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SETTING A COMMON GROUND FOR COLLABORATIVE CARE AND CLINICAL INTERVIEWING

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ABSTRACT

Background: A relationship and communication matrix and collaborative assessment and care, as part of a set of elicited principles and strategies, are hallmarks of person-centered medicine and health care. Their formulation and cultivation have been predicated on both humanistic and scientific grounds.
Objectives: This paper is aimed at articulating the bases, key concepts, and strategies for establishing common ground among clinicians, patient, and family for organizing all person-centered clinical care, starting with clinical interviews.
Method: For addressing these objectives, a selective review of the clinical literature was conducted. This was complemented by contrasting the findings with the results of similar papers and reflecting on their implications.
Results: One of the broadest and most compelling factors for organizing person-centered clinical care effectively in general, and particularly concerning interviewing, assessment, and diagnosis as well as treatment planning and implementation, seems to be setting up *common ground* among clinicians, patient, and family. Crucial dynamic matrices of common ground seem to be (1) assembling and engaging the key players for effective care, (2) establishing empathetic communication among these players, (3) organizing participative diagnostic processes toward joint understanding of the presenting person's personhood and health (both problems and positive aspects), and (4) planning and implementing clinical care through shared decision making and joint commitments. Critical guiding considerations for common ground appear to include holistic informational integration, taking into consideration the person's chronological and space context, and attending to his or her health experience, preferences, and values. Among the most promising strategies for operationalizing common ground is the formulation

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of a narrative integrative synthesis of clinical and personal information as joint distillation of the assessment process and as foundation for planning care. These considerations also serve as framework for the delineation and organization of effective clinical interviewing.
Discussion: These findings are supported, first, by historical and anthropological research, which elucidates health care as part of social cooperation for the preservation and promotion of life. *Common ground* appears substantiated by the principles of person centered medicine, and represents one of its most clear projections. Also supportive of common ground is recent research on the positive perceptions of clinicians on procedures that are culturally informed and consider personal experience and values.
Conclusions: It appears that the establishment of a common ground among clinicians, patient, and family is a critical step for the effective person-centered organization of clinical care in general and for interviewing, diagnosis, and treatment planning in particular.

Keywords: common ground, collaborative care, clinical interviewing, assessment, comprehensive diagnosis, joint understanding, shared decision making, person-centered medicine

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BACKGROUND

While the simplest concept of person-centered medicine may involve putting *persons* first in health care, more considerate notions speak of having the person at the center of health [1, 2] and as the proper target of health actions [3]. Here the person is to be understood in a contextualized manner, as illustrated by Ortega y Gasset [4] aphorism "I am I and my circumstance; and if do not save it, I do not save myself." Furthermore, in specific reference to major aspects of the health field, conceptual outlines have been discussed over the years concerning person-centered clinical care [5] and people-centered public health [6].

Recent systematic explorations of person- and people-centered care through literature reviews and international consultations conducted by the International College of Person Centered Medicine [7] have identified the following as key

concepts: 1. Ethical commitment, 2. Holistic framework to understand health and illness, 3. Cultural awareness and responsiveness, 4. Communicational and relationship focus at all levels, 5. Individualization of care, 6. Establishment of common ground among clinicians, patient and family for collaborative diagnosis and shared decision making, 7. People-centered organization of integrated services, and 8. Person-centered health education and research.

Adams and Grieder [8], recognized experts on treatment planning, have posited *common ground* as the keystone for making such planning person-centered. Thus, to large degree, the above notions and principles of person-centered medicine would be relevant and helpful to understand the bases of establishing a common ground, substantiate its practical importance, and delineate its components and principal features.

OBJECTIVES

This paper is aimed at articulating the bases, features, and strategies for establishing a common ground among clinicians, patient, and family for organizing all clinical care in a person-centered manner, starting with clinical interviews.

