Epstein <i>et al.</i> 2005 [27]	Epstein <i>et al.</i> suggest their own operational definition of patient-centered care. "(1) Eliciting and understanding the patient's perspective - concerns, ideas, expectations, needs, feelings and functioning. (2) Understanding the patient within his or her unique psychosocial context. (3) Reaching a shared understanding of the problem and its treatment with the patient that is concordant with the patient's values. (4) Helping patients to share power and responsibility by involving them in choices to the degree that they wish."
McCormack <i>et al.</i> 2011 [18] *	Although existing communication measures tap into elements of patient-centeredness, most do not comprehensively assess patient-centered care. "Hence, a comprehensive measure of patient-centered care should assess the patient's (and family members' or other caregivers') communication as well as the clinician's and the qualities of the interaction itself that are jointly created by all parties (e.g., negotiation, consensus building)." "We developed the domains to reflect a normative (creating a new standard) rather than descriptive (what is happening) approach." (These domains are taken from Epstein & Street (2007) [29] as seen below.)
Clayton <i>et al.</i> 2011 [28] *	"Patient-centered care and patient-centered communication are two interwoven concepts relating to the composite term patient-centeredness that indicates a desire to address the individualized nature of each patient's values, needs, and concerns." "Patient-centered communication, on the other hand, is considered a component of patient-centered care, encompassing four communication domains: the patient's perspective, the psychosocial context, shared understanding, and sharing power and responsibility" (The rest of their definition of patient-centered care proper was taken from Epstein & Street (2007) [29] as seen immediately below.)
Epstein & Street (2007) [29]	Exchanging Information, Fostering Healing Relationships, Managing Uncertainty, Recognizing and Responding to Emotions, Making Decisions, Enabling Self-Management and Patient Navigation, Crosscutting.

Table 2 Elements that Characterize Patient-Centered Care at the Patient-Health Professional Level

Elements	Sub-Elements
Engaging the Patient as a Whole Person	Adopting a biopsychosocial perspective Respecting the individual, their needs and preferences Acknowledging the relational patient
Recognizing and Responding to Emotions	Identifying and understanding emotional cues Validating and reacting to emotional cues
Fostering a Therapeutic Alliance	Establishing and sustaining trust Sharing power with the patient
Promoting an Exchange of Information	Facilitating information exchange Ensuring information retention
Sharing Decision-Making	Finding common ground Engaging patients in their care
Enabling Continuity of Care, Self-Management and Patient Navigation	Enabling continuity of care Enabling patient self-management Enhancing patient navigation

Table 3: Distribution of Elements of Patient-Centered Care at the Patient-Health Professional across Articles Analyzed

	Engaging Whole Person	Sharing Decision-Making	Promoting Exchange of Information	Fostering Therapeutic Alliance	Recognizing and Responding to Emotions	Enabling Patient Navigation	Other
Stewart <i>et al.</i> 2014 [5]	✓	✓	✓	✓			
Mead and Bower 2000 [15]	✓	✓		✓			
Frampton and Charmel 2009 [20]	✓	✓	✓	✓			✓ (Patient as Relational, Healing Environments, Healing Art)
Gerteis <i>et al.</i> 1993 [21]	✓	✓	✓		✓	✓	
Dwamena <i>et al.</i> 2012 [10]	✓	✓					
Ontario Medical Association 2010 [22]	✓			✓		✓	
Davis, Schoenbaum, Audet 2005 [23]		✓	✓			✓	✓ (Quality Assurance)
Institute of Medicine 2001 [3]	✓	✓					
Van Berckelaer <i>et al.</i> 2012 [25]		✓		✓		✓	✓ (Communication, Structure of Care, Incorporating the Patient's Voice)
Fredericks <i>et al.</i> 2012 [26]	✓	✓	✓	✓			✓ (Health Promotion)
Epstein <i>et al.</i> 2005 [27]	✓	✓		✓			
Epstein and Street 2007 [29]	✓	✓	✓	✓	✓	✓	✓ (Managing Uncertainty, Cross-Cutting)

component of responding to emotional needs is managing uncertainty in patients, particularly those with severe illness [18,27]. Uncertainty is a psychological construct that can provoke harmful emotional responses [18,29]. A patient-centered, communicative approach will employ emotion-focused strategies that recognize the existence of irreducible uncertainty; in these cases, professionals should acknowledge, reassure and express commitment to the continuity of their patient's care [21,29]. Professionals may need to suggest other coping resources like counseling or support groups, particularly for seriously ill patients [18].

