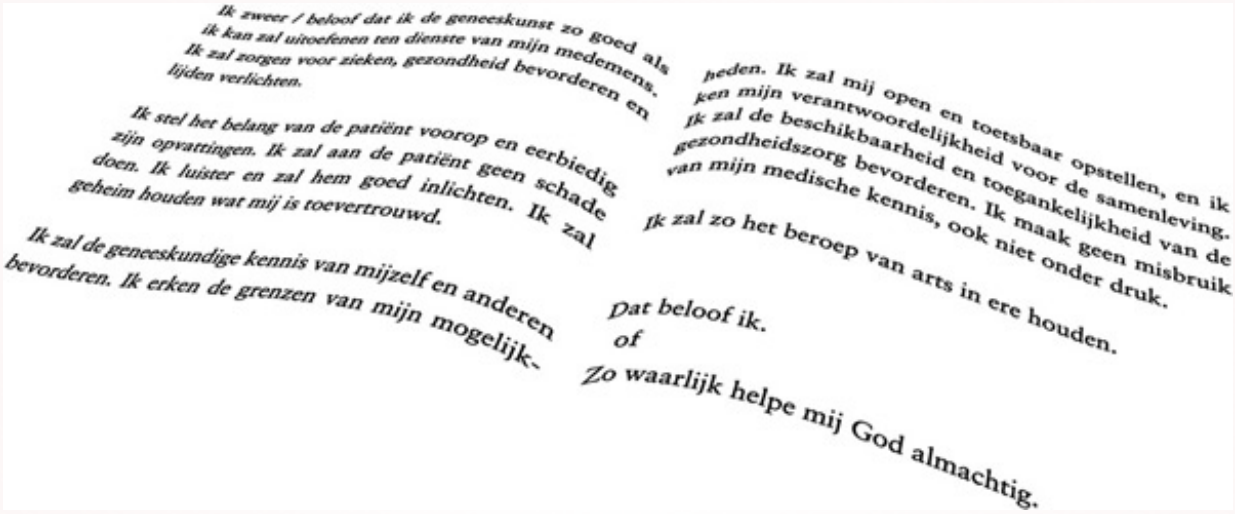
A Patient-Centered Approach in General Practice

Insights from professional-client interactions outside GP practice



Ik zweer / beloof dat ik de geneeskunst zo goed als
ik kan zal uitoefenen ten dienste van mijn medemens.
Ik zal zorgen voor zieken, gezondheid bevorderen en
lijden verlichten.

Ik stel het belang van de patiënt voorop en eerbiedig
zijn opvattingen. Ik zal aan de patiënt geen schade
doen. Ik luister en zal hem goed inlichten. Ik zal
geheim houden wat mij is toevertrouwd.

Ik zal de geneeskundige kennis van mijzelf en anderen
bevorderen. Ik erken de grenzen van mijn mogelijk-

peden. Ik zal mij open en toetsbaar opstellen, en ik
ken mijn verantwoordelijkheid voor de samenleving.
Ik zal de beschikbaarheid en toegankelijkheid van de
gezondheidszorg bevorderen. Ik maak geen misbruik
van mijn medische kennis, ook niet onder druk.

Ik zal zo het beroep van arts in ere houden.

Dat beloof ik.
of
Zo waarlijk helpe mij God almachtig.

"Hippocratic Oath"

MSc THESIS

MAARTJE MEIJERS

A Patient-Centered Approach in General Practice

'Insights from professional-client interactions outside GP practice'

MSc programme
Applied communication Science

Specialisation
Health and Society

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PREFACE

Wageningen, 15-08-2015

Dear reader,

This thesis forms part of my MSc graduation for the study Applied Communication Sciences with the specialization Health and Society at Wageningen University.

As a child I always wanted to become a doctor. Unfortunately I was not placed for the study of Medicine and this dream fell apart. Looking back, I can truthfully say that I am grateful for what an alternative academic journey has brought me. Rather than being a doctor myself, I discovered the value of combining medical, social and communicational sciences. In addition, I have every confidence than we can create a bright future through continuous effort to build bridges between these disciplines.

As part of the master's programme, I went to Spain for an internship where I evaluated a 'Health Promoting Hospital' primarily from a patient's perspective. While finding myself in a hospital setting, the fact that the communication between doctor and patient had a key influence on the study outcomes intrigued me. Back in the Netherlands, in February 2015 I got the opportunity to have a closer look at the interaction between GPs and patients. Exploring opportunities that may be beneficial for primary care exactly touched upon my interest.

Foremost, this study would not have been possible without the supervision of Laura Bouwman. Thank you for all your appropriate guidance that helped me in the battlefield of coherent terminology, and for teaching me the finer details of conducting research. Besides, you conveyed your efforts for reducing gaps between science and practice with contagious enthusiasm.

Furthermore my thanks go out to Ton Dapper, a general practitioner who is passionately trying to find new ways of effective communication in GP practice today. Your great enthusiasm and thinking along with me has been a great help. I highly appreciate the possibility to attend the general practice, which has been an enrichment of my study. Additionally, I would also like to thank the nurse practitioner who allowed me to have a look in her daily practice as well.

A special thanks to all the interviewees who shared their stories with integrity, sincerity and transparency. The insights resulting from these inspirational interviews are a true pearl of this research.

Finally, due to the sensitive and complex situation of GP practice nowadays, I would like to express my appreciation to all the people that offered me a helping hand in the process of writing this thesis. For me personally it has been a learning adventure in which I was particularly challenged to balance between my modesty and critical thinking. In any respect, I feel I have given everything I had.

To conclude, I have developed great admiration for the profession of the general practitioner. I hope to offer positive prospects for a future in which primary care will still be able to serve the health needs of our population.

Maartje Meijers

about doctors….

“The doctor of the future will give no medication, but will interest his patients in the care of the human frame, in a proper diet and in the cause of prevention and disease”

(Thomas A Edison)

and patients…

“the patient should be made understood that he or she must take charge of his own life. Don’t take your body to the doctor as if he were a repair shop”

(Quentin Regestein)”

SUMMARY

Background: The general practice fulfils an essential task to serve the health needs in society. Because the challenges in health care today are different and more complex than ever before, the GP-patient relationship has changed radically. The patient has been increasingly acknowledged as an active partner in health care and should be empowered to take on joint responsibility. In turn, GPs have a key role in involving patients and their viewpoints and should be skilled to achieve supportive consultation goals. Hence, a Patient-Centered Approach (PCA) in GP practice is suggested to be a fruitful way to strengthen health care interactions and to ensure social acceptability of the inevitable health care reforms.

Aim: Despite the considered benefits, PCA is threatened to become subordinate through predominating conceptual, practical, and ethical considerations. Therefore the aim of this study is to gain insight into the effectiveness and barriers of PCA in GP practice and into the action that is required to overcome these barriers. Interestingly, PCA is not unique to primary care. Also outside the health care setting interpersonal interactions take place in various domains (psychological, organizational, political, educational) and on different levels (individual, collective) across populations. Assessment of PCA in professional-client interactions outside the GP practice could identify active elements that may advance PCA in GP practice.

Methods: To accomplish the research aim, this study had a qualitative descriptive design and consisted out of 3 research methods. First a literature study was established in order to identify the current state-of-the-art of PCA in GP practice. Secondly, an explorative study in a general practice served as a field experience for PCA in GP-patient interaction. Thirdly, qualitative interviews were conducted for which purposive sampling was used to select professions outside the GP practice who were considered to offer insight into active elements of PCA in professional-client interactions. The emerging insights from all the three research methods were compared and led to the identification of shared insights for advancing PCA in GP practice.

Results: Definitions and results of PCA remain mixed, which hamper its full potential. In a first attempt to clarify the concept, the literature study reduced the identified definitions into 5 key dimensions on different levels. Common dimensions related to the *patient's context, patient's agency*, *professional support*, and a *supportive system*. In particular the dimension of *doctor-patient interaction* was shared unanimously, whereupon this study justified it as a key component for PCA in GP practice. Currently, hierarchical tensions within GP practice remain to result in unclear roles of both GP and patient. Although interviewees acknowledged the complexity that could arise from hierarchical structures within their interactions, this not deterred their expected or desired outcomes. Their perceived inferiority of hierarchical tensions was related to the absence of strict guidelines and accountability that resulted in a sense of freedom. For a large part this enabled a balance between authority and autonomy at personal discretion. Overall, professionals managed an appropriate distance that enhanced professional's empathy and credibility and simultaneously led to an increased awareness of clients that control, responsibility, as well as opportunities were in their own hands.

Conclusion: Literature shows a major contradiction in the acknowledged potential of PCA while inconclusive results still hamper its application. The current system's characterisation of general practice still seems to align with predominant evidence-based thinking, which leaves little room for own interpretation of PCA in general practice. Therefore it is urgent to restore the essence of GP practice that ideally is characterized by a context-sensitive and integral working method that pays attention to the patient as a whole and to the meaning of their complaints. Addressing PCA on all levels of care establish better coordination, integration and efficiency of care and can overcome barriers for implementation of PCA through: incorporating organizational changes that disburden primary care from systemic pressure and productivity-driven health care; helping physicians in achieving collaborative partnerships with patients; and empowering patients towards agents who are involved in their own health and well being.

Keywords: Exploratory research, General practice, Patient-Centered Approach, Professional-client interaction

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INTRODUCTORY CONSIDERATION

de patiënt. Maar wat hij
is doorgeslagen bemoeizuc
zorgverzekeraars en grote m
de farmaceutische industrie

Door **Anneke Stoffelen** Foto's **Marcel van den**

Een groepje huisartsen stond vorige maand om middernacht voor het ministerie van Volksgezondheid in Den Haag. Ze hingen *Het manifest van de bezorgde huisarts* aan de deur. 'Het roer moet om in de gezondheidszorg', luidde de boodschap. 'Erken dat het model van marktwerking mislukt is', schreven de huisartsen aan minister Schippers (VVD) en de zorgverzekeraars. En: 'Toon vertrouwen in de deskundigheid van de beroepsgroep. Stop dan ook de grenzeloze verzameldrift van nutteloze data.'

Het manifest raakte een open zenuw bij collega-artsen. Afgelopen maand ondertekenden ruim 7.300 huisartsen het stuk online, tweederde van de beroepsgroep. Waar komt die opwinding vandaan?

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Afvinkwerk

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[" Last month, a number of General Practitioners stood in front of the ministry of Public Health in Den Haag. They brought the 'manifest of the worried general practitioner' with them. 'There is a need for radical reform', was the message of this manifest…

The manifest became a running sore by colleague practitioners. In the last month, more than 7300 general practitioners signed the manifest online, two-thirds of the profession. Where is this agitation coming from? "…]

* Volkskrant, 10-04-2015

In recent years the health care system increasingly has faced challenges due to population growth, rise in chronic diseases, breakthroughs in treatment of health conditions and market forces in health care. This has resulted in a system that is under pressure and financially unstable (Van Royen et al., 2010; Mezzich et al., 2010). The tendency towards an overworked and uncaring general practice has led to calls for (infra)structural changes (Epstein & Street, 2011). Of prime importance is the role of both the patient and caregiver that has changed radically (Jung, 2001). Previously, a doctors' approach was paternalistic and asking the patient "Where does it hurt?" led to determination of the pathological condition. However, the awareness rose that health and disease are not static but influenced by biological, social, behavioural and economical determinants. Interaction between these determinants results in health developing over an individual's lifetime. Health was no longer seen as solely successful treatment of disease but should be complemented by an everyday life perspective that focuses on what creates health.

In parallel, the definition of health revised from "health as a state of complete physical, mental and social well-being" (WHO 1946) towards a new dynamic concept of "health as the ability to adapt and to self-manage" (Huber, 2011). The concept encompasses the potency to be or feel

healthy even when disease may have been diagnosed. The emphasis on resilience and self-management enables personal growth and fulfilment of life goals and therefore exceeds addressing patients in their sick role. Applying such a positive health perspective in general practice requires adaptive interactions between doctors and patients. The WHO refined adaptive interactions for quit some time as "taking action in *partnership* with individuals to *empower* them through mobilization of human and material *resources*" (WHO, 1998). Through a process of shared empowerment, people can gain greater control over decisions and actions affecting their health. By establishing closer relationships between people their life goals and a sense of how to achieve them, autonomous feelings can strengthen. On that account, autonomy can provide direction to a persons' life, give meaning to health and wellbeing and be a stimulus for self-actualization. Though, "action in partnership" and "mobilization of resources" emphasizes an important role for the health care provider. Facilitation of skill development and (access to) information should be provided in a stimulating and reflecting way while taking into account the patient as a whole. This process requires motivation, time, courage and renewed insights with regard to medical responsibility and professionalism. Although general practitioners may be willing to cooperate, they often get entangled in the reality of everyday practice. On the one hand practitioners face multiple challenges like systemic pressure, lack of time and rapid technological developments. On the other hand, the patient has become more vocal and demanding, which roughly tends towards the view of 'patients as consumers'. Though, what patients want does not always reflect what they need. In some occasions patients may express unrealistic expectations with regard to consultations, treatment and outcomes. A hidden risk is the tendency towards indifferent behaviour and urging doctors to respond by "you name it, we've got it".

All in all, motivational crises are prowling whereupon Patient-Centered Medicine (PCM) is threatened to become subordinate (see newspaper report). As a result practitioners may feel forced to cut back on the doctor-patient interaction in an 'old' paternalistic manner. Despite its potential, current approaches seem not to fulfil the prerequisites for provision of communal, effective, efficient and Patient-Centered Care (PCA). The general practice today lacks consequent exchange of information, mutual discussion of treatment options, consideration of patients' lasting questions and understanding of what is explained.

However, even though both GPs and patients are struggling, expectations and judgements by patient and practitioners still display major similarities and correspondingly underline the importance of a Patient-Centered Approach (PCA) (Jung, 2001). Besides, it should not be forgotten that an essential milestone has already been reached; the changed roles of practitioners and patients obviously have granted that patient-centeredness deserves to be part of the consultation. However, achieving a milestone does not suggest being complacent. Due to ongoing transformations in our society and enduring changes in our need for health care, it does not get us anywhere by "waiting for evidence" before taking action. Considering the famous words "Noblesse oblige" implicates to keep looking ahead and responding to new developments while retaining the good.

READING GUIDE

The first chapter provides an introduction to the topic of a Patient-Centered Approach in the GP practice and describes the research interest including the identified research gaps. Chapter 2 continues with the research aim and the research questions, followed by the theoretical and structural framework. Chapter 3 involves the research rationale and portrays an overview of the study and of the methodology, which consists out of 3 different methods (*literature study, explorative study and qualitative interviews*). The chapters 4, 5, 6 encompass each individual research methodology followed by their results. In chapter 7 all results are gathered in order to answer and discuss on the research questions. The final chapter 8 provides the conclusion.

1. INTRODUCTION

1.1 Research Interest

General practice: continuity and generalism

In primary care setting, people present themselves when having health problems and seeking for professional care. For this reason, the General Practice (GP) fulfils an essential task with regard to health needs in society and holds a prime position for effectiveness of the health care system (van Weel, 2011). The WHO therefore regards primary care as forming the basis of the health care system (WHO, 2009). The strength of primary care mainly relates to the continuity of care and its general nature.

Generalism: Diseases and problems in primary care are characterised by a generic character. In contrast with other health care professionals or specialists, the activities of a GP mainly involve a contextual and integral working method, focused on risk assessment and enhancement of patients' self-healing capacities.

Continuity: Continuity of care in general practice can take on different forms: continuity across the health care spectrum relating to other professionals directly involved (for e.g.: a pharmacist or specialist); continuity of information (integrated health care systems with all relevant patient-, and prescription information); and continuity of care over time. Within the Netherlands –and other developed countries- almost every person has contact with his or her family physician at least once a year (Noorman, 2012). The continuous relationship with a defined population over time is also considered as a gatekeeper's function. A general practitioner is the first medical professional within the health care spectrum to take decision on diagnosis and possible prescription of medicine. The fact that nine out of ten patients are not referred to secondary care emphasizes a clear responsibility for the general practice (Jung, 2001).

Both generalism and continuity of care strongly emphasizes the personal dimension of primary care. Although this personal dimension is vital for the general practice to be successful (Hudon, 2013), its acknowledgement knows a long history.

From Evidence-Based Medicine to Patient-Centered Medicine

In the early 1990s, the concept of Evidence-Based Medicine (EBM) entered the scientific literature, involving basically a positivistic, biomedical perspective. When considering medicine merely as a cognitive-rational enterprise, EBM can offer the best available evidence about the most adequate treatment. Nowadays, EBM is still viable because numerical evidence is considered as a legitimate part of medical practice and judgement (Little, 2013).

However, its neglect of psychosocial factors has lead to severe critiques and has resulted in an extensive history of attempts to make care more considerate and humanistic (Mezzich et al., 2010).

The challenges in health care today are different and more complex than they were in the 20th century. Early diagnosis and the simultaneous presence of different diseases have both increased. Rather than the sum of care for individual diagnoses, attention to patients' problems in the context of their multimorbidity (multiple coexisting diseases) is now at least as important (Starfield, 2011), which cannot be reduced to single objective measures (Sacristán, 2013). Besides standard metrics related to physiological outcomes, survival or mortality ("hard" outcomes), the focus shifted toward symptoms, signs and experienced outcomes by patients like for instance social and physical functioning and quality of life ("soft" outcomes) (Godlee, 2012; Reuben, 2012). Therefore, traditional diagnosis by professional observations, interpretations and laboratory values require complementation of adequate recognition of health problems that are perceived important to people (Starfield, 2011).

Additionally, the rapid growth of technology, eHealth and other media has expanded the availability of medical information and knowledge (Choi, 2015). Because medical information gained accessibility, patients have become more interested in their health care. A growing number of patients consider themselves as medical consumers and claim the right to appropriate health care based on the recognition that they deserve special treatment. Through disposing of alternative opinions about diagnosis and treatment, patients' expectations and preferences have made their way (Dwamena et al., 2012).
Long traditions of the belief that professionals know what is best for their patient have made room for the view that patients are, beside the professional, experts on their own bodies, symptoms and situations (Holmstrom & Roing 2010). This view has been captured in what is called '**Patient-Centered Medicine'** (PCM). In this approach, patients' individual needs, preferences and uniqueness of a person are taken into account. Contrasting biomedicine on its own, patient-centered medicine has a humanistic, biopsychosocial perspective that considers the person as whole and is seen as a core element for integrative care (Maizes, Rakel, & Niemiec, 2009; Greenfield, 2014).
Against the background of all health care transformations, the paradigm shifted from disease to patient to person (van Weel, 2014), and thereby moving away from a 1-size-fits-all approach (Mezzich et al, 2010). Patient-centered medicine does not imply individualization of treatment (the best for every average patient) but urge for individualization of therapeutic decisions (the best for every individual patient). As a result, PCM rather than EBM has the potential to improve health outcomes of individual patients in everyday clinical practice.

Patient-Centered Care
Efforts to promote **Patient-Centered Care (PCC)** depend on the quality of personal, professional, and organizational interactions and therefore should consider the impact on all these three levels (Epstein & Street, 2011).
Internationally, the Institute of Medicine (IOM, 2001) identified the concept of patient-centered care as of one the six domains of quality as a key to efficient and effective health care. It is aimed for (by healthcare politicians and governments) that patient-centered care leads to more active patients that can better self-manage their care and thereby abating the economic constrains on the health care system (and increase efficiency and quality of care) (Street et al., 2009).
Since the WHO has disseminated active patients advocacy in health care as early as 1977 (WHO, 2009), the role of the patient as an active partner in health care has been increasingly acknowledged (Dwamena et al., 2012; Bergstresser, 2013; Epstein, 2014a). To support individuals to have greater interest in their own health, several promoting initiatives have been developed (Hibbard & Gilburt, 2014). These initiatives comprise for instance public health programmes aimed at behavioural change and initiatives for shared decision-making. Positive associations have been demonstrated with increased knowledge, satisfaction, treatment adherence and less use of health services (Smith et al., 2010; Zill et al., 2013). On *organizational level*, systems changes should unburden a productivity-driven and overworked general practice. The shift from traditional biomedical models toward more symmetrical models simultaneously emphasised the transformation of physicians' expert role toward a more supportive role. From a *professional level* this requires skilled physicians who are able to achieve supportive consultation goals of solidarity, empathy and partnership. Physicians have a key role in "inviting" patients to be involved in health care (Ward et al. 2012). Involvement can influence behavioural, physical and physiological responses to health and illness (Zill, 2013). Patients report lower symptom burden, use less health services and both doctors and patients gain satisfaction (Little, 2013). In addition to patient-centered care as a professional evolution, it is driven by a refocusing of medicine's regard for the patients' viewpoint. Health care systems have incorporated that patients constitute an essential component and own the right to be fully informed and involved (Choi, 2015). Consultations have transformed into dialogues that engage patients as active partners. In turn, patients have a role in actively seeking information, asking questions, taking initiatives and giving direction to the interaction. From a *patient level* this requires skilled and empowered patients who can take on joint responsibility.

Generally applicable to all levels, the desired extent of organizational, professional and patient involvement has shown to be highly heterogeneous mainly depending on the doctor-patient relationship and personal characteristics and (Clayton, 2011; Hudon, 2013).

Patient-Centered Approach: GP-Patient interaction

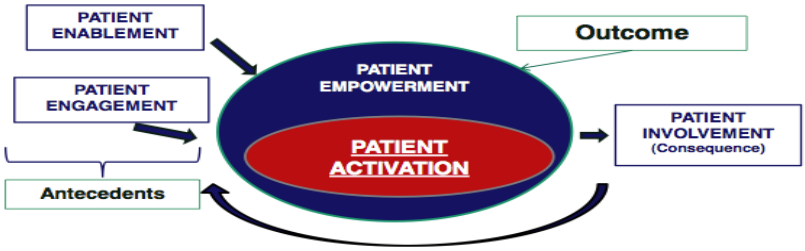
An important starting-point in the development of PCC has been mutual investment by doctors and patients in an ongoing relationship over time (Cocksedge, 2011). Hence, is argued that the **Patient-Centered Approach (PCA)** implies a paradigm shift in doctor-patient relationship (Sacristan 2013) and is determined by the quality of interactions between doctor and patient. For quality of interaction, the role and responsibility of doctors and patients are essential factors. Only when both make efforts in the direction of patient-centeredness, beneficial effects on health outcomes are enabled (Brand & Stiggelbout 2013; Ishikawa, 2013). Despite the collaborative nature of health care interactions (Mead & Bower, 2002), patient-centered care mainly has been defined from the viewpoint of physicians' behaviors, which increased demand on their interpersonal skills (Stewart et al. 2003; Epstein & Street, 2011; McCormack et al., 2011). Nevertheless, doctors appear to vary in their willingness to make shared decision. To avoid regret that is caused by negative outcomes of patients' choices (Kenealy, 2011), doctors often interrupt patients' narratives and use close-ended questions to control the consultation (Epstein, Flowers & Beckman 1999). Though, patients may typically show instable preferences and often expect a greater benefit from the consultation than is available in practice (Kenealy, 2011). Hence, next to competence and attitude of doctors that is supposed to facilitate the consultation, the competence and responsibility of patients are required as well (Clayman, 2010). Where several individuals are very proactive and self-determined about their health, many other individuals are more passive and lack autonomous feelings (Hibbard & Gilburt 2014). Encourage participation alone is not enough if strategies do not pay attention to patients' capacities to reach authentic participation that ensures their autonomy. Mutual participation requires communication skills and sensitivity towards the needs of every individual patient. Meanwhile, there have arisen different strategies to revise doctors and patients' position in health care and in their continuous relationship.

Patient-Centered Strategies

The premises of patient-centered care depend on dynamic, supportive and contextual approaches over time. Consequently, patient-centered approaches may only be partially or not be achieved when restricting to traditional philosophy and methods so far. Patient-centered care can in itself be the goal of a doctor-patient interaction and could be achieved by means of several patient-centered strategies. Alternating the biomedical perspective, the strategies share the emphasis on autonomy in health care interactions (WHO, 2006). Important is the notion of "agency" which means that autonomy cannot be given to people or done to someone, but emerges from a more sustainable process where autonomy is achieved together with the people themselves (WHO, 2006).

In practice the strategies have many common and overlapping elements, which may undermine their usability. To consider their unique contribution, the study of Fumagalli (2013) attempted to position all different strategies (Figure 1). Patient empowerment has been regarded as the overarching concept and was identified as followed: "the acquisition of knowledge, self-awareness, skills, personal attitudes in controlling and influencing own behavior for improving quality of life and health decision-making by means of patient-physician relationship, communication, access to information and health education" (Fumagalli, 2013).

Figure 1: Patient-Centered Strategies*



*Adopted from Fumagalli, L.P. (2013) Empowering the Patient: antecedents and consequents from a systematic literature review

In the field of health care, empowerment has initially been defined by Feste and Anderson (1996) as ' a philosophy that is based on the assumption that for being healthy, people must be (en)able(d) to elicit changes in both their personal behaviour and in their context that influences their lives'. Furthermore, patient empowerment can be seen as the granting of patients to take an active role in decision making about their health care. Active patients refer to a more behavioral concept and have been defined as 'an individual's knowledge, skill, and confidence for managing their health and health care' (Hibbard & Gilburt 2014).
"*Patient empowerment*" and "*patient activation*" overlap in their aim at improving a set of individual elements (like for instance knowledge, skills, confidence and personal capabilities) in order to increase self-management of health and disease (EHMA, 2013). They focus on changing the patient role from care recipient to an active patient that has power and control on their health status in general (empowerment) and particularly in presence of specific health status or diseases (activation). As an effect of both patient empowerment and activation, the concept of "*patient involvement*" can be interpreted as a *consequence*. It refers to an increased intensity of participation when patients are empowered to develop an active role in their health care. It may also be valid the other way round and entails the improvement of patient knowledge and skills in self-care. Preceding empowerment and activation, the concepts of "*patient engagement"* and "*patient enablement"* can be interpreted as *antecedents*. Engagement refers to forms of patients' participation in their health care whether enablement encompass all actions, activities and interventions that aim to develop required knowledge and capabilities of patients to cope with diseases and improve their quality of life.

Summary table of the introduction

Summarizing the introduction, the overview in table [1] highlights each level of PCM, PCC, and PCA. Overall, PCM involves the complementary perspectives of EBM and PCM. For PCC, the interactions between organizational, professional and patient all influence the provision of patient-centered care. Finally, PCA equates with the interaction between GP and patient and could be achieved by means of several patient-centered strategies.

Table 1. Summary of the introductory concepts: PCM, PCC, PCA

Perspective	**Patient-Centered Medicine (PCM)**	=	Evidence-Based Medicine (EBM) - provider-centered - disease-oriented care - "hard" outcomes - visit-based care	Patient-Centered Medicine (PCM) - patient-centered - patient-centered care - "soft" outcomes - care over time	
Structure	**Patient-Centered Care (PCC)**	=	Organizational elements - Supportive system - Finances - Time - Power sharing - Innovation	Professional attributes - Professional competences - Interpersonal skills - Personal characteristics - Professional Responsibility	Patient attitudes - Perspective on health and disease - Perception of care - Participation in care - Personal characteristics
Process	**Patient-Centered Approach (PCA)**	=	**GP –Patient Interaction** ↓		
Strategies		=	"Empowering the patient" Patient activation		
	Antecedents		Patient enablement Patient engagement		
	Consequents		Patient involvement Autonomy		

* Adopted from "A system theory of patient-centered care" (McCormack and McCane, 2006) and EHMA Annual Conference (2013)

1.2 Research Gap

Conceptual ambiguity

In spite of an increased amount of research and health policy around the concept of patient-centered care, consensus on a specific definition is still lacking. A frequently used definition of patient-centered care is "respecting and responding to individual patient preferences, needs and value and ensuring that patient values guide all clinical decisions" (Institute Of Medicine, 2001).

The variety in definitions and an understanding how patient-centered approaches, strategies and outcomes differ, complement or even may strengthen each other, hinders the implementation of patient-centered approaches (Epstein, 2014b).

The conceptual ambiguity has various consequences and may foster heterogeneous use of the concept, imprecise measurement and inconsistency of results (Epstein, 2014b). Some studies found positive relationships between patient-centered care and health outcomes (Rathert, Wyrwich & Boren, 2012) while other studies are missing significant results (Dwamena et al. 2012; Sanders et al., 2013). Although the pathways are theoretically promising, the mechanisms accounting for the health outcomes remain non-conclusive. Many of the measures confound health behaviour with health outcomes (Epstein & Street, 2011). Situations in which trust and treatment compliance have increased but health conditions have worsen, may lead to controversial convictions whether patient-centered care has been –successfully- achieved or not.

As a result, the efforts towards patient-centered approaches are likely to remain superficial and unconvincing. Consequently, improved measurement and conceptual clarification have taken on some urgency (Epstein, 2014b).

Practical impediments

Conceptual ambiguity may also constitute differences in perceptions of a clinical encounter between patients and professionals, lack of knowledge, scepticism and uncertainty (Little, 2013). Consistently, other practical barriers involve lack of appropriate interpersonal skill training of GP's, time constraints and a strong tradition of biomedical medicine (Brand & Stiggelbout, 2013). These strong traditions are maintained by clinical trials that are limited to standard biomedical metrics or biomarkers and therefore do not identify the nature and extent of health problems as experienced by patients. Following, guidelines that have been justified on the basis of the evidence-based outcomes of these trials are not developed with consideration of the nature of the primary care setting. Physicians adhering to these clinical guidelines are predisposed to emphasize the management of diseases rather than the reduction of symptoms and signs as experienced by patients. As a result, determination of the level of evidence of benefit in primary care composes practical barriers in research as well as in practice.

Currently in GP practice, EBM and PCM focus on different elements of health (care) and seem to belong to different worlds. However, EBM and PCM are not contradictory but complementary movements. Interchanging ideas and principles can be beneficial for integration of these worlds (Bensing, 2000; Sarcristán 2013).

Ethical considerations

The relative importance of an individual patients' viewpoint versus the level of evidence-base composes barriers on a more ethical level. Ethical questions remain whether person-focused care by its non-disease focus disadvantage any level of evidence-base (Bergstresser, 2013).

