receive good care. In the United States a fragmented healthcare system, and difficulties in accessing care, have exacerbated the problems.[8]

In most industrialised countries reform in mental health care has led to the closure of long stay mental hospitals and the development of community mental health teams. Such teams are expected to meet the whole range of health and social needs. Hospital admissions are often short and infrequent, and physical health care is not necessarily given priority. In Britain the national service framework for mental health states that people with a severe mental illness should have their physical needs assessed. However, many mental health practitioners have little training in physical care. Physical assessments of psychiatric inpatients by junior psychiatrists are poor,[9] and the monitoring of physical health and health education by community mental health staff is generally unsatisfactory.[10]

Most patients with severe mental illness are in frequent contact with primary care services, and for many this is their only contact with health services. However, such contact does not necessarily ensure that they receive good physical health care. The orientation of primary care is reactive, and this does not fit well with patients who may be reluctant, or unable, to seek help. Short consultation times make it difficult for doctors to assess mental state and conduct a physical assessment, especially in vague or suspicious patients. When patients are accompanied by mental health staff more emphasis may be given to psychological and social issues. Doctors who are inexperienced in, or uncomfortable with, mental health work may resist intensifying their engagement with a patient by actively asking about symptoms and performing a physical examination.

A study in the US has highlighted that structured physical assessments of patients with schizophrenia are effective in revealing physical illness.[7] In the UK the NHS Executive has suggested that general practitioners should be paid for showing that they have assessed the general physical health of patients with severe mental illness and made any necessary interventions.[11] For such schemes to be successful practices would need to identify their patients with a severe mental illness and to have an effective and acceptable screening mechanism. This should highlight physical symptoms and unmet physical healthcare needs, such as cervical screening and dental care.

The lifestyle of patients with severe mental illness suggests a need for health promotion—which can be effective. For instance, group therapy is effective in helping patients with schizophrenia stop smoking.[12] But progress in this is hampered by negative staff attitudes. Initiatives in this area should be accompanied by research, so that the most effective approaches can be identified and widely adopted.

The evidence suggests that it is possible to improve the physical health of this vulnerable section of the population. Progress will, however, depend on both mental health and primary care staff being aware of the problem and being willing to find imaginative solutions which are acceptable and useful to patients.

Michael Phelan *consultant psychiatrist*

Department of Psychiatry, Charing Cross Hospital, London W6 8RP

Linda Stradins *mental health nurse*

Ealing, Hammersmith, Fulham Mental Health Trust, Gloucester House, London W6 8BS

Sue Morrison *general practitioner*

Marylebone Health Centre, London NW1 5LT

1 Philips RJ. Physical disorder in 164 consecutive admissions to a mental hospital: the incidence and significance. *BMJ* 1934;2:363-6.
2 Koran LM, Sox HC, Marton KI, Moltzen S, Sox CH, Kraemer HC, et al. Medical evaluation of psychiatric patients. 1. Results in a state mental health system. *Arch Gen Psychiatry* 1989;46;733-40.
3 Makikyro T, Karvonen JT, Hakko H, Nieminen P, Joukamen M, Isohanni M, et al. Comorbidity of hospital-treated psychiatric and physical disorders with special reference to schizophrenia: a 28 year follow-up of the 1966 northern Finland general population birth cohort. *Public Health* 1998;112:221-8.
4 Harris EC, Barraclough B. Excess mortality of mental disorder. *Br J Psychiatry* 1998;173;11-53.
5 Brown S, Birtwistle J, Roe L, Thompson C. The unhealthy lifestyle of people with schizophrenia. *Psychol Med* 1999;29;697-701.
6 Brown S, Inskip H, Barraclough B. Causes of the excess mortality of schizophrenia. *Br J Psychiatry* 2000;177;212-7.
7 Jeste DV, Gladsjo JA, Lindamer LA, Lacro JP. Medical comorbidity in schizophrenia. *Schizophrenia Bull* 1996;22:413-27.
8 Goldman LS. Medical illness in patients with schizophrenia. *J Clin* Psych 1999;60 (suppl 21):10-5.
9 Rigby JC, Oswald AG. An evaluation of the performing and recording of physical examinations by psychiatric trainees. *Br J Psychiatry* 1987;150:533-5.
10 Gournay K. Setting clinical standards for care in schizophrenia. *Nursing Times* 1996:92:36-7.
11 NHS Executive. *Health Service Circular*. London: NHSE, 1999 (HSC 1999/107).
12 Addington J, el-Guebaly N, Campbell W, Hodgins DC, Addington D. Smoking cessation treatment for patients with schizophrenia. *Am J Psychiatry* 1998;155:974-6.