METHOD

For addressing these objectives, a selective review of the clinical literature was conducted. This included particularly papers related to person-centered medicine and more generally literature involving clinical care with focus on relationship issues, communication, and collaborative care. This led to the identification of two sources specifically on common ground, two papers on communication and empathy germane to engagement for establishing common ground, two sources on person-centered diagnosis involving joint understanding of the clinical situation, and two sources on treatment planning involving shared decision making, which has common ground at its base. This was complemented with a comparison between the findings made and relevant perspectives in similar papers and reflecting on their implications. The reviewed papers are identified in the Results and the Discussion sections connected to the presented findings and reflections.

RESULTS

It has been proposed and demonstrated that the organization of person-centered clinical care should be substantiated and guided by philosophical and conceptual principles, giving attention to the personhood of the patients, health professionals, and family members involved in caring for life and health [1]. Based on extensive

clinical experience, Tempier [2] has proposed that "what is good for the persons is what is good for their health and mental health."

Among the key principles of person-centered medicine helpful to guide clinical care are those elucidated through systematic studies [7], which start with ethical commitment [9, 10]. This is usually formulated based on Aristotelian and Kantian insights as well as on fundamental human rights. The remaining principles are principally strategic and science-based.

One of them involves establishing common ground among health professionals, the patient and family members, in order to organize key clinical tasks in a collaborative fashion. These involve, first, the basic task of diagnosis aimed to the joint understanding of the clinical situation and not only the identification of existing illnesses, and second, collaborative treatment planning conducted as share decision making. The cruciality of establishing a common ground for person-centered care has been highlighted most cogently by Adams and Grieder [8].

Common Ground Matrices

The overarching strategy for establishing a common ground may be unpacked into a set of dynamic matrices as follows:

1. *Assembling and engaging the key players for effective care*

The individuals who tend to play a critical role in clinical care are the various involved clinicians representing different disciplines and specialties, the patient as the person presenting for evaluation and care, and the relevant family members. Specific players need to be pointedly identified and then engaged.

Concerning the collaborative clinician–patient relationship, Tasman [11] has cogently pointed out that this relationship must start since the first encounter and represents the fundamental matrix for the whole of care. The value of clinicians of various disciplines and specialties involved with a given patient to work coordinately with each other has been analyzed by Ghebrehiwet [12], who has pointed out that a well-articulated team approach is a hallmark of person-centered care. The need to foster communication among clinicians, patients, and families has been studied and advocated for by Amering [13].

2. *Establishing empathetic communication among key players*

The need to establish empathy in clinical communication appears to lead to a closer examination of the role of the professional's empathy in the methodology to access the subjectivity of the patient, as pointed out by Botbol and Lecic-Tosevski [14]. At

first seen as the professional's ability to listen sympathetically to the comments of the patient and to consider his wishes and needs, the notion of empathy has gradually widened to include representations that the physician (or other health professional) makes of the clinical situation in which the person in need of care is involved. In short, these are representations that the professional makes of the health situation of the person suffering through the health professional's own empathy, triggered by the words and the acts of the patients and of their carers.

This mechanism is well described by the concept of "metaphorizing-empathy" proposed by Lebovici [15] from his work with babies and their mothers. It is also close to the notion of "narrative empathy" proposed by Hochmann [16] based on his work with autistic children and on the philosophical ideas brought up by Ricoeur [17] in his book "Time and Narrative." It is also consistent with Kleinman's [18] assumptions on illness narratives. This important development in person-centered medicine marks the full recognition of the role of the clinician's subjectivity as a diagnostic and treatment tool within the framework of the clinician–patient relationship.

3. *Organizing participative diagnostic processes*

The World Psychiatric Association (WPA) published in 2003 the International Guidelines for Diagnostic Assessment (IGDA) at the core of which is a diagnostic model articulating standardized multiaxial and idiographic personalized components [19]. These guidelines propose the interaction among clinicians, the patient, and the family to formulate together a joint statement on contextualized clinical problems, the patient's positive health, and expectations on health restoration and promotion. This diagnostic model has been applied in different countries as illustrated by the Latin American Guide for Psychiatric Diagnosis [20] and has been one of the starting points for the design of a Person-Centered Integrative Diagnosis model [21].