A major concern behind the growing recognition for patient-centeredness is an ethical view that patients should be treated as persons and is perceived as the 'right thing to do' (Entwistle, 2013). Patient-centered dimensions often invoke a way of seeing people as agents who are actively involved in their own health and well-being. The fear exists that if patients are let too loose, doctors may be overwhelmed by unbearably dependant and demanding patients. Some patients are responsive; other want to discuss; some ask questions; and other do what their doctor wants. The better the doctor understands the patient, the more the patient is likely to take 'the appropriate action'. However, the observable signs of a patient's preparedness or wish

to talk, communicate or to remain silent, can seldom be described by the usual terminology. Questions that arise are how and for what professionals should look for in order to determine whether their way of delivering care is 'patient-centered? (Davis, 2013). Furthermore, it is argued that a *person*-focus rather than a *patient*-focus is critical for understanding needs and problems as experienced by patients themselves (Starfield, 2011). Patient-focused care may underestimate the importance of long-term relationships with patients independent of care for specific diseases episode. By contrast, person-focused care is thought to better considerate the duration of time over which priorities should be set (short or long term). It therefore incorporates attention to relevant skills such as the accumulation of knowledge and resilience to health threats, which are critical as patients move from one health problem to another (Starfield, 2011).

2. RESEARCH AIM

As a response to the complex challenges in health care today, PCM is thought to generate more active patients who can better self-manage their care which increases efficiency and abates the economic constrains on the system (Street et al., 2009). On the level of PCC this implicates a professional evolution driven by a refocusing of medicine's regard for the patient's viewpoint. As a result, the clinical consultation transformed into a dialogue that should engage patients as active partners. PCA in GP practice therefore mainly implies a paradigm shift in the GP-patient interaction.
An important starting-point for PCA has been mutual effort from both GP and patient toward an ongoing relationship over time (Cocksedge, 2011). On the one side, physicians have a key role in inviting patients to be involved in health care. On the other side, patients should take on a role in participating, providing direction and active information seeking. Though, the desired level of patient involvement appears to be highly heterogeneous, depending on the doctor-patient relationship and their personal characteristics (Clayton, 2011; Hudon, 2013). Achieving PCA thus equates a doctor-patient interaction that requires interpersonal attitudes and skills. However, due to predominating conceptual ambiguity, practical impediments, and ethical considerations, patient-centeredness is threatened to become subordinate. Therefore the aim of this study is to gain insight into effectiveness and barriers of PCA in GP practice and into the action that is required to overcome these barriers.

However, PCA is not unique to primary care and is also applied in areas like health related law, medical education, research and quality assessment (Sacristan, 2013). Also outside the health care setting interpersonal interactions take place in various domains (psychological, organizational, political, educational) and on different levels (individual, collective) across populations (WHO, 2006; Hudon et al., 2011). When considering its universality, these interactions can be described in terms of 'provider-consumer-' or 'professional-client interaction'. All terms have in common the profession-related *guidance* by provider or professional and on the other hand the *guiding* autonomy of the consumer or client. For achieving such a guidance-guiding balance, supportive interactional skills and ongoing accessibility hold a prime position. This reveals a clear link with work fields such as coaching, counselling, alternative healing and rectory (Cocksedge, 2011). The applied supportive skills may reduce client's dependency on the (health) professional while enhancing the capacity and sustainability to behavioural change (WHO, 2006). However, behavioural change is a complex and ongoing process that can change, grow or diminish over time. As a result, outcomes are not by definition indisputable, controllable or predictable and are not indisputable in hands of the professional. Repeatedly, this underlines a professionals' facilitative role rather than a prevailing one. This reveals another link with work fields and areas such as academic institutions (Weiss, 2002), government agencies (Mattessich, 2001), lay health workers (Jacobs, 2003), social movements and community organizations (Yassi, 2003) and political will (in WHO, 2006).

Similar to doctor-patient interaction, all interpersonal interactions are embedded in socio-physical and political context whereupon core values for applying a guidance-guiding balance can be found in many different domains of life. As long as the anchors of these values for doctor-patient interaction are threatened to become subordinate, it may be an opportunity to consult guiding-guidance balances in professional-client interactions outside the primary care setting. Following on the aim to gain insight into barriers for implementing PCA in GP practice, characteristics of professional-client interactions outside GP practice are assessed and ought to provide insight into the action that is required to overcome these barriers.

2.1 Research Questions

Its broad applicability indicates why PCA is a relevant health issue of today. It has the potential to address the whole person including individual competences embedded in social and physical context and could positively contribute to GP-patient interaction. Due to conceptual ambiguity, practical impediments and ethical considerations (Epstein, 2014a) all efforts made towards PCA are likely to remain superficial and unconvincing (Scholl et al., 2014). Therefore the research question of this study is:

'What are barriers towards Patient-Centered Approaches in GP practice and what action is required to overcome these barriers?'

SUB RESEARCH QUESTIONS

In order to answer the research question, two sub research questions have been formulated.

While efforts for PCA are undertaken on large scale, questions remain on why PCA should be used, what it means and crucially how health services, professionals and patients have a role in this. For achieving PCA's full potential, clarification on the concept, use, and measurement have taken on some urgency (Epstein, 2014b). On that account, insight is needed into the state-of-the-art of PCA, which is formulated as a first sub research question:

1. *'What is the state-of-the-art of PCA in GP practice with regard to effectiveness and barriers for application'?*

Secondly, due to the fact that PCA is embedded in socio-physical and political context, it is applicable to many different domains of life in terms of 'professional-client interactions'. As long as PCA in 'doctor-patient interactions' is threatened to become subordinate, this study aims to gain insight into action that can overcome this by assessing characteristics of professional-client interactions outside GP practice, which is addressed by a second question:

2. *'What are characteristics of PCA's in professional-client interactions outside GP practice'?*

Overall, results may provide new insights for applying PCA in general practice. It may positively contribute to PCC at all relevant levels regarding *organizational* changes that disburden primary care from systemic pressure and productivity-driven health care; helping *physicians* in achieving collaborative partnerships with patients; and empowering *patients* towards 'agents' who are actively involved in their own health and well being.

2.2 Research Frameworks

The following section elaborates on two different frameworks, which form a base for the research. The first is a theoretical framework which will provide more profound background information with regard to the topic of patient-centered approach. The second structuring framework is based on a review of Hudon et al. (2011) that summarized the main shortcomings of patient-centered approaches in literature. To construct a useful second framework in this report, the main elements by Hudon et al. (2011) have been operationalized into the following framework elements (1) Core Values & Mindset, (2) Tools & Techniques, (3) Measurement & Indicators. These elements will be addressed within all the research methods in order to structure and answer the research questions.

2.2.1 Theoretical Framework

Carl Rogers (1902-1987): A quiet revolutionary

Rogers became a clinical psychologist in 1920 when the field was only at its initial stage. Rogers' work as a psychologist was particularly influenced by the emphasis on patient's self-insight and self-acceptance within the therapeutic relationship. He articulated his own views on effective counselling and psychotherapy by introducing his "non-directive" method. Within this method he advocated the term "client" rather then "patient" based on a hypothesis about human growth and personality change whereby 'the client self has the capacity to understand those aspects of life which are causing him pain and the tendency towards self-actualization and maturity to achieve a greater degree of internal comfort' (Rogers, 1950). Thereby, he entrusted the therapist to create a psychological atmosphere in such a way as to permit strength and capacity for this tendency. To achieve a therapeutic atmosphere the method avoided questions, advice, suggestions, interpretations, or other directive techniques but fully relied on a process of accepting and listening to the client. As refined in one of his essays (Rogers, 1957), he reduced this process into three "core conditions" of the therapeutic relationship. The first he called "unconditional positive regard" by fully accepting the client for who he or she is, with both positive and negative impulses and feelings. The next condition is "empathic understanding" which he defined as "the professional's sensitive ability and willingness to understand a client's feelings, thoughts and struggles from the client's point of view and thereby adopting his frame of reference (Rogers, 1949; pp 84). The third condition he called "congruence" which referred to the professional to be genuine, real, authentic, or congruent in the relationship so that the therapy would become increasingly effective and powerful (pp. 199-206). The latter indicates that Rogers became increasingly aware that the professional's attitudes were as essential as his particular techniques (Kirschenbaum, 2004). Rather than judgment and directive techniques, clients are in need of supportive professionals to feel safe and to help them gain deeper understanding, trust their inner experiences and achieve positive action (Rogers, 1950).

Due to the focus on the inner experience of clients, Rogers adopted the concept of "client-centered" to describe the essence of his method. He popularized this concept in a book (Client-Centered Therapy, 1951), which then became a major influence on other helping professions as well. By developing wider applications of his work, Rogers demonstrated that "empathic understanding", "unconditional positive regard" and "congruence" were also applicable in other diverse fields as for instance education, business and leadership. The wide applicability of client-, student- and group-centered approaches inspired Rogers to adopt an overarching concept to describe his method namely the "person-centered approach". Together with colleagues, Rogers asserted his method not only in writing and teaching but also build theoretical support through empirical research. To expand the evidence-base for a person-centered approach, various measurements and variables were devised including professionals' acceptance, empathy and congruence and persons' inner feelings, insight, self-acceptance, positive action and many other concepts.

In short, professionals that achieve a supportive and growth-producing atmosphere can enhance a process of self-determination and provide opportunities for "more fully-functioning persons" (Rogers, 1957). The uniqueness of this approach might be one of the reasons why Rogers has been described as a quiet revolutionary and why his work was received as a first step in moving away from a medical model (Kirschenbaum, 2004).

Michael Balint (1896-1970): "Patient-centered Medicine"

Following Rogers, the concept of client-centered therapy found support by the psychoanalyst Michael Balint who was the first who explored this concept in the context of general practice (Balint, 1957). Similar to Roger, his work focused on the relationship between professional and patient wherefore in the medical field he introduced the term "patient-centered medicine". Hereby he aimed to contrast the traditional 'illness-oriented medicine' with another way of medical thinking. This thinking focused on patient-centered thinking as an "overall diagnosis", whereas patients had to be understood as unique human beings. To facilitate this way of thinking within the medical field, in the late 1950s, Balint began to run seminars for General Practitioners which today is still known as 'Balint Groups'. Although being a psychoanalyst, Balint did not had the intention to turn GPs into psychotherapists but rather to help them reaching a better understanding of the psychological and emotional content of a doctor-patient relationship. By this, a 'Balint group' can encourage GPs to see their patients as human beings and to become better listeners (Balint, 1969). Subsequently, gradually reaching a deeper level of understanding of their patients' feelings will enable them to mobilize their emotional intelligence in the interests of both the patient and themselves. Learning to listen with close attention was one of the most important skills of the 'Balint Group' method (which we now call "communication skills") and was able to improve the therapeutic potential. Furthermore, the method did not include lectures but was fully based on consultation presentations and discussion in small groups of GPs. This group setting intended to provide a space to deliberate on those consultations that left professionals drained, stuck or puzzled and to find new ways forward. Despite its psychoanalytic origin about the dynamics of human relationships, the method appeared highly accessible because the utilization of everyday consultations did not require specialist knowledge (Balint, 1970). Balints' method was described in the book '*The Doctor, his Patient and the Illness* (1957), which became his most famous work. His ideas grew in popularity and the 'Balint groups' spread across the world and also led to the foundation of the International Balint Federation in 1972. In Germany the 'Balint Group' method has become part of the official curriculum of medical students. In spite of the continuously changing nature and context of general health care practices, it still remains based on the interaction between people who seek for help and the helping professionals. This emphasizes the relevance of Balints' work and makes him as once a doctor, psychotherapist, teacher, writer and humanist one of the most influential names in today's general practice.

George Engel (1913-1999): "The Biopsychosocial model"

After Rogers, several other movements took up the tendency that challenged the biomedical model. In particular George Engel passionately put forward his visions on making medicine more scientific and humanistic at the same time, which he unified in his "Biopsychosocial model" (Engel, 1977). With this model he aimed to revive the lived experience of the patient while simultaneously adhering to the successes of the **bio**medical model (Epstein, 2014b). Empirical support from a disease standpoint was remained but would be complemented with equal standing **psycho**logical and **social** components. In order to identify these additional components, health care providers were now supposed to recognize the patients' perspective and interest during their clinical consultations. Rather than solely a biomedical focus, the emphasis shifted towards more patient-centered interactions while making use of open-ended and non-directive methods (Smith et al., 2013). Once again the patient-centered elements – this time within the Biopsychosocial model- were widely disseminated and received international acknowledgement (the Academy on Communication in Healthcare; the European Association for Communication in Healthcare; the Institute for Healthcare Communication; the Institute of

Medicine: in Smith et al., 2013).
While trying to expand scientific evidence and to enhance implementation, teachers, scholars and researchers including Engel himself identified the need for more explicit strategies and specific patient-centered definitions (Epstein, 2014b). The application of patient-centered approaches involves an individualistic focus which makes it hard to achieve a general scientific base. In other words, it appeared essential to seek for consistent –interview- methods in order to capture all relevant biological, psychological and social components. Only then the patient-centered efforts would be able to flourish.

Andrew Weil (1942): Integrative Medicine

In line with the impetus of Rogers, Engel and many others, new movements keep attempting to integrate the concept of patient-centeredness in health care.
The emerging field of "integrative medicine" seeks to represent a broader paradigm than only a biomedical perspective by building bridges between conventional, complementary (used *alongside* conventional medicine) and alternative (used *instead* of conventional medicine) medicine (Maizes et al., 2009). It is a result from thoughtful integration of concepts, values and practices with a view to maintaining the integrity of each model. By combining the best out of every system, it creates the opportunity to provide both curative and preventive health care (Weil, 1998). Moreover, research among patients, physicians and other practitioners suggested that primary health care should have a central role in practicing integrative medicine because of its corresponding philosophy (Ben-Arye et al. 2008). Integrative medicine has been defined as being patient centered, emphasizing therapeutic relationship and healing oriented. In order to optimize a self-healing capacity, it pays attention to both evidence-based medicine and to the person as a whole (body, mind and spirit) assisted with all aspects of lifestyle (Barret et al., 2003). All these dimensions are essential within the clinical encounter and for the understanding of health and disease. More specifically, it is through conversation that patients can be enabled to recognize their ambivalences and to find out how to achieve goals that give meaning to their lives (Maizes et al., 2009). Integrative medicine considers "Motivational Interviewing" to be a major influence on the therapeutic relationship (Kligler, 2014). However, several barriers like for instance economical, organizational and conceptual factors are threatening these attempts at integration. However, it has been suggested that the real dangers of abandoning integration provide a major incentive to overcome these barriers. Because evidence for integration of medicine is emerging, it is argued that it would become ethically impossible for the medical profession to refuse it (Cohen, 2004). The evolvement of integrative medicine also brings forward new themes, terminology and theoretical structures. Because complementary and alternative approaches have to offer more empowering, holistic and intuitive elements, conventional medicine could build on it and thereby strengthen its present legitimacy (Barret et al. 2003; Cohen, 2004).

The guiding principles of the theoretical framework provide a base for the emerging concept of a patient-centered approach in health care. It highlights the importance of a therapeutic relationship between professional and patient, and emphasises the need for an empathic professional that supports the patient towards empowerment based on their self-healing capacities, all seen as core elements for an integrative care perspective.

2.2.2 Structural Framework

It is argued that everything known about PCA today can be captured into three elements of underlying (1) philosophy, (2) utilization and (3) outcomes, which have shown to summarize the concept of PCA in an exhaustive and precise way (Hudon et al., 2011). Furthermore, these elements closely aligned the identified research gaps as described within the introduction of this thesis. On that account, there is chosen to use these elements as a base for this research and have been further operationalized into a structural framework consisting out of: (1) Core Values & Mindset, (2) Tools & Techniques, (3) Measurement & Indicators (table 2).

Table 2: Construction of the structural framework

Hudon (2011)	Research gaps	Structural framework
Philosophy	1. Conceptual ambiguity	What are core values and mindset* characteristics?
Utilization	2. Practical impediments	Which tools and techniques are used?
Outcomes	3. Ethical considerations	What are indicators and measurements for (successful) PCA?

This structural framework will be used for building up the result sections of all three research methods (literature study, explorative study and qualitative interviews) used in this study in order to provide an overall structure and finally answers to the research questions.

* *Mindset*: is a set of assumptions, methods, or notations held by one or more persons which may create a powerful incentive for them to continue to adopt or accept prior behaviours, choices, or tools. It may also be regarded as a "paradigm" of a "philosophy of life"

3. RESEARCH RATIONALE

3.1 Overview of the study

Figure 2 provides an overview of the study and mainly highlights how the research was build on the theoretical and structural framework. The guiding principles of the theoretical framework provided a base for the concept of PCA in health care. Following, the identified research gaps and the summarizing elements of PCA by Hudon et al. (2011) were combined and operationalized into a structural framework. Finally, this resulted into the formation of the research question and 2 sub research questions.

Figure 2: Overview of the research gaps, frameworks, and research questions

Title:	**A Patient-Centered Approach in GP practice** Insights from professional-client interactions outside GP practice		
Theoretical Framework	Integrative Care A therapeutic relationship An empathic, supportive professional An empowered, autonomous patient		
Research Gaps	Conceptual ambiguity	Practical impediments	Ethical considerations
Hudon et al. (2011)	Philosophy	Utilization	Outcomes
Structural Framework	1. Core values & Mindset	2. Tools & Techniques	3. Measurement & Indicators
Research Questions	'What are barriers towards PCA in GP practice and what actions is required to overcome these barriers?'		
Sub Research Questions	(1) 'What is the state-of-the-art of PCA in GP practice with regard to effectiveness and barriers for application?'	(2) 'What are characteristics of PCA in professional-client interactions outside GP practice?'	

3.2 Overview of the methodology

In order to answer the research question, the research had a qualitative descriptive design and consisted out of 3 research methods (figure 3). First a literature study was established in order to identify the current state-of-the-art of PCA in GP practice. The second element was an explorative study in a General Practice to explore and observe PCA in GP-patient interaction in practice. This served as a field experience to enrich the literature study and formed additional input to set up the qualitative interviews. Thirdly qualitative interviews were conducted for which purposive sampling was used to select professionals who were considered to offer insight into PCA in professional-client interaction. Because professionals were not selected on random basis and each in-depth studied case led to individual conclusions and usefulness for the GP practice, the design can be defined as a case study (Walliman, 2006).

Figure 3: Overview of the Methodology

Methodology			
	METHOD 1	METHOD 2	METHOD 3
	Literature study	Explorative study	Qualitative interviews
Process	◆ Critical Bibliography *a)* Cochrane review: Dwamena et al. (2012) *b)* Literature: 2011 – onwards	◆ Observe and explore GP-patient interaction within GP practice ◆ Observe and explore Nurse Practitioner-patient interaction	◆ purposive sampling: select professionals who may offer insight in a guidance-guiding balance in professional-client interaction ◆ Coding and Analysing interviews: simplified 4-steps 'qualitative data analysis' by Creswell (2009)
Outcomes	◆ Gain insight into the state of art of PCA in the GP Practice	◆ Field experience ◆ Enrich the literature study ◆ Additional input for the final qualitative interviews	◆ Gain insight into useful elements of professional-client interactions for PCA in GP practice

4. LITERATURE STUDY

4.1 Methods

A literature study was established in order to identify the state-of-the-art of PCA in GP practice. The most recent Cochrane review on PCA interventions (Dwamena et al, 2012) was thought to provide an adequate base for the effectiveness of PCA in clinical consultations for the given period of time. The review searched the databases MEDLINE, EMBASE, PsychLIT, CINAHL and HEALTH STAR for the period 2000-2010 whereas an earlier version of this review searched between 1966-1999. Cochrane Reviews are substantial and highly structured documents, which reflects clear commitment and expertise of their contributors (Tovey, 2013).

For the year 2011 and onwards, an additional research strategy was established. This search took place through the global search function of the Wageningen Library website which covered all relevant databases including Web of Science, PubMed and PsycINFO.
For the research strategy the following criteria were composed:

Inclusion criteria	Exclusion criteria
- From 2011 and onwards - Written in English - Full text available	- When not specifically relevant to General Practice (e.g. 2nd or 3rd line) - When restricted to interventions only for specific diseases - When restricted to psychotherapy, counselling or mental health only - When restricted to specific age or group of patients (e.g. children, elderly)

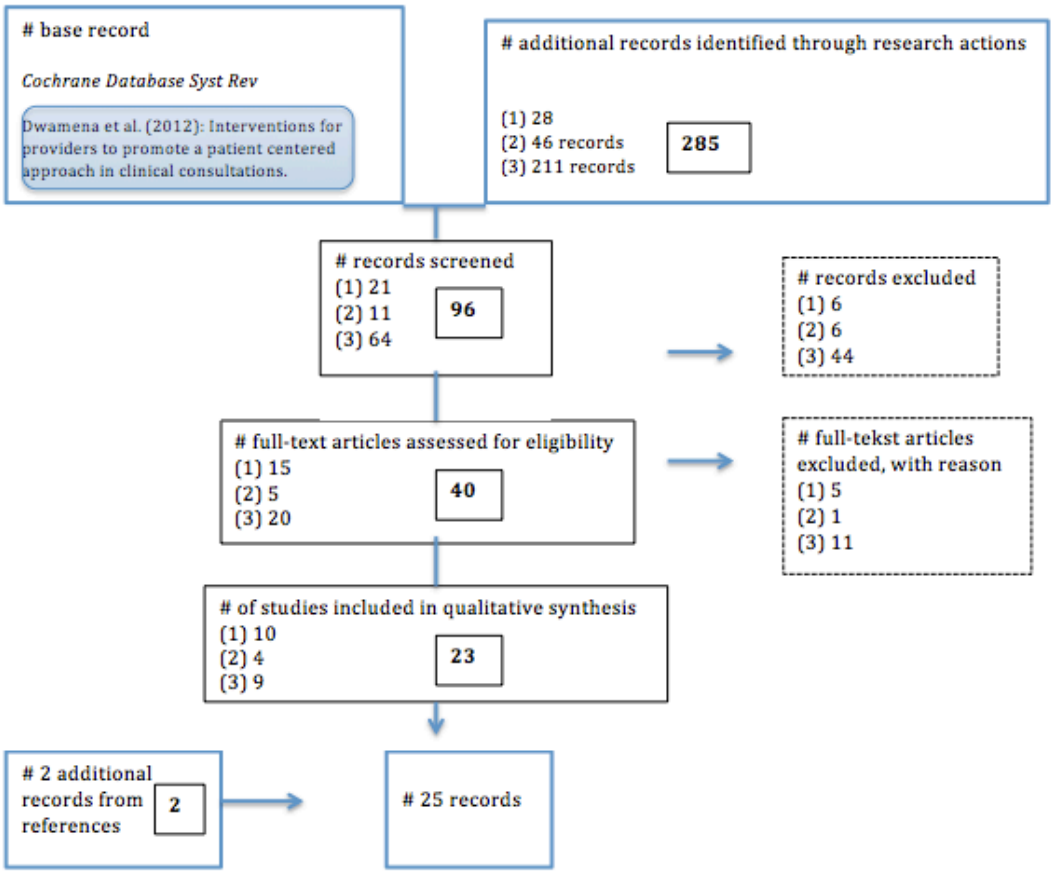
The search was conducted by combining the keywords 'General Practice', 'Patient-Centered Approach' and 'Patient Empowerment' because they were best operationalized within the databases and therefore considered most suitable to achieve a comprehensive insight into PCA. Prime synonyms of the keywords were included to complement the search (table 3). The search strategies were composed as followed: (1) Patient Empowerment AND Patient-Centered Care; (2) Patient-Centered Approach AND General Practice and; (3) General Practice AND Patient Empowerment.

Table 3: Search Strategies

Patient Empowerment	**Patient-Centered Approach**	**General Practice**
* Self-actualization * Self-management * Self-determination * Autonomy * Participation * Motivation	* Patient-centered* * Patient-centeredness * Patient-centered care * Person-centeredness * Person-centered care * Person-centered approach	* GP consultations * Family practice * Primary care * GP-patient interaction * GP-patient communication * GP-patient relationship
(1) **Patient Empowerment** **AND Patient-Centered Approach**	**(2)** **Patient-Centered Approach** **AND General Practice**	**(3)** **General Practice** **AND Patient Empowerment**

In total**, 285** records were retrieved from the systematic search. When revising the references that were already used in the introduction, **2** records were additionally included. Verifying the search strategies for the databases individually (Web of Science, PubMed and PsycINFO) did not result in the identification of other papers, which supported the validity of the systematic search. After de-duplication and screening of titles and abstracts, an amount of **40** records were valued as possibly relevant for the start of the art of PCA. In case of any doubt about in-or exclusion, the article was retained for complete reading. After assessment of the potentially eligible articles, a final number of **25** articles was achieved (figure 4).

Figure 4: Systematic Search



Further analysis of the articles concerned the assessment of their relevance with regard to the 3 elements of the structural framework: (1) Core values & Mindset; (2) Tools & Techniques; (3) Measurement & Indicators. The relevant parts of the articles were allocated to one of the structural elements and thereafter were subdivided into different headings. All headings were judged on their frequency and relevance which in the end resulted in main characteristics of the literature study. In the discussion of this research, the main characteristics were compared with the emerging results from both the explorative study and the qualitative interviews as later on in this study.

Additionally, in an attempt to reduce the conceptual ambiguity surrounding PCA, the study also assessed all definitions of PCA that were expressed in the literature. The definitions were divided into key dimensions, judged on their frequency in literature and on the level of care (process, patient, professional or system) to which they belonged. Per level the dimensions were reduced into 1 overall dimension, except for the patient level that was reduced into 2 dimensions. In total, this resulted in 5 overall dimensions of PCA according to the identified literature.

4.2 Results

4.2.1 Core values & Mindset

a) Cochrane review Dwamena et al. (2012)

Effectiveness

The study of Dwamena et al. (2012) defined Patient-centered care as a philosophy of care that encourages: shared control of the consultation, decisions about interventions or management of the health problems with the patient; and/or a focus in the consultation on the patient as a whole person who has individual preferences situated within social contexts. Their definition aligns the paradigm of holism, which suggests that people need to be seen in their biopsychosocial entirety. Therefore, doctors should involve the patient's knowledge, experience needs and preferences in order to understand the patient as a unique human being. This requires the use of skills and behaviours that promote a relationship in which patients actively participate as partners in healthcare decision-making.

Barriers

Within the reviewed literature, the meaning of PCC continues to include a set of concepts that are compatible and opinions vary about which components and which outcomes of PCA are most important. Different elements of PCA may be differently constructed, used and valued by different stakeholders, and for different reasons, which allows PCA to be defined differently across studies. While some regard PCA as a means to particular (and varied) ends, according to Dwamena et al. (2012) the growing international importance of PCC can only be justified if PCA is seen as worthy in its own right.

Overall, the review update confirmed the earlier findings by Levin et al. (2001) that there is fairly strong evidence to suggest that the investment in training with regard to PCC skills and performance of health professionals, lead to significant increases in the patient-centeredness of clinical consultations.

b) Additional literature 2011- onwards

PCC Policy and Research

PCA has gained international acknowledgment as a core value in GP practice and has been advocated in research, policy and practice developments to promote PCC on the level of legislation and regulation of health care (Scholl et al., 2014). As a key component, a sincerely collaborative, supportive and therapeutic doctor-patient interaction is highly valued by both doctors and patients.

GP-Patient Relationship

Achieving partnership may influence the use of resources, can build trust and encourage mutual problem solving (Cocksedge, 2011; Mercer, 2012). Hence, strengthening primary health care through the prism of doctor-patient interactions is suggested to be a fruitful way to insure social acceptability for health care reforms (Krucien, 2013).

Professional competence

Core activities have been described as: to understand the full range of clinical problems presented by patients and carry out preventive services; to help patients identify and manage health risks; to take into account the social and personal context and to involve patients' priorities and goals when making decisions about treatment.

Personal Agency

Collectively, the literature demonstrated that PCA has been associated with a large variety of positive patient outcomes including adherence to treatment, self-management (Clayton, 2011; Elwyn, 2014), health outcomes, survival (Meterko, 2010) and improved healing relationships (in Greene, 2012). Besides, as a business case for PCC, patients who reported stronger relationships with their clinicians underwent fewer tests, and reduced malpractice complaints, symptom severity, use of health services and health care costs (Hudon et al., 2011; Constand, 2014). Finally, all health care professionals in general may benefit from a patient-centered orientation

by knowing that they have more effectively addressed the needs of their patients (Wasson, 2008; Sevin, 2009 in Greene 2012). Likewise, from an ethical perspective, patient-centered care is perceived as the right thing to do (Epstein & Street, 2011). Emphasis is put on relational autonomy, which encompasses an interpersonal relationship and professional support that people may need to develop their personal autonomy capabilities (Entwistle & Watt, 2013).

Clinical complexity

Though, the personal dimension simultaneously constitutes clinical complexity ranging between complaints, short-or long-term conditions and preventative- or end-of-life care, which all implicate different psychosocial, cultural, medical and communicational approaches. Moreover, approaches are accomplished over time en thus encounter changing circumstances, knowledge, technology and priorities. Together with standardized checklist, guidelines, workload and financial incentives, practical barriers hinder the implementation of PCA (Klinkman, 2011; Krucien, 2013). Coherently, the current state-of-the-art has shown heterogeneous use of PCA (Hudon et al., 2011; Scholl et al., 2014) resulting in evidence on the effectiveness of PCA remain mixed and inconclusive.

Integrative Medicine

Next to PCA, patient-centered communication is considered as the most central component of PCC whereas other concepts of patient enablement, empowerment, participation and involvement are all closely related and share their emphasis on putting patients at the heart of health care. Due to the considerable overlap in concepts, processes, outcomes and the lack of a clear definition, PCA may be regarded as a poorly conceptualized phenomenon (Rathert et al., 2012; Scholl et al., 2014). On the other hand, the conceptual ambiguity has also been approached by viewing PCA as a multifaceted construct (Ishikawa, 2013). Addressing PCA on all levels as a multifaceted approach to overcome barriers may establish better coordination and integration of care (greenfield, 2014) and enables seeing PCA as a resource rather than as a burden (Ishikawa, 2013).