Towards a global definition of patient centred care

The patient should be the judge of patient centred care

Key messages about patient centred care can be drawn from the paper by Little et al in this issue of the *BMJ* (p 468).[1] Firstly, strong agreement exists between the definition of patient centredness that arises empirically from this observational study of patients in the United Kingdom and another definition arising from reflections on practice in South Africa and Canada,[2] suggesting an international definition of patient centred medicine. Secondly, the premise of the observational study is correct—that the best way of measuring patient centredness is an assessment made by the patients themselves.

Patient centredness is becoming a widely used, but poorly understood, concept in medical practice. It may be most commonly understood for what it is not—technology centred, doctor centred, hospital centred, disease centred. Definitions of patient centred care seek to make the implicit in patient care explicit. Such definitions are, we recognise, oversimplifications

Primary care p 468

BMJ 2001;322:444–5

bmj.com

An additional table appears on the BMJ's website

which help in teaching and research but fail to capture the indivisible whole of a healing relationship. Perhaps qualitative research comes closer to conveying the qualities of such care.

Acknowledging these limitations, researchers seek answers to crucial questions about patient centred medicine. What is it? Do patients want it? Do doctors practise it? What are its benefits? Little et al focus on the first two questions.[1] Their results indicate that the answer to the second question is a resounding "yes." Patients want patient centred care which *(a)* explores the patients' 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. Here, then, is the beginning of a truly international definition, based on both British patients' views and the reflections of clinicians from South Africa and Canada.[2] Interestingly, a comparison of the observational study by Little et al[1] with the conceptual framework put together by our group in 1995[2] showed that the observational study strongly supports the conceptual framework. Specifically, 13 of 19 items created by Little et al grouped together as expected according to Stewart et al[2] (see table on bmj.com).

Regarding the question whether doctors practise patient centred care, data indicate that doctors vary but on the whole provide most patients with partially patient centred care. Specifically, the average patient centred score on a scale of 0-100 is 50.7 (SD 17.9, range 8-93).[3] Some doctors are very patient centred and show a wide range of scores, indicating a flexible style. Many others are not very patient centred and show a narrow range of scores, indicating a fixed style.[4] There is also evidence of tangible benefit: patient centred communication is positively associated with patient satisfaction, adherence, and better health outcomes.[5]

A systematic search of Medline for the terms "patient centred (centered) approach" or "patient centredness (centeredness)" in 1995-2000 identified 65 papers. Four additional papers were identified through searching authors' names for the years 1995-2000, from a recent conference (international conference on health and communication for health professionals, educators and researchers, Barcelona, September 2000), and the reference list of Little et al.[1] Of the 69 papers, 55% were research papers, 35% on theory, 7% on education, and 3% descriptions of programmes. Of the 38 research papers five were randomised intervention studies; six measured health outcomes; and 22 measured patient centredness (eight by direct observation, six by patient perception questionnaire,[6–11] one by both direct observation and patient perception questionnaire,[12] five by assessing physician or student experiences, and two through a patient centred intervention only). The 69 papers originated from the UK (21), the United States (19), Norway (5), Italy (5), Canada (5), South Africa (3), Australia (3), and Germany (2), with one each from Israel, Netherlands, Finland, Spain, Belgium, and one unknown. In the Cochrane consumers and communication group no review has been conducted on the patient centred approach.

