Relationship-Centered Care in the Physician-Patient Interaction: Improving Your Understanding of Metacognitive Interventions

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PRACTICE **POINTS**

- Relationship-centered care emphasizes that all relationships in health care are important, including not only relationships between physicians and patients but also among physicians and colleagues, staff, students, community, and self.
- The physician-patient relationship can be complex, and metacognition can lead to habitual practice of simple techniques to optimize the interaction.

The concept of relationship-centered care was first introduced approximately 20 years ago, but this important concept has not yet been widely disseminated in clinical practice. Relationship-centered care in the health profession focuses on all relevant relationships in health care, not only between health care professionals and patients but also among colleagues, staff members, students, community, and self. This review summarizes the key literature to date on relationship-centered care as it pertains to the physician-patient relationship. Becoming more aware of the physician (self) and patient is a form of metacognition, thinking about what is happening in the moment as physicians and patients come together. Considering the complexity of the physician-patient relationship, we can implement simple metacognitive techniques toward the daily habitual practice of relationship-centered care.

Cutis. 2021;107:320-324.

Communication and relationships cannot be taken for granted, particularly in the physician-patient relationship, where life-altering diagnoses may be given. With one diagnosis, someone's life may be changed, and both physicians and patients need to be cognizant of the importance of a strong relationship and clear communication.

In the current US health care system, both physicians and patients often are not getting their needs met, and studies that include factors of race, ethnicity, and socioeconomic status suggest that physician-patient relationship barriers contribute to racial disparities in health care.[1,2] Although patient-centered care is a widely recognized and upheld model, relationship-centered care between physician and patient involves focusing on the patient and the physician-patient relationship through recognizing personhood, affect (being empathic), and reciprocal influence.[3,4] Although it is not necessarily intuitive because it can appear to be yet another task for busy physicians, relationship-centered care improves health care delivery for both physicians and patients through decreased physician burnout, reduced medical errors, and better patient outcomes and satisfaction.[5,6]

Every physician, patient, and physician-patient relationship is different; unlike the standard questions directed at a routine patient history focused on gathering data, there is no one-size-fits-all relationship-centered

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The authors report no conflict of interest.

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doi:10.12788/cutis.0266

conversation.[7-10] As with any successful interaction between 2 people, there is a certain amount of necessary self-awareness (Table 1)[11] that allows for improvisation and appropriate responsiveness to what is seen, heard, and felt. Rather than attending solely to disease states, the focus of relationship-centered care is on patients, interpersonal interaction, and promoting health and well-being.[15]

This review summarizes the existing literature on relationship-centered care, introduces the use of metacognition (Table 1), and suggests creating simple habits to promote such care. The following databases were searched from inception through November 23, 2020, using the term *relationship-centered care*: MEDLINE (Ovid), EMBASE (Ovid), APA PsycInfo (Ovid), Scopus, Web of Science Core Collection, CINAHL Complete (EBSCO), Academic Search Premier (EBSCOhost), and ERIC (ProQuest). A total of 1772 records were retrieved through searches, and after deduplication of 1116 studies, 350 records were screened through a 2-part process. Articles were first screened by title and abstract for relevance to the relationship between physician and patient, with 185 studies deemed irrelevant (eg, pertaining to the relationship of veterinarian to animal). The remaining 165 studies were assessed for eligibility, with 69 further studies excluded for various reasons. The screening process resulted in 96 articles considered in this review.

Definitions/key terms, as used in this article, are listed in Table 1.

Background of Relationship-Centered Care

Given time constraints, the diagnosis and treatment of medical problems often are the focus of physicians. Although proper medical diagnosis and treatment are important, and their delivery is made possible by the physician having the appropriate knowledge, a physician-patient relationship that focuses solely on disease without acknowledging the patient creates a system that ultimately neglects both patients and physicians.[15] This prevailing physician-patient relationship paradigm is suboptimal, and a proposed remedy is relationship-centered care, which focuses on relationships among the human beings in health care interactions.[3] Relationship-centered care has 4 principles: (1) the personhood of each party must be recognized, (2) emotion is part of relationships, (3) relationships are reciprocal and not just one way, and (4) creating these types of relationships is morally valuable[3] and beneficial to patient care.[16]

