GUEST EDITORIAL

The medical consultation - systemic solution-oriented and person-centred

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Introduction

Today, medicine and healthcare systems are in crisis [1-4]. On first reading such a claim will prove astonishing for some, given that modern medicine is associated with an ever-increasing range of wonderful innovations and extraordinary benefits which former generations were only able to dream of. In order to try to understand the current crisis, we need to look back at the history of medicine. The goal of medicine has always been to help persons with health problems. Through different times and cultures, multiple medical methods and philosophies have been employed and the patient has always been the focal point of interest at the centre of care [5,6]. Indeed, in former times, empathic dedication to the person was often the only way for the doctor to help the patient. More recently, medicine has gained deep scientific insights into the biological basis of health and disease. This has led to many successes in ameliorating or healing defective functions of body and mind as a function of medico-technical advances. However, due to this predominantly biologically driven point of view the patient was more and more seen as the carrier of a disease rather than a person with his unique experience of the effects of the disease, which we may term 'the illness'. This