Fostering a Therapeutic Alliance

While not all patient-centered care authors focus on the relationship as central to a patient-centered approach, themes emerged that implicated the health professional's responsibility to sustain and improve the relationship itself. One aspect is *establishing and sustaining trust*. A trusting relationship has both instrumental and intrinsic value, as it leads to better patient outcomes while improving the therapeutic experience for professional and patient. [15]. Building trust requires fostering a relationship between health professional and patient that can endure over time [5,27,25].

To foster a therapeutic alliance, health professionals are also responsible for *sharing power with the patient*. The patient-physician relationship does not exist in a vacuum and authors note that extra attention should be paid to the way social, cultural, psychological and other factors impact a patient's ability to be involved in their care [24,26]. Sharing power requires an intentional exchange of power with the patient, in which professionals and patients share their preferences for control in the relationship [18,28]. This involves allowing patients to engage more fully in their care while recognizing that individual patients may have varying interest in sharing control [15,26]. The professional role requires unique responsibilities that reflect the lesser power of the patient within the therapeutic alliance and it is therefore important that the particular patient remains central as the focal point of the patient-centered care approach. Similarly, health professionals must consider how the therapeutic alliance can appropriately transition when responsibility for a patient's care is concluded.

Promoting an Exchange of Information

Information sharing is a fundamental theme in the patient-centered care literature; particularly in the way it enables the application of other patient-centered care elements. One major aspect of promoting this exchange is the importance of *facilitating information exchange*. In a study that focused on patient interpretation of patient-centered care, Van Berckelaer *et al.* found that patients appreciate clear, timely and courteous communication [25]. Clear communication also involves providing informational resources, helping patients evaluate and utilize resources and improving patient education [18,20,27,29].

Improving an exchange of information also requires *ensuring information retention*. For example, health professionals are increasingly using complex medical procedures and tests, widening the knowledge gap between patients and health professionals. While health professionals must be equipped with expert knowledge, patients notice and resent when medical or technical jargon overshadows the patient's unique personal story [12,24]. Health professionals sometimes ask patients to repeat their understanding of a complex procedure back to them, to ensure that patients grasp the medical information they are given.

Sharing Decision-Making

Sharing decision-making entails an interactive collaboration and mutual influence of the patient and the health professional [30]. To do this, health professionals should be focused on *finding common ground* with patients about their health problems. While some authors consider common ground as a shared understanding of the patient's problem in a way that is in accordance with the individual patient's values [27-29], Stewart *et al.* consider common ground as a "mutual understanding and mutual agreement in three key areas: (1) defining the problem, (2) establishing the goals and priorities of treatment and (3)

identifying the roles to be assumed by both the patient and the clinician" [5].

For health professionals, collaborating on decision-making with patients, requires *engaging patients in their care*. Health professionals should provide an encounter that empowers their patient to take an active role in decisions about their care, to the extent that the patient wishes to take an active role. Shared decision-making requires a practice style that allows the patient to trust the healthcare professional's guidance while also being involved in their own care plan, to the extent that the patient wishes to be involved [3,23,25,27]. Communicative tools are effective for engaging patients and although professionals are responsible for some of the decisions at hand (such as a physician making an order in a patient's health record), using an accommodating communication style will help patients feel comfortable as part of the process [18]. Engaging patients may also require assessing decision quality with patients [29].

Enabling Continuity of Care, Self-Management and Patient Navigation

Health professionals are essential to *enabling continuity of care* [21]. In healthcare contexts continuity refers to care that occurs in relationships that are relatively consistent and coherent for patients. Achieving continuity requires explicit communication with patients about their care plan to sustain patient adherence to treatment goals [18,27]. It likewise requires explicit communication among health professionals who are involved with carrying out that plan, ideally in a seamless manner (from the patient's perspective).

Patient-centered care also involves patients and health professionals sharing in the management of the patient's health issues. This includes *enabling patient self-management*, whereby patients self-manage some aspects of their condition. For example, health professionals may guide patients on how to adjust or utilize certain therapies or medications in response to fluctuating symptoms of a chronic disease, or they may guide patients on how to self-manage some aspects of their recovery from an acute illness or injury. Effective communication enables better care management (both shared and self-management) while simultaneously increasing patient autonomy [18]. By helping patients to set graspable and unambiguous care goals and to select self-management strategies, helps to foster their autonomy and enable self-management. Fostering patient autonomy and enabling self-management likewise facilitates patient navigation.

Patient-centered care authors note the importance of *enhancing patient navigation* [18,20,22]. Patient navigation is defined as the set of skills necessary for managing a variety of healthcare settings and experiences, enabling the patient to "move along a care pathway" [18,22]. While access to care and ease of moving between healthcare settings and services is mainly addressed at the system or institutional level, health professionals have a role in providing guidance to their patients in this regard. At the therapeutic relationship level, patient navigation

also requires discussion of the patient's support system, particularly when treatment is ongoing [20].