In the literature, PCA and PCC were often used interchangeably whereupon 19 definitions of PCA and/or PCC were identified (table [1] of appendix I). They date from 2015 back to 1993 whereas some articles referred to pre-existing definitions. Reducing the definitions to key dimensions resulted in 5 overall dimensions on different levels of PCA (table 4). On process level, the dimension *doctor-patient interaction* was shared among all definitions. On patient level, common dimensions related to the *patient's context* and *patient's agency*. The key dimensions for professional level concerned *professional support*, and on system level a *supportive system*.

Table 4: Identified key dimensions of patient-centered approach

(Attendance)	(Level)	Identified key dimensions of patient-centered care		(Reduced to)
Shared ELEMENTS	(Process)	• Partnership • Continuous relationship • Therapeutic alliance • Find common ground • Mutual decisions and respect		**GP-patient interaction**
Other ELEMENTS	a. (Patient)	• Biopsychosocial perspective • Everyday life perspective • Respect for patients' values, preferences and needs	• Patients as persons • Whole persons (approach) • Persons' holistic properties • Situational Circumstances	**Context**
		• Active participation • Responsibility • Dignity	• Choice • Empowerment • Self-determination	**Agency**
	b. (Professional)	• Provision of Information/education • Legitimizing illness experiences • Doctor as a person • Involvement of patients	• Supportive role • Sharing power/responsibility • Acknowledging patients' expertise	**Professional support**
	c. (System)	• Access and supportive system • Continuity and Coordination of care • Transition between health care settings	• Transparency • Health promotion	**Supportive system**

4.2.2 Tools & techniques

a) Cochrane review Dwamena et al. (2012)

Effectiveness

PCA in clinical consultations is increasingly advocated and incorporated into training for healthcare providers. It is demonstrated that training providers to improve their ability to share control with patients about topics and decisions addressed in consultations successfully taught providers new skills. In this regard, short-term training (less than 10 hours) was even successful as longer training. Addition of condition-specific educational materials is suggested to further support the improvement of PCA. Furthermore, a growing consensus has identified provider-patient communication as a key to achieving patient-centered care.

b) Additional literature 2011- onwards

All identified models and framework for PCC had in common the incorporation of strategies to either achieve partnership, effective communication or promotion of health (Scholl et al., 2014). As a result, rather than disposing of one distinct approach that is 'patient-centered', clinicians have the possibility to select strategies that best suits the patient and the context while being assured to satisfy core elements of PCC.

Guidelines

Despite the existence of standardized disease management protocols (Davis, 2013), doctors often manage by inflexible use of checklist approaches (Entwistle & Watt, 2013), use of short cuts and quick decision strategies and often restrict documentation to only medical diagnosis rather than involving classification tools for social problems (Klinkman, 2011).

Interaction techniques

The diversity in clinical consultations emphasizes the need of tailored methods, which asks for physicians who are able to identify, adapt or integrate approaches that best suit the situation (Elwyn, 2014).

For helping patients to identify and reflect on their own skills, values and needs, decision aids have been developed in order to prepare patients for decision-making processes and discussing on decision options. Despite its potential, professional attitudes, competing demands, time pressure and lack of training constitute barriers for achieving its full potential (Elwyn, 2014).

Communication (methods)

Research on doctor-patient interaction has pursued patient-centered communication as an ideal style for the clinical consultation (Ishikawa, 2013). Hence, complementing clinical skills with communication skills is necessary to facilitate the doctor-patient interaction.

Next to information provision on diagnosis and treatment, skills for provision of support and empathy are of key importance as well (Mercer, 2012). In addition, incorporating patients' perceptions in an early stage of treatment can subconsciously lead to beneficial patient outcomes (Greenfield, 2014). Listening to their perspectives provides a caring, empowering and respectful context that influences patients' trust and their affective state (Greenfield, 2014).

Shared decision making (SDM) has been regarded as a useful technique for helping patients become well-informed and to elicit and integrate patients' personal preferences in relation to available and reasonable options (Sanders et al., 2013; Elwyn, 2014). Another effective counselling method is motivational interviewing (MI) that is focused on supporting change by seeking to elicit ambivalence and motivation before taking action (Hall, 2012; Elwyn, 2014; Codern-bove, 2014). Although both communication methods originate from distinct domains, they have in common fundamental communication skills including reflective listening, information exchange and responding to emotions. MI and SDM can be applied as sequential methods whereby motivating patients to change is followed up by making preferred treatment decisions, or they can be integrated as an ongoing process when patients not only face competing treatment options but behaviour change (for long-term conditions) is relevant as well (Elwyn, 2014). Physicians may benefit from taking into account both approaches, and their integration may contribute to the establishment of patient-centered orientation in GP practice

(Elwyn, 2014). However, because challenges of implementation and integration will arise as the complexity of problems in GP practice increases, both methods need to be taught, assessed, measured and rewarded in order to be valued as core elements of daily practice and to envision progress of PCA.

Technology

Furthermore, also the importance of advances in health information technology has been underlined (Klinkman, 2011). Although challenging, it may provide new ways to integrate decision support tools with PCA and benefit continuity of health care.

4.2.3 Measurement & Indicators

a) Cochrane review Dwamena et al. (2012)

Effectiveness

The move toward observing performance and skills of health care professionals is based on the studies that demonstrate a correlation between effective provider-patient communication and improved patient health outcomes. The increased patient-centeredness in clinical consultation is indicated by a range of measures relating to clarifying patients' concerns and beliefs; communicating about treatment options; levels of empathy and patients' perception of providers' attentiveness to them and their concerns as well as their diseases.

Barriers

While the methodological quality of the trials is improving, disease-specific measures will remain idiosyncratic to the clinical conditions of interest. The use of single item consultation and health behaviour measures limit the strength of the conclusions. Observational measures should be complemented with self-report measures whereas patient and provider satisfaction measures assess the felt impact of the interventions and are required to demonstrate success of interventions. Because the variability in aims of PCA is reflected in the heterogeneity of outcomes measured, there is a clear need to determine which elements of multi-faceted studies are essential in helping patients change their healthcare behaviours

Identification of 'active' elements of apparent effectiveness of multifaceted interventions will enhance the adaptation to different health systems with different goals. Furthermore, future trials could specifically assess the effects of interventions on other levels of care as well, such as changes in the organization of care in promoting PCC in the clinical consultation.

b) Additional literature 2011- onwards

Objective Outcomes

A considerable part of the literature focused on evidence-based measurement scales (for e.g. 'Primary Care Assessment Tool'; 'Patient-Centered Clinical Method'), on evidence-based indicators ('Quality and Outcomes Framework'; 'General Practice Assessment Questionnaire') and on the evaluation of elements on organizational level (quality of care; economic valuation). Although mainstream measurement for evaluating quality of care is regarded as an ongoing international priority (Cocksedge, 2011; Olsson et al., 2013), attention for estimating the value of healthcare features for patients more personally has increased (Sanders et al., 2013).

Patient-oriented outcomes

It is recognized that outcomes should be complementary defined by what is valuable and meaningful to patients. The need for more descriptive measurement of health care experiences led to complementation of objective with subjective measures, indirect with direct effects, and disease- with patient-oriented outcomes. Among others these included assessment of self-rated wellbeing, behaviour change, satisfaction, costs of care and quality of life (Cocksedge, 2011; Sanders et al., 2013).

Other descriptive measurement related to the level of patient-provider interaction and included evaluative methods for interpersonal communication and competence. 2 coding schemes were identified to measure patient-centeredness within communication, (Measure of Patient-Centered Communication (MPCC) and 4 Habits Coding Scheme (4HCS) (Clayton, 2011); 2 scales

were identified to measure the level of jointly decision making (OPTION scale and Decision Conflict Scale)(Elwyn, 2013); and 2 instruments were identified to measure reliability and characteristics of MI interactions (Motivational Interviewing Treatment Integrity (MITI) and Motivational Interviewing Skills Code (MISC) (Codern-Bové, 2014). However, most descriptive measurements operationalized Patient-centeredness differently, which hinders generalization of conclusions.

Patients' viewpoint

Predominant methodologies for patient-oriented outcomes included direct observation of the clinical consultation and self-assessment involving both patients' and physicians' experiences of the consultation. Self-assessment demonstrated to be better predictions of outcomes (Hudon et al., 2011). 2 instruments were identified for assessing patients' perspectives on PCC in GP practice: the Patient Perception of Patient-centeredness (PPPC) and the Consultation Care Measure (CCM). Although addressing key dimensions of PCC, both were limited in their ability to assess care over time because the instruments are visit-based (Hudon et al., 2011).

Several other attempts aimed to foresee in more patient-focused performance measures and were mainly focused on enablement, satisfaction and empowerment.

Empowerment has been regarded as an intermediary outcome that may positively influences self-efficacy, which is linked to health and behavioural change (Mercer, 2012; The Lancet, 2012). Enhancing the personal ability to understand and manage health and disease is crucial for improving outcomes of health.

The Patient Enablement Instrument (PEI) is an indicator for consultation quality as perceived by patients (Brusse, 2013). However, positive scores for PEI may depend on patients who come from low enabled states. The more widely used instruments that measure patient satisfaction reflects the extent to which patients' perceptions and pre-consultation expectations of consultations has been met (Brusse, 2013). Though satisfaction on its own may be limited as an outcome because of measuring perceptions on the health care process rather than achievements of benefit or health gain (Howie et al. 2005). Building on both concepts led to development of the Patient Enablement Satisfaction Survey (PESS) and has proven to be a comprehensive indicator for effectiveness in GP practice.

Personal Capabilities

From a more ethical perspective there has been requests towards personal capabilities-based metrics that serve as guidelines for investigating and identifying people's values and needs for self-management and care. It is argued that patients' experiences are shaped within clinical interactions and vary according to one's circumstances in life, which involves ongoing supportive care without expectation of cure and requires indicators over time (Enwistle & Watt, 2013).

Future Research

The conceptual heterogeneity has led to wide variation in scales and dimensions designed to measure PCA (Scholl et al., 2014). Arising out of these various measurements, literature indicates inconsistent and mixed relationships between specific elements of PCC and outcomes (Rathert et al., 2012). To overcome the inconclusive results, future research should examine specific 'active' dimensions of PCC and should therefore also identify moderating and mediating variables in the PPC-outcomes relationship.

The total amount of headings that were created based on the identified main characteristics for PCA in the literature are displayed in part (A) of table 5. An extensive textual outline for all these headings can be consulted in the final part of appendix I. Following, part (B) shows all emerging insights for the state-of-the-art' of PCA within the literature, as described above.

Table 5: Headings (A) and Emerging insights (B) for the state-of-the-art' of PCA

	1. Core Values & Mindset		**2. Tools & Techniques**	**3. Measurement & Indicators**	
A	GP Practice International legislation Integrative care Multiform complexity Conceptual Ambiguity Consultation Time Partnership	Participation Empathy Credibility Enablement Empowerment Patients as Persons Relational Autonomy	Standardized Disease Protocols Patient-Centered Communication Decision Aids Shared Decision-Making Motivational Interviewing Medicalization and Marketization (Health information) Technology	Quality of care Economic Valuation; Direct Observation Communication Coding Subjective Measurement Patient Enablement	Self-Assessment Patient Perceptions Patient Satisfaction Empowerment Capability Metrics Multidimensional
	Emerging insights				
B	*PCC policy & research* *Integrative Medicine* *Clinical complexity* *GP-patient relationship*	*Professional competence* *Personal agency*	*Guidelines* *Interaction techniques* *Communication (methods)* *Technology*	*Objective outcomes* *Patient-oriented metrics*	*Patients' viewpoint* *Personal capabilities* *Future Research*

5. EXPLORATIVE STUDY

5.1 Methods

The second part of the methodology encompassed an explorative research in General Practices located in Tienhoven and Maarssen (Central Netherlands). The practices were selected on forehand and were not intended to be representative for the Netherlands. The explorative research covered 2 days; one day accompanying a general practitioner in Tienhoven (involving 7 GP-patient interactions) and one day accompanying a nurse practitioner in Maarssen (involving 5 NP-patient interactions). The general practitioner was already familiar with PCA and in particular with Motivational Interviewing (MI), which was noticeable in his work and reflected by the explorative results.
It was decided to also include a nurse practitioner because of the speciality in chronic diseases. Besides, since January 2014, the government has dedicated a structural expansion to the general practice by means of nurse practitioners (Praktijk Ondersteuner Huisarts (POH).
All patients were asked permission for the researcher to attend the consultation. Participants were informed that the focus of the research was on the interaction between GP/NP and patients. Encoding of participant data ensured confidentiality.
The exploration served as a field experience in order to enrich the literature study and formed additional input for structuring the qualitative interviews. It encompassed observational research which was complemented by additional information and explanation by the practitioners themselves. In line with the research methodology of this study, the exploration was outlined by the 3 elements of the structural framework (Core values & Mindset; Tools & Techniques; Measurement & Indicators). The emerging insights were finally compared with the insights that emerged from both the explorative study and the qualitative interviews later on in this research.

5.2 Results

Based on the observations and interviews with the GP and the NP, the collected exploration is portrayed in table [6]. According to the structural framework, the textual outline of the results is first presented below.

5.3 Explorative research: General Practitioner (GP)

5.3.1 Core values & Mindset

The importance of maintaining and retaining the GP-patient relationship was regarded by the GP as one of the core values in General Practice. Likewise, continuity of care was considered to be the strength of the general practice. The 3-level construct of care was highlighted (System, Doctor and Patient Level) including the challenge –how- to align them by a humanistic approach. The work of GP's was further described as: 'Guiding, inviting and giving direction (in a non-judgmental manner); exploration of norms, values and resources; and a process of learning, internalisation, clarification of ambivalence, (self)reflection and regained perspective".
Patients visit on their own initiative. Starting a consultation, every patient is given room for explaining the reason for the visit. Differences in characteristics and capabilities of patients were approached by addressing the unique identity of every individual.

5.2.2 Tools & Techniques

The length of consultation is set at 10 minutes per patient. Prior to every consultation, the (health) status and medical background of the patient is entered in the EPD (electronic patient dossier).
During and/or after consultation the outcome(s) are processed within the EPD following a so-called "SOEP" order: Subjective, Objective, Evaluation and Plan.

Prescription of medication was present as one of the main basic tasks inherent to the general practice. Motivational Interviewing (MI) was applied intentionally as an interview technique in order to help patients change behaviour. The overall spirit of MI was described as 'collaborative, 'evocative' and honouring of the 'patients' autonomy'. The technique was further explained as involving 4 principles using the acronym RULE (Resist, Understand, Listen, Empower) and several communication styles and skills which can be captured by the acronym OARS (Open-ended questions, Affirmations, Reflective listening and Summary). Additional elements mentioned were the inclusion of intentional moments of silence and a communication balance between doctor and patients' speaking, which intends to have a percentage around 30 vs. 70%.
Furthermore, attendance to training, education, workshops and updating of skills was acknowledge and interpreted as inherent to the medical profession of a general practitioner.

5.2.3.Measurement & Indicators

Physical, social, and mental health status were the main indicators to measure health and disease. Objective indicators included measurement units like blood pressure and weight. Subjective indicators included outcomes from doctors' and patients' perspective as for instance feelings of satisfaction and preferences.

5.4 Explorative research: Nurse Practitioner (NP)

5.4.1 Core values & Mindset

The Nurse Practitioner emphasized the continuous relationship with patients, which involves being aware of an appropriate closeness and distance in the nurse-patient relationship. A core value is that the control remains in hands of patients. Other values were respecting the patient, allowing self-reflection and offering tailored care. It is aimed to focus mainly on a patients' (social, mental and physical) context and for the other part on the medical context (specific disease and accompanying medication).
Due to the specificity of diseases, protocolling is required and obviously present. Consequently, in particular for patients with chronic conditions (most patients are 'at risk'), the concept of patients' autonomy is highly relevant in terms of medication use, treatment compliance, diet and physical exercise. Thereby patients' attitudes varied from well willing, indifferent and to dependent on the professional. Differences in characteristics and capabilities of patients were approached by offering: the possibility to bring a partner of relative during the consultation; the possibility of referring to additional health care professional (for e.g. nutritionist or physiotherapist); the possibility of providing the information in different ways (verbal, paper, internet, brochure etc.) and the possibility of repeating preceding information during successive consultations. Frequently, patients saved their questions and remarks, if possible, until their next appointment.

5.4.2 Tools & Techniques

Length of consultation is set at 20 minutes per patient. Prior to every consultation, the (health) status and medical background of the patient was assessed in 'PortaVita' (integrated care system). During and/or after consultation, the outcome(s) are processed within the online system. Depending on the type of disease the amount of visits per year has a fixed frequency. Visits for diabetics, heart- and pulmonary diseases are set at four times a year and visits for quitting smoking are set at twice a year. Patients are invited to come, and are free to decide whether they obey the recommended amount of visits per year.
In the case of several diseases (for e.g. DM II), patients received a personal notebook to compile measurement units and/or laboratory values. Consultations regular include referrals to other health professionals, with whom close liaisons are maintained.
The attendance to training, education, workshops and updating of skills was regarded as an occasional but desirable activity for all health professionals.

5.4.3 Measurement & Indicators

Medical prehistory and therapeutic indication were leading elements. Assessment of family history is part of every treatment procedure (automatically resulting in attention for both medical and social factors)

Every consultation included measurement of blood pressure and weight (following the protocol). Laboratory values (blood glucose levels, HbA1c, cholesterol and kidney function) were examined once or twice a year (depending on the type of chronic disease(s). Additionally, Pulmonary Function Tests or ECG could be requested.

Table 6: Observation and interview results (A) and emerging insights (B) for GP- and NP practice

		Core Values & Mindset	**Tools & Techniques**	**Measurement & Indicators**
A	**GP**	• Maintaining GP-patient relationship • The strength of the general practice is the continuity of care • Guiding, inviting and give direction (in a non-judgmental manner) to exploring norms, values and resources, internalisation, clarifying ambivalence, (self)reflection, regained perspective and learning.	• Medical prescription • Motivational interviewing (including training, principles and (core) skills) • Communication balance 70/30 (patient/gp) • SOEP (*Subjective, Objective, Evaluation, Plan*) (integrated care system) • Referral to secondary care • By GP: (re)training and/or education	• Physical, social and mental health status • Objective measurement units (BP pressure, weight etc.) • Subjective outcomes from patients' perspective (e.g. satisfaction)
	NP	• Continuous relationship; involves appropriate closeness and distance in the nurse-patient relationship • Control is in hands of patients • Respecting the patient, allowing self-reflection and offering tailored care	• Medical measurements *(BP and weight)* • Portavita (integrated care system) • Referral to other health care professionals • by Nurse Practitioner: (further) (re)training and/or education	• Measurement units *(blood sample, BP pressure, weight)* • Laboratory values *(blood glucose levels, HbA1c, cholesterol, kidney function)* • Pulmonary Function Tests, ECG • Prehistory • Therapeutic indication
	Emerging insights			
B		Continuity Respect Individualized care	Gatekeeping Health Information Technology Motivational interviewing Training and education	Prehistory Biopsychosocial status Subjective indicators

6. QUALITATIVE INTERVIEWS

6.1 Methods

Sampling strategy

The third and last research method concerned qualitative interviews. Developing an in-depth exploration of a central phenomenon by using interview techniques is thought to be best achieved by purposeful sampling strategies (Cresswell 2005: pp 203). Therefore, purposive sampling was used to select professionals who were considered to offer insight in 'PCA' in professional-client interactions outside GP practice. PCA is universally characterized by profession-related guidance versus the client's guiding autonomy but still remain embedded in socio-physical and political context. In order to identify core values for PCA in a variety of domains of life, it was determined which working fields and professions were most relevant to provide insight into PCA. As described in the research aim, PCA particularly applied to professionals with a facilitative role and disposing of supportive interactional skills. Subsequently, the following professions were selected: Preacher; Choir director; Top-level sport (master)coach; Community sport coach; Shiatsu- and life art therapist; Deputy head societal organization; Hospitality director/entrepreneur; Nursing tutor.

Interview Design

Interviews were open-ended and semi-structured, which is considered to be systematic but sensitive to the conversational dynamics (appendix II). This design is appropriate because it allows participants to express their views as well as their personal experiences (Nohl, 2009), it minimizes the influence of the researcher (Creswell, 2005) and simultaneously allows the researcher to react upon it and finally to compare results (Nohl, 2009).

3 interview questions were formulated according to the 3 elements of the structural framework, which was based on the research gaps in combination with the summarizing elements of PCA by Hudon et al. (2011) (figure 5, appendix II). Furthermore, the interview questions were adapted to additional insights of the explorative study. Due to differences between the state-of-the-art of PCA and what was observed in GP practice, interviewees were additionally questioned to cite examples of their interactions in order to identify possible gaps between what they say or think and what they practice (appendix II). Secondly, due to the uniqueness of each patient consultation in GP practice, the interview methodology was supplemented with an assessment of profession-specific and contextual characteristics.

The interviews were designed for duration between 30 and 60 minutes. Along the interview methodology, requests for clarification, reflection and restatement were prompted when needed.

Data collection

A number of 8 professionals was invited for interviewing of whom 7 participated, whereas 1 professional exempted due to time constraints. Contact to professionals was initiated with personal invitation by email including a general information letter about the research (appendix II). The interviews took place on work-related locations as preferred by the participants. In one occasion the interview was held by telephone because a face-to-face appointment was not possible within the period for data collection. Permission was obtained for recording of interviews and publication of name and surname. Other personal data remained confidential.

One pilot interview was conducted in order to test duration and construct validity of the interview questions. Because the pilot appeared to be successfully in line with the expectations and was decided to add to the results as an 8th interview.

Data analysis

As a first assessment, profession-specific characteristics of the professional-client interactions were mapped based on their: socio-physical context (including the target level and the setting); professional guidance (including professional principles); clientele guiding (based on their

autonomy) and intended results (expected or desired). Although there was no general practitioner interviewed, its profession was still included serving as a comparative base for all the professions outside GP practice.
For a second assessment, the data analysis followed a simplified 4-step version of 'the qualitative data analysis' by Creswell (2009). The simplification allowed a selective transcription of the interviews: since this study has a predefined focus on professional-client interaction, several parts of long-lasting interviews were identified as irrelevant and were not included. Creswell's method was further suitable because it allows predefined coding and comparison and interpretation of the findings against the backdrop of literature as well as own experiences (2009: 177). The 4-steps included:

1. Transcribing interviews; all *relevant parts* of the recorded interviews were transcribed from audio into a text format
2. Reading through the data; in order to retrieve a general sense of the overall meaning
3. Generating codes and themes; allow a combination of predefined and emerging coding in order to address a larger theoretical perspective in the research (2009: 187).
4. Interpreting the meaning of the themes; interpretation and comparison with information gleaned from literature, theories or own experiences (2009: 189).

6.2 Results

Each interviewed professional featured particular characteristics of their professional-client interactions (table 7). The target level varied from a defined population, to individual level, and to a specified target group and settings were domestic or profession-specific.
The clientele guiding mainly depended on the extent of autonomous feelings and on the voluntary, occupational or compulsory base of visit. The professional guidance varied in conformity with professional core activities and profession-related leading principles (e.g. Hippocratic Oath; the Bible; rules of play; policy). The combination of clientele guiding, professional guidance and the socio-physical context largely determined the intended (expected or desired) results that predominantly consisted out of satisficing improvement, self-determination and growth.

As a second result, the interviews fluently led to sufficient information and examples in order for the research questions to be answered. Creswell's qualitative data analysis led to transcription of identified relevant interviews parts as portrayed in appendix III. Repeated listening to the interview recordings did not resulted into modification of transcription. Reading through the interview data provided a general sense of the results.
Predefined coding of words and sentences that were considered relevant for the study were marked in bold. Next, these markings were allocated to one of the three elements of the structural framework from this study (Table 9)(original Dutch versions are portrayed in table [8] appendix III). Placing the categorized markings below one another made the interview data organized and comparable. Comparison of data resulted into (overarching) emerging insights as also portrayed in table [9].

Table 7: Descriptive background information accounting for each interview participant

⌘ = level ⭘ = setting ⦿ = principle(s)	**Socio-physical context (interaction)**	**Professional guidance (control)**	**Clientele guiding (autonomy)**	**Intended results (expected/desired)**
Interviewees Name, (sexe) Profession (place)				
0. General Practitioner	⌘ Defined part of the population over time ⭘ In general practice	Provision of care ⦿ (Evidence-based) medicine and the 'Hippocratic Oath'	- Right to be fully informed & involved - Preferences, values and needs	- Diagnosis, improvement of disease and health - Shared understanding and satisfaction
1. Monique Maan (f) Preacher (Arnhem)	⌘ district community and individual level ⭘ church or domestic setting	Preaching and pastoral care ⦿ The Bible	- Voluntary based - Own perspectives on religion	- Enhance self-reliance - That people feel seen, heard and acknowledged in what they stand for
2. Ardjoena Soerjadi (m) Choir director (Houten)	⌘ Amateur and prof. musicians ⭘ Practice setting or the performing space	Conducting music ⦿ The musical work	- Voluntary or occupational based - Enthusiasm, skills and musicality	- Quality of performance - Satisfaction by choir director, musicians & public
3. Marc Lammers (m) Mastercoach (National Hockey)	⌘ Team and individual level ⭘ Playing field	Coaching ⦿ Rules of play	- Voluntary but occupational based - Sportsmanship, perseverance, skills	- Quality of play, winning matches, satisfaction - Satisficing socio-emotional-physical scores
4. Berna Nijboer (f) Community sport coach (Hoogeveen)	⌘ Individual level (child and parents) ⭘ domestic setting/ own environment	Promotion and coordination of sport ⦿ sports policy	- The will, capacity, motivation, preferences and resources to sport	- Sport and movement - Taking on commitment and structure
5. José Wikkerink (f) Shiatsu therapist (Wageningen)	⌘ Individual/ personal level ⭘ Treatment room/location	Providing the art of living ⦿ Traditional Eastern medicine	- On own initiative; opportunities in own hands - Sense of freedom	- gained insight, acceptation, freedom - Lasting consciousness and self-actualization
6. Derk Tetteroo (m) Deputy head Bureau Frontlijn (Rotterdam)	⌘ Municipality and individual level ⭘ Domestic setting	Coaching and training ⦿ Situational circumstances and debt accumulation	- Voluntary based - Situational circumstances, motivation/necessity	- Self-reliance of clients - Enabled continuity of gained skills and outcomes
7. Carel Lovers (m) Director Lovers hospitality & canal cruise (Amsterdam)	⌘ Company and individual level ⭘ Company/business setting	Running business ⦿ The company	- Occupational based - Involvement, Intrinsic motivation, hospitality, attitude,	Profits, high satisfaction, low absenteeism/illness - Relationship over time and the happiness of employees
8. Arda de Zeeuw (f) Nurse-and tutor (Utrecht)	⌘ Educational/ individual level ⭘ Educational setting	Teaching ⦿ education and nursing policy	- Voluntary based with educational obligations - Motivation, skills	- Assessing knowledge and skills - Learning and growing students (knowledge ánd social skills)

6.2.1 Core values & Mindset

Integrative Care: Descriptions of core activities from each profession highlighted that the level of focus (individual, collective or specified target group) including its accompanying setting were main starting points for the interactions between professional and client. Though, each interviewee emphasised the need to adopt the interaction to the situation, context and capabilities of the client.

"[…] Development is at all times based on personal capabilities and the personal situation, to ensure that it is in the client's best interest" (Derk Tetteroo)

Hereto, the interviewees had in common their use of complementary approaches rather than restricting to their profession-related guidance. Among others these approaches were referred to as 'holism', 'everyday life perspective', complementation of eastern with western medicine', and complementation of IQ, with EQ and SQ.

" […] There is no one truth, there are several truths and it is about determining what is best in a specific situation, to what you need according to your context" (Monique Maan)

Responsibility: The interviewees frequently mentioned the importance of responsibility, which was mainly interpreted as on the one hand maintenance of responsibility and on the other hand, providing, enabling, stimulating or involving clients to take their own responsibility. For this balance, professional principles were seen as a starting point, which was also referred to as leadership.
Rather than strict leadership, it was often indicated that appropriate leadership also involved responding to the capacity, capability and autonomy of clients. In this sense, leadership was linked to shared responsibility and empathy and could form a base for mutual trust and respect, which was finally deemed to enhance professional credibility as well.

"[…} My contribution is to make people aware of the opportunities they have by themselves to feel sick or healthy" (José Wikkerink)

Collaboration: The extent of collaboration was also in coherence with the amount of time available, which often determined the balance between professional guiding and clientele guidance. Time was mentioned among all interviews and took on different meanings and forms, but collectively encompassed the opportunity for own timetabling by the professional. Depending of the amount of time, outweighing short-term solutions and long-term perspectives, prioritisation, decision-making and conscious planning were common strategies throughout all interactions and settings.

"[…] Purposive guidance is best achieved through collaboration and mutual trust"
(Ardjoena Soerjadi)

Meaningfulness: The opportunity to give own meaning to the factor of time was also frequently referred to as a sense of freedom. The sense of freedom appeared not only essential for professionals themselves but was also indicated to be relevant for clients. In that sense, freedom allowed the professional-client interactions to change into more informal relationships when appropriate and could contribute to positive atmospheres and climates of trust and learning. In the end, achieving such positive climates was indicated to shape the foundations for sustainability of their interactions, grounded in unconditional compassion for their work and love for their fellow man.

6.2.2 Tools & Techniques

Communication: Communication was considered a key element for interaction and to provide a basis for application of additional approaches. Sincerely and genuine contact with client was mentioned as an essential prerequisite for knowing the client and to adapt approaches accordingly. Of all the specified communication techniques (e.g. MI, NLP, MBTI), it was indicated that these were not leading but that only the most useful and comprehensible elements were

applied. Furthermore, communication encompassed several dimensions that mainly related to conversations in words and room for discussion, but on the other hand also highlighted the importance of nonverbally approaches as for instance body language, drawing and visualising. These approaches were also considered to be helpful in explaining and working towards end goals and to contribute to an approachable and simplified character of interactions.

[…] "We aim to offer accessibility and low threshold working methods in order to provide rapid remedial interventions" (Berna Nijboer)

Coaching: The strategies applied were primarily referred to as coaching or coaching leadership, which emphasized the importance of motivation, activation, affirmation, reflection and feedback. With regard to several professions, also training held a prime position and emphasised the supportive role of the professional.