Assessment of the Need for Relationship-Centered Care

Relationship-centered care has been studied in physician-patient interactions in various health care settings.[17-23] For at least 2 decades, relationship-centered care has been set forth as a model,[4,24,25] but there are challenges. Physicians tend to overrate or underrate their communication skills in patient interactions.[26,27] A given physician's preferences often still seem to supersede those of the patient.[3,28,29] The impetus to develop relationship-centered care skills generally needs to be internally driven,[4,30] as, ultimately,

TABLE 1. Important Concepts in Relationship-Centered Care

Key terms	Definition used in this review
Search term	
Relationship-centered care[3,a]	Focusing on the patient and the physician-patient relationship through recognizing personhood, affect (being empathic), and reciprocal influence
General terms[b]	
Awareness (self-awareness)[c]: inclusive of mindfulness[d] and presence[12,13,e]	Being present and mindful of the emotions and responses expressed in the physician-patient interaction
Burnout	The end result of emotional exhaustion, depersonalization, and a sense of ineffectiveness
Metacognition	Thinking about thinking
Metacognitive interventions for relationship-centered care	Specific cognitive interventions that primarily relate to thinking about relationship-centered care, defined in this article to encompass reflection (self-reflection), awareness (self-awareness), mindfulness, and presence[12]

[a]In this review, focused on the relationship between physician and patient.
[b]Not part of key terms for the review.
[c]As applied to relationship-centered care in the physician-patient interaction.
[d]The ability to be aware in the moment as well as reflect on prior physician-patient interactions.
[e]The intent to understand patients through focus, awareness, and attention.[14]

physicians and patients have varying needs.[4,31] However, providing physicians with a potential structure is helpful.[32]

A Solution: Metacognition in the Physician-Patient Interaction

Metacognition is important to integrating basic science knowledge into medical learning and practice,[33,34] and it is no less important in translating interpersonal knowledge to the physician-patient interaction. Decreased metacognitive effort[35] may underpin the decline in empathy seen with increasing medical training.[36,37] Understanding how metacognitive practices foster relationship-centered care is important for teaching, developing, and maintaining that care.

Metacognition is already embedded in the fabric of the physician-patient interaction.[33,34] The complex interplay of the physician-patient interview, patient examination, and integration of physical as well as ancillary data requires higher-order thinking and the ability to parse out that thinking successfully. As a concrete example, coming to a diagnosis requires thinking about what has been presented during the physician-patient interaction and considering what supports and suggests the disease while a list of potential differential diagnosis alternatives is being generated. Physicians are trained to apply this clinical reasoning approach to their patient care.

Conversely, although communication skills are a key component of doctoring,[38] both between physician and patient as well as among other colleagues and staff, many physicians have never received formal training in communication skills,[26,32,39] though it is now an integral part of medical school curricula.[40] When such training is

TABLE 2. Metacognitive Interventions to Create Habits Toward Relationship-Centered Care[1,14,32,39,42,50]

Cue (as you do this)	Think about . . . (to eventually make it habit)
Placing hand on doorknob to enter patient room, taking 1 or more deep breaths, or knocking before entering	Entering the room with presence—ready to focus, attend, and be self-aware in order to understand the patient
Greeting the patient	Smiling, noting eye color (creates eye contact), noting patient clothing/jewelry
Introducing yourself	Sitting down in front of the patient, leaning toward the patient, keeping body language open (eg, head nodding, uncrossed legs/arms)
During the first 30 seconds (can set a small timer [eg, on your phone, in your pocket])	Getting the chance to say, "Let's get a list of what you'd like to talk about today," which can be embedded in the electronic health record as a reminder to start with this
As patient begins to talk	Not interrupting for at least 30 seconds; allowing the patient to say 3–5 sentences without interrupting
Silence after patient's initial opening remarks	Setting an agenda—explaining what will be accomplished during the visit, being explicitly conscious of time (eg, "We have *X* minutes to accomplish *Y*.")
Integrating the electronic health record	Telling the patient what you are doing (eg, logging into their record, checking laboratory values), sharing the screen with the patient so they can see what you are doing, inviting the patient to look at the screen, pointing to the screen when necessary
Facial expressions, vocal tone	Mentally or explicitly commenting on/confirming any emotion you think is strongly expressed by the patient (eg, "You sound upset about what happened. Is that correct?")
Explicitly expressed emotion by the patient (eg, in words or through tears)	Naming and validating emotions
Examining the patient	Noting patient jewelry or tattoos—asking about them (to try to connect with the patient's story/life circumstances)
During/end of examination	Explaining any findings, explaining management/plan of treatment, giving follow-up directions, confirming understanding (asking patient to teach back)
End of clinic	Writing down 3 things that reflect on that day's clinic or patients (eg, relating to what was done well, what didn't go well, successes or failures)