Addressing the nature of diagnosis, the eminent historian and philosopher of medicine Laín-Entralgo [22] cogently argued that diagnosis goes beyond identifying a disease (nosological diagnosis) to also involve understanding of what is going on in the body and mind of the person who presents for care. Diagnostic understanding also requires a process of engagement and empowerment that recognizes the agency of patient, family, and health professionals participating in a trialogical partnership [13].

4. *Planning and implementing clinical care through shared decision making and joint commitments*

Experienced clinicians suggest that treatment planning is the most important purpose of diagnosis [8]. In previous decades, the main purpose of diagnosis

seemed to have been to identify an existing disorder and this informed the concept of validity of a diagnostic system. More recently, such validity concept, labeled "physio-pathogenic validity" is contrasted with an emerging one termed "clinical validity" related to value to inform clinical care [23]. The current edition of the American Psychiatric Association's [24] Diagnostic and Statistical Manual of Mental Disorders, DSM-5, is presented as principally aimed to assist clinical care. Furthermore, a survey among the members of the 43-country Global Network of National Classification and Diagnosis Groups [25] identified treatment planning as the key role of diagnosis.

It has been cogently argued that person-centered treatment and care must be made collaboratively among clinicians involved, the patient and his or her family. This collaborative approach is established for both diagnostic formulation and treatment planning by the Person-Centered Integrative Diagnosis model [21] and its practical application for Latin America, the GLADP-VR [26].

As pointed out by Adams [27], treatment plans are at the heart of any care process and are critical in guiding treatment decisions, as well as having an important role in patient engagement and treatment success. Adding to this, Arora and McHorney [28] have advised that treatment plans should be built upon and reflect both shared understanding and decision making between the patient and the health professional. Furthermore, shared understanding and shared decision making are to be rounded-up by the joint-commitment of all key players to the implementation and follow-up of treatment plans. Thus, all these crucial clinical care activities are to be built on common ground established among clinicians, patient, and family.

Guiding Considerations for Common Ground

Helpful guiding considerations for establishing *common ground,* adjusted from those outlined by Adams [27], may include the following:

1. *Holistic informational integration.* This is to be applied to the understanding of both illness and positive heath. It corresponds to one of the key principles of person-centered medicine as elucidated by Mezzich et al. [7].
2. *Addressing the person's longitudinal and cross-sectional context.* A contextualized concept of the whole person is at the core of person-centered medicine. It is predicated on the previously mentioned Ortega y Gasset's [4] dictum on circumstances that round-up the person's identity. Complementing this dictum, the scope of these circumstances may be optimized by referring to both cross-sectional and longitudinal dimensions. The later extend from the person's historical roots and filiation to his or her life project [29].

3. *Attending to health experience, preferences, and values.* This feature brings to the front the key principles of person-centered medicine involving ethical commitment to the person's values [30] as well as that on cultural awareness and responsiveness [31, 32].

Common Ground Implementation

The operationalization or effective implementation of *common ground* may start with its first two dynamic matrices as outlined above, namely, (1) assembling and engaging the key players for effective care, and (2) establishing empathetic communication among them. The considerations formulated there are quite relevant as basic steps for common ground implementation. From the next two matrices of common ground, i.e., organizing participative diagnostic processes and cultivating shared decision making and joint commitments, emerge a promising collaborative activity and formulation, a *narrative integrative synthesis* of clinical and personal information as joint distillation of person-centered assessment processes and foundation of person-centered care planning.

One such synthesis was proposed as part of the International Guidelines for Diagnostic Assessment (IGDA) [19]. The comprehensive diagnostic statement included in the IGDA Guidelines encompassed a standard multiaxial formulation and, of particular relevance to common ground, a *personalized idiographic formulation*. The latter integrates the perspectives of the clinician, the patient, and the family into a jointly understood narrative summary of the clinical problems, the patient's positive points, and expectations for the restoration and promotion of health. It was presented as likely to be the most effective way to address the complexity of illness, the patient's whole health status and expectations, and their cultural framework.