[…] "Coaching leadership is letting people discover by themselves the instructions you envisaged" (Marc Lammers)

Innovation: Frequently mentioned was the need to learn and to change over time, which was mainly achieved by continuous improvement, proactive anticipation and innovation. With regard to the latter, the use of (innovative) communication technologies (e.g. skype, facetime) was considered as an essential tool to communicate in a person-centered way.
To optimize knowledge and skills, training and education was regarded as an activity inherent to all professions but in some occasions was also indicated to be suitable for clients within learning contexts.
Cooperation: Next to continuous co-operating with clients, cooperation was mainly interpreted by the interviewees as close collaboration with other expertise and social services. Sharing and outsourcing of challenges that are out of reach was not considered as undermining to own expertise and working experience but was mainly regarded as beneficial to all parties involved.

6.2.3 Measurement & Indicators

Growth: For a considerable part, interviewees indicated 'to measure is to know'. Depending on the profession measures related for instance to profits and cost reduction. Though, different importance was attached to those measures whereas often preferences were given to outcomes that were important, valuable and meaningful for both professional and clients. Besides, in some occasions it was emphasised that neither the professional nor the client were necessarily accountable for external goals to be obtained. Rather than depending on evidence-base indicators, numbers or values, frequently emphasised were outcomes as personal growth, social skills and continued learning. Additionally, also the value of self-assessment was highlighted as for instance by numerical judgement or biopsychosocial states as scored by clients themselves.

"[…] Life lessons and growth may be more valuable than measuring performance" (Arda de Zeeuw)

Sustainability: Other indicators often showed overlap with elements that were already mentioned as core values and mainly related to empowerment, self-determination, self-management and self-capacity. All these indicators had in common to be results that were aimed to continue decisively. Likewise, the importance of achieving a relationship over time was mentioned wherein clients should feel themselves accepted, heard en felt.

"[…] It is a skill and an art bringing out the best in people" (Carel Lovers)

Feasibility: Furthermore, it was highlighted that not all in life and in interactions is controllable and measurable or insightful. Therefore, achieving satisficing outcomes was desirably focused on management of expectations and preferences, including situational and contextual feasibility of outcomes.

Summarizing, analysis of interview results led to an extraction of characteristics and finally to emerging insights from the professional-client interactions (table 9).

Table 9: Extracted characteristics (A) and emerging insights from professional-client interactions (B)

	1. Core values & Mindset		**2. Tools & Techniques**		**3. Measurement & Indicators**	
Extracted characteristics						
A	Everyday life perspective Holism Target group Time Leadership Responsibility Motivation Self-reliance Trust	Involvement Relationship Respect Collaboration Atmosphere Meaningfulness Compassion Self-capacity Freedom	Anamnesis Communication Listening Explanation Stimulating Activating Affirmation Correcting Feedback	Information Simplicity Innovation Technology Co-operation Working experience Training/education Visualising Contact	Satisfaction Learning Growth Skills Feasibility	Self-assessment Sustainability Self-management Self-Capacity Commitment
Emerging insights						
B	Personalization Responsibility	Collaboration Meaningfulness	Communication Coaching	Innovation Cooperation	Growth Feasibility	Sustainability

Summary table of results

Comparison of all emerging insights from the literature study, the explorative study and the qualitative interviews, led to 9 shared insights that could be regarded as active elements for a professional-client interaction. Subsequently, critical reflection on these active elements may provide insight into action that is required to overcome barriers for implementation of PCA in GP practice (Table 10).

Table 10: Shared insights for required action to overcome barriers for PCA

	Core values & Mindset	**Tools & Techniques**	**Measurement & Indicators**
Insights from the literature study	PCC policy and research Integrative medicine GP-patient interaction Clinical complexity	Guidelines Interaction techniques Communication (methods) Technology	Objective outcomes Patient-oriented metrics Patients' viewpoint Personal capabilities
Insights from the explorative study	Continuity Individualized care Respect	Gatekeeping Health Information Technology Motivational interviewing Training and education	Prehistory Subjective indicators Biopsychosocial status
Insights from the interviews	Personalized care Responsibility Collaboration Meaningfulness	Communication Coaching Innovation Cooperation	Growth Feasibility Sustainability
	↓	↓	↓
SHARED INSIGHTS	**Continuity** **Responsibility** **Integrative care**	**Communication** **Innovation** **Cooperation**	**Biopsychosocial measures** **Goal-oriented outcomes** **Expectations**

7. DISCUSSION

7.1 The state-of-the-art of PCA in GP practice

7.1.1 Effectiveness and barriers in literature

Patient-Centered Approach (PCA) is thought to be beneficial for the doctor-patient relationship and has been associated with a large variety of positive patient outcomes (Clayton, 2011; Greene, 2012; Elwyn, 2014). Interventions to promote PCA within clinical consultation improved patient-centeredness and patient health outcomes as indicated by a range of measures relating to involving patients' concerns and beliefs; communicating treatment options; and patients' perception of providers' empathy and attentiveness to their concerns as well as their diseases (Dwamena et al., 2012). Besides, both short and long training for enhancing physicians' skills and ability to shared decision-making and control have shown to be successful.

Despite its potential, results of PCA remain mixed and inconclusive mainly depending on heterogeneous understanding, use and measurement of the concept. (Dwamena et al., 2012; Hudon, 2013). In a first attempt to clarify the concept, the literature study reduced the identified definitions into 5 key dimensions on different levels (table 5). Common dimensions related to the *patient's context, patient's agency*, *professional support*, and a *supportive system*. In particular the dimension of *doctor-patient interaction* was shared unanimously, which justifies it as a key component in GP practice and the suggestion to be a fruitful way for ensuring social acceptability of the inevitable health care reforms. However, the amount of definitions for PCA reflects the multiplicity of values, strategies and outcomes and the unawareness about how these overlap, complement or even may strengthen each other (Epstein, 2014b).

Critically seen, literature shows a major contradiction in the acknowledged potential of PCA while inconclusive results still hamper its application. Hence, it can be questioned what deters the necessity to give the concept of PCA more tangible substance for achieving its full potential.
A possible explanation may be that supportive literature on PCA lags behinds because research is still committed to decisive evidence for PCA. However, due to the multifaceted nature of the concept, there is realistically little point in focusing on a one-to-one relationship between PCA and outcomes. In fact, the apparent effectiveness of PCA actually justifies to identify the 'active elements' of the multifaceted nature of PCA (Dwamena et al., 2012). This encompasses a clear need for research in other setting whereas identification of active elements will enhance adaptation to the uniqueness of PCA in each consultation and to differences in context and goals.
The recognition that the challenge in front of us is not just identifying best practices and creating new standards for PCA has already been pronounced and expressed (Klinkman & van Weel 2011). For genuine transformation in GP practice, there must be build from bottom up and identified how to integrate those elements that are absolutely critical to its success in everyday care.
Astonishingly, within the reviewed literature, the meaning of PCA continues to include a set of concepts that are compatible and opinions vary about which components and which outcomes of PCA are most important. Different elements of PCA are differently constructed, used and valued by different stakeholders, and for different reasons (Dwamena et al. 2012).
On that account, it seems plausible that implementation of PCA foremost is hampered through barriers on a higher level. The foundations of PCA are largely dependent on health policy and governmental influence. Application of PCA requires a health care system that is organized around patient-centered principles rather than around management of diseases. Addressing PCA on all levels of care to overcome barriers may establish better coordination, integration and efficiency of care (greenfield, 2014) and enables seeing PCA as a resource rather than as a burden (Ishikawa, 2013).

7.1.2 Effectiveness and barriers in GP practice

However, because the state-of-the-art in literature is not necessarily equal to what is practiced, the explorative study was considered as an adequate complementary approach. The mind-set of both GP an NP strongly aligned with the basic premises of PCA from the theoretical framework, based on a continuous relationship with patients over time. Further application of PCA in particular appeared hampered by perceived time constraints and a challenging balance between respecting and responding to the unique character of each patient, and on the other side the health care system holding the GP and NP accountable for reporting on consultations and their actions. Practically seen, this confirms that difficulties with adhering to patients' autonomy while not undermining own expertise and working experience (Entwistle & Watt, 2013) form a considerable barrier for PCA in GP practice. On a more ethical level this aligns with barriers of what is stated in literature as 'difficult to determine how and what professionals should look for to ensure their way of delivering care is patient-centered while incorporating 'the person as a whole' (Davis, 2013).

Overall, the explorative results indicate that although application of PCA is desired, in reality the clear protocolling required by the system results in maintenance of unclear roles of both the GP and the patient. As a result, the contribution of GP mainly covers management of diseases rather than the enhancement of patients' self-healing capacities. Even though structural expansion of the Nurse Practitioner (NP) to take management of chronic care out of GPs' hands has proven to be operational on its own, it does not overcome the strict medical guidelines that overrule the application of PCA.

The current system's characterisation of general practice still seems to align with predominant evidence-based thinking. This involves that each presented problem should be given the most suitable diagnosis followed by the most effective intervention. However, clinical reasoning in general practice originally implicates to complement symptoms and signs with inclusion of contextual information and causation. When considering that GPs currently have to do with the short timeframes and a minimum of means, the current system nearly put GPs under the same umbrella as specialists. Simultaneously, that leaves little room for own interpretation of PCA in general practice. The same is equally true for the patients themselves whereby the emphasis on 'active patients' mainly seems mainly a means of reducing the costs rather than stimulating genuine involvement in health care. That does not offer an attractive perspective and is also not in line with empirical observations. Consequently, this hinders the essence of GP practice today that ideally is characterized by a context-sensitive and integral working method that pays attention to the patient as a whole and to the meaning of their complaints (WHO, 2009).

7.2 Insights from outside GP practice

7.2.1 Insights from professional-client interactions

Mapping distinct characteristics of each included profession outside GP practice appeared a first essential result preceding the interview analysis. It showed that the level of focus (defined population, individual or specified target group), the setting (professional or domestic) and the reason of visit (voluntary, occupational or compulsory base), largely determines the balance between professional guidance and the guiding autonomy of clients (table 9).
Whereas the context primarily was taken into account in all interactions, responding to contextual differences was acknowledged as a major challenge. This challenge mainly encompassed adjusting the interaction to each unique situation, based on both the clients' capabilities and on their own professional expertise and working experience. Although interviewees acknowledged the complexity that could arise from hierarchical structures, this was not perceived as deterring the expected or desired results.
Remarkably, while professional guidance was initially affirmed as a starting point in many interactions, through further inquiry the professional role becomes more nuanced. In general, interviewees modified to a form leadership that considerates authority as a basic principle which at all times should be complemented with shared responsibility. Critically seen, hierarchical tension not remains undetected but shows a rapid changeover into an emphasis on collaborative relationships. Hereby, a collaborative partnership over time was highly valued and in particular managed through outweighing short-term solutions and long-term perspectives. The interviewees further managed by ensuring clients to be involved in their own development, also referred to as by situational and/or coaching leadership. Overall, this enabled an appropriate professional distance that enhanced professional's empathy and credibility and led to an increased awareness of clients that control, responsibility, as well as opportunities were in their own hands.

However from another critical perspective, the perceived inferiority of hierarchical tensions could also relate to the often-indicated absence of strict guidelines and accountability that resulted in a sense of freedom. For a large part this enabled the interviewees to balance authority and autonomy at personal discretion. This also supported the necessity for expectation management to ensure mutual agreement on expected or desired results. The interviewees predominantly perceived self-reliance of clients as a main outcome whereas personal capabilities were frequently addressed by focusing on processes of growth, learning and wisdom rather than on biopsychosocial measures. To reach such results, professionals also felt more free to adopt and integrate tools and techniques that best suited the situation. In addition they frequently emphasised the importance of including alternative methods and using (modern) technology. Analytically seen, the perceived absence of predominating organizational or system rules thus also seems to allow more leeway for creativity and innovation. As indicated by the interviewees this also enhance their ability to provide unconditional support and positive regard.
Finally noteworthy, interviewees recognized that 'unconditionality' was also based on love and compassion for their work and the human being. To a greater or lesser degree these were interpreted as being major principles for achieving sincerely relationships and sustainable outcomes. Transferring such positive, active elements of professional-client interactions to interactions in health care could be of extensive value for achieving sustainable interaction in primary care and advancing PCA.

7.2.2 Comparing emerging insights from each research method

The emerging insights from all the three research methods appeared to have much in common and resulted into formulation of nine shared insights. Despite the shared insights, underlying values, interpretation or application at times appeared different.

Still, accounting for all methods, the insights frequently overlapped throughout the 3 structural framework elements. Elements that were primarily considered as a core *value* for the professional-client interaction, often were likewise perceived as an interactional *technique* or *outcome*. However, considering, accepting and using such relatedness may overcome the stagnation in research and practical application: it is believed that for improving responsiveness to needs, preferences and values for PCA, efforts should incorporate an understanding of the full range of factors that jointly influence advancement of PCA (Greene, 2012).

Continuity

Continuity of care mainly refers to a continuous relationship with a defined population over time. Accounting for both the literature and explorative study, time is considered as the most limited but essential resource in health care (Klinkman, 2011; Desborough, 2014). While the interviewees recognized the importance of professional-client relationships over time, they managed their time differently. Rather than focusing on the amount of time available per interaction, time was organized into outweighing short-term solutions and long-term perspectives, prioritisation, and mutual and feasible planning. As a result they perceived to be less time-limited and to have more freedom for own timetabling. Such a sense of freedom was highly valued by both professional and client and also enhanced the ability to provide unconditional support, positive regard and to establish a climate of respect, trust, understanding and mutual effort. Likewise in literature, respectful and trust-based relationships enable a good understanding of patient's personal situation and increase physician's credibility (Holmstrom & Roing, 2010). Patients founded their GPs' to be in a good position to acknowledge and promote their expertise and to help them maintain hope (Hudon, 2013). Involving patients' expertise and listening to their perspectives have shown to provide a caring and empowering context (Greenfield, 2014), and was similarly recognized in both GP practice and by the interviewees. This may advocate for adaptive strategies to ensure responsiveness to patient's problems as they experience them, not only as professionals define them (Starfield, 2011)

Responsibility

Within GP practice, the intended emphasis on patients' perceptions seemed to be partially undermined by more authoritative perceptions on organizational level due to protocolling and guidelines that emphasize management of diseases rather than determination of what creates health (Starfield, 2011; Davis, 2013). In addition, letting patients in control of their own health and care while adhering to an appropriate extent of professional authority, appeared a major challenge in GP practice. Although physicians are inclined to have a key role in inviting patients to be involved, (Ward et al. 2012) in GP practice it remains challenging for (enabling) patients to take on responsibility.

While the role of the patient as an active partner in health care has been increasingly acknowledged (Dwamena et al., 2012; Epstein, 2014a), the notion of 'agency' highlights that autonomy cannot be given to people or done to someone, but emerges from a more sustainable process where autonomy is mutually achieved (WHO, 2006). The interviewees managed working towards interactional sustainability by ensuring clients to be involved in their own development and by situational and/or coaching leadership. Overall, this enabled an appropriate professional distance that enhanced professional's empathy and credibility and led to an increased awareness of clients that control, responsibility, as well as opportunities were in own hands. Situational leadership mainly stimulated action competence and incitement to commitment and structure while taking into account the personal situation and capacities in order to building on client's their own strength. Coaching leadership mainly covered consciousness and ownership by letting clients discover by themselves the guidance you

envisaged. Both forms of leadership considerate authority as a basic principle, though at all times complemented by shared responsibility.

Integrative care

Whether referred to as individualized, personalized or tailored care, all insights jointly acknowledged the need for skilled professionals who are able to identify, adapt or to integrate methods that best suit the situation. Research among patients and physicians suggested that primary health care could have a central role in practicing integrative medicine because it is resulting from thoughtful integration of concepts, values and practices while maintaining the integrity of both models of EBM and PCM (Barret et al., 2003).

However, the current situational diversity in general practice that implicates different medical, psychosocial, cultural and communicational approaches has shown to be a major challenge. Though, the interviewees managed adapting to situational diversity by using complementary approaches based on mind-sets like 'openness to multiple perspectives', an 'everyday life perspective' or a 'holistic approach'.

Communication

Communication has been defined as the most consistently component of PCA and facilitates the ability to find common ground (Clayton, 2011; Constand, 2014). Effective communication should start with active listening—empathically attuning to patient's medical and nonmedical needs (e.g. values, fears, life events)—that can have major influence on both the process and outcomes of the interaction (Greene, 2012). Even though the mindset in GP practice and of the interviewees perfectly aligned with values of listening and empathy, interpersonal communication skills remain crucial.

What we now call communication skills have earlier been acknowledged in terms of a non-directive method that avoids advice, suggestions, interpretations, or other directive techniques but fully relies on professional's accepting and listening to the client to achieve a therapeutic atmosphere and self-actualization (Rogers, 1950).

In particular the method of Motivational Interviewing (MI) acknowledges that through conversation patients can be enabled to recognize their ambivalences and find out how to achieve goals that give meaning to their lives (Maizes et al., 2009). Although MI has the potential to address a number of common complexities, within the GP practice, consultations encompass more than resolving ambivalence and enhancing motivation. It is argued that comprehensive patient-centered interactions require elements of both a biomedical focus and of non-directive methods (Smith et al., 2013). Correspondingly, interviewees in particular took advantage of several elements of MI that primarily included self-reflection, achievement of life goals and open-ended methods. Besides, interviewees emphasised the importance of keeping interactions approachable while using simple language and offering safety and exemplary behaviour when appropriate. They managed by complementing 'conventional' communication strategies with the use of alternative methods like non-verbal approaches (e.g. expression, body language), methods of drawing and visualising, and feedback and feed forward.

Innovation

In addition to alternative methods, interviewees stressed the advantages and benefits of interactions in domestic setting as well as the use of modern communication technology (e.g. skype, facetime). The latter was regarded as desirable, quick and efficient, whether the first enhanced genuine communication and increased understanding of (the needs within) the client's personal situation.

Similarly, doctor-patient interactions have expanded beyond the in-office visit by means of virtual medicine, peer support groups, and a range of information and communication technologies that support decision-making and provision of care (Greene, 2012). According to literature, it is argued that because visit-based and conventional communication strategies will decline (Yee, 2011), information-based technologies may be helpful in achieving PCC (Epstein & Street, 2011; Sacristán 2013). In GP practice, and in particular the NP with regard to chronic care, the information chain system and follow-up of technological developments were perceived

helpful and essential. However, the explorative study indicated that incorporation of eHealth is somewhat ambitious to serve the current generation. Besides, rather than consultations out of office, general practice mainly continued to be location-depended. Furthermore, due to medical accountability, integrity and privacy protection technological feasibility for general practice requires further exploration. Interviewees mentioned to minister such feasibility in terms of entrepreneurship, which involved on-going innovation while keeping anticipating and securing own profession-related borders.
Another more joint perspective on innovation concerned profession-related training and education, which was a shared value among all emerging insights. In literature, both short and long term training for providers' interpersonal skills and patient-centeredness was shown effective and recommended to be included in pre- and post-graduate training and certification (Dwamena et al., 2012).

Cooperation
Because medical information gained accessibility, patients have become more interested in their health care (Choi, 2015). Through disposing of alternative opinions about diagnosis and treatment, patients' expectations and preferences have made their way (Dwamena et al., 2012). Long traditions of the belief that professionals know what is best for their patients have made room for the view that patients are, beside the professional, experts on their own bodies and capabilities (Holmstrom & Roing, 2010), which should be acknowledged by means of collaborative interactions (Hall, 2012; Krucien, 2013). Although sincere collaborative relationships were highly valued in both GP practice and among all interviewees, collaboration with other –health care- professionals was perceived equally important. Specifically the interviewees ought to cooperate with other caregivers and/or social services whereas outsourcing of expertise was considered to add value on the long term. However, due to the generic nature of primary care, rising health care costs, and patients' preferences, accurate referral to 2nd and 3rd was indicated to be a precise effort. An early solution in literature, which nowadays could be taken as an exemplary valuable tool, was the 'Balint group' method that involved consultation presentation and discussion in small groups of GPs in order to share expertise, experience and workload (Balint, 1969). Furthermore, 'Balint groups' improved therapeutic potential because GPs became better listeners and were encouraged to see their patients as human beings. Overall, with regard to current efficiency and well-known time constraints, linking appropriate referral to sharing of workload between health care professionals, is deemed crucial to primary care (Krucien, 2013).

Biopsychosocial measures
Originating from Engel (1977), the biopsychosocial model aimed to make medicine more scientific and humanistic at the same time by revive the lived experience of the patient while adhering to the successes of the biomedical model. Because attention to patients' problems in the context of their multimorbidity nowadays cannot be reduced to single objective measures, the focus has shifted towards symptoms, signs and the patient's perspective (e.g. social and physical functioning, QoL) (Godlee, 2012; Reuben, 2012). Therefore, traditional diagnosis, interpretations and laboratory values require complementation of recognizing health problems that are perceived important to people (Starfield, 2011). As indicated by both GP and NP, their continuous relationship with patients is intrinsically linked with the incorporation of patients' prehistory and the importance of both objective and subjective measurement. However, next to inclusion of their past life-story, building on patients' pre-existing knowledge was considered as an enduring challenge. By contrast, legitimization of illness experience and a 'shared narrative' has shown to influence patients' self-confidence and coping abilities and can be helpful in everyday practice (Cocksedge, 2011; Hudon, 2013).
Interviewees indicated not to restrict to specific objective measures and felt free to incorporate measures that matter to them most. While feeling less dependent on specific biopsychosocial measures, according to own insights they interconnected outcomes as for instance: socio-emotional scores and physical-emotional scores; assessing knowledge by social skills; linking IQ and EQ to SQ; and incorporating wisdom and happiness. Finally, it was emphasised that not all in

life is measurable and controllable whereupon great value was attached to life lessons and experience. Potentially relevant for GP practice, literature affirmed that drawing on life experience and knowledge enables patients to develop new skills and to move towards actions as well (Hudon, 2013).

Patient-oriented outcomes

Viewing the person as a whole has long been acknowledged to provide a supportive and growth-producing atmosphere in the process toward self-determination and 'becoming a more fully-functioning person' (Rogers, 1957). Nowadays, recognition for self-efficacy, self-management and self-determination has been a revived, rapidly increasing component of primary health care (Hudon et al., 2011; Cocksedge, 2011; Rathert et al., 2012). Although perceived as desirable components, application in GP practice is less self-evident because of varying patients' willingness and capabilities in achieving these components. The interviewees unanimously perceived self-reliance of clients as a main outcome whereas personal capabilities were frequently addressed by focusing on processes of growth, learning and wisdom rather than on biopsychosocial measures. In accordance with literature, the 'Capability Approach' involves an interpersonal relationship and professional support that people may need to develop their personal autonomy capabilities and to what they pursue in life (Davis, 2013). Despite well-established application in international human development, further exploration is needed to illuminate its specific potential within health care (Entwistle & Watt, 2013). Other alternative approaches in literature have recommended goal-oriented outcomes that focus on achievement of personal goals across a variety of dimensions and determine how well these goals are being met (Reuben, 2012). As such, clinical usefulness is conceptualized to include the dimension of "personal utility" and may be an empowering strategy towards making changes and achieving life goals (Hall, 2012).

Expectations

Although direct measures are required to assess quality and effectiveness, further selection of outcomes should focus on measures seen as important by both patients and physicians (Dwamena et al., 2012). Among others, self-reported measures have demonstrated to adequately assess the felt impact of health care processes and to complement observational measures. However, in GP practice, quantifying the value that should be attached to patients' satisfaction and other subjective measurement remained disputable due to its resemblance towards 'patients as consumers'. What patients want, does not always reflect what they need. In some occasions patients may express unrealistic expectations with regard to consultations, treatment and outcomes. The interviewees succeeded to keep interactions realistic by means of expectation management. Therefore they mainly focused on improvements that were satisficing for both parties and at all times were feasible and adjusted on a personal basis. On the one hand professionals should therefore be receptive to clients' cues, and on the other hand clients' should express their feelings and fears. As such, incorporating agendas of both professional and client has shown to make corresponding or conflicting perceptions visible and to offer opportunities for negotiation and coming together, as opposed to traditional paternalistic approaches (Constand, 2014).

7.3 Limitations

Accounting for all studies, limitations of the research process require transparency.
In order to achieve an increased understanding of the topic, this study had an exploratory research design and used three different research methods. Although findings from exploratory research could be susceptible to judgmental bias and are not easily generalized, the design allows the freedom to define what findings are considered as most relevant. For this study, all results were analysed through an interpretative lens whereas defining and comparing the most relevant emerging insights was crucial for answering the research question. Furthermore, the use of multiple methods can be considered as time consuming. Though, multimethod research expands the research to a broader and more comprehensive perspective on the issue. In particular the qualitative methodology enabled collection of rich data not available through other methods.

A limitation of the literature study was the assumption that the Cochrane review by Dwamena et al. from 2011 provided an adequate literature base for barriers and effectiveness of PCA interventions so far. There was only additionally searched for articles published in 2011 and onwards which might have excluded important work before. However, for achieving a state-of-the-art of PCA in GP practice today, up-to-date research was deemed most relevant. Besides, important work on PCA from the past was also incorporated in the theoretical framework.
Another limitation of the literature study was the exclusion of articles from solely a patients' perspective, which led to potential omission of relevant material. However much of what a patient experiences, occurs outside of the encounter in the GP practice. Likewise, what patients want does not always reflect what they need. Because the focus of this study was in particular on the GP-patient interaction and on implementation of PCA by GPs in practice, patients' perspectives and preferences were considered to be not fully covering the issue.
Overall, the literature study on PCA mainly concerned international publications while the explorative study and the qualitative interviews specifically were applicable to PCA within the Netherlands. Future research could overcome this discrepancy by further assessing the feasibility of the emerging insights of this study for Dutch General Practice Care.

A limitation of the explorative study was that pre-knowledge about PCA and subjectivity of the researcher could have influenced results. Though, a certain amount of previous knowledge on PCA was necessary for knowing what to observe and to enable high accuracy of the interpretations. Furthermore, because the subjective interpretations appeared to be highly for complementing the objective observations, the name of this research method was referred to as 'explorative study' rather than 'observational study'.

A limitation of the interview design was that participants were subjectively selected through purposeful sampling and not necessarily represents a professional-client interaction on its own. In spite of being regarded as judgmental or selective, developing an in-depth exploration of the central phenomenon was thought to be best achieved by a purposeful sampling strategy. Considered as a case study, each in-depth studied interaction led to unique interpretations and usefulness for the GP practice.
Finally, the richness of the interview data exceeded expectations. Considering the available time and space, the exploratory research only elaborated on the most relevant parts for this study. Future research could desirably identify the full potential of all the data.

7.4 Recommendations

Action that is required to overcome barriers for implementing PCA in GP Practice

7.4.1. Academic recommendations

The guiding principles of the theoretical framework still appear an adequate base for the emerging concept of PCA. In its origin, PCA is considered as involving a humanistic, biopsychosocial perspective that considers the person as a whole, emphasises a healing oriented relationship, and is seen as a core element of integrative care. In addition, achieving a therapeutic atmosphere requires an empathic professional that supports the patient towards empowerment based on their self-healing capacities.

Through an exploratory research design, the emerging insights not recommend a one-size-fits all answer, but correspond with the nature of PCA being no one-size-fits all approach
Because the variability in aims of PCA is reflected in the heterogeneity of outcomes measured, there is a clear need to determine which elements of multi-faceted studies are essential in helping patients change their healthcare behaviours. Identification of 'active' elements of apparent effectiveness of multifaceted interventions will enhance the adaptation to different health systems with different goals.

It is argued that PCA is equated with professional-client interaction and can be strengthened by an integrative care perspective that pays attention to the person as a whole (body, mind, spirit) while maintaining the integrity of EBM. Though**,** to enhance the potential of PCA it is necessary to differentiate the increasing specialization that is inextricably linked with the importance of EBM, whereas the general practice remains particularly characterized by an integrative and contextual working method. Subsequently, it should be recognized that a distinct professional expertise is underlying specialized care respectively general practice care. Whereas specialist's expertise is based on appropriateness according to clinical guidelines, GP's expertise also disposes of other resources of knowledge as for instance pre- and family history, and social- and mental functioning.

More ethically seen, GP-patient interaction not only extends beyond EBM but also beyond conventional communication. Future research should focus on more goal-oriented outcomes that centre on achievement of personal goals across a variety of dimensions and determine how well these goals are being met. As such, clinical usefulness is conceptualized to include the dimension of "personal utility" and may be an empowering strategy towards achieving life goals and changing behaviour rather than the people. Additionally, because consultations are more time-focused than visit-based, personal utility has also the potential to incorporate the accumulation of patient's knowledge.
Furthermore, observational measures should be complemented with self-reported measures whereas meaningful measures to both doctors and patients assess the felt impact of the interaction. Overall, future trials could specifically assess the influence on PCA from all levels of care including: changes in the organization of care in promoting PCA in the clinical consultation; training and interpersonal skills of physicians; and helping patients change their healthcare behaviours.

7.4.2. Practical recommendations

Taking into account the relevance of PCA at all levels may improve responsiveness to the values and needs of PCA in GP practice and enhance its application.
Foremost, efforts should incorporate organizational changes that disburden primary care from systemic pressure and productivity-driven health care. As a result this should enable physicians in achieving collaborative partnerships with their patients to empower them towards agents who are involved in their own health and well being.
It is emphasized that GP practice should be characterized by a context-sensitive and integral working method that pays attention to the meaning of patients' complaints. This requires an additional focus on inclusion of contextual information and causation. Being a gatekeeper implicates to enhance patients' self-healing capacities rather than management of diseases. Optimizing self-healing capacities may further advocate for adaptive strategies to ensure responsiveness to patient's problems as they experience them, not only as professionals define them. Responsiveness starts with becoming better listeners while providing room for self-reflection, because it is through conversation that patient can be enabled to recognize their ambivalences and to find out how to achieve goals that give meaning to their lives. PCA may extend beyond communication because much of it relies on knowledge of the patient that accrues over time and encompasses more than management of diseases. Working towards such relational autonomy could be addressed by ensuring patients to be involved in their own development. Through situational or coaching leadership, professional authority and expertise is maintained while patients through ownership based on their personal capabilities discover by themselves the guidance that is envisaged
Furthermore, professionals should be skilled to identify, adopt and integrate methods and perspectives that best suit the situation. Going beyond conventional communication approaches also emphasises complementation of PCA with non-directive, non-verbal and other alternative methods (e.g. drawing and visualising) that increase approachability and understanding of interactions. Technological innovation can be helpful but should not undermine genuine contact. Feasibility and what is best for each unique individual patient and not for the average should be considered. Cooperation can be best addressed by sincere collaborative relationships with patients and by sharing workload through precisely outsourcing of expertise to other health care professionals. In addition, for sharing expertise, on-going training and education should be seen as inherent to the medical profession.
To conclude, collaborative interactions require time-, and expectation management. Considering short-term solutions, long-term perspectives and both agendas of doctor and patient facilitates mutual understanding, trust, effort, negotiation and unconditional support, which may leave traditional paternalistic approaches far behind.