mandatory, less than 1% of physicians continue to believe that there was no benefit, even from a single 8-hour communications skills training session.[41] Communication cannot be taught comprehensively in 8 hours; thus, the benefit of such training may be the end result of metacognition and increased self-awareness (Table 1).[42,43]

Building Relationship-Centered Care Through Metacognitive Attention

Metacognition as manifested by such self-awareness can build relationship-centered care.[4] Self-awareness can be taught through mentorship or role models.[44] Journaling,[40] meditation, and appreciation of beauty and the arts[45] can contribute, as well as more formal training programs,[32,38,42] as offered by the Academy of Communication in Healthcare. Creating opportunities for patient empowerment also supports relationship-centered care, as does applying knowledge of implicit bias.[46]

Even without formal training, relationship-centered care can be built through attention to cues[9]—visual (eg, sitting down, other body language),[47,48] auditory (eg, knocking, language, tone, conversational flow),[48,49] and emotional (eg, clinical empathy, emotional intelligence)(Table 2). Such attention is familiar to everyone, not just physicians or patients, through interactions outside of health care; inattention may be due to the hidden curriculum or culture of medicine[40] as well as real-time changes, such as the introduction of the electronic health record.[51] Inattention to these cues also may be a result of context-specific knowledge, in which a physician's real-life communication skills are not applied to the unique context of patient care.

Although the theoretical foundation of relationship-centered care is relatively complex,[9] a simple formula that has improved patient experience is "The Big 3," which entails (1) simply knocking before entering the examination room, (2) sitting, and (3) asking, "What is your main concern?"[30] Another relatively simple technique would be to involve the patient with the electronic health record by sharing the screen with them.[52] Learning about narrative medicine and developing skills to appreciate each patient's story is another method to increase relationship-centered care,[40,53] as is emotional intelligence.[54] These interventions are simple to implement, and good relationship-centered care will save time, help manage patient visits more effectively, and aid in avoiding the urgent new concern that the patient adds at the end of the visit.[55] The positive effect of these different interventions highlights that small changes (Table 2) can shift the prevailing culture of medicine to become more relationship centered.[56]

Metacognitive Attention Can Generate Habit

Taking metacognition a step further, these small interventions can become habit[11,14,39] through self-awareness, deliberate practice, and feedback.[43] Habit is generated by linking a given intervention to another defined cue. For example, placing a hand on a doorknob to enter an examination room can be the cue to generate a habit of entering with presence.[14] Alternatively, before entering an examination room, taking 3 deep breaths can be the cue to trigger presence.[14] Habits can be created in just 3 weeks,[57] and other proposed cues to generate habits toward relationship-centered care are listed in Table 2. By creating habit through metacognitive attention, relationship-centered care will become something that happens subconsciously without further burdening physicians with another task. Asking patients for permission to record video of an interaction also can create opportunities for self-awareness and self-evaluation through rewatching the video.[58]

Final Thoughts

Physicians already have the tools to create relationship-centered care in physician-patient interactions. A critical mental shift is to develop habits and apply thinking patterns toward understanding and responding appropriately to patients of all ethnicities and their emotions in the physician-patient interaction. This shift is aided by metacognitive awareness (Table 1) and the development of useful habits (Table 2).

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