Building on the above as well as on the more recent Person-Centered Integrative Diagnostic Model [21] and on a web approach to recovery and shared decision making [33], Adams [27] has articulated and illustrated with a detailed clinical case the essentials of an integrated narrative synthesis of the patient's clinical and personal data from a comprehensive diagnostic statement. Such a synthesis serves as a bridge between assessment and creation of a treatment plan and focuses on the value of a written narrative that captures the essence of joint understanding and the importance of dialog between key players that is the foundation of common ground.

Adams [27] points out that disagreement must be acknowledged and reconciled in the process, without which healing relationships may dissolve. The process of moving from mere information and ritualistic procedures to shared understanding, shared planning, and joint commitment is at the heart of what it means to be

person-centered. Effective clinical solutions that are endorsed and supported by the patient may only come from this process.

Addressing the feasibility of such proposals, Adams indicates that bridging the gap between current conventional practice and what should be regular person-centered care practice is possible. Citing Davidson et al. [34], he submits that given adequate time for completing the integrative summary, along with the support and training necessary to include a formulation or narrative in the process of moving from assessment to creating treatment plans, many clinicians can develop the skills necessary to be more holistic and person-centered in routine care.

Toward a Person-Centered Clinical Interview

The considerations on common ground presented above may be helpful for setting the bases, organizing and conducting a person-centered clinical interview. The International Guidelines for Diagnostic Assessment (IGDA) [19] offer helpful guidelines.

The interview process should include a preparatory phase to ensure a quiet and reasonably comfortable environment where patients and families are received cordially and respectfully.

The body of the interview should cover in an effective, smooth, and considered manner the different areas of information relevant to an adequate diagnostic formulation and an initial treatment plan. It is essential to establish empathy, to attend to subjectivity and intersubjectivity, and to listen carefully to the patient and available family. This phase should conclude with the formulation of a jointly understood initial diagnostic assessment (which would continue later as the clinical care process unfolds), and shared decisions on what the next steps would be, as well as ensuring that the patient and family are aware, involved, and satisfied with such formulation.

The closure phase of the interview should include a warm farewell connected to future visits or clinical activities. It is important to conduct the interview in a respectful, warm, empathetic, and empowering manner.

DISCUSSION

The concepts and procedures presented in the preceding section appear to be consistent with or supported by the following perspectives and findings.

Historical and anthropological research, going back as much as that of Neanderthals, has described health care as integral part of social, small group, and family cooperation that were crucial for the preservation and promotion of life [35].

Common ground as a powerful factor for person-centered care appears substantiated by several principles of person-centered medicine (such as ethical commitment, holistic framework, cultural awareness and responsiveness, relationships and communication matrix, and collaborative care), and represents one of its most crucial applications and facilitators [9, 36, 37].

Also supportive of common ground is recent research on the positive perceptions of health professionals on clinical procedures that are culturally informed and consider personal experience and values [38].

CONCLUSIONS

Establishing *common ground* among health professionals, patient, and family for collaborative care appears to be at the core of the person-centered approach. It is consistent with most of the key principles of person-centered medicine and may be one of the most powerful factors to achieve person-centered care. Important and helpful information has been elucidated on the dynamic matrices where common ground plays, such as assembling key players for clinical care, promoting engagement and empathy among them, organizing participative comprehensive diagnosis, and shared decision making and commitment for health actions. Guiding considerations for establishing common ground have also been identified. Powerful strategies for implementing common ground have been outlined, particularly the collaborative formulation of an integrated narrative synthesis of the patient's clinical and personal information to serve as a bridge between assessment and the creation of a treatment plan. Within this general framework, an outline for the organization and conduction of clinical interviews has emerged.

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