Astonishingly, the 'Hippocratic Oath' as the medical leading principle for GP practice, beautifully pronounces the reverence for both the GP and the patient. In the end, compassion for medicine is largely based on servitude, accompanied by an unconditional love for human beings. Referring back to the basis, this may provide a revived exploration to overcome barriers for implementing PCA in GP practice. The famous words "noblesse oblige" have proven its validity and implicate to keep looking ahead while retaining the good

8. CONCLUSION

On the one hand, achievement of a therapeutic doctor-patient interaction is suggested to be a fruitful way to strengthen health care and to ensure social acceptability of the inevitable health care reforms. On the other hand, definitions and results of PCA remain mixed whereas conceptual ambiguity, practical barriers, and ethical considerations hamper its implementation.
In short, literature shows a major contradiction in the acknowledged potential of PCA while inconclusive results still hamper its application.
In a first attempt to clarify the concept, the literature study reduced the identified definitions into 5 key dimensions on different levels. Common dimensions related to the *patient's context, patient's agency*, *professional support*, and a *supportive system*. In particular the dimension of *doctor-patient interaction* was shared unanimously, whereupon this study justified it as a key component for PCA in GP practice.
Subsequently, the guiding principles of the theoretical framework still appear an adequate base for the emerging concept of PCA. In its origin, PCA is considered as involving a humanistic, biopsychosocial perspective that considers the person as a whole, emphasises a healing oriented relationship, and is seen as a core element of integrative care. In addition, achieving a therapeutic atmosphere requires an empathic professional that supports the patient towards empowerment based on their self-healing capacities.

Although research seems still committed to decisive evidence for PCA, there is little point in focusing on a one-to-one relationship between PCA and outcomes. Achieving the full potential of PCA may be better achieved by paying attention to more meaningful and goal-oriented outcomes. Furthermore this encompasses a clear need for identifying active elements within the multifaceted nature of PCA.
Through assessment of professional-client interactions outside GP practice, this study gained insight into active elements of PCA to overcome the barriers for PCA in GP practice. Although interviewees acknowledged the complexity that could arise from hierarchical structures within their interactions, this not deterred their expected or desired outcomes. The perceived inferiority of hierarchical tensions seems plausibly related to the absence of strict guidelines and accountability that resulted in a sense of freedom. For a large part this enabled a balance between authority and autonomy at personal discretion. Overall, professionals managed an appropriate distance that enhanced professional's empathy and credibility and simultaneously led to an increased awareness of clients that control, responsibility, as well as opportunities were in their own hands.

By contrast, hierarchical tensions within GP practice remain to result in unclear roles of both GP and patient. On that account, it seems plausible that implementation of PCA foremost is hampered through barriers on a higher level. The current system's characterisation of general practice still seems to align with predominant evidence-based thinking. Simultaneously, that leaves little room for own interpretation of PCA in GP practice and does not offer an attractive perspective. Therefore it is urgent to restore the essence of primary care that ideally is characterized by a context-sensitive and integral working method that pays attention to the patient as a whole and to the meaning of their complaints.

Accepting the multifaceted concept of PCA enables to see it as a resource on its own rather than as a burden. Addressing PCA on all levels of care establish better coordination, integration and efficiency, and can overcome barriers for implementation of PCA through: incorporating organizational changes that relieve primary care from systemic pressure and productivity-driven health care; helping physicians in achieving collaborative partnerships with patients; and empowering patients towards agents who are involved in their own health and well being. Because in the end, the real strength lies in human being, not in the system.

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APPENDICES

It is more important to know what sort of person this disease has
Than to know what sort of disease this person has.

Attributed to William Osler, Physician (1849–1919)

APPENDIX I Textual Outline Literature Study

Table 1: **19 definitions and key dimensions of PCA/PCC**

Gerteis et al. (1993)	**PCC**: Respect for patients' values, preferences, and needs; coordination, integration and continuity of care
Mead & Bower (2000)	**Five distinctive dimensions of Patient-centered care**: (1) a biopsychosocial perspective; (2) patient as person; (3) having power and responsibility; (4) therapeutic alliance; and (5) doctor as person.
Stewart (2001)	**6 dimensions of Patient-centered care** (a) explores the patients' main reason for the visit, concerns, and need for information; (b) seeks an integrated understanding of the patient's 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; (e) enhances the continuing relationships between the patient and the doctor, and (f) being realistic)
IOM (2001)	**Patient-centered care**: respectful and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions.
Epstein et al. (2005)	**Three core values of patient-centeredness:** (1) considering patients' needs, wants, perspectives, and individual experiences; (2) offering patients opportunities to provide input into and participate in their care; and (3) enhancing partnership and understanding in the patient-physician relationship.
IAPO (2006)	To achieve **patient-centred health care**, health care must be based on **five principles**: (1) respect; (2) choice and empowerment; (3) patient involvement in health policy; (4) access and support; and (5) information.
Leplege et al. (2007)	The concept of **person centeredness has four main meanings**: addressing the person's specific and holistic properties; addressing the person's difficulties in everyday life; regarding the person as an expert who should participate actively in their rehabilitation; respecting the person "behind" the impairment or disease.
Mezzich et al. (2009)	**Person-centered care** is dedicated to the promotion of health as a state of physical, mental, sociocultural, and spiritual well-being, as well as to the reduction of disease, and founded on mutual respect for the dignity and responsibility of each individual person.
Berwick (2009)	**Patient-centered care** is "The experience (to the extent the informed, individual patient desires it) of transparency, individualisation, recognition, respect, dignity, and choice in all matters, without exception, related to one's person, circumstances, and relationships in health care".
The Picker Institute (2009)	**Patient-centered care encompasses 8 dimensions**: (1) respect for the patient's values, preferences, and expressed needs; (2) the provision of information and education; (3) access to care; (4) provision of emotional support; (5) respecting the involvement of family and friends; (6) providing for continuity and secure transition between health care settings; (7) ensuring physical comfort; and (8) ensuring coordination of care
McCormack et al. (2011)	"We define **person centred care** as an approach to practice that is established through the formation and fostering of therapeutic relationships…. [It] is underpinned by values of respect for persons, individual right to self-determination, mutual respect and understanding."
Hudon et al. (2011)	In the absence of a clear consensual model in the literature, the review of Hudon et al. employs **a patient-centered care framework based on** the **4 dimensions** common to Stewart et al and Mead and Bower's review: (1) disease and illness experience (patient-as-person in Mead and Bower's model), (2) whole person (biopsychosocial perspective), (3) common ground (sharing power and responsibility), and (4) patient-doctor relationship (therapeutic alliance).
Clayton (2011)	A popular definition of Davis et al. (In: 'A 2020 vision of patient-centered primary care') is that **patient-centered care** provides the care that the patient needs in the manner the patient desires at the time the patient desires
Dwamena et al. (2012)	**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".
Hudon (2013)	**Six major themes of patient-centered care**: 1) developing a partnership ; 2) promoting their interests in the health care system; 3) knowing and starting from their personal situation; 4) legitimizing their illness experience; 5) acknowledging their strengths and promoting their expertise and 6) helping them maintain hope.
Constand (2014)	**Patient-centered care** in healthcare is defined as care provision that is consistent with the values, needs, and desires of patients and is achieved when clinicians involve patients in healthcare discussions and decisions
Scholl et al. (2014)	**15 dimensions of patient-centeredness**: essential characteristics of clinician, clinician-patient relationship, clinician-patient communication, patient as unique person, biopsychosocial perspective, patient information, patient involvement in care, involvement of family and friends, **patient empowerment**, physical support, emotional support, integration of medical and non-medical care, teamwork and teambuilding, access to care, coordination and continuity of care.
Greenfield (2014)	**Six themes** representing core 'ingredients' **of person-centeredness** in the integrated care context: "Holism" *(I want to be treated as a whole person)*, "Naming" *(want to be acknowledged as a unique, respected, equal person)*, "Heed" *(I want to be listened to and get proper attention)*, "Compassion" *(I want to be cared for with authentic empathy and warmth)*, "Continuity of care" *(I want to be seen by the same doctor each time)*, and "Agency and Empowerment" *(I want to be involved in my care)*, all depicting patient expectations and assumptions on doctor and patient roles in integrated care. When these needs are met, patient experience of care is at its best.
Choi (2015)	**Patient-centered care**, in contrast to doctor-centered, refers to understanding a patient as a unique human-being, trying to grasp the thoughts and feelings of the patient, to communicate kindly with the patient (a concept of '**caring'**), and establishing a relationship of sharing medical information and power-sharing between doctors and patients (a concept of '**sharing'**).

Table 2. **Identified values, tools, and measurement with regard to a patient-centered approach**

References	Core Values & Mindset	Tools & techniques	Measurement & indicators
Dwamena (2012)	PCC interventions are effective	Shared Decision-Making (as an indicator for PCC) (Short-term) training of GPs	direct effects on patient encounters: consultation process variables indirect effects on patient outcomes: satisfaction, healthcare behaviour change and health status
Scholl (2014)	Inconsistent results. Evidence on the effects of patient-centered interventions on patient healthcare behaviors or health status is mixed.		15 dimensions of patient-centeredness Conceptual heterogeneity attains wide variety measurement and causes inconsistency in results
Davis et al. (2013)	Person-centered health care and the Capability Approach	Determine care priorities based on people's shared participation in determining their health self-management needs	QALY's ignore the clinician-patient relationship Creation of new "personal" capabilities-based metrics
Entwistle & Watt (2013)	Consideration of capabilities Patients as Persons	Standardized checklist are inflexible Argue for a Capability Approach	Outcomes that reflect what people say they value in life and appreciate from service provision
Hodgkin & Taylor (2013)	Medicalisation and marketisation	Truly patient-centered consultation incorporates the provision of information to patients and the tools to make a truly informed decision.	
The Lancet (2012)	Patient Empowerment		
Ryan et al. (2014)		Range of economic techniques that might be used to generate quantitative estimates of the value of experiences of healthcare delivery	Economic Valuation Methods
Greenfield	Person-centeredness		Six themes representing core ingredients of person-centeredness in integrated care context
Elwyn (2013)	Patient decision support interventions (DESIs)		The International Patient Decision Aid Standards (IPDAS) has produced a checklist and an instrument to assess the quality of patient decision aids interventions
Elwyn (2014)	Integration of SDM & MI	Shared Decision-Making (SDM) Motivational Interviewing (MI)	
Constand (2014)	25 different Patient-Centered Care (PCC) frameworks/models :3 main objectives of patient-centered care provision should include effective communication, partnership, and health promotion	Patient-Centered Clinical Method Information provision and uptake by the healthcare professional, as well as respect for patient autonomy are main facilitators of a positive clinical interaction.	Consensus on 3 components of patient-centered care provision Effective communication is the most definable and consistent component of patient- centered care.
Clayton (2011)	Patient-Centered communication	Measure of Patient-Centered Communication (MPCC) & 4 Habits Coding Scheme (4HCS)	Methods for evaluating competency in communication and interpersonal skills include patient satisfaction surveys, audio or video recording of real or simulated patient encounters, and behavioral checklists.
Ishikawa (2013)	4 perspectives on patient-Centered communication Patient Competence	Ottawa Decision Support Framework (for shared decision-making)	OPTION (observing patient involvement) scale Decisional Conflict Scale
Klinkman (2011)	The disease technology path and The person-centered path	Primary Care Model Three-dimensional biopsychosocial model	International Classification of Primary Care
Hudon (2011a)	The Patient-Centered Medical Home (PCMH)	Whole-person approach	Patient Perception of Patient-Centeredness (PPPC) and the Consultation Care Measure (CCM) Direct observation and self-assessment
Hudon (2011b)	Patient Enablement The instrument can be used to measure enablement after consultation in a family practice setting.	Patient Enablement Instrument (PEI)	Measure quality of the consultation Health outcomes: Self-Management and QoL Intermediary outcomes that promote coping or self-efficacy that are linked to health and behavior change.
Codern-Bové (2014)	Incorporating different forms of expression during the	Motivational Interviewing: could help to build patient-centered health care	Motivational Interviewing Skills Code (MISC) and Motivational Interviewing Treatment Integrity

	Motivational Interviewing	relationships.	(MITI)
Desborough (2014)	Patient Enablement and Patient Satisfaction		Patient Enablement and Satisfaction Survey (PESS): could provide a comprehensive indicator of the effectiveness of care
Mercer (2012)	(Patient perception of) GPs empathy and Patient Enablement	The consultation is the core activity of general practice	CARE (empathy) measure and Patient Enablement Instrument (PEI)
Hudon (2013)	Partnership with their family physician is the most important aspect of enablement.	Family physicians are in a privileged position to enable patients: The Enabling Process	Individual Empowerment
Sanders (2013)	Patient Participation	Shared Decision-making (SDM)	Patient-oriented outcomes and disease-oriented outcomes
Hall (2012)	A truly collaborative therapeutic relationship is a powerful motivator.	Motivational Interviewing Transtheoretical model of behavior change (the 'Stages of Change')	Patient outcomes improve when they are an active collaborator in their treatment. Motivation is a dynamic state that can be influenced, and fluctuates in response to a practitioner's style.
Cocksedge (2011)	Holding relationships in primary care Both GP and patient emphasize the importance of pre-existing knowledge of past life-story,	Establishing and maintaining a trusting, constant, reliable relationship that is concerned with ongoing support without expectation of cure.	Quality and Outcomes Framework (QOF) Allocation of value away from biomedical indicators towards essentially unmeasureable aspects of primary care, such as doctor-patient relationships over time.
Brusse (2013)	Satisfaction depends on the fulfillment of prior expectations for medications, tests, referrals, and other onward services for which the general practitioner is in effect a 'gatekeeper'.	Patient Enablement Instrument (PEI)	Consultation Outcomes With the wide variety of health issues that present, primary health care is handicapped by a lack of alternative, generally appropriate, patient-focused performance measures.
Olsson (2013)	Interaction between a patient and the care provider is the key component.	Person-Centered Care as an intervention	subjective measures (well- being, quality of care and patient satisfaction) and objective endpoints (HbA1c, BMI, cost of care, length of hospital stay)
Rathert (2012)	Mixed relationships between PCC and clinical outcomes Patient-Centered Medical Home	Whole-person approach	Clinical Outcomes Patient Satisfaction, Self-Management Future research should identify moderating and mediating variables between PCC and outcomes

Textual Outline Literature Study

1. Core values & Mindset

General practice

Throughout the world consensus exist about the purpose of primary health care to serve the health care **needs** of the population. **Core activities** of general practitioners have been described as: to understand the full range of clinical problems presented by patients and carry out preventive services; to help patients identify and manage health risks; to take into account the social and personal context and to involve patients' priorities and goals when making decisions about treatment (Klinkman, 2011). Despite worldwide variations in circumstances and processes of health care, the risen demand for care in line with the ageing population and the increased number of chronic diseases have internationally led to re-organizations of the general practice (Krucien, 2013). Because cure is not always possible and the boundaries of pathology are often unclear, the traditional biomedical approach may be insufficient in managing these everyday problems in current practice (Cocksedge, 2011).

Patient-Centered Care

In favor of clinical encounters that support and maintain rather than cure, reorganizations followed a **patient-centered model**. This model points to an overall reorganization of primary care focusing on the patient rather than disease and promotes the active involvement of patients in care delivery (Krucien, 2013; Olsson, 2013). For delivery of care, the interaction between the patients and the health care provider has been widely acknowledged as a key component of in general practice (Hudon, 2011; Olsson, 2013). Reorganizing health care through the prism of **doctor-patient interaction** is thus suggested to be a fruitful way to insure social acceptability of health care reforms, to strengthen primary health care and subsequently improving quality and efficiency of the overall health-care system (Krucien, 2013).

Patient-Centered Care (PCC) is thought to have many benefits and has been associated with a large variety of positive patient outcomes including adherence to treatment, improved self-management and health (outcomes) and greater patient satisfaction (Clayton, 2011; Elwyn, 2014). It may also improve patients' emotional state and reduce malpractice complaints, symptom severity, use of health care resources and health care costs (Hudon, 2011; Constand 2014). The Cochrane review of Dwamena (2012), also demonstrated that patient-centered interventions are effective but also

highlights differences between direct and indirect effects. Generally positive direct effects were found but results on indirect effects were **mixed**. Mixed **results** on healthcare behaviors or health status were also concluded by the earlier version of the Cochrane review by Lewin et al. in 2001. Other results suggested that the positive relationship between PCC and health outcomes is mainly achieved indirectly through intermediate pathways like achieving mutual trust (Street et al. in Clayton, 2011). Likewise, mixed relationships were found between specific elements of PCC and clinical outcomes but simultaneously positive relationships between PCC with intermediate and distal outcomes (Rather, 2012; Scholl, 2014).

International legislation

Patient-Centered Care (PCC) has been advocated in policy and practice developments to promote patient-centeredness on the level of legislation and regulation of health care (Scholl, 2014). It has gained **international** acknowledgement as a core value in general practice, among others by the Geneva Conferences on Person-Centered Medicine from which the International College of Person-Centered Medicine (ICPCM) emerged (Scholl, 2014). In the UK, PCC is a core element in professional medical guidance and is on the agenda of the British National Health Service (NHS) (Zill, 2013) and of influential British think tanks like the Health Foundation and the King's Fund (Scholl, 2014). In 2003, Health Canada emphasized the essence of patient-centeredness in health care by creating the Interdisciplinary Education for Collaborative Patient-Centered Practice (IECPCP) initiative (Zill, 2013). In Germany, a large research priority program on patient-centeredness and chronic diseases was launched in 2007, including a total funding volume of over 20 million Euros allocated to 77 research projects (Zill, 2013; Scholl, 2014) In 2010, patient-centeredness has been framed as a core principle of the Australian Safety and Quality Framework for Health Care (Scholl, 2014). In the United States, the Institute of Medicine (IOM) put forward patient-centeredness as one of six goals for improvement of the US health care system. This has been supported by the Patient Protection and Affordable Care Act (PPACA) in 2010, which also led tot foundation of the Patient-Centered Outcomes Research Institute (PCORI) to foster better research on PCC (Zill, 2013; Scholl, 2014). In addition, the PPACA has turned attention toward innovative delivery systems that include elements of PCC to better serve the needs of individual patients, such as accountable care organizations, loan repayment schemes and the Patient-Centered Medical Home (PCMH) (Rathert, 2012). The latter specifically accounts for primary care and has been defined by the American Academy of Family Physicians as: 'a model of health care delivery that is based on ongoing personal relationship with a doctor, which provides continuous and comprehensive health care' (Klinkman, 2011). A general practice that operates as a PCMH applies a whole person approach and consists of a personal doctor coordinating all involved health care professionals who are responsible for the ongoing care of the patient throughout all stages of life (Hudon, 2011; Klinkman, 2011; Rathert, 2012).

Multiform complexity

An overall challenge in primary care are frequently attending patients with **chronic** and **complex** problems, which has major influence on the **doctor-patient relationship** (Cocksedge, 2011). Another challenge is patients primarily presenting their complaints rather than diseases when consulting their GP (Sanders, 2013). This requires skills going further than diagnosis and treatment but rather of **listening**, ongoing **accessibility** and **empathy** (Cocksedge, 2011). Complexity in clinical consultations vary from long-term health conditions to preventative or end-of-life care, which all implicate different **psychosocial**, **cultural**, **medical** and **communicational approaches** (Elwyn, 2014). In many situations the problems presented do not fit neatly into one or another category or may have different effective or preferred treatment options. Also, PCC is accomplished over time and thus encounter changing circumstances, priorities, guidelines and medical knowledge (Klinkman, 2011). PCC therefore requires practitioners who are skilled enough to **integrate**, where needed, **methods** of biomedicine with patient-centeredness (Elwyn, 2014). Several other **barriers** have been found in financial, technical and organizational elements and include: payment schemes corresponding with GPs' activities, financing of information technology and referral to secondary and tertiary care (Krucien, 2013). Appropriate referral among others includes the sharing of workload between health care professionals, which is crucial for factors such as efficiency and time (Krucien, 2013).

Consultation Time

Regarding the current circumstances of health care delivery, time is the most limited resource (van Weel, 2011). Besides skills and professionalism, the **consultation time** is essential for PCC (Desborough, 2014). This aligns with the Dutch Patient Consumer Federation (NCPF) who considers time as one of the most important prerequisites for adequate consultation. General practitioners have between 7 and 20 minutes to address 2–7 different problems, resulting in an average of having 4 minutes per problem (van Weel, 2011). Even though patient-centered consultations may only take 30-50 seconds more time than a traditional biomedical approach (in Brand & Stiggelbout, 2013), often physicians claim the opposite and frequently indicate to experience time pressure (The Lancet, 2012). What is expressed by GPs' as beyond their control seems in conflict with patients' reported difficulties on waiting time, accessibility and coordination of care (Hudon, 2013). Practitioners now frequently cope by using short cuts and quick decision strategies based on incomplete information to have time left to sort out the problems that require specific care (Klinkman, 2011). Together with inflexible use of standardized checklist approaches, this may constitute barriers in the pursuit of patient-centeredness (Entwistle & Watt, 2013). Noticeable, when practitioners properly attend and adapt their advices to the patients' context, it may save further tests, time and even costs (Greenfield, 2014).

Conceptual ambiguity

Patient-centered care can only become reality if barriers on all relevant levels have been overcome and ways to address them are socially accepted (Scholl, 2014). Besides financial, technical and organizational aspects, other barriers originate from the concept of PCC itself. The current state of art has shown heterogeneous use of the term (Hudon,

2011; Scholl, 2014). Most frequently cited for general practice, is the model developed of Stewart et al. (2001) which proposes 6 dimensions of PCC: exploring both the disease and the illness **experience**, understanding the **whole person**, finding **common ground**, incorporating **prevention** and **health promotion**, enhancing the **patient-doctor relationship**, and being **realistic**. Still, a comprehensive and systematic analysis of existing conceptual definitions is lacking. **Table 1** shows the identified key definitions and dimensions of PCC for this study. Explanations for conceptual ambiguity vary from statements of patient-centeredness being a multifaceted construct (Ishikawa, 2013) to patient-centeredness as a poorly conceptualized phenomenon (Scholl, 2014). The different understanding of the concept including its many related terms may lead to confusing or misleading ways of use and may constitute a barrier to the implementation of PCC (Entwistle & Watt, 2013; Scholl, 2014).

Frameworks and models

Recent efforts have urged to disentangle conceptual ambiguities whereas several frameworks and models have been proposed. Frequently cited is the model of Mead and Bower (2002) who reviewed the conceptual and empirical literature on PCC and the various aspects of the doctor-patient relationship. They identified the following dimensions: **biopsychosocial perspective, patient-as-person, sharing power and responsibility, therapeutic alliance, and doctor-as-person.** A more recent framework by Hudon et al. (2011) combined the frequently cited model of Mead & Bower (2002) with the well-known model of Stewart et al. (2001) into 4 dimensions: (1) **disease and illness experience** (doctor and patient-as-person), (2) **whole person** (biopsychosocial perspective), (3) **common ground** (sharing power and responsibility), and (4) **patient-doctor relationship** (therapeutic alliance).

Ishikawa et al. (2013) aimed to account for the multifaceted concept by adopting four major sociological perspectives (functionalism, conflict theory, utilitarianism and social constructivism), each addresses different aspects of the doctor-patient interaction. Because the theoretical perspectives all define expected roles and goals within the interaction differently, this may explain the conceptual and operational confusion regarding PCC.

Another model for PCC integrated 15 identified dimensions mapped onto different levels (micro, macro and meso) of care (Scholl, 2014)(see also table 1). All dimensions were seen as interrelated rather than independent, as reflected in the analyzed literature. The dimensions were divided into underlying *principles* of patient-centered care (**unique person, biopsychosocial perspective, essential characteristics of the clinician and clinician-patient relationship**), which could be implemented by a range of patient-centered *activities* (**patient information, patient involvement in care, involvement of family and friends, patient empowerment, physical and emotional support**) and *enablers* (**clinician-patient-communication, integration of medical and non-medical care, coordination and continuity of care, access to care, teamwork and team building**) that could be helpful to implement those activities.

The most recent scoping review of patient-centered approaches in health care by Constand et al. (2014) found 25 different frameworks and models. For all existing frameworks and models it is argued that consensus exists on three core objectives of patient-centered care including effective communication, health promotion and partnership, whereas patient-centered communication has been described as the most definable and consistent component of PCC.

Patient-centered communication

Patient-centered communication is considered the most central component of patient-centered care (Clayton, 2011; Ishikawa, 2013; Scholl, 2014). Though patient-centered communication and patient-centered care are two interwoven concepts whereupon questions remain whether patient-centeredness can be seen as an approach or a communication style (Clayton, 2011). Epstein et al. (2005) distinguished the following 4 domains of patient-centered communication: *eliciting and understanding the **patient's perspective**; understanding the patient within his or her unique **psychosocial context**; reaching a **shared understanding** of the problem and its treatment with the patient that is concordant with the patient's values and helping patients to **share power and responsibility** by **involving** them in choices to the degree that they wish.* Later on, Epstein and Street (2011) highlighted 6 components of patient-centered communication: *fostering healing **relationships**, exchanging **information**, responding to **emotions**, making decisions, managing **uncertainty**, and **enabling** patient **self-management** which also includes facilitating **patient navigation** and **patient empowerment**.* In 2011, the study of Clayton described four domains of patient-centered communication: the **patient's perspective**, the **psychosocial context**, **shared understanding**, and **sharing power and responsibility**. Besides the manifold definitions, patient-centered care and communication share the aim to address patients' individual values, concerns and needs. Though, whereas effects of PCC are mainly indirect, patient-centered communication trials have demonstrated to improve physiological measures (blood pressure and blood sugar), behavioral measures (treatment adherence and psychosocial adjustment) and subjective measures (satisfaction and evaluation of overall health status) (Ishikawa, 2013; Greenfield, 2014). Improvement of health outcomes requires effective communication that encompasses the exploration of disease and illness of patients in order to develop an understanding of their healthcare experiences (Constand et al. (2014). Exploration revealed three main communication elements *(**sharing information; compassionate and empowering care provision; and sensitivity to patient needs**)* and key strategies (***surrounding information provision and uptake by the healthcare professional, as well as respect for patient autonomy**)* that were main facilitators for a positive patient-centered consultation. Correspondingly, Greenfield (2014) showed that by means of the acknowledged importance for patients' **psychosocial**, **physical needs** while **empowering** and **listening** to them, patient-centered communication has the ability to broaden traditional biomedical approaches.

Empowerment

Study results emphasize the need for physicians to observe and accept patients' choices regarding their own health rather than to control and determine what may be best for patients (Holmstrom, 2010). This provides opportunities to differentiate between patients who prefer a passive role and patients who are willing to play an **active role** in making decisions regarding their health. Accordance to patient-centeredness, the concept of patient empowerment has in

common the emphasis on **shared responsibility** and a **collaborative relationship** between doctor and patient based on **respect** and **trust** in each individuals beliefs. A comparative concept analysis by Holmstrom (2010) demonstrated that patient-centeredness and patient-empowerment are complementary approaches and had similar outcomes like enhanced treatment compliance, fewer diagnostic tests and referrals, positive patient health outcomes and patient satisfaction. By an increased understanding of their own viewpoints patients can empower themselves through enhanced self-management of their health. Though, this requires awareness of the significance of beneficial behavior changes to their lives. On the other hand, patient empowerment can be achieved through a process of patient-centeredness. This suggest that patient empowerment is broader than patient-centeredness, which may place greater demands on physicians and organization of the health care system in order to enhance and promote patients' ability to feel in control of their health. (Holmstrom, 2010). In spite of the conceptual similarities, application of PCC and empowerment has been far from obvious. The concepts have often been used interchangeably or even been treated as synonymous (The Lancet, 2012). This has emphasized the need for a return to their basics in order to clarify confusions.

During a first European Conference on Patient Empowerment (ENOPE, 2012), over 250 participants have discussed how patient empowerment should be defined. Consensus was achieved on patient empowerment as a process of helping people gaining control which encompasses to take initiative, to make decisions and to solve problems (Lancet, 2012). Empowerment multiple times has been framed as an individual process that involves exploration of their own strengths and ideas, reduction of sadness or anxiety and improvement of self-esteem (Hall, 2012; Hudon, 2013). By drawing on life experience and knowledge, patients are able to develop new skills and to move towards action as well (Hudon, 2013). As a result, being able to make more individual and healthier choices can improve health (Hall, 2012).

Likewise, from a patients' perspective, Hudon (2013) proposed several corresponding elements for fostering empowerment: understanding patients' context and promoting their interests and expertise; developing a partnership; legitimizing their illness experience, acknowledging their strengths and helping them maintain hope. Also the Lancet (2012) demonstrated joined expertise and decision-making to be key elements for successful implementation of patient empowerment. Although many future challenges have been identified, starting a dialogue on patient empowerment within collaborative relationship has been regarded a critical next step.