Discussion

The patient-centered care literature we reviewed uses different approaches to define key concepts and determine the best way of establishing effective patient-professional relationships consistent with patient-centered care. Some authors rely on normative responsibilities that professionals *ought* to consider, while others rely on observation and patient feedback. Increasingly, empirical research has been done to confirm or deny some of the claims about patient-centered care and best practices to achieve it. This research is useful for determining next steps in developing patient-centered care theory and patient-centered relationships between patients and health professionals.

Patient feedback data reveals that most patients want a meeting with a health professional that is tailored to the patient's particular needs. To improve decision-making, including tailoring to patients' needs, patients and health professionals should discuss the patient's preferred role in the process [31,32]. A patient-centered approach extends collaboration beyond individual decisions, focusing on enabling shared long-term management (if the relationship will go beyond a single episode). We noted that in one study, patients' most frequent complaint was that physicians, in particular, do not listen to their problems or care about their concerns [33]. In another study, clinicians often overestimated the effectiveness of the information they provided, often not assessing the level of their patients' understanding [34]. A patient-centered approach requires humility for health professionals to remain vigilant in reflecting on how they provide care.

It is important to recognize that sharing information is a value, a behavior and a skill. Its importance may vary depending on a patient's perspective [17]. For example, some patients lose trust when ambiguous information is given; critically ill patients tend to prefer more direct communication styles [35]. On the other hand, one recent study found that while facilitating behavior is strongly related to a patient's active participation, communication-inhibiting behavior did not result in reduced active patient participation; rather, inhibiting behaviors were even positively related to patient expression of concerns and cues [32]. Thus, providing a patient-centered exchange of information does not always require constant use of facilitating behavior. A patient-centered approach requires sensitivity to the goals of the patient.

Other studies found that patients place importance on having trust in the competence, skills and knowledge of their health professional and this often relates directly to their communication style [18,36,37]. Physicians, particularly when dealing with serious illnesses like cancer, often misread emotional cues and fail to initiate conversations about emotions [38,39]. Preferences about communication methods may differ among patients; some prefer to be asked about their emotions directly, while

others prefer to express emotions when they are asked about their life and everyday activities [40]. Thus, patient-centered care theory will need to determine how to effectively consider patient emotions and ideally develop operational guidelines to communicate that understanding to patients.

Some authors have argued that patient-centered care should shift its focus to relationship-centered care, arguing for the importance of the doctor-as-person within patient-centered care theory, conceptualizing a balanced responsibility between physician and patient [15,41]. We worry that such a shift would obscure, if not ignore, the inherently asymmetrical relationship of the physician and patient and the legal, institutional and social power of the medical professional. Such a shift seems to withdraw from a central premise of patient-centered care: that the patient is the starting place and constant reference point, for both the patient and health professional, who work in partnership towards developing and acting on a plan of care that emanates from the particular patient's goals, preferences and capabilities. Studies have shown that medical students inevitably lose patient-centeredness (cf. Mead and Bower's definition [15]) when they fail to see patients as partners in a relationship [42]. Thus, while partnership implies collaboration among the partners towards a common goal, it appears to us that patient-centered care will be most effective when the central role of the patient is emphasized and the responsibilities of the health professional are not diminished.

Towards Theoretical Consistency

Those writing about patient-centered care theory typically acknowledge the lack of consensus in its definition and application. Since patient-centered care is an increasingly popular theoretical tool and an expectation of good practice, with heavy uptake of patient-centered models in medical education, quality assurance and an expanding list of professional roles [5,11], addressing the need for theoretical consistency becomes even more important. In our observation of the patient-centered care literature, we found that while there was great variation in theory, variance was typically a matter of degree: comparable fundamental elements were common among most authors.

Our review intentionally included elements that are supported by evidence and that are simple and action-oriented. However, the literature is sparse on several aspects of patient-centered care; "engaging the patient as a whole person" is well represented in the patient-centered care literature but has few well-tested, operational items. While influential patient-centered care theories use reductive dimensions of patient-centered care as guiding concepts [15,21], more recent patient-centered care theory is well supported by evidence and more easily applied in the healthcare setting [18,23].

