Why the 'reason for encounter' should be incorporated in the analysis of outcome of care

INTRODUCTION

In the traditional medical model, the diagnosis takes a central stage in the delineation of treatment and care. The diagnosis as the determinant of the response to patients[1] has been the general line of medical education,[2] is at the core of most evidence-based guidelines and protocols,[3] and shapes the payment of physicians' performance.[4]

Since its renaissance in the 1960s, general practice has questioned the narrow focus on the diagnosis as the single determinant of professional performance and pursued a person-centred, holistic approach of health care;[5,6] diseases do not come in isolation but occur in the context of an individual with the disease, and it is to this broader context that health care has to respond.

Yet, despite the growing international support of people at the centre of health care, professional performance is mainly regulated and awarded in relation to the diagnosis, disregarding the broader individual and social context of diseases, even in countries with a long and strong primary care tradition.[3,7] Person-centredness should be part of every consultation. Clarifying the patient perspective parallel to the health problem can be a practical way of achieving this.

In this article we call on the discipline of general practice to clarify patients' perspectives in a systematic way, in patient care and research. We argue that patients' reasons to seek medical care reflect their personal needs and expectations, and we illustrate how the use of the International Classification of Primary Care (ICPC)[8] can help better understand the process and outcome of care. ICPC was a major step in the development of health informatics for primary care, by incorporating different aspects alongside the classification of health problems.[9] For this article, the 'reason for encounter'[10] is of particular importance. It enables the recording and coding of presenting symptoms, but also of requests (for prescriptions, referrals, or investigations) or cognitions and emotions, and worries, concerns, and fears, that bring people to contact healthcare services. In this respect, ICPC is a unique instrument to collect person-centred data for research and patient care.

PUTTING HEALTH PROBLEMS IN CONTEXT

Each contact starts with a patient's decision to see a healthcare professional: of the many who feel ill, and may consider to contact their GP, only a small minority actually do so.[11,12] This results in a consultation, home visit, or telephone- or e-mail consult, all referred to as 'consultation' in this article. The decision to consult can be determined by a variety of factors: patients may consult because of the severity and impact of their signs and symptoms. But the decision could also be triggered by worries and fears they, or their important others, experience. Alternatively, the decision may stem from the need for symptom relief or reassurance, or a request for a prescription or certificate. All these determining factors are reasons for contact or encounter.[8] This reflects the individual patients' perceived needs, expectations, and priorities around their health problem. Understanding individual expectations makes it possible for an individualised response, that patients value,[13,14] and which determines the effectiveness of treatment.[15] Therefore, it is important that GPs understand what it was that made the patient decide to come and consult, and that they are skilled to explore this. Unfortunately, current primary care data make it difficult to assess the responsiveness of care to the individual patient's context, or how this has influenced the process and outcome of care.

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REASONS FOR ENCOUNTER AND PROFESSIONAL PERFORMANCE

Consider three patients with an upper respiratory tract infection, who consult with the same physical symptoms, in all three cases caused by the same virus. The first consults because of a request for an antibiotic, the second because of fears of pneumonia, and the third to be advised of the possibility to go on holiday. In all three cases, the GP will come to a similar diagnosis — upper respiratory tract infection, in ICPC[10] terms: R74. Yet, the three consultations will follow quite different discourses, in acknowledgement of the three quite different personal reasons for contact — again, in ICPC[10] terms: 'request for a prescription (R50)'; 'fear of disease (R27)'; and 'advice (R45)' — leading to different responses from the GP. This may illustrate why variation in management of diagnoses between GPs can be explained to a large extent by the patient's reason for encounter.[16,17] Given these implications, establishing what actually brought the patient to the surgery should be an integral part of the consultation, approached with the same rigour as clarifying the health problem.

Patients' reasons to consult reflect their behaviour with regards to illness and disease. Identifying individual needs and expectations will make it not only possible to address, but also, where appropriate, to change them. This is where the 'doctor as a drug', the 'placebo effect', comes in; the exchange of words, touch, rituals, and other non-verbal exchanges[18] that are core aspects of every consultation. From this, it can be understood that the GP's response works through in follow-up contacts,[19] and the impact of continuity of care.

Medically unexplained symptoms (MUS) are an appropriate example in this respect, when this is a persistent problem for the patient over a longer period of time ('persistent MUS'). Establishing the absence of pathology may bring the biomedical agenda to a conclusion, but this may be insufficient to alleviate patients' symptoms or worries.[20] From quantitative studies it has become clear that persistent MUS are associated with insufficient initial responses by GPs to patients' psychological needs,[21] with an accompanying failure to change the patient's behaviour. Furthermore, persistent MUS are related to a mismatch between the

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reassurance that GPs provide and the patients' perceived need for a convincing explanation.[22,23] A randomised trial showed that when patients with MUS received a firm diagnosis and confident prognosis, substantially more of them improved, compared to MUS patients receiving uncertain diagnosis and prognosis.[19] An important finding in this respect is that patients do not always have psychological needs.[24] This asks for a better exploration of patients' expectations during initial and follow-up consultations, to improve the outcome of care;[25,26] in other words, a better clarification of the reason for encounter.

TOWARDS RESPONSIVE CARE

GPs are responsible for providing up-to-date, safe, and effective care. This is the professional agenda, which often involves pro-active care, directed at (aspects of) health problems that the patient may not be aware of (and for that reason would be unable to present).

Yet, this professional agenda should match the patient's agenda before it can yield success. Depression is a case in point. It is a common health problem, also in patients with chronic physical illness, and chronic care programmes recommend screening for depression as a part of routine care. Although screening increases the numbers of patients that will be diagnosed with, and treated for depression, this does not improve depression outcomes.[27] Explanations for this have been that 'screen-detected' patients have less severe depression,[27] but probably more importantly that 'clinically-detected' patients differ from screen-detected patients in their expectations of their GP, their valuing of their health, and what they consider appropriate support.[14] Health care that is enforced on patients without taking their needs or expectations into account is not effective. Consequently, health care should not only be directed at the health problem but be responsive towards patients' expectations.

The person-centred nature of primary care is in all probability an important determinant of the effectiveness of primary care: it achieves better population health despite performing less well in disease-specific outcomes compared to specialist care; the paradox of primary care.[15] This should be the more reason to include patients' perceived needs and expectations in the data of routine patient care and in the scientific analysis of general practice performance. As these expectations determine patients' decisions to consult, addressing expectations should take place right at the start of the episode of care and not as a mere afterthought further down the line.

CONCLUSION

The ICPC[8] has developed the method to record patients' reason for encounter and to collect important person-centred information during contacts and episodes of regular general practice care, and analyse it scientifically. Their relation to the diagnosis and diagnostic and therapeutic interventions will cast a more profound insight into what GPs actually do and how this determines the outcome of care. This will make it possible to collect and handle person-centred information in a practical way and align it with the use of old general practice values,[5] such as continuity, person-centeredness, and comprehensiveness, for the care of patients and for research.

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