However, it has been widely acknowledged that people differ in their abilities to understand and foresee the consequences of their (healthy) behavior. Additionally, patients often dispose of limited or conflicting information on healthy lifestyle choices, Therefore, they cannot be full actors without the encouragement to become knowledgeable, better skilled and to **gain confidence** and experience in the **self-management** of their health care (Lancet, 2012). Although empowerment is not meant to substitute professional acute care, by learning to self manage, people will learn to make decision that are best suited to them. Health and social services are supposed to around someone's life and not the other way round (Lancet, 2012). In particular for long-term conditions, participants of ENOPE (2012) agreed that it cannot be afforded to neglect empowerment. Simultaneously, international political commitment for patient empowerment is forthcoming: patient empowerment is embedded in a new European health policy (Health 2020) by The WHO Regional Office for Europe. Implementing empowerment in health care systems is possible if it can be seen as a resource, not as a burden for doctors and patients. As stated by the ENOPE (2012): "Empowerment is not about trying to wrest power from the doctors, it is essentially helping people lead more proactive and fulfilling lives". It is also about respecting rights and voice, therefore soliciting both doctors' and patients' perceptions about how to promote enabling attitudes is an essential step. Physicians are in a privileged position to enable patients, by their attitudes and behaviors, to gain control over and improve their health and to increase their individual empowerment (Hudon, 2013).

Patient Enablement

The study of Hudon (2011) defined **patient enablement** as the extent to which patients are capable of understanding and **coping** with their issues of health. The concept is linked with positive changes in quality of life, in main complaints, well-being and self-management (in Hudon, 2011). To maximize the impact of physicians' interventions, trials also demonstrated the importance of understanding patient's personal lifestyles, desires, expectations and concerns that could help patients making choices and taking action. This professional intervention has been framed as "**the enablement process**" aiming to recognize, support and emphasize patients capacity to exert control over their health and lives (Hudon, 2013).

Empathy

The study of Mercer (2012) showed that although various factors influence enablement, perceived GP **empathy** is crucial for patient enablement in general practice consultations. In particular patients with longstanding problems, with 3 or more long-term conditions or multimorbidity (reflecting poor chronic general health) showed reduced enablement scores. Whereas emotional distress demonstrated additional negative effects, patients' perceptions of the doctors' empathy had positive effects on patient enablement (Mercer, 2012). Moreover, low perceptions of GP empathy never led to maximal patient enablement and therefore the study results suggested a link between enablement, empathy and outcomes (in Mercer, 2012). Likewise, Hudon (2011) indicated that a **trust-based relationship** and a good **understanding of patients' personal situations** combined with **professional competence**, increased physicians' **credibility**. Subsequently, credibility could increase awareness, stimulate the willingness to discuss behavioral change and the ability to take action. In other words, patients have founded their GPs' to be in a good position to acknowledge and promote their expertise, and to help them maintain trust and hope (Hudon, 2013).

Patient participation

"Medical consumerism" has provided patients with privileges of choice and medical information accessible online have influenced the dominance of knowledge by physicians (Greenfield, 2014). Goodyear (2013) showed that because patients' roles have become more diverse, this allowed greater engagement with managing their health. Engaging patients in **self-management** has been a rapidly increasing component of primary health care and has emerged

alongside other coexisting evolvements. As active collaborators in clinical consultations, patients (health) outcomes, treatment expectations and adherence can improve (Hall, 2012). Furthermore, physicians can encourage patient participation by recognizing the patient's expert role and involving their **self-efficacy**, concerns and preferences (Greenfield, 2014). Patients have confirmed that legitimization of their feelings maximized the impact of their physician's intervention (Hudon, 2013). Though, a precise definition of patient participation is still lacking, which constitutes a barrier for consistent study results and further operationalization of the term (Sanders, 2013).
Besides, it is argued that patient participation is not only about patients as consumers of health services empowered through better information, greater choice, better information, and the privileges of choice (Hodgkin, 2013). For the other part it is about patients having the possibility to act as equal and informed partners in clinical encounters. Although professionalism demands physicians subordinating their interests to the interests of their patients, as moral equals, both patients and physicians have responsibilities toward fulfilling their roles in clinical encounters (Brusse, 2013). Astonishingly, all the elements of patient-centered communication, empowerment and enablement have been mainly addressed to physicians' behavior. To find common ground and mutual agreement in dialogues, patient behavior and competence are prerequisites as well (Ishikawa, 2013).

Partnership

A sincerely collaborative and therapeutic **relationship** can be a strong motivator and is highly valued by both doctors and patients (Hall, 2012; Krucien, 2013). As defined by Constand et al. (2014), developing a partnership with patients occurs when doctors and patients find common ground whereupon which important decisions can be mutually developed. Relationship building can gain insight in the problems patients are most concerned with and how these problems affect their lives. Partnership can influences the use of **resources**, can build trust and encourages mutual problem solving (Mercer, 2012). The element of **trust** has also been defined by Cocksedge (2011), as expressed by the term "holding work" which encompasses establishing and maintaining a trusting, supporting and reliable ongoing doctor-patient relationship without expectation of cure. Especially the latter may be a significant and empowering therapeutic step for both doctor and patient. Without expectations, even frustrations about frequently attending patients or lack of progress could be altered positively by keeping patients ticking over through **listening**, **support** and **trust** over time. Therefore, Cocksedge (2011) regards "holding work" as a routine part of the general practice and as a possible strategy for self-management. Likewise, also the study of Hudon (2013) confided that acknowledgment of struggles and legitimization of illness experience can influence patients' self-confidence and their coping abilities. Both doctors and patients have highlighted the importance of the "**shared narrative**" and pre-existing knowledge of patients past life-story, which can be helpful in everyday consultations (Cocksedge, 2011). The additional listening time and skills were both seen as offering possibilities for changing health-related behavior. Also Hudon et al. (2013) recognized that family physicians frequently interact with people affected by long-term conditions, placing them in a privileged position to increase individual empowerment by enabling patients gaining control over and improving their health.
However, supporting people to change longstanding behaviors that pose significant health risks still remains a major challenge in general practice (Hall, 2012). In considering and managing patients in this way, reported tensions for the doctor-patient relationship can disempower doctors who lose their capacity to intervene in a meaningful way (Cocksedge, 2011). Physicians have reported the necessity for communication competencies that relate to **negotiation** in order to maintain equivalent doctor-patient roles in decision-making (Clayton, 2011). Despite the beneficial assumptions for participation of patients, the desired level of patient involvement has shown to be highly heterogeneous depending on the doctor-patient relationship, the nature of long-term conditions and personal characteristics (Clayton, 2011; Hudon, 2013). The need for individualized approaches is particularly visible in cases of patients who prefer decisions to be made by their physician. Regardless of an inactive role in health care, even this can be referred to as **patient autonomy** because the patient still 'decides who decides' (Kenealy, 2011). Other complexities arise when emphasizing the need to respect patients' autonomy is equalized to recognizing patients' responsibilities. Information provision about available treatment options may lead to patients feeling insisted, unsupported and distressed to make decisions on their own (Entwistle & Watt, 2013). Assuming that autonomous choices are both informed and free from controlling influences fails to reflect the various ways in which patients' independency are shaped.

Relational Autonomy and Capability Approach

Entwistle & Watt (2013) offered a way of understanding **relational autonomy** as dynamically shaped through communication, trusting relationships and the environment. The perspective is referred to as the '**capability approach'** and involves encouraging forms of interpersonal relationship and professional support that people may need to develop their **personal autonomy capabilities**. Respecting people as relatively autonomous involves people who actively develop their personal capabilities in relation to what they pursue in life (Davis, 2011). Development of capabilities is framed as both an open-ended and pluralistic process in the sense that patients are regarded as active agents in their own development while recognizing that people vary in the level of support they need (Epstein and Street 2011).
Besides well established applications of the capability approach in social justice and international human development (in Robeyns, 2011), further exploration may illuminate its potential within health care (Entwistle & Watt, 2013). Current applications of person-centered care already has been increasingly acknowledged and among health care staff and leader been considered as positive descriptors (Entwistle &Watt 2013).

Patients as Persons

Viewing persons as **active agents** of their own capabilities in person-centered care is in contrast with recognition of patients as recipients of care in *patient*-centered care (Davis, 2013; Greenfield, 2014). The acknowledgement for the personhood rather than for sick roles implies responsiveness to individuals (Entwistle & Watt, 2013). Simultaneously it

incorporates attitudinal shifts toward a person-centered orientation in health care and allows patients to be seen as subjects around whom health care services find integration (Greenfield, 2014).
All terms for patient-or person-centered care an near synonyms have in common their attempt to rectify health care being either too disease-oriented (traditional biomedical approaches) or too system-centered (one-size-fits-all approaches) (Scholl, 2014). It can be argued to overarches several preceding approaches in health care such as biomedical (Epstein and Street 2011) and biopsychosocial perspectives (Mead and Bower 2000); viewing patients as whole persons (Stewart 2001), involving patient's context and difficulties in everyday life (Leplege et al. 2007) and so on. Therefore, person-centeredness is considered a core element of integrated care (Greenfield 2014).

Integrated care

Chaining person-centeredness to the concept of **integrated care** can improve both models together and apart in the sense that all concepts of patient enablement, empowerment, partnership, patient's expectations and preferences, emphasize putting patients at the heart of health care. Integration may establish better coordination of care, reduced healthcare cost and improved health outcomes (Greenfield, 2014). Connect person-centeredness with the integrated care context is underway (College of Person-centered Medicine, the International Foundation for Integrated Care, the International Alliance of Patients' Organizations, the Patient-Centered Outcomes Research Institute, and others) and in several European countries person-centeredness has been implemented in mainstream integrated health care provision (Davis, 2013; Greenfield, 2014).

2. Tools & techniques

All identified approaches to PCC incorporate common strategies to achieve effective communication, partnership, and health promotion. This indicates that clinicians have the possibility to select approaches that best suits their patient's needs while having the confidence that it will satisfy core elements of PCC provision. Disposing of this possibility could optimize implementation of PCC in differing contexts of patients.

Standardized disease management protocols

In spite of the existence of standardized disease management protocols (Davis, 2013), studies have demonstrated an inflexible use of the standardized checklist approaches (Entwistle & Watt, 2013) and doctors who often restrict their documentation to only medical and mental health diagnostic coding despite standard classification tools for social problems are existing too (Klinkman, 2011). Following on from that, the study of Klinkman (2011) delineated prospects for person-centered diagnosis and treatment in general practice in 2019, while keeping in mind the current time of change. Among others, an ongoing interaction between general, mental and social health problems in a three-dimensional **biopsychosocial space** has been envisioned. By correlating these three domains in such a space, it is aimed to better integrate person-centered diagnosis in routine medical practice. All medical conditions may affect one another and changes in severity or level of problems may change over time. However, intensification of existing problems requires skills for understanding and managing these interactions as a core part of GPs' routines (Klinkman, 2011). Therefore, the challenge remains to implement these manner of biopsychocial, person-centered diagnosis into practice. Hence, the article describes the need to build from bottom up by identifying successful elements that are critical to person-centered care rather than creating new standards because of the difficulties that arise when implementing anything more.

Patient-Centered Communication

Research on doctor-patient interaction has pursued **patient-centered communication** as an ideal style for the clinical consultation (Ishikawa,2013). Physicians' interpersonal and communication competence and skills are associated with enhanced symptom management and reduced referrals (Clayton, 2011; Ishikawa, 2013). It also improves the understanding and the ability to address patients' emotional issues, which can reduce patients' distress and uncertainty (in Schoenthaler, 2014). Furthermore, **communication skills** have been related to quality of disease-specific knowledge, quality of decision-making and quality of information, which all contribute to (patients' perception of) overall quality of care (Clayton, 2011; Schoenthaler, 2014). Quality and clarity of explanation and communication have been evaluated as being of high importance and have the potential to improve patient satisfaction (Clayton, 2011) By contrast, deficiencies in communication has been related to reduced treatment compliance, utilization of preventive health services, patients' trust and health-seeking behaviors (in Clayton, 2011). Hence, clinical skills should be complemented by communication skills and are both necessary to facilitate the doctor-patient interaction (Ishikawa, 2013). The importance of understanding patients whom attempting to communicate their own values and preferences has been a focus in communication research since early times (in Forrow et al. 1988). Incorporating patients' perceptions in an early stage of treatment can subconsciously lead to beneficial patient outcomes (Greenfield, 2014). Listening to their perspectives provides a caring, empowering and respectful context that influences patients' trust and their affective state that can enhance health outcomes (Greenfield, 2014). The involvement of the patient perspective has been an important focus of research in patient-centered communication. With regard to the general practice, the **Patient Centered Clinical Method** has been found an appropriate method to achieve an understanding of both patients and their diseases (in Booth & MacBride, 2007). The method incorporates both the agenda of physicians by explanation of diseases in terms of taxonomy and the agenda of patients wherefore physicians' receptivity to patient cues and encouragement to express expectations, fears and feelings are key (Constand, 2014). Addressing both agendas offers the opportunity to deal with conflicting perceptions by means of negotiation and is in contrast with traditional paternalistic methods (Constand, 2014).
Another focus in communication research has been the attempt to judge the level of **jointly decision making**. Within the literature, an identified instrument to assess whether physicians have involved their patients in making decision has been

the **OPTION scale** (observing patient involvement) (Elwyn, 2013). The instrument expresses the level of sharing by items like eliciting patient's expectations, concerns and decision-making preferences, explaining pros and cons of treatment options and verifying patient's understanding. Comparable, another instrument that has been mentioned is the **Decisional Conflict Scale** that evaluates a patient's decision uncertainties and factors like awareness of benefits, risk and perceived effective decision making, which all can influence the uncertainty (in O'Connor, 1995).

Shared Decision Making

A well-known tool with regard to the process of decision-making has been the method of **shared decision-making (SDM)**. In recent times this concept has gained the acknowledgement to be crucial for provision of PCC (Sanders, 2013; Elwyn, 2014). The technique includes the physician's task to help patients become well-informed and to elicit and integrate patients' personal preferences in relation to available and reasonable options.
However, previous reviews often did not consider its health-related outcomes as primary outcomes (Knight, 2006, Schoener, 2006; in Elwyn, 2014) but rather used SDM as an indictor for PCC (Dwamena, 2012). Most work on SDM has pertained to single time dichotomous decisions whereupon its relevance for long-term conditions remains underexposed (Elwyn, 2014). Also perceived time constraints, strong biomedical traditions and certain patient or situation characteristics have been described as possible barriers to successful implementation of SDM (in Elwyn 2004). SDM has yet not been included in medical education whereupon its application is far from self-evident (Elwy, 2014). In spite of the required conscious effort, research has shown that brief training of GP's skills in SDM resulted in significant better patient involvement and mutual satisfaction (Rollnick, 2010, in Elwyn, 2014). Indeed, the method of SDM has even received international support by the development of the Ottawa Decision Support Framework, which was designed as a guide for interventions aimed at preparing doctors and patients for making shared decisions (Ishikawa, 2013). Furthermore, the successful elements of SDM are applicable to all situations in which competing options exist or need prioritization, and therefore the method has the potential to expand its scope (Elwyn, 2014).
Elwyn (2012) has described a simplified way of the shared decision making process in practice. It basically assumes that a constructive doctor-patient relationship has been achieved followed by the need for a decision. Next, three sequential steps are highlighted: clarification of the urge to consider the options in collaboration; adequate explanation of the options in detail; and helping patients to elicit their option preferences. Applicable to all steps, patients are empowered to consider testing, treatment or coping options. Professional guidance is only provided when needed (Elwyn, 2010) and decisions are made conjointly exploiting the best available evidence (Sanders, 2013). Moreover, the strongest evidence for SDM comes from the use of decision support tools (Elwyn, 2014).

Decision aids

The aim of these tools is to prepare patients to discuss on decision options with their practitioner by helping patients to identify and reflect on their own skills, values and needs (Holmstrom, 2011; Ishikawa, 2013). Examples of **decision aids** are leaflets, websites, videos and other computer or online programs which all provide evidence-based medical information and structured guidance in the process of decision making (Elwyn et al. 2006). The supporting tools should only be used when possible and appropriate whereas successful application has shown to improve patient empowerment (Holmstrom, 2011). Positive outcomes have also been demonstrated by a Cochrane review on 86 trials that suggested consistent improvement in patients' knowledge, confidence and better risk perceptions (Stacey, 2011, in Elwyn, 2014). Patient decision support interventions (DESIs) also showed to improve treatment adherence and patients' ability to self-manage long-term conditions (Elwyn, 2013). However, these latter effects have been argued not to be in congruence with aim of the tools. Therefore, the International Patient Decision Aid Standards (IPDAS) Collaboration has produced a checklist and an instrument to assess the quality of DESIs. Despite this quality assurance, challenges for DESIs remain with regard to professionals' attitudes, competing demands, time pressure and lack of training (Elwyn, 2014). From a patients' perspective, the rejection of decisional responsibility when facing complexity of diagnosis has been reported as a potential barrier. Moreover, the common occurrence of undifferentiated problems impedes the identification of the decision aid needed for advancement of the consultation. It seems that implementation is hampered because underlying issues are under-specified and under-investigated (Elwyn, 2013). Comparable to other attempts to improve practice performances, many barriers arise when other competing priorities take supremacy and uncertainty whether the measure will add value is in favor of the status quo (Elwyn, 2014).

Motivational Interviewing (MI)

Natural responses of physicians toward competing options and perspectives have been described as 'repeated health advice with greater authority or educating patients about forthcoming health risk in an authoritarian manner' (Hall, 2012). When these approaches to such opposition (also described as 'resistance' in the psychological literature) do not succeed, patients may be characterized as lacking skills and insight or as being unmotivated. However, research on behavior change has shown that paternalistic or authoritative approaches may increase resistance and deter change (Miller, 2002, in Hall, 2012). **Resistance** has closely been related to **motivation** that can be shaped by the way physicians respond (Hall, 2012). This relationship has also been acknowledged by the Transtheoretical model of behavior change (the 'Stages of Change' model by Proachaska and DiClemente, 1983) that described readiness to change as a dynamic process. The model also highlights that health related behavior can fluctuate and be influenced by outweighing the pros and cons which can generate ambivalence. In particular, **ambivalence** is noticeable in oppositions between immediate rewards and adverse long-term consequences (Hall, 2012). In such conflicting states, individuals are stuck between three critical components of motivation: the extent of immediate priority ('readiness to change'); the perceived importance ('willingness to change); perceived confidence ('ability to change;).
Building on this preceding work, Miller & Rollnick (1991) argued that motivational strategies could be tailored to an individual's stage of change according to the model of Prochaska and Diclemnente. Bundling together these strategies,

Miller & Rollnick developed an effective counseling method (1991) referred to as '**Motivational Interviewing (MI**). Instead of viewing resistance as a barrier, MI addresses resistance as ambivalence that can be resolved by identification of personal motives for change (Elwyn, 2014). Its overall spirit has been described as engaging, collaborative, empathetic and respecting of personal autonomy (Hall, 2012; Codern-Bové 2014).
MI is wide applicable across many domains that require clarification of ambivalence to motivate behavior change (hall, 2012). More recently, MI has attracted considerable interest as a patient-centered approach by facilitating counseling work of physicians while considering patients' perceptions and commitment to changing their health related behavior (Elwyn, 2014). Accounting for primary care several applications have been identified such as treatment adherence, engagement in prevention programs, pain and stress regulation and in particular management of risk factors for SnAP (smoking, nutrition, alcohol, physical activity) (Parsons 2005 in Hall, 2012). MI has received increased appreciation due to positive evidence for lifestyle change, health and psychological outcomes (Hall, 2012). Because it has been shown that MI produces better results than brief advices in conventional care (Codern-bove, 2014), the method is particularly valued by physicians who are frustrated about quick consultation times and ineffectiveness of traditional and prescriptive approaches (Elwyn, 2014).
Responding to these frustrations in the health care setting, Miller and Rollnick attempted to simplify their method by means of four guiding principles referred to by the acronym RULE: Resistance of the righting reflex, Understanding motivations of patients, Listening with empathy and Empowering of patients (Hall, 2012).
Overlapping, MI sessions can be divided into three different phases: assessment (elicit patients' own motivations), reflection (further elaboration on the readiness to change) and summary (reflecting it back to the patient) (Codern-bove, 2014). These phases have in common the potential to build motivation to change as well as to strengthen commitment to change (Hall, 2012; Elwyn, 2014). In practice, the succession of the therapeutic technique may depend on the facilitative role of the physician who is supposed to adopt a non-confrontational style that leads the patient into the direction of change (Hall, 2012). The study of Codern-Bové et al. (2014) analyzed several MI sessions and concluded that interactional dilemmas and augmentation of complexity may emerge when physicians encounter individuals who dispose of low motivation for change. Despite similar structures of MI (assessment, reflection, summary) and four-hour training sessions, differences were seen in professional practice used to motivate patients toward change.
Although some actions facilitated reflection on readiness to change (declarations, use of reiterations, open-ended questions), actions that were not facilitative predominated the interactions that were analyzed (prematurely emphasizing change, focusing on risks, adhering to the protocol). Only one professional implementation of MI sessions resembled the Miller & Rollnick model by which interactions are focused on transforming ambivalence into change.
Other professional actions tended to resolve resistance and interactional dilemmas by means of directive or confrontational methods. Despite physician's interest and the acknowledged importance of collaborative relationships, the majority of interaction was approached from a biomedical perspective. Therefore, a second main suggestion of the study was that not all MI sessions appraised patient-centeredness as a core element (Codern-bove, 2014). Thereby, lack of agreement and negotiation around ambivalences has been showed to result in silences from both physicians and patients For avoidance of brief or hostile interactions, initial agreement on the existence of ambivalence as well as follow-up on patients' expressed concerns is necessary to provide a supportive, patient-centered approach. Based on these finding the study recommends highlighting comprehensive MI techniques in communication and training of physician in order to achieve collaborative, patient-centered relationships (Codern-bove, 2014). Although training may enhance the implementation of MI, the existence of several other barriers remain to produce significant 'cons' on the decisional balance (Hall, 2012). Among others these barriers include quick consultations and the desire for quick fix options, other reported time pressure and the required professional skills to meet the spirit of MI. By contrast, these barriers do not abrogate the 'pros' when adopting MI approaches. Considering the main phases of 'readiness', 'willingness' and 'ability', has the potential to address a number of common complexities within the general practice and provides a complementary tool to resolve ambivalence and enhance motivation to change (Hall, 2012).

Integrating MI and SDM

As reflected within the reviewed literature, the process of shared decision making has been regarded useful for outweighing available and reasonable treatment options in order to decide on treatment (Sanders, 2013; Elwyn, 2014). By contrast, motivational interviewing is focused on supporting change by seeking to elicit ambivalence and motivation before taking action (Hall, 2012; Elwyn, 2014; Codern-bove, 2014). In spite of the methods originating from distinct domains, their overlap has been considered and physicians may benefit from taking into account both approaches. Next to their unique utility, it is discussed that MI and SDM can be applied as sequential methods whereby motivating patients to change is followed up by making preferred treatment decisions (Elwyn, 2014). In other cases it may even be desirable that MI and SDM are integrated as an ongoing process when patients not only face competing treatment options but behavior change (for long-term conditions) is relevant as well. Additionally, recognition for integration may contribute to the establishment of patient-centered orientation in general practice (Elwyn, 2014). The methods have in common the emphasis on developing relationships, trust and empathy and the ethical imperatives of viewing the patient as a person and respecting autonomy. Furthermore, depending on the clinical encounter, they share fundamental communication skills including reflective listening, information exchange and responding to emotions (Elwyn, 2014). Both approaches provide well-described and practical principles to achieve patient-centered care regarding the context of primary care in which health related behavioral changes both depend on evidence-base medicine and patients' preferences (Elwyn, 2014). As also acknowledged for both methods on their own, considerable challenge of implementing and integrating them will arise as the complexity of problems in general practice increases. Progress in patient-centered care therefore requires both methods to be taught, assessed, measured and rewarded in order to be valued as core elements of daily practice and to envision development in primary care.

Medicalization and marketization

Another important emphasis has been envisioning the future with regard to improving provision of PCC. The study of Hodgkin (2013) argued several trends having the potential to enable and empower patients and to enhance the shift toward more social and holistic perspectives on care. Managing the rising amount of patients with multimorbidty, long-term or chronic conditions will require better help, information and support. For this, mobilization of resources and capacities in patients' their context asks primarily for a social model rather than a biomedical model. In other words, medicalization could stimulate the digital revolution in order for patient-centered consultation to incorporate the tools to enable truly informed decision-making.

Technology

Correspondingly, also the study of Klinkman (2011) recognized the importance of maintaining a balance between person and disease, caring and technology. To meet the needs of the population is the activity of primary care, which also requires eliciting the populations' voice into practice. For this, besides their formulated model for future person-centered diagnosis in general medicine, also a disease technology path has been envisioned referred to as a 'patient-centered primary care data model'. Advances in health information technology may provide new ways to integrate decision support tools with person-centered care. In accordance with all the (above mentioned) attempts to improvement, the challenges of integrating all elements into everyday practice are underlined but not undermine the importance to build from bottom up, as intrinsically linked with advances in technology (Klinkman, 2011).

3. Measurement & Indicators

Within the reviewed literature, consensus exists over the importance and need for appropriate measurement of care. Both monitoring and evaluation have been considered as prerequisites to proceed with the paradigm shifts towards more patient-centered care (Hudon, 2011; Cocksedge, 2011; Scholl, 2014). A considerable part of the literature has focused on evaluation of more organizational elements such as economic valuation and quality of care.

Economic valuation

A widely applied improvement attempt, relates to the utilization of economic techniques in order to provide quantitative estimates of the value of particular healthcare systems and processes (Ryan, 2014). Several **economic valuation methods** have been shown to be frequently used for questions of value including: Allocation of Points; Analytic Hierarchical Process; Best-Worst Scaling (BWS); Contingent Valuation (CV); Discrete Choice Experiments (DCE); Measure of Value; Person Trade-Off (PTO); Ratings Scale; Standard Gamble (SG); Time Trade-Off (TTO). Because these methods are primarily focused on economic values, there has been limited attention to estimate the value of healthcare features for patients personally. Feasibility of using economic valuation methods for a broader range of healthcare experiences requires further investigation (Ryan, 2014).

Quality of care

Improving quality of primary care is regarded as an ongoing international priority (Cocksedge, 2011; Olsson, 2013; Sanders, 2013). Mainstream measurements for evaluating quality of care have utilized evidence-based indicators. Worldwide, evident examples are for instance the Quality and Outcomes Framework (Qof) within the United Kingdomand the General Practice Assessment Questionnaire (GPAQ), which all share the aim to improve quality of care (Mead & Bower, 2008; in Cocksedge, 2011). Though, the study of Cocksedge (2011) showed that solely using evidence-based indicators have increasingly been argued to pursue inflexible guidelines and protocols to achieve the objectives on which their remuneration is based (Cocksedge, 2011). In contrast to the attempts of improving quality of care, dominance of evidence-base indicators may produce unintended consequences like reducing the continuity of care. As a result, even proponents of evidence-based medicine have come to the acceptance that outcomes should complementary be defined by what is valuable and meaningful to a patient (Epstein, 2011). Significant investments have been made to develop and apply instruments and survey methods relating to people's experiences in clinical encounters (Ryan, 2014)

Objective and Subjective measurement

Literature reflects the general need for more descriptive measurement of healthcare experiences in order to achieve comprehensive assessments of quality of care (Cocksedge 2011; Ryan, 2014). The Cochrane review of Dwamena (2012) identified both **objective effects** and **subjective effects** on patient consultations. **Direct effects** related to consultation process variables like communication of treatment options, attentiveness to patients' diseases, their beliefs, concerns and levels of empathy. **Indirect effects** included health related behavior change, health status and satisfaction. The review of Sanders (2013) showed similar distinctions between objective and subjective outcomes, which both demonstrated to have positive effects of PCC. **Disease-oriented outcomes** included pathologic and physiologic indicators such as BMI and HbA1c. **Patient-oriented outcomes** included cost of care, mortality, morbidity and self-rated well-being, satisfaction and quality of life.

Direct observation and Self-assessment

The systematic review of Hudon (2011) has identified ways of designing reliable instruments that emphasize the importance of patients' experiences in patient-centered care. The most predominant methodologies included: **direct observation** (by means of objective structured checklists) of the clinical consultations and **self-assessment** involving both patients' and physicians' experiences of the consultation. Moreover, patient's self-assessment demonstrated to be better predictions of outcomes than either physician's self-assessment or the direct observation (Hudon, 2011).

Quality-Adjusted life year

A frequently referred example that emphasizes the importance of the patients' perspective is the quality-adjusted life year (**QALY**) measure (Davis, 2013). The measure represents person's preferences respecting the quantity and quality of life when imagine to live under certain health care outcomes. Despite its subjective elements, several critical evaluations argued that the measure reflects a single-time evaluation and includes the assumption that people's experiences do not fluctuate. As argued by Hudon (2011), the continuity of (the interactions in) primary care suggest that measurement is best assessed by evaluating patient-centeredness in care over time in stead of by single-visit indicators. (Hudon, 2011). Additionally Brusse, (2013) highlighted the need to be aware of the differences between immediate consultation benefits and the long-term value of consultation of future health on the other hand.

Personal capability-based metrics

From an ethical perspective, Entwistle & Watt (2011) stated that patients' experiences are shaped within clinical interactions and vary according to one's circumstances in life. Therefore, they highlight the inaccuracy of one-size-fits-all solution in determining care priorities. Rather than standardized disease management protocols, they call for creation of '**personal capabilities-based metrics** which serve as guidelines for investigating and identifying people's values and needs for self-management and care. Their view on ongoing supportive care without expectation of cure aligns with the need for allocation of value away from biomedical indicators toward more 'unmeasureable' indicators like doctor-patient interaction over time (Entwistle & Watt, 2011; Davis, 2013).

Communication Coding Schemes

Regarding the patient-provider interaction, 2 coding schemes have been identified that measure and evaluate patient-centeredness: the Measure of Patient-Centered Communication (**MPCC**) and the 4 Habits Coding Scheme (**4HCS**) (In Clayton, 2011). Though, coding schemes are descriptive rather than evaluative whereupon difficulties have been reported with precise determination of which behaviors can be hold responsible for certain patient responses and outcomes. Evaluative methods for competency and interpersonal communication skills remain underdeveloped and limited to satisfaction surveys and behavioral checklists (Clayton, 2011). Most communication coding methods have operationalized patient-centeredness differently, which is an indication for a lack of conceptual clarity (Clayton, 2011).