The elements and sub-elements that we propose may not be applicable to all care settings. Some settings or professions may need additional elements to heighten patient-centeredness, while others may find these six elements and their sub-elements sufficient. For example, a one-time encounter for a specific consultation may not

require fostering a long-term, patient-centered therapeutic alliance. Yet, the one-time consultation still warrants a patient-centered approach to foster an alliance suitable to achieve the therapeutic goals of that consultation. Further, every consultant has a role in facilitating continuity of care. Thus, appropriate responsiveness to individuals ought to be present in all patient-centered approaches. We are convinced that, at minimum, the six elements described in this paper will be relevant for all relationships between patients and health professionals, although the extent to which may vary. The elements and sub-elements we identified mutually support each other and, in this way, may not be strictly distinct elements. This bodes well for reaching theoretical consistency. Yet, at this point, the extent to which these elements and sub-elements constitute the necessary and sufficient conditions to define patient-centered care in patient - health professional relationships remains an open question.

Although there is a wealth of grey literature on patient-centered care, this literature often uncritically applies early definitions of patient-centered care as the foundation of their patient-centered approach. While we do not question the legitimacy of these early theories, our hope is that scholars will continue to engage with the complexity of patient-centered care constructs and conduct research to inform and validate constructs in different contexts, including different contexts of patient - health professional relationships. Stewart *et al.* are exemplars of on-going theoretical and empirical scholarship to iteratively promote and transform the clinical method for patient-centered primary care medicine [5]. Similarly, books published through the Patient-Centered Care series by Radcliffe Medical Press and elsewhere expand the scope of scholarship on patient-centered care. These initiatives should help bring patient-centered care towards more theoretical consistency and robustness.

Perhaps the more difficult task for advancing patient-centered care in patient - health professional interactions will be to develop quality assurance measures that are comprehensive, context-specific and operational. As Epstein *et al.* argue, there are many barriers to properly measuring patient-centered communication and these barriers apply equally to patient-centered care in general [27].

The type of evidence used to validate patient-centered care constructs is equally important to consider. Evidence for the effectiveness of various patient-centered care constructs are difficult to measure given the variety of metrics available; some rely on patient satisfaction and/or patient experience, while others measure patient outcomes [43].

Measures that rely on patient satisfaction alone are often inadequate to determine whether care is patient-centered [15]. Patients are often satisfied by behaviors that are familiar [27] and some patient-satisfying behaviors can have negative effects on patient outcomes [44]. Further, strong ethical justifications for patient-centered care in patient - health professional interactions are found in the role responsibilities of the health professional *qua* professional and in the deontological ethical approach of professions.

Some recent literature on measuring patient experience may be helpful for health professionals interested in gaining patient input. These include a scoping review of patient experience questionnaires by Wong and Haggerty [45] and The Health Foundation's evidence scan of the patient experience measurement literature [46]. Patient input could also contribute to guide the development of patient-centered care definitions, measurement tools and educational programs. Inclusion of patient input reflects a theory that takes its own conditions seriously by remaining responsive to the changing needs and preferences of patients.

A limitation of our analysis and resulting set of elements may be in determining their applicability across professional roles. Our focus was on a generic therapeutic relationship between health professionals and their patients, yet we drew on literature and empirical studies specifically involving physicians or physicians-in-training. Our approach may have neglected functions of health professional roles within teams or within a system that impact a patient-centered relationship (e.g., nursing roles that impact a particular patient-physician relationship, or physician roles that impact a particular patient-nurse relationship). Likewise, institutional factors (e.g., staffing, policies, available resources) can affect elements of patient-centeredness in relationships of care. Another limitation of our study may be our methodological approach. While some literature reviews have attempted to discover consistent, core themes that apply to the entirety of patient-centered care literature, ours has attempted through a critical interpretive review to highlight the insight offered by concepts that are not always consistently reflected in theory. While our approach is more readily optimized for operational benchmarks, it lacks the precision of a systematic review.

Conclusion

Patient-centered care remains a poorly defined theory with much variation in its theoretical development, practice guidelines and measurement tools. Tools that measure elements of patient-centered care at the level of therapeutic relationships are especially lacking. Through a critical interpretive review of common themes in literature that defines or describes patient-centered care at the level of therapeutic relationships, we have elaborated six major elements (each with sub-elements) that reflect important aspects of patient-centered care in patient - health professional relationships. Uniquely, our approach re-orientes patient-centered communication (from promoting patient-centered care [27]) to a guiding component of patient-centered care in patient - health professional relationships. The inclusion of psychological constructs, empirical evidence and easily applicable strategies in patient-centered communication will most likely improve the operationalizing potential of patient-centered care. This work provides avenues for future development of quality assurance benchmarks. More empirical research, particularly research that involves the patient's perspective,

is necessary for the validation and continued evolution of patient-centered care theory.

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