Patient perceptions of patient centredness are important to study. The Medline search indicated that most educators and researchers focused solely on experts' ratings of observed behaviour in clinical encounters. However, in one study of both observation of the clinical encounter and patient perceptions the patients' perception of the patient centredness of the interaction was the stronger predictor not only of health outcomes but also of efficiency of health care (fewer diagnostic tests and fewer referrals).[2] This can be described as the ultimate patient centred finding: the patients', not the experts', views on patient centredness predicted important outcomes.

Two common misunderstandings about patient centred medicine may be perpetuated by Little et al's study. Firstly, they and others they cite[8] expressed concerns that patients "may not prefer a patient centred approach" and hence its universal adoption would be "unwise." This concern rests on the misconception that being patient centred means sharing all information and all decisions. Being patient centred actually means taking into account the patient's desire for information and for sharing decision making and responding appropriately. Secondly, the basic question of Little et al's study (Do all patients in primary care want all components of patient centredness?) implies that patient centred care can be neatly separated into divisible parts. The patients' responses indicated, in contrast, that they uniformly valued all aspects of patient centredness. Further, although components are used for ease in teaching and research, patient centred clinical practice is a holistic concept in which components interact and unite in a unique way in each patient-doctor encounter.

Moira Stewart *professor and director*

Centre for Studies in Family Medicine, Department of Family Medicine, The University of Western Ontario, London, Ontario, Canada N6A 5C1 (moira@julian.uwo.ca)

1 Little P, Everitt H, Williamson I, Warner G, Moore M, Gould C, et al. Preferences of patients for patient centred approach to consultation in primary care: observational study. *BMJ* 2001;322:468-72.
2 Stewart M, Brown JB, Weston WW, McWhinney IR, McWilliam CL, Freeman TR. *Patient-centred medicine transforming the clinical method.* Thousand Oaks: Sage Publications, 1995.
3 Stewart M, Brown JB, Donner A, McWhinney IR, Oates J, Weston WW, et al. The impact of patient-centered care on outcomes. *J Fam Pract* 2000;49:796-804.
4 Stewart M, Brown JB, Weston WW. Patient-centred interviewing part III: five provocative questions. *Can Fam Phys* 1989;35:159-61.
5 Stewart M. Effective physician-patient communication and health outcomes: a review. *Can Med Assoc J* 1995;152:1423-33.
6 Williams GC, Freedman ZR, Deci EL. Supporting autonomy to motivate patients with diabetes for glucose control. *Diabetes Care* 1998;21:1644-51.
7 Woodcock AJ, Kinmonth AL, Campbell MJ, Griffin SJ, Spiegal NM. Diabetes care from diagnosis: effects of training in patient-centred care on beliefs, attitudes and behaviour of primary care professionals. *Patient Educ Couns* 1999;37:65-79.
8 Dowsett SM, Saul JL, Butow PN, Dunn SM, Boyer MJ, Findlow R, et al. Communication styles in the cancer consultation: preferences for a patient-centred approach. *Psycho-oncology* 2000;9:147-55.
9 Laerum E, Steine S, Finset A, Lundevall S. Complex health problems in general practice: do we need an instrument for consultation improvement and patient involvement? Theoretical foundation, development and user evaluation of the Patient Perspective Survey (PPS). *Fam Pract* 1998;15:172-81.
10 Malterud K, Hollnagel H. Women's self-assessed personal health resources. *Scand J Primary Health Care* 1997;15:163-8.
11 Kinmonth AL, Woodcock A, Griffin S, Spiegal N, Campbell MJ. Randomised control trial of patient centred care of diabetes in general practice: impact on current wellbeing and future disease risk. The Diabetes Care from Diagnosis Research Team. *BMJ* 1998;317:1202-8.
12 Stevenson FA, Barry CA, Britten N, Barber N, Bradley CP. Doctor-patient communication about drugs: the evidence for shared decision making. *Soc Sci Med* 2000;50:829-40.