

Teaching and learning about empowerment in family medicine

JOHN YAPHE*

Historically the doctor patient relationship is characterized by paternalism and an imbalance in power in favour of the doctor. This serves the dependency needs of some patients in some situations but carries with it many negative consequences. One view of medicine sees the role of the doctor as that of teacher or facilitator providing the conditions for health. All healing is seen as self-healing. The doctor can provide information and a therapeutic environment to allow the patient to make good choices for growth and health. Many situations exist in which this is not appropriate such as for patients with severe, urgent, life threatening conditions or for patients with diminished capacity to decide. However in most situations in family medicine with adult patients, the respect for autonomy leads to a situation in which supporting the patient to make independent decisions is a desired goal. Power differences may inhibit that goal so that patient empowerment becomes a tool for reaching it.

Empowerment may take many forms. Provision of adequate relevant understandable information to permit decision making is one aspect. Creating an environment in which the patient feels confident and competent to challenge the physician, ask questions and make a decision that serves their best interest is another.

There are objections to the use of the term empowerment. Some feel that in their work they meet patients at "eye level" and there is no power difference.

They would prefer to use the term enablement which implies a process of developing innate patient abilities to act rather than ceding or seizing power. Howie defines enablement as helping patients to understand and cope with their health and illness.¹ It is not clear if this distinction is important.

Power is determined by many factors in the medical world. Knowledge, status, wealth, access to resources, and the ability to make decisions all make up the doctor's power. The patient's power is derived from their ability to choose their physician or other medical service, their ability to pay, their own knowledge, wealth, status and their right to accept or refuse treatment. The threat of departure, censure and legal action can also contribute to the patient's sense of power, leading to the practice of defensive medicine.

How can an empowered or enabled patient population working in an egalitarian environment contribute to good medical care? Research on patient centred care has shown that this approach may improve diagnostic accuracy, therapeutic outcomes and patient satisfaction. It may reduce costs and risks by reducing the use of unnecessary tests employed in defensive medicine. It may reduce the risk of legal suits by improving communication and increasing trust.²

How can doctors and patients be educated towards an egalitarian style of practice? This usually begins with education of doctors in methods of communication. Valuing the patient as a per-

*Department of Family Medicine,
Sackler Faculty of Medicine,
Tel Aviv University, Israel

son and not as a disease, diagnosis or source of income is the first step. Valuing the patient's unique narrative or life history is another step. Work with students, trainees and practitioners on their own sense of well-being and self-worth is a third component that can decrease their need for a sense of power in the consultation.

The following clinical vignette was observed recently as part of a study of conflict between doctors and patients conducted in primary care in Israel: A 60 year old widow has suffered from diffuse pain in her arms and legs, insomnia and tearfulness for many months. Her mother and sister are both known to have osteoporosis. To evaluate her limb pain, he patient was referred to an orthopedic surgeon who recommended a bone density measurement. The patient returned to her family doctor to obtain a referral for the test. The doctor informed the patient that the test is not covered by her health insurance because her age and other factors. The patient was frustrated by the doctor's refusal of her request and stated that she could not afford the test. She asked the doctor for her help because she believed she could arrange the test for her. The doctor was frustrated by the patient's insistence and her ignorance of the rules of the health care system. She referred the patient to the clinic manager to determine if she had the authority to approve the test.

This episode demonstrates many aspects of the problems and challenges inherent in empowerment. Both characters in this drama, the doctor and the patient, suffer from the constraints of the health care system and their relationship. The both experience the emotions of anger, frustration and powerlessness in addition to the physical suffering of limb pain, the emotional suffering of depression and the existential suffering of loss. In addition, both participants are immigrants to the country

in which the study was conducted. Both have faced the struggles of displacement and re-integration into a new society. It is clear that both require support and encouragement along with tools to feel empowered in their special situation.

How then can we empower both doctors and patients to function well in a system with limited resources? On the medical side, the theory and methods of patient centred medicine can provide a useful approach. Medical students can be trained in communication skills and clinical methods based on patient centeredness. In early clinical exposure, students see patients as people. Each patient has a unique life story and a unique way of coping with health and disease. Patients live in a context outside of the health care system. Understanding the patient's world is a key to understanding the patient and how they cope with illness. In the clinical years the students can learn to value the patient's understanding of health and disease. This may be culturally determined so a cross cultural approach can help build bridges of understanding. Attention to patient explanatory models and patient expectations may be helpful. Often this is taught in simulation labs with trained actors. Group discussion with peers and skilled tutors is a proven method of heightening student sensitivity to patient needs. However this can also be taught in the real world following every patient encounter. Preceptors in general practice can be trained to help students to understand the reasons for every patient encounter and to elicit the patient's agenda. Students can learn to negotiate with patients by following the examples of their teachers. They can also learn methods of patient education by observation and experience.

On the patients' side, the physician has a significant role to play in patient empowerment. By addressing the pa-

tient's agenda, needs and expectations at every visit the doctor sends a strong message to the patient about how they should be treated. By educating and informing about the disease and treatment options they create new expectations in the patient for every encounter. Family physicians can help to prepare patients for their encounters with secondary or tertiary care. Patients can be taught to demand respect and information from their doctors and to stand up for their rights. Patients can help ensure cooperation between physicians by aiding in the flow of information.

There are many populations that require special attention to redress inequalities in medical care. Women, the elderly, the handicapped, ethnic minorities and others have often received less than egalitarian treatment compared to adult males from the dominant culture. Conscious efforts by physicians to address the special needs of these populations may help promote their empowerment.

But patient empowerment is not only the responsibility of medical practitioners. Patients have the right to organize themselves to receive the treatment they feel they deserve. Self-help groups are a good example of this approach. These groups can support and educate their members by teaching them ways to obtain the care they need. They can also lobby for research into their condition and work to educate practitioners about their needs.³

Patient empowerment can also result from social legislation. Charters of

patients' rights are one example of this. Patients' rights laws regarding safety, informed consent and free choice are another. Public education in the communications media is one approach to informing and empowering patients. Health administrators have a duty to teach the health care workers in their organizations ways to protect and promote patients' rights.

The notion of patient empowerment is a powerful and far-reaching concept because it challenges many of our fundamental concepts of the nature and the tasks of medicine. Much work needs to be done in educating patients and the profession on the paths to empowerment. Research is also required to assess the effects of patient empowerment on medical outcomes.

REFERENCES

1. Howie JG, Heaney DJ, Maxwell M, Walker JJ. A comparison of a Patient Enablement Instrument (PEI) against two established satisfaction scales as an outcome measure of primary care consultations. *Fam Pract* 1998 Apr; 15 (2): 165-71.
2. Stewart M. Reflections on the doctor-patient relationship: from evidence and experience. *Br J Gen Pract* 2005 Oct; 55 (519): 793-801.
3. Yaphe J, Rigge M, Herxheimer A, McPherson A, Miller R, Shepperd S, et al. The use of patients' stories by self-help groups: a survey of voluntary organizations in the UK on the register of the College of Health. *Health Expect* 2000 Sep; 3 (3): 176-81.

Originally published in: Rev Port Clin Geral 2007;23:365-7