Motivational interviewing instruments

Examples of identified communication coding methods that relate to smaller components of patient-centered communication are found within the techniques of Motivational Interviewing (MI) and Shared Decision Making (SDM).
In order for MI to measure reliability in both real-practice settings and in training, the instruments of Motivational Interviewing Treatment Integrity (**MITI**) and Motivational Interviewing Skills Code (**MISC**) have been developed (Moyers, 2003, 2005; in Codern-Bové 2014). Among others these instruments apply behavioral coding of MI sessions alongside reliability assessment systems. By making use of such tools, behavioral and relational characteristics of MI interactions for both doctor and patient can be identified (Codern-bove, 2014).
With regard to SDM, most work has pertained to single time dichotomous decisions and previous reviews often did not consider its health-related outcomes as primary outcomes (Knight, 2006, Schoener, 2006; in Elwyn, 2014) but rather used SDM as an indictor for PCC (Dwamena, 2012).

Perceptions on Patient-Centeredness

Conceptual heterogeneity has led to wide variation in scales and dimensions designed to measure PCC. In order to identify existing items and (sub)scales, the systematic review of Hudon (2011) compared instruments assessing patients' perspectives on PCC in general practice. In total, 11 instruments were found that included relevant items or (sub)scales. Though, these instruments only partially covered the concept and were not applicable for specific assessment of PCC. Subsequently, 2 instruments were found to be fully dedicated to PCC: (the Patient Perception of Patient-Centeredness (**PPPC**) and the Consultation Care Measure (**CCM**). Although addressing key dimensions of PCC, both were limited in their ability to assess care over time because the instruments are visit-based. Furthermore, the study also highlighted the limitation that due to the multifaceted nature of the concept only instruments measuring at least 2 dimensions of PCC were included.

Multifaceted interventions

The study of Olsson (2013) demonstrated that although **multifaceted interventions** may be useful, they induce complexities in assessing cause-effect pathways from interventions through final health states. Therefore the (combination of) components found to be resulting in the measured effects remain inconclusive (Olsson, 2013). Methodological problems in research design and execution constitute possible explanation for the fact that patient-centered care interventions have only been studied to a limited extent. This has resulted in a general lack of appropriate measures for that assesses efficacy and value of patient-centered care (Brusse, 2013).

Patient Enablement Instrument (PEI)

One attempt to foresee in more objective, patient-focused performance measures has been the **Patient Enablement Instrument (PEI**), which is an indictor for consultation quality as perceived by patients. The instrument has proven to be reliable and valid and has been widely used to measure enablement of patients after consultation in general practice (Brusse, 2013). The survey scores for self-assessed improvements in clinically relevant attitudes, understanding of disease and illness and capacity for treatment and self-management. Critically seen, positive scores of PEI therefore require patients who come from less enabled states which provides room for improvement. This may have implications for perceived quality in those consultations where patients already possess a good level of understanding and capacity.
Even though PEI may be featured as a measure of performance, it has been argued that the measuring enablement still meets the requirement to be useful by centering on issues identified by patients as important rather than important issues identified by doctors. The instrument tracks consultation quality while avoiding possible influences of non-clinical factors like dissatisfaction with consultation outcomes or with their physician.

Regarding influencing factors, the study of Mercer (2012) has shown several causal elements for patient enablement and consequently consultation outcomes. The potential factors were divided into categories of consultation factors, patient factors and system factors. **Consultation factors** included continuity of care, consultation length and physician's interpersonal approaches such as a having interest in patient's life, being empathetic and positive and promoting health. Suggested **patient factors** encompassed positive perceptions on the interaction and patient characteristics like age, ethnicity as well as socio-economic status. With regard to **system factors**, larger size of the practice reduced levels of patient enablement and also related to continuity of care and consultation length.

Empowerment

Furthermore, patient 'enablement' is regarded as closely aligned with 'empowerment' in the sense that enhancing the personal ability to understand and manage health and disease is crucial for improving outcomes of health. As such, it may represent an **intermediary outcome** and has shown positive impact on coping or **self-efficacy** that is linked to health and behavior change (Mercer, 2012; The Lancet, 2012).
To some extent, the term also reflects the level of collaboration within partnership by which health outcomes improve and is measurable by for instance treatment adherence, absent or present misunderstandings and satisfaction with the interaction (Codern-Bove, 2014).

Satisfaction

Despite their overlapping elements, the more widely used instruments that measure patient **satisfaction** has been devised as conceptually distinct from enablement. Patient enablement principally measures consultation quality and health gain, while satisfaction is a complementary concept that tends to reflect the extent to which patients' perceptions and pre-consultation expectations of consultations (like prescription and referral) have been met (Brusse, 2013). The study of Brusse (2013) also implies that distinction between the concepts can be observed in patients that are enabled but not satisfied, as for instance patients who despite being enabled remain dissatisfied by the consultation outcomes. Although patient satisfaction has been acknowledged as an important indicator, it is limited as an outcome because of measuring patients' perceptions and experiences of health care processes rather than achievements of benefit or health gain (Howie et al. 2005; in Brusse, 2013). By contrast, the PEI has been appraised as a more objective measure of consultation quality because it is less likely to be influenced by fulfillment of outcome expectations. The relationship between expectation and enablement still needs further exploration in order to clarify the extent to which patient expectations could be understood as patients' predictions or as patients' preferences of outcomes.

Patient Enablement and Satisfaction Survey (PESS)

Building on both concepts, researchers have developed a method that combines Patient Satisfaction being acknowledged as a valuable health outcome indicator, with the PEI that has shown to be successful in health care settings. This **Patient Enablement and Satisfaction Survey (PESS)** has proven to be a valid and reliable survey designed for primary care (Desborough, 2014). Reflecting the patients' needs within these setting, the tool could provide a comprehensive indicator of the effectiveness of general practice.

Multifaceted and Future research

Measurement and indicators have argued to be important enhancers for the implementation of patient-centered care into general practice. To some extent, the inconsistency in patient-centered care outcomes could be the result of the multifaceted nature and heterogeneous use of the concept (Scholl, 2014). Until now only few randomized controlled trials have been dedicated to the concept which is an indication for theory to be operationalized more conceptually than empirically (Constand, 2014). Both objective and subjective measures are in need of more closely examination. Rather than only satisfying the patient, these measures should align with policy priorities that have emphasized the importance of a patient-centered focus in health care (Brusse, 2013). **Future research** should also seek to understand how mediating and moderating variables affect the processes and outcomes in patient-centered interactions (Rathert, 2012). Ideally, integrating both explicit conceptual and empirical use of theory throughout operationalization of the concept, development of measurement, education and training may encourage the shift toward patient-centered orientation in health care (Constand, 2014).

APPENDIX II (explorative) Interview design

- **Procedure van het interview**
- **Interviewvragen**
- **Voorbeelden uit de huisartsenpraktijk**

- **Procedure van het interview**

Het interview zal een drietal hoofdvragen beslaan zoals hieronder weergegeven. Het gesprek zal plaatsvinden op een onderling overeengekomen locatie (met eventuele uitwijkmogelijkheid naar een skype gesprek).
Er zal toestemming worden gevraagd voor opname van het gesprek ten behoeve van een zo nauwkeurig en betrouwbaar mogelijke uitwerking van het resultaat.
De resultaten worden bij de schriftelijke uitwerking van de opnames alleen in verband gebracht met het door u uitgeoefende beroep. Wat betreft uw persoonsgegevens is volledige anonimiteit gegarandeerd.

- **Interviewvragen**

Figuur 5. Structurering van de interviewvragen

Structureel raamwerk	**Interviewvragen**
1. core values & mindset	1. Waar streeft u naar in uw werk?
2. tools & techniques	2. Hoe/op welke wijze bereikt u het door u geschetste doel/streven?
3. measurement & indicators	3. Wanneer is het door u geschetste doel/streven bereikt?

* De blauwe gedeelten bevatten hulpvragen en voorbeelden t.b.h. de onderzoeker

(1) Waar streeft u naar in uw werk?
* Wat wil ik weten: Welke/wat voor mindset ligt ten grondslag aan de professional-client interactie en communicatie
- Waar richt u zich op?
- Wat zijn daarbij uw uitgangspunten, kernwaarden en/of principes?
Hulpvraag: Houdt u vast aan bepaalde normen, waarden en overtuigingen?
Voorbeelden: Patient/persoonsgerichtheid; inachtneming van unieke eigenheid van een persoon, inclusief sociaal/fysieke context

(2) Hoe/op welke wijze bereikt u het door u geschetste doel/streven?
* Wat wil ik weten: Worden er tools, technieken of methoden gebruikt of ingezet ten behoeve van sturing vs. autonomie?
- Kunt u concrete voorbeelden noemen
Schetsen voorbeeldsituatie(s) (eventueel herhaling voorbeeld huisartsenpraktijk)
- Gebruikt u hiervoor (bepaalde/speciale) methoden en/of technieken?
Voorbeelden: Educatie, training
Voorbeelden: Motiverende gespreksvoering, gezamenlijke besluitvorming

(3) Wanneer is het door u geschetste doel/streven (voor zowel u zelf als de client) bereikt?
* Wat wil ik weten: Een graadmeter voor wanneer de professional-client interactie naar tevredenheid of als succesvol wordt beschouwd.
- Hoe meet/bemerkt u dat?
Hulpvragen: Is er verschil in/tussen (tevredenheid van het) het bereikte doel voor de professional vs. de client?
Voorbeelden: Zijn er bepaalde randvoorwaarden waar aan moet worden voldaan?
Voorbeelden: Denk aan objectieve (lichamelijke meetwaarden, economische waarden) en subjectieve uitkomstmaten (tevredenheid, (wederzijds) vertrouwen, zelfredzaamheid, etc.)

- **Voorbeeld(en) uit de huisartsenpraktijk**

Om u een concreter voorbeeld te geven van sturing-autonomie balans in professional-clien interactie, wordt hieronder een drietal voorbeeld situaties uit de huisartsenpraktijk geschetst, beschreven door huisarts Ton Dapper.

1. patiënte (65 jaar) heeft gehoord slokdarm kanker te hebben. Het "goede nieuws" is dat er geen uitzaaiingen zijn gevonden en dat patiënte curatief d.w.z. genezend geholpen kan worden middels een uitgebreide operatie waarbij het grootste gedeelte van de slokdarm verwijderd zal worden. De consequentie hiervan is dat ze een "buismaag" krijgt: Een groot gedeelte van de maag wordt gebruikt om het zieke en verwijderde gedeelte van de slokdarm te vervangen. Dit alles vraagt van de patiënt een forse verandering van leefstijl en eten en diverse controles in ziekenhuis. Patiënte "weigert" om geholpen te worden: dit is geen leven voor haar zegt ze. Ze kiest voor een relatief goede kwaliteit van leven die ze nog te gaan heeft.... (NB; patiënte is na 1.5 jaar rustig overleden)

2. patiënt (52 jaar) blijkt suiker ziekte te hebben. Krijgt hier nu medicatie voor. Echter het protocol (de "NHG standaard" diabetes) zegt dat de patiënt daarbij altijd behandeld moet worden voor zijn bloeddruk en cholesterol.. ook als deze relatief normaal zijn. Dit verlaagd het risico op complicaties als oog en nier problemen aanzienlijk. Patiënt weigert ! medicatie voor normalisering suiker vindt hij voldoende. "Hij wil geen bord met pillen als ontbijt als hij opstaat"

3. patiënt, goed gezond (32 jaar) wil perse naar "pre scan".. "je weet maar nooit en als je erop tijd bij bent heb je meer kansen".. zijn huisarts vindt dit in het algemeen onzinnige zorg. Maar ..."als de dokter even een briefje schrijft dan krijgt hij een gedeelte vergoed"

APPENDIX III Textual and Structural Outline Qualitative Interviews

TEXTUAL OUTLINE INTERVIEWS (Original Dutch version)

1. Monique Maan - Predikant in diaconessenkerk

Wekelijks **leid ik** de zondagse kerkdienst waarbij het **preken** (naast zingen en bidden) een belangrijk onderdeel is. Overige werkzaamheden m.b.t. **het pastoraat** kunnen heel **divers** zijn; bezoeken van ouderen (vergrijzing in de wijk), zieken of terminale patiënten, een kraambezoek, of gespreksvoering n.a.v. baanverlies of scheiding. De problemen en het geluk uit het dagelijks leven kom je in de kerk ook tegen en vergt een **alledaags perspectief**. Contact kan **op aanvraag** van de mensen zelf of **op initiatief/aanwijzing** van anderen zoals bijvoorbeeld contactpersonen ("mijn oren en ogen") in de gemeenschap. Ook wordt er vanuit wijkteams een beroep op ons gedaan (vb. tegengaan eenzaamheid onder ouderen).
In mijn werk heb ik zowel **verantwoordelijkheid voor het welzijn van mensen afzonderlijk maar ook voor het functioneren van de hele groep**. De individuen kiezen elkaar niet uit maar hebben wel allen gekozen **vrijwillig lid** te zijn van de kerk en vormen daardoor een gemeenschap. Op basis van dit lidmaatschap zie ik de mensen met enige regelmaat, wat ook mogelijkheid geeft tot meer informele interactie. Als predikant ben je onderdeel van de groep maar tegelijkertijd op gepaste professionele afstand voor uitvoerbaarheid van mijn werk. Zowel formeel als informeel zijn de liefde van god en gelijkwaardigheid van mensen voor mij belangrijke uitgangspunten.
Ik besteed het meeste **tijd** aan individuele vragen en contacten. Deze interacties gaan met name over **zingeving** zoals; wat is 'goed', welke keuzes dragen bij aan **kwaliteit van leven** en **reflectie** op wat mensen overkomt. Dit alles staat vaak in relatie tot de **bijbel** en het **geloof** waarmee de mensen zijn **opgevoed**, een aspect dat tevens **beïnvloedbaar** en/of **veranderbaar** is gedurende de **levensloop**. Sommige individuen ervaren deze verandering als **verlies** (van dierbare ideeën, gedachten en overtuigingen) en anderen ervaren dit als **groei** (een natuurlijke verandering gedurende je leven).
De gemeenschap beslaat met name hoogopgeleiden die tevens nieuwsgierig zijn hoe ik persoonlijk over zaken denk en die het ook goed kunnen hebben als dat verschilt van hun eigen denken. Dat geeft mij ook een gevoel van **vrijheid** en vormt een belangrijke voorwaarde om in gesprek te gaan met elkaar. Ik blijf als privépersoon niet buiten schot en krijg daar ook de ruimte voor (verschil met andere gemeenten waarin collega's zich minder vrij voelen door overheersende beeldvorming zoals 'wat de dominee zegt, dat is zo' en de interactie beperkt tot 'empatisch mee-hummen'). Daarentegen is de mens **mondig** genoeg om hun eigen keuzes te blijven maken. Dat is in overeenstemming met mijn voornaamste doel; het **stimuleren, motiveren en activeren en inspireren** (ook vanuit de bijbel) om hun eigen keuzes te maken. Er is niet één waarheid maar het gaat om de **afweging** van perspectieven om in een specifieke situatie te bepalen wat je nodig hebt en wat goed is voor jou en je omgeving. De **sfeer** in de gemeente wordt gekenmerkt door de gedachte dat je al pratend en discussiërend verder kunt komen, zelfs als men lijnrecht tegenover elkaar staat. Bovendien scherpt dit mensen om te blijven nadenken. De mogelijkheid tot het stimuleren van zelf nadenken, nieuwe inzichten en ontwikkeling vind ik het mooiste van het vak.
Werken met mensen kan ook uitmonden in conflictsituaties (i.t.t. de beeldvorming dat 'in de kerk je het goed moet hebben met elkaar en men zonder ruzie goed overweg kan'). Verschillen in opvattingen en ideeën zijn soms lastig, met name omdat ik er persoonlijk bij betrokken ben. Als predikant kan ik niet alles laten gezeggen. **Sturen** en **corrigeren** acht ik soms nodig wanneer mensen geloofsuitspraken doen die niet overeenstemmen met wat er in de bijbel staat (vb. discriminatie). Hier wijs ik de mensen op, soms op **directe** wijze in de vorm van '**opvoeden'**, of door deze uitspraken op meer **indirecte** wijze terug te koppelen. Als professional moet ik ook kunnen **loslaten** en tevreden zijn met wat ik heb kunnen bijdragen.
In alle interacties is de bijbel mijn houvast maar daarnaast kan ik ook gebruik maken van bepaalde (verbindende) rituelen, zegening of gebeden; allen hebben gemeen dat we ze **samen** uitvoeren. Op deze wijze krijgt het gesprek wat extra's, je kunt een gesprek markeren of het bijzondere ervan benadrukken.
Mijn doel is bereikt als mensen zelf weer verder kunnen of als mensen het idee hebben 'ik mag hier zijn en ik doe mee' en bovenal als mensen zich '**gekend** en **gezien'** voelen. Dit vergt ook een stukje **inlevingsvermogen**, omdat eigen ideeën over het behalen van deze doelen niet per definitie overeenstemmen met de beleving van de ander. Daarbij is het zaak om zo goed mogelijk in beeld te krijgen welke **verwachtingen** iemand heeft van mij en mijn werkzaamheden. Dit draagt bij aan mijn eigen **geloofwaardigheid**. Daarbij heb ik het 'voorrecht' om **geen externe doelen** te hoeven behalen of te verantwoorden. Dat zit tevens verweven in mijn eigen beeld van wat de kerk en het geloof zou moeten zijn; dat de wereld om je heen wat van je merkt, en er ook wat aan heeft dat je er bent want je bent er niet alleen voor jezelf. Te allen tijden probeer ik **openheid uitstralen**, om de mensen te laten weten dat ik er voor hen ben als zij dat willen.

2. Ardjoena Soerjadi - Dirigent

De doelen in mijn werk zijn nauw met elkaar verweven. De uitvoering van een muziekstuk zou ik als hoofddoel beschouwen. Als dirigent streef ik ernaar om mijn **ensemble** (= 'samen') een muziekstuk aan te leren om **gezamenlijk** tot een goed muziekstuk te komen. Vakmatig gezien staat de kwaliteit van het muziekstuk voorop in relatie tot tevredenheid van het ensemble. In de praktijk blijkt het **proces even zo belangrijk als het doel**. Het werken met een ensemble vraagt om een **persoonsgerichte benadering**; duidelijk verschil(lend) per niveau (professioneel vs. amateuristisch) en type mens. Zeker m.b.t. amateurkoren is het proces veel bepalend (en moet men zich goed voelen om een stuk te kunnen leren). De basis waarop een amateurmusicus musiceert is enthousiasme en plezier (als mensen het niet leuk of moeilijk vinden, valt deze basis weg). Bij amateurs is het belangrijk er aandacht aan te besteden of mensen lekker in hun vel zitten en zich **betrokken** voelen bij het project/doel (anders blijft het te abstract) omdat ze dan een betere uitvoering kunnen creëren/leveren. Dat is niet noodzakelijk voor professionele musici die ongeacht de omstandigheden o.b.v. professionaliteit een fantastische uitvoering kunnen neerzetten. Hier ligt een sterke vakmatige basis aan ten grondslag. Benadering van professionele musici berust daarom meer op het respecteren van vakmatigheid (i.t.t. gezelligheid) en prikkelen op **vaardigheden** en zich zo uitgedaagd en betrokken voelen. Betrokkenheid lukt niet altijd direct, soms heeft dat meer tijd nodig (die er niet altijd is). **Sfeer** en **doseren** is te allen tijden van belang; enerzijds musiceren op speelse of ontspannen manier en anderzijds de teugels strakker aantrekken. Goede afwisseling is essentieel en gaat op gevoel en **ervaring**. Het tijdsbestek (tijd tot aan de uitvoering) speelt ook een rol; planmatig en bewust bepalen wat op dat moment de behoefte en noodzaak is en daar de balans op aanpassen. Dat vergt ook het stellen van prioriteiten en maken van afwegingen; wat zijn de beste mogelijkheden om het doel van dat moment te bereiken binnen de tijd die je hebt. Soms haal je er meer uit door 'los te laten' en "muzikale expressie" te verkiezen boven technische perfectie. Als dirigent coach je het ensemble door zowel aan te sturen als los te laten: "vasthouden maar niet doodknijpen". Het fascinerende van dirigeren is dat je tegelijkertijd **coach**, **mentor** en **docent** bent. Ik ben opgeleid om muzikaal te (be)oordelen. Vanuit die positie is het makkelijk om kritiek te leveren. Toch blijft het mensenwerk. Om een krachtige positie te behouden vraagt de praktijk ook om **respect**, mensen in hun **waarde** laten en een stukje **inleving**; je afvragen met wie je te maken hebt en waarom iets gebeurt (achterliggende factoren/oorzaken). Werken met groepen kan ook uitdagend zijn omdat een effectieve benadering niet voor iedereen gelijk is. Het gaat erom mensen op hun waarde te schatten. Dit kan d.m.v. actief contact en het scheppen van **wederzijds vertrouwen**. Enerzijds moet men erop kunnen vertrouwen dat jij als dirigent een waardige leider bent en anderzijds moet je een deel van de **verantwoordelijkheid** ook bij individuen zelf laten/leggen (zelfvertrouwen). Deze manier van bevestigen werkt stimulerend voor **motivatie** en **betrokkenheid**. **Doelgericht** (en positief) **sturen** werkt het best in **samenwerking** (vb. vragen "wat heeft u nodig?"). Met de meeste mensen musiceer je gedurende langere tijd, dat maakt het **informeler**. Positieve betrokkenheid als leider is essentieel maar moet niet omslaan in te sterke emotionele betrokkenheid want dan raak je het **leiderschap** kwijt. Als dirigent heb je (vakmatig en positioneel) het beste overzicht en moet je er altijd boven blijven staan. Je hebt niet altijd gelijk maar behoudt wel altijd de **leiding**. Het docentschap komt naar voren door het werken vanuit de inhoud van de muziek. Bij koormuziek zit vaak tekst en werkt het bevorderlijk om te verwijzen naar de inhoud daarvan. Tevens kun je eigen interpretatie aanvullen door musici bij elkaars partijen betrekken. Werken met muzikale mensen maakt het mogelijk te doceren d.m.v. gebaren, expressie, aankijken of knikken waarmee soms dieper is door te dringen dan met woorden. Hoewel ik beroepsmatig heb geleerd om muziek te verwoorden, vraagt de praktijk ook om 'voelen en voelbaar maken'. Het mooiste is als men voelt en begrijpt waarom een stuk om een bepaalde speelwijze vraagt, in plaats van dit puur eenzijdig te dicteren. Een geslaagde interactie met mijn ensemble wordt niet alleen bepaald door alleen de kwaliteit of de **tevredenheid** van mijzelf of het publiek maar is pas volledig bereikt als mijn musici het ook zo ervaren.

3. Marc Lammers - topsport (master)coach

Het succes van mijn werk als coach wordt sterk bepaald door goede communicatie. Voor goede communicatie is het, naast **eigen kennis**, **ervaring** en **passie**, essentieel om spelers te **betrekken** in de interactie omtrent hun eigen ontwikkeling. **De kunst van het coachen is dat de instructies die jij als coach voor ogen hebt, door spelers zelf ontdekt worden.** Deze aanzet tot verandering vraagt om een stapsgewijze aanpak zonder mensen het gevoel te geven dat ze iets wordt opgelegd. **Coachend leiderschap** berust daarom niet alleen op instructie en informatiezending maar benadrukt het belang om **open vragen** te stellen (vb. "Wat zou je er zelf aan kunnen doen"?) waardoor spelers **zelf** gaan **nadenken**. Gebruikmakend van een persoonlijk ontwikkelingsplan (POP) waarin spelers gecoacht worden om hun eigen plan bedenken en uitvoeren, maakt dat ze onderdeel worden van het proces en **gemotiveerd** raken om het plan te laten slagen. Zelf nadenken prikkelt een gevoel van **eigen verantwoordelijkheid** waardoor vaak eenvoudiger een uitkomst of oplossing kan worden gevonden.
Professioneel gezien berusten normen en waarden die ik hanteer met name op ethisch vastgestelde grenzen (vb. (spel)regels). Mijn eigen normen en waarden blijven meer op de achtergrond of moet ik soms bewust opzij zetten. Het

gaat om aanpassing in communicatie die een speler vervolgens in staat stelt om het beste in zichzelf naar boven te halen. Zo is elke vorm van coaching uiteindelijk gebaseerd op **wederzijdse inspanning** en worden doelen gezamenlijk bereikt. Dit maakt het voor een coach tevens belangrijk om inzicht te krijgen wie er tegenover je zit en hoe daarop te reageren. Het vraagt **inlevingsvermogen** om te ontdekken wat iedere individuele speler nodig heeft en hoe en waar iemand ondersteund kan/wil worden. Een voor mij effectieve methode die hieraan bijdraagt is bijvoorbeeld de Myers-Briggs Type Indicator (*MBTI). Elke speler is uniek en het in kaart brengen van karaktereigenschappen maakt het mogelijk om coaching daarop aan te passen. Een andere methode ter ondersteuning is NeuroLinguïstisch Programmeren (*NLP), wat zich richt op het overdragen van vaardigheden voor **doelgerichte verandering**. Echter een belangrijke voorwaarde is dat **"mensen wel willen *veranderen* maar niet *veranderd* willen worden".** In zowel topsport als coaching raken mensen vaak pas overtuigd om te veranderen door **1)** confrontatie met hun persoonlijke metingen (meten=weten) **2)** toevoegen van expertise; bewijs voor wat deze metingen betekenen **3)** (inspireren met) voorbeelden van positieve verandering **4)** stimuleren van **eigenaarschap**.
Wat betreft het laatste punt ligt de focus niet zozeer op het **IQ** (kennis is overal) maar meer op het **EQ** (denk aan passie, kwetsbaarheid, verantwoordelijkheid bij de mens leggen) en steeds vaker ook op het **SQ** (hoe inspireer je mensen om een uitdagend doel neer te zetten en te bereiken). Er is veel winst te behalen door mensen te **inspireren** tot verandering in plaats van te instrueren. Zowel in topsport, de bedrijfswereld, de gezondheidszorg en vele andere domeinen is het mogelijk mensen te inspireren om **uitdagende doelen** neer te zetten. Een uitdagend doel is dat alleen als dat voor jou persoonlijk geldt. **Positief visualiseren** kan hierbij een hulpmiddel zijn, het zorgt voor een focus op de dingen die je kunt bereiken doordat je er zelf invloed op hebt. Dit kan tevens een gevoel van 'flow' teweegbrengen. Deze '**flow'** kan worden versterkt door middel van constante feedback, een (voortdurende) manier van coaching die mensen in staat stelt om zelf verder te kunnen. Met name in topsport gaat men snel over **van feedback naar feedforward**. Feedforward is feedback gericht op de toekomst. Ook in geval van emotie of frustratie vraagt dit allereerst bevestiging van het gevoel om vervolgens weer door te pakken en niet te blijven hangen in onzekerheid. Voor een snelle, directe en efficiënte manier van feedback leveren, zijn de **huidige moderne communicatie technieken** (bv. Skype, Facetime) een uitstekend middel om mijn spelers direct het gevoel te geven gezien en ondersteund te worden. Toch blijft coaching **maatwerk** (ook wel '**situationeel leiderschap'**) gezien er zich ook situaties voordoen waarin een fysieke afspraak meer wenselijk is.
Naast het *verlenen* van feedback kan ik ook om feedback *vragen*, als graadmeter voor het verloop van de interactie en communicatie. Echter voert **tevredenheid** van de spelers zelf de boventoon, zij moeten het uiteindelijk waarmaken. Belangrijke indicatoren hierbij zijn bijvoorbeeld **sociaal-emotionele scores** en **lichamelijk-emotionele scores** (cijfermatig van 0-10 door spelers zelf te beoordelen). Scores op fysiek vlak komen vervolgens direct bij een dokter terecht en scores op emotioneel vlak bij een sportpsycholoog. Dat benadrukt tevens het belang om nauwe **samenwerking** aan te gaan met andere **expertises**. Erkenning en uitbesteding van zaken die buiten jouw kracht als coach liggen is essentieel. Zelf heb ik tevens een eigen mental coach (opgeleid in communicatie) en is expertise daardoor zeer dichtbij; iemand die mij 'coacht in het coachen'.

* **Neurolinguïstisch programmeren (NLP);** model voor doelgerichte verandering waarbij vaardigheden van zogeheten experts in kaart worden gebracht (*gemodelleerd*) en als techniek aan anderen onderwezen kunnen worden. Betreft een wisselwerking tussen 3 elementen (1) *Modelleren*: menselijke vermogens overdraagbaar maken met behulp van psychologische technieken; (2) *Analyse van de subjectieve ervaring*: het bepalen van patronen in de beleving; (3): *Communicatietechnieken*: manieren om harmonieuze relaties op te bouwen en boodschappen te verhelderen en te versterken.
* **Myers-Briggs Type Indicator (MBTI)**: geeft een indicatie met wat voor type mens je te maken hebt (vb. introvert vs. extravert, handelend op gevoel vs. op ratio).

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4. Berna Nijboer - Buurtsportcoach (stimuleringsprijs 2015)

Als sportfunctionaris houd ik mij voornamelijk bezig met het uitvoeren van sportbeleid, promoten van sport en coördineren van sportactiviteiten. Het doel is om kinderen (m.n. in achterstandswijken) aan het sporten te krijgen. Daarbij is het streven om juist de kinderen eruit te pikken die vanuit zichzelf weinig of niet bewegen. Het gaat hierbij zowel om het '**binnenhalen' als 'behouden'** van deze kinderen. Het hoofddoel is sport maar ook in gevallen waar het hoofddoel niet haalbaar blijkt, is de achterliggende gedachte om kinderen (en hun ouders) te **stimuleren, activeren tot ondernemerschap en hen verbintenis en structuur** aan te laten gaan. Het **initiatief tot actief contact ligt bij ons**. Daarna(ast) is het van grote waarde om een **persoonlijk gesprek** aangaan met zowel het kind als de ouders. Het meenemen van de **context** en de **persoonlijke situatie** is essentieel; gesprekken vinden bij voorkeur in vertrouwde omgeving/thuis plaats wat tevens inzicht geeft in de mogelijkheden en capaciteiten per situatie/per gezin. Op basis van dit **maatwerk** kan worden ingeschat hoeveel **sturing** of behoefte aan **autonomie** er wenselijk is. De interacties zijn vrij **oplossingsgericht** maar opties worden allereerst waar mogelijk afgestemd op persoonlijke voorkeur. We proberen **laagdrempelig** te werken; het de mensen zo makkelijk mogelijk te maken en om snel en actief drempels weg te halen. Daarbij wordt er regelmatig **nauw samengewerkt** met bijvoorbeeld jongerenwerkers, maatschappelijk

werkers en **andere hulpverlening**. Daarnaast is het wenselijk dat we ouders en kinderen **motiveren** om **zelf** ideeën te komen en in te zien hoe belangrijk sport voor hen kan zijn. Vaak is de 'wil' aanwezig maar is er een zetje nodig om daadwerkelijk **tot actie** te **komen**. De cursus **motiverende gespreksvoering** kan hierbij helpen d.m.v. gesprekstechnieken zoals doorvragen en mensen voornamelijk zelf aan het woord te laten.
Bovenal is werkervaring heel belangrijk, zowel om nieuwe situaties aan te gaan en als graadmeter voor het behalen van doelen.

