

itoring, we found a serious adverse event rate of 3.4 per 100 patient years (1.1 for haemorrhage, 2.3 for thrombosis) including a mortality rate of 1.1 per 100 patient years for patients managed within a primary care-based clinic.¹⁴ Gender appeared to have little influence on the risk of adverse events, with men having a very slightly higher RR than women of having a non-serious event (RR = 1.03, 95% CI = 0.8 to 1.3), with a lower risk than women of having a serious outcome (RR = 0.89, 95% CI = 0.3 to 2.4). Similarly, age appeared to have little impact on risk of adverse events.

Goudie *et al* report data from a primary care-based observational study over 5 years.¹⁵ They report 18 major bleeding events, including four fatalities over 664.8 patient years giving a major haemorrhage rate of 0.6 per 100 patient years, including a haemorrhagic fatality rate of 0.06 per 100 patient years. Unfortunately, data are not provided regarding thrombosis rates, nor any data on the quality of INR control achieved. They do suggest, however, that it is dependency rather than age per se that is important in terms of haemorrhage risk.

Near-patient testing has a role in primary care. However, practitioners need to ensure that they are using tests appropriately and that the test characteristics are suitable for the purpose of testing either for diagnosis or monitoring.

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The journey towards patient-centredness

PATIENT-CENTREDNESS is at the heart of medicine.¹ It is a core value of our discipline, recognised as the best way of helping an individual promote, preserve and restore their integrity of health.² Patient-centredness is about giving the patient's viewpoint much more status in our hierarchy of clinical inputs;^{3,4} a revolution in the discussion of prognosis with dying patients was an early sign of this approach.⁵ Although the method has been endorsed in the rhetoric and vocational training of general practice for more than two decades, progress is slow and appears not yet to be widely realised in day-to-day consulting, even in specially selected consultations.⁶ Yet poor responsiveness to patients' wants can too often lead to misdirection and waste of professional time and effort. Being responsive may often mean acknowledging and understanding the patient's wants rather than directly complying with them.⁷

The challenge is to consult both better and more efficiently. Attempts to relate consultation process to patient outcomes, such as satisfaction and enablement, have been rather unrewarding so far.⁸ This may mean that no one process suits even a significant proportion of patients. More research is needed here and several recent studies suggest a way forward. Little *et al* have recently shown that a pre-consultation leaflet encouraging patients to voice their concerns and ask questions can reinforce communication in consult-

ations.⁹ Once in the consultation it is noteworthy that avoiding interruption of the patient's initial exposition carries no time penalty¹⁰ and is both an opportunity to hear the patient's viewpoint and a more general sign of willingness to listen.

But patients often do not voice their views without prompting. In this issue of the Journal, McLean and Armstrong report a promising approach to helping patients voice their concerns.¹¹ They found that active eliciting of patients' concerns improved an already high level of satisfaction by over 7% at the cost of a non-significant increase in consultation time. This represents over a third of the way to complete (100%) satisfaction. The authors ask whether eliciting patient concerns is worth the cost of apparently longer consultations. This seems strange, for how else can we then acknowledge that 'patients' wants are not capricious whims but needs in themselves'¹²? Assessment of overall time cost must include subsequent consulting behaviour, but the authors admit that their study was not designed to measure this.

In her review of patient-centredness, Stewart emphasised that this means 'taking into account the patient's desire for information and responding appropriately'.¹³ So being patient-centred can, perhaps counterintuitively, sometimes mean being brief and authoritative. Only by eliciting patients' concerns and wants can we know when to act thus. The

costs of not reaching shared understanding with patients may not always be immediately apparent, but Britten and colleagues have convincingly shown how common this problem is in relation to prescribed medication¹⁴ and there is now good evidence that poor concordance results in poor patient outcomes.¹⁵

The concept of patient-centredness has gained the attention of policymakers in the UK. Their response has been to address patient concerns about delays in access to primary care services by offering alternative pathways and services^{16,17} and by attempting to improve the working of general practice appointment systems.¹⁸ But this is only one aspect of patient-centredness, and the care process itself, especially the professional consultation, is probably much more important. Patients increasingly want to understand their condition better and be more involved in decisions about care. This includes domains that were considered exclusively professional until recently, such as data entry into medical records¹⁹ or quality improvement activity.²⁰ Consultations are becoming more varied and less formal. There is growing use of telephone consulting,²¹ and increased availability of e-mail consulting seems likely to follow.²²

Patients' access to better and more reliable information is improving, with greater availability of patient information materials — often now integrated with general practice software — and quality-assured information resources on the Internet (such as those being made available by the BMJ group). But such information is not personalised and does not necessarily bring either understanding or shared decision making. This is a central function of the consultation and it needs both skill and time.^{23,24} A promising additional approach to enhancing a patient's understanding is to provide a recording of the consultation for them to take home and replay at will. In effect this both lengthens and deepens the consultation without further medical input. It may also change perceptions of the ownership of the consultation.

Liddell and colleagues report a randomised trial in this issue of the Journal.²⁵ They included all patients attending for consultations and, understandably, a number reported that their consultation was straightforward and so did not use the tape. However, most of these would have liked a tape of one or more previous consultations with their doctor. Many of us might initially feel threatened if a patient walked into a consultation and asked to record the encounter, but this study suggests that the process has real potential to improve understanding. It is tantalising to read that when some participants shared the tape, this was 'somewhat or very unhelpful'. Further qualitative work on this aspect is needed. This study opens the door to new possibilities. It is now not too radical to envisage a time when audio recordings might be routine, providing patients with a completely new electronic medical record.

Total patient-centredness may be hard to imagine, but the journey there is vitally interesting.²⁶ While it may seem disappointing that the two trials in this issue offer only modest achievements in terms of hard outcomes, it is most encouraging to see the concept of patient-centredness being developed into interventions that can be formally evaluated using rigorous designs. In the UK we can look forward to when this aspect of practice will be more directly rewarded in another revision of the general medical services contract.²

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