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5. Derk Tetteroo - Adjunct directeur bureau Frontlijn

Het grootse belang van ons ontwikkelingsbureau is om te **ontwikkelen** vanuit de mensen (in achterstandsituaties) zelf. De interacties zijn op **vrijwillige** basis waarbij de doelgroep inclusief hun **persoonlijke** situatie uitgangspunten zijn. We streven naar groei in **samenwerking** en in eigen directe omgeving bij de mensen thuis. We staan daardoor niet tegenover maar naast de burger. Persoonlijk contact en een volledig gedetailleerd beeld van de situatie is nodig voor signalering van knelpunten vanuit het **belang** van de burger.
We zijn pragmatisch ingesteld (weinig middelen) maar dragen te allen tijden uit dat we niet alleen komen om te praten maar ook echt om te helpen en daadwerkelijk iets kunnen en willen betekenen. Het gaat om versimpelen van de kluw van problemen. Naast directe, **korte termijn** oplossingen is het van belang om ook **perspectief** op **lange termijn** te bieden. Dit vereist allereerst reductie van stress(oren) ten gevolge van de achterstandsituatie. Vervolgens is het mogelijk mensen te leren hun **eigen verantwoordelijk** te nemen in/voor hun eigen situatie. Het hoofddoel is uiteindelijk om mensen **basisvaardigheden** aan te leren ter verhoging van hun **eigenwaarde** en bevordering van **zelfredzaamheid**.
De methodiek van **coaching** en **training** berust voornamelijk op **uitleg** en (praktische) **gezamenlijke** actie; "voordoen, samen doen, nadoen en zelf doen". **Terugkoppeling** zorgt voor sneller begrip en inzien van de gevolgen van hun eigen handelen. Luisteren (het totaalplaatje in beeld), **motiveren** en **bevestigen** (positieve bejegening) is essentieel en legt ook de basis voor een benodigde vertrouwensband. Het aanleren van vaardigheden moet in kleine stapjes en vereist **geduld**, **tijd**, **intensiteit**, **acceptatie** en **inzicht** in maximaal haalbare uitkomsten per situatie. We leveren **maatwerk** en werken met vaste teams maar werken ook nauw **samen** met vele instanties en hulpverlening. Het doel van een duurzame interactie is bereikt als ons maatwerk **beklijft** en mensen zelf verder kunnen (leidt tevens tot kosten reducering). Succes is tegelijkertijd zichtbaar wanneer mensen op vrijwillige basis blijven terugkomen en zelf inzien/vragen wat ze nodig hebben. Door middel van een **nazorgtraject** bieden we hulp die nooit stopt, de deur staat altijd open.

6. José Wikkerink - Shiatsu- en levenskunst therapeut

Het uitgangspunt van Shiatsu is de traditionele Chinese geneeskunst. Centraal staat het denken in **totale systemen** en hoe gezondheid en ziekte ontstaan vanuit een groot perspectief. Het gaat hierbij om bewustzijn van 5 elementen: aarde, metaal, water, hout en vuur. Deze elementen werken samen en hebben een bepaalde dienstbaarheid naar elkaar, wat leidt tot een goed functionerend organisme. Ik ga er vanuit dat het potentieel van elk organisme volledig aanwezig is, het hoeft zich alleen nog maar te **ontwikkelen**. Dat gebeurt vanuit het diepe verlangen om te willen leven. De kunst is dat men zich in de juiste verhouding vanuit verticaliteit (intrinsiek verlangen, de natuur) in de horizontale wereld (de tijd, vaak voort gestuurd door angst, haast, druk, stress en verantwoordelijk) beweegt . Essentiele vragen daarbij zijn "wat zijn ziektemakers"? en "hoe worden/blijven we heel"? Daarvoor moet men zich vooral laten inspireren door zuivere **verlangens** (verticaal, zoals de natuur) en niet door misleidende **behoeften** (horizontaal) die vaak tot ziekte leiden. Wijsheid ontstaat wanneer men erin slaagt om vanuit dit systeem in de wereld te staan. Ik probeer aan te haken bij dat wat er **nu** speelt en te kijken of ik daar op in kan spelen vanuit mijn **expertise** en **competenties** zodat men weer in de juiste verhouding in beide assen beweegt. Ik heb een diep verlangen om mensen hierbij te helpen, mede gebaseerd op **onvoorwaardelijke liefde** die ik naar mensen voel. Andere belangrijke waarden in mijn interactie met mensen zijn het gevoel van **vrijheid** en **harmonie**. De interacties zijn een **gezamenlijke** zoektocht met als voorwaarde dat men wel een eigen verlangen moet hebben om op zoek te gaan. Ik streef ernaar om mensen in **beweging** zetten en **bewust** te maken van het effect van hun handelen naar anderen en de wereld toe. Mijn uitgangspunt is om een bijdrage leveren aan de mogelijkheden die iemand zelf in handen heeft om zichzelf ziek of gezond te voelen. Tevens moeten gewenste uitkomsten persoonlijk **haalbaar** zijn, waarvoor ik de cliënt eerst beter moet leren kennen. Als de gezamenlijk bedachte oplossing uiteindelijk wordt opgepakt, vind ik dat het doel eigenlijk wel bereikt is. Ik wil de mens vooral niks opleggen, blijvend prikkelen en open vragen stellen is theoretisch gezien goed maar doe ik niet altijd. Ik houd het graag dichtbij de werkelijkheid en **simpel**; geen zweverigheid of moeilijk taalgebruik. Mijn werkwijze betreft met name **benoemen** en/of abstract **tekenen**. Ik laat mensen ook zelf tekenen om zo zicht te krijgen op hoe mensen het zelf ervaren. Ik start altijd met een **anamnese**; aard van de klacht, hoe lang het al speelt, familiaire achtergrond, etc. Vervolgens ga ik, ongeacht de aanleiding, voor een holistisch beeld alle dimensies na (fysiek, emotioneel, mentaal, spiritueel) en houd ik een dossier

bij. Om te kijken waar de mogelijkheden liggen in het leven maak ik tevens gebruik van een **spel** dat bestaat uit kaartjes met **levenswaarden** (onvoorwaardelijke liefde, creativiteit, vrijheid, vrede, verbinding etc.; zijn verlangens; moeiteloos). Opgelopen 'deuken' in het leven (vaak angst) houden het uitstralen van levenswaarden tegen waarop behoeften worden gecreëerd die deze gaten moeten vullen (erkenning, waardering, bewondering, bevestiging; van buitenaf; moeten). Dat leidt tot afhankelijkheid en is niet duurzaam. Behoeften kun je middels sleutels ('universele wetten': ik accepteer mezelf zoals ik ben) terugbrengen bij de mens zodat de gaten van binnenuit worden uitgedeukt. Er ontstaan dan littekens maar levenswaarden kunnen daar weer langs op. Deze denkwijze helpt om weer volledig te worden. Door het spiegelen van eigen levenswaarden kunnen mensen zich (weer) erkend voelen in zichzelf.
De interactie tussen hulpverlener en cliënt leg ik graag uit aan de hand van de **reddingsdriehoek**: redder (wil graag slachtoffer helpen), slachtoffer (wil graag gered worden) en aanklager (wijst op fouten van het slachtoffer). Een hulpverlener die in reddersrol opgelopen deuken van slachtoffers vult is niet duurzaam omdat deze daardoor afhankelijk en in zijn slachtofferrol blijft. Het gaat er om mensen hun **eigen verantwoordelijkheid** te laten nemen. Door een combinatie van **aanmoedigen** (aanklager), **mededogen** (redder) en **kwetsbaarheid** (slachtoffer) kan eigen verantwoordelijkheid worden bereikt. Hulpverleners moeten niet gaan 'medelijden' maar respecteren wanneer slachtoffers willen l**ij**den en bovenal aanmoedigen van het persoonlijk intrinsiek verlangen om het leven te l**ei**den. Wijsheid ontstaat wanneer iemand de tools in handen neemt die beschikbaar zijn voor een overgang van **lijden** naar **leiden** en zo uit het slachtofferschap stapt. Een **tevreden** gevoel is hierbij wel degelijk van belang. Dit kan ik enerzijds **cijfermatig** bevragen maar is anderzijds vaak meer gevoelsmatig dat ik iemand iets heb kunnen meegeven; **inzicht**, **bewustzijn** of **acceptie** of een **bevrijdend** gevoel. Wat ik ten slotte ook altijd toepas is het **beklijven** in het lichaam. Hierbij gaat het erom naar een balans toe te werken opdat **alle dimensies** (fysiek, emotioneel, spiritueel) op hetzelfde moment aanwezig zijn. Zo geef ik uiting aan mijn respect en diepe verlangen naar een **samenwerking** tussen **oosters** denken (verticaal) en **westers** denken (horizontaal).

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7. Carel Lovers – Directeur Lovers Amsterdam

Het streven in mijn werk zou ik omschrijven als **voldoening** van al onze inzet, met als hoofdzaak steeds blijven **groeien**. Voortdurend op jacht naar **winst** als kernwaarde wordt vergezeld door het principe om in alle **eerlijkheid** zaken te doen. Een groot bedrijf betekent grote **verantwoording**. Dat gevoel wordt versterkt doordat ik **langdurig** dezelfde mensen in dienstverband heb met wie je een **werkrelatie** opbouwt. Het liefst houd ik zoveel mogelijk zelf in handen. Op sommige vlakken moet je **verantwoordelijkheid** ook overlaten aan anderen, en moet men deze verantwoordelijk vervolgens ook dragen. Daarbij **stimuleer** je werknemers om voor je te gaan. Het is aan de (bedrijfs)**leider** om in gang te zetten dat ze voor jou en het bedrijf in de juiste richting gaan. Allereerst is het daarvoor belangrijk om werknemers blijvend **informatie en uitleg** te verstrekken. Overgang naar **motiveren** blijft lastig maar is essentieel. Vaak ontstaat er eerst een 'natuurlijke tegenwerking' (m.n. bij introductie van iets "nieuws"). Echter als leider moet je **gezag** laten gelden, er is maar 1 baas en mijn wil is wet. Bij het proeven van een eerste positieve vooruitgang ontstaat er vaak al **intrinsieke motivatie** en gaat verdere **ontwikkeling** en groei als haast vanzelf.
Een ander knelpunt betreft de huidige generatie; **opvoeding**, **opleiding** en **houding** van werknemers zijn in de loop der jaren veranderd. Het vraagt om een andere tactische manier van **communiceren** waarbij **coaching** een steeds grotere rol speelt. Het is de kunst om per individu zijn of haar **potentieel** te bepalen en dat er ook weet uit te halen.
Het creëren van een **vertrouwenssfeer** is te allen tijden essentieel. Het gaat om **oprecht interesse** tonen, vragen stellen, maar géén bemoeienis want dan gaat de vertrouwenssfeer verloren. De vertrouwensband ontstaat niet alleen gevoelsmatig maar is wat mij betreft grotendeels gebaseerd op **naastenliefde** (wederom versterkt door langdurige werkrelatie met werknemers). Omgang met werknemers vereist **respect** en **aandacht** waardoor er **betrokkenheid** ontstaat en behouden blijft. Het gaat om oprecht en echt contact, niet alleen op de werkvloer zelf maar ook daarbuiten rekening houdend met de **context** en achtergrond van de werknemer (denk aan telefonisch **contact**; **informele sfeer**; bedrijfsfeesten; bij de mensen thuis; ziekenbezoek, etc.)
Met betrekking tot het ondernemerschap gaat het erom steeds op zoek te gaan naar nieuwe mogelijkheden, elke dag hierin vooruit lopen en te blijven **anticiperen**. Een ondernemer is altijd **waakzaam** en **innovatief**. Ook bijscholing en cursus (v.b. gastvrijheid, veiligheid, ehbo, horeca-gerelateerd, etc.) komen hieraan te pas.
Wat betreft behalen van resultaat geldt; **meten** is weten. De **cijfers** van het bedrijf zijn leidraad (denk aan winst, maar ook weinig ziekte en verzuim). Uiteindelijk gaat het toch ook om het levensonderhoud en het **geluk** van mijn werknemers, dat ben ik met de tijd **wijzer** geworden.

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8. Arda de Zeeuw – verpleegkundig docent en MSc Leren en Innoveren

Ik streef naar een goede, ontspannen **sfeer**, **contact** met studenten en collega's en het creeëren van een **leerklimaat**. Ik werk graag alleen, met de mogelijkheid om met collega's te overleggen. Onderwijs heeft veel **sturing** in de organisatie, daar ga ik in mee maar de invulling en **tijdsindeling** bepaal ik zelf. Die **vrijheid** vind ik belangrijk, Vrijheid ervaar ik als het leven tussen de regels door, daar kan ik erg van genieten. Ik streef niet expliciet naar

autonomie maar zonder dat element in mijn werk zou ik het werk meer als een harnas ervaren. Ik richt mij op een **evenwicht in sturing en vrijheid**. Een ander belangrijk aspect is **sfeer**. Het leven in het algemeen en in mijn werk in toenemende mate, zitten veel **verplichtingen**, **richtlijnen**, **metingen**. Deze ervaar ik als teveel **sfeerbepalend**, **controlerend**, soms zelfs als **ondermijnend** aan mijn **werkervaring** en **deskundigheid**. Daartegen kom ik soms in verweer. Niet alles hoeft van mij inzichtelijk te zijn of gemeten te worden. Het leven is niet controleerbaar! Ik richt mij op de sfeer in het team waarin ik werk, ik investeer daar veel in. **Onderling oprecht contact** hebben is voor mij wezenlijk. **Duidelijk** zijn in **taalgebruik**, de ander (in mijn geval studenten) de mogelijkheid geven zelf **(levens)ervaring** op te doen, ook in negatieve zin, **bemoedigen** in **zelfverantwoording** en **zelfbepaling**, dat vind ik mijn taak. Elk mens wil gezien worden en elk mens kan leren.
Ik ben graag **dienstbaar** naar collega's en studenten toe. Daarin zit **satisfactie** en **creativiteit**, zelf invulling zoeken hoe ik dit doe, met wie en hoeveel tijd ik er in stop. In deze dienstbaarheid zit ook **zingeving**, het is nuttig om anderen een mooi vak te leren en kennis te delen maar ook **levenslessen** te leren (b.v. hoe ga je om met tegenwind in je leven?) Belangrijke kernwaarden: **verantwoordelijkheid** nemen, **betrouwbaar** zijn, **zingeving** zoeken, **plezier** hebben onderweg. Materie niet bepalend laten zijn is mijn streven.
Door aandachtig en consequent te **observeren** (de ander, de sfeer, nonverbaliteit) kan ik dichter bij mijn doelen komen. Door anderen te **bevragen** wat hen bezich houdt, raakt, blij maakt. Mijzelf moet ik zo nu en dan in acht nemen, **anticiperen** op de grenzen die ik voel, fysiek vooral. Dit is om te voorkomen dat ik uit balans raak. Zelf **initiatief** nemen om in werksituaties de stress en druk die er is, bespreekbaar te maken en te **delen** met collega's en **vieren** wat er te vieren is. Tijd maken voor een gesprek of een grapje. Dagelijks zoek ik naast mijn reguliere taken, contact met studenten. Ik wil graag weten hoe het met hen gaat, ervaar contact als plezierig en loop in mijn beleving 4 jaar lang een stukje met hen mee. Met de één intensiever als met de ander. Door vragen te stellen (en mijn eigen ideeen , gepast, bij mij te houden) en **oprechte belangstelling** te tonen ontstaat soms waardevol contact. Als ik merk dat studenten **zelf inzicht opdoen** of iets (af)leren, dan ervaar ik dat als zinvol en mooi. Er wordt volop getoetst, daarin is het leren wel te meten (omdat we ook **vaardigheden toetsen**). Belangrijk is ook het **voorbeeldgedrag** van een docent en de **veiligheid** die er geboden wordt. Dat effect is te zien als een groep samenwerkt. Soms **uitdagen** tot ander/ passend gedrag (je bent tenslotte jong) maakt problemen lichter. Ik vertraag graag een beetje, als het past. **Tijd** is maar tijd. Soms heb je zaken niet in de hand en moet je leren wachten of geduld hebben. In de loop der jaren heb ik geleerd dat leren/ het leven in fases en processen gaat. Doelen worden bereikt als ik **groei** zie, studenten zie **leren** (niet alleen **inhoud** of **kennis** maar ook **sociale vaardigheden**). Studenten **bevestigen** in wat zij op dat moment doen en kunnen is meer nodig dan prestaties meten.

Table [8] Structural Outline Qualitative Interviews (Original Dutch version)

(1) Core Values & Mindset	(2) Tools & Techniques	(3) Measurement & Indicators
Predikante		
Diversiteit van het pastoraat; Vergt een alledaags perspectief; Verantwoordelijk voor zowel het welzijn van individuen als van de gemeenschap als groep contact op eigen aanvraag of op aanwijzing van anderen Vrijwillig lidmaatschap en informele sfeer en gevoel van vrijheid; predikant is onderdeel v.d. gemeenschap met gepaste professionele afstand Gelijkwaardigheid van mensen Interacties m.n. gericht op zingeving Niet één waarheid; afweging van opvattingen Persoonlijke betrokkenheid vereist soms ook loslaten	De bijbel is mijn houvast -Additioneel gebruik van (verbindende) rituelen, zegening of gebeden; allen gezamenlijke Uitvoering; directe sturing ('opvoeden'); indirecte sturing (opvattingen terugkoppelen) Het **stimuleren, motiveren en activeren en inspireren** (ook vanuit de bijbel) om eigen keuzes te maken Sturen en corrigeren soms nodig	Geen externe doelen te behalen of te verantwoorden Mensen die zich gekend en gezien voelen, zelf weer verder kunnen. Dat de wereld om je heen wat van je merkt en daar ook wat aan heeft Wanneer mensen zelf weer verder kunnen en zich gekend en gezien voelen.
Dirigent (choir director)		
Persoonsgericht vs. groepsbenadering Leiderschap: samenwerking ("ensemble") mét sturing (amateur) gevoel en betrokkenheid; (professioneel) prikkelen op vaardigheden Proces is belangrijker dan doel: gevoel en ervaring Wederzijds vertrouwen; respect, inleving, op waarde schatten, sfeer, doseren en bevestigen	Coach, mentor, docent Expressie/gebaren Dirigeerstok Tekst van muziek Doceren/Uitleggen Voelen en voelbaar maken planmatig	Kwaliteit van (uitvoering) het muziekstuk Tevredenheid van dirigent & orkest & publiek
Topsportcoach (top-level sport coach)		

- naast eigen kennis, ervaring en passie, spelers betrekken in de interactie omtrent hun eigen ontwikkeling; wederzijdse inspanning - De kunst van het coachen is dat de instructies die jij als coach voor ogen hebt, door spelers zelf ontdekt worden. - Coachend leiderschap benadrukt het belang om open vragen te stellen; zelf nadenken prikkelt, geeft gevoel van eigen verantwoordelijkheid en motiveert: stimuleren eigenaarschap - inspireren (tot uitdagende doelen) i.p.v. instrueren - "mensen wel willen *veranderen* maar niet *veranderd* willen worden"; vergt inlevingsvermogen en doelgerichte verandering - coaching blijft maatwerk (situationeel leiderschap)	Myers-Briggs Type Indicator (MBTI) NeuroLinguïstisch Programmeren (NLP) verandering door: **1)** confrontatie met hun persoonlijke metingen (meten=weten) **2)** toevoegen van expertise; bewijs voor wat deze metingen betekenen **3)** (inspireren met) voorbeelden van positieve verandering **4)** stimuleren van eigenaarschap. - positief visualiseren -(constant) feedback en feedforward; o.a. mbv moderne communicatie (skype/facetime)	- Verlenen van, én vragen om feedback - tevredenheid van spelers zelf voert de boventoon; Belangrijke indicatoren hierbij zijn bijvoorbeeld **sociaal-emotionele scores** en **lichamelijk-emotionele scores** **-** nauwe **samenwerking** aangaan met andere **expertises** - Naast IQ, ook EQ en SQ - "flow"
Buurtsportcoach (Community sport coach)		
- stimuleren, activeren tot ondernemerschap en aanzetten tot verbintenis en structuur - binnenhalen' en 'behouden' - sturing en autonomie naar inschatting - interacties zijn oplossingsgericht en laagdrempelig - motiveren tot zelfnadenken en activatie	- eigen initiatief tot actief contact - maatwerk; persoonlijke en contextuele gespreksvoering - motiverende gespreksvoering - nauwe samenwerking met andere hulpverlening	- (werk)ervaring als graadmeter of doelen bereikt zijn.
Adjunct directeur bureau Frontlijn		
Ontwikkelen/ing vanuit mensen zelf Samen werken aan groei; op vrijwillige basis Korte termijn; Signaleren knelpunten, stress Lange termijn: perspectief en zelfredzaamheid door aanleren basisvaardigheden uitgaan van eigen kracht; regie en verantwoordelijkheid bij de burger: vertrouwen en motivatie	Algemene methodiek coachen & trainen; (uitleggen en voordoen) Kracht van positieve bejegening Luisteren en terugkoppeling "nazorgtraject" maatwerk: stapsgewijs gevraagd & ongevraagd advies	Bedrijfscijfers Voldoende score client (beklijving/maximaal haalbare) Zelfstandig functioneren Kosten reductie en duurzame relatie
Alternatief Genezer - shiatsu		
Onvoorwaardelijke liefde naar de mens; vrijheid en harmonie Samenwerking oosters en westerse geneeskunst; totale systemen; 5 elementen Mogelijkheden tot ziekte en gezondheid zelf in handen; eigen verantwoordelijkheid Vanuit eigen verlangen van de mens samenwerken naar haalbaar resultaat o.b.v. van mijn professionele expertise en competenties	Anamnese Benoemen, spel spelen (spiegelen van eigen levenswaarden), samen zoeken naar mogelijkheden Visueel: schetsen en tekenen Bijhouden dossier Cijfermatig bevragen Inspelen op het hier en nu; behoeften vs. verlangen (levenswaarden)	Tevredenheid Verkregen inzicht, bewustzijn, acceptatie, bevrijd gevoel Cijfermatige beoordeling Wijsheid: mensen het heft in eigen handen; uit hun slachtofferrol; van lijden naar leiden
Directeur Lovers Amsterdam		
Leiderschap; gezag; verantwoordelijkheid Voldoening van inzet Blijven groeien; winst maar eerlijkheid Stimuleren; motiveren; in juiste richting sturen Vertrouwenssfeer, werkrelatie, ook informeel	Ondernemer: waakzaam & innovatief Coaching + Informeren en uitleggen Bijscholing en cursus Vragen, geen bemoeienis Oprecht contact, bellen/langsgaan	Meten = weten; Cijfers, winst Ziektecijfers en verzuim Geluk van werknemers Voldoening Vertrouwensband
Verpleegkundig docent (Nurse tutor)		
Zoeken naar evenwicht in sturing en vrijheid Sturing: Veel organisatorische sturing in onderwijs; verplichtingen, richtlijnen, metingen; ondermijnt soms mijn eigen werkervaring en deskundigheid Vrijheid: eigen invulling en tijdsindeling Dienstbaarheid: satisfactie en creativiteit Creëren leerklimaat, zingeving en levenslessen:, betrouwbaar zijn, zingeving, uitdagen, plezier; tijd maken voor oprecht contact, delen en vieren Eigen grenzen bewaken, anticiperen, initiatief nemen Tijd is maar tijd: het leven gaat in fasen en processen	Mogelijkheid geven zelf (levens)ervaring op te doen; bemoedigen in zelfverantwoording en zelfbepaling. Doelen bereiken door aandachtig en consequent obersveren (de ander, de sfeer, non verbaliteit), te bevragen en oprechte belangstelling Docent: Duidelijk taalgebruik, voorbeeldgedrag en veiligheid bieden Studenten bevestigen in hun kunnen/ doen is meer nodig dan prestatiemeting	Vaardigheden volop getoetst Niet alles inzichtelijk of gemeten; het leven is niet controleerbaar Zelf inzicht opdoen en leren Doelen worden bereikt als ik groei zie, studenten zie eren (niet alleen inhoud of kennis maar ook sociale vaardigheden)

Table [9]: Interview results (English translation of table 8)

	1. Core values & Mindset	2. Tools & Techniques	3. Measurement & Indicators
Interview results			
1	Everyday life perspective Responsibility for wellbeing of the community Equality; sense of freedom; Hope and the love of god On voluntary base; informal atmosphere; openness Bible is guiding but not the only truth; considering different perspectives; situational meaningfulness Personal involvement but appropriate professional distance; empathy and credibility	The bible Stimulating, motivating, activating and inspiring to make own choices Use of binding rituals, blessing, prayers Direct guidance; "raising and correcting" Indirect; "feedback & reflection" Mapping of expectations; Communication and discussion is the key	Not accountable for external goals to be obtained; servitude People feel seen, heard and acknowledged in what they stand for Personal growth (as a natural change during a lifecourse) Quality of life
2	Leadership on group and individual level The process is more important than the outcomes Guided co-operation; empathy and involvement Guiding and releasing; based on experience Person-centered approach: coach, mentor, teach Time planning; proportionated efforts; prioritising Enjoy; confirm; appreciate; positive atmosphere	Verbal: explanation and teaching Non-verbal: use of baton, expression, gestures, to feel and to make tangible Textual interpretation of musical work Amateurish approach: enthusiastic but goal-oriented collaboration Professional approach: elicit competencies	Quality of the performed musical work Satisfaction by choir director, musicians and public Mutual trust, respect, responsibility
3	**"Coaching leadership; let people discover by themselves the instructions you envisaged"** Involving people in their own development Stimulate consciousness; thinking by themselves; responsibility; and ownership = Mutual effort Situational leadership; requires tailored empathy Change behaviour but not the people; inspiring towards challenging targets rather than instructing The strength and power of getting in a "flow"	MBTI (Myers-Briggs Type Indicator) NLP (Neuro-Linguistic Programme) Change through: (1) confronting with measurement (2) adding evidence (3) inspiring examples (4) build ownership Visualising matters Persistent feedback and feed forward Modern communication (e.g. Skype) Close collaboration with other expertise	Provision of, and asking for feedback Satisfaction of players is of key; indicated by socio-emotional scores and physical-emotional scores Including IQ, EQ and SQ (holistic)
4	Stimulate action competence and incite to commitment and structure; movement of children "Acquiring and maintaining" the target group Solution-focused interactions; approachable To activate and to motivate to think themselves Guiding and guidance by estimation and experience	Active contact on professional initiative Tailored approach; personal & contextual Motivational interviewing techniques Close collaboration with assistance services	Sport and movement Fulfilment of commitment & structure Work experience as an important yardstick whether goals are achieved
5	Development of people within their own situation and capacities; building on their own strength Control and responsibility rests by the citizens Short term: signalling bottlenecks Long term: reduce stress and increase self-reliance; teaching basic skills: patience, intensity, acceptation Shared efforts: trust and motivation	General methodology of coaching and training; explanation and demonstration Listening and provision of feedback Gradual processing and after-care track Tailored and positive approaching Solicited and unsolicited advice Close cooperation with assistance services	Self-reliance of the clients; sufficient scoring on maximum feasible level The results to continue decisively Successful company; cost reduction and sustainability
6	Collaboration between eastern & western medicine; Unconditional love for human and life: striving for harmony in sense of freedom Opportunities to feel sick or healthy in own hands; (helping to take) own responsibility Collaborating towards feasible outcomes: based on client's desire & professional expertise/competence Responding to life values of the "here and now"	Anamnesis (including all dimensions; totality of systems; holistic view) Verbal: Nominating Non-verbal: drawing and sketching Play that reflects people's life values; jointly searching for opportunities in life Maintain written record Ask for numerical judgement(s)	Gained insight, consciousness, acceptation, sense of freedom Wisdom: people taking control in own hands to move out of their victim role Satisfaction (in *desires*, not in *needs*) Numerical judgement Right balance out of verticality (nature) moving in horizontal world (time)
7	Leadership; authority but shared responsibility Stimulating. Motivating, steering in right direction Continuous growth in profits; fair business Satisfaction of effort Climate of trust, work- and informal relationship	Entrepreneurship; alert and innovative Coaching; inform, explain, question Involvement; no interference Sincere, genuine contact; calling and visit Education and training	"To measure is to know": profits Low absenteeism and illness Happiness of employees Satisfaction Relationship over time
8	Balancing between guidance and freedom *Guiding*: Much organizational guidance in education; obligations, guidelines and measurement; may undermine my professional experience & expertise *Freedom*: own implications, time planning, creativity Servitude gives me satisfaction Time is just time; life is about stages and phases Creating learning environment and lessons from life	Clear language, exemplary behaviour, offering safety, affirming capacities Encourage self-responsibility, self-determination, reliability, meaningfulness, joy, sharing, celebrating, genuine contact Attentive and consequent observation (person, ambiance, nonverbal) Secure my own borders and anticipate	Frequent assessment of knowledge and skills; Not all is measurable and insightful; life is not controllable Affirmation of students' doing, knowing and capacities is more necessary Learning and growing students; not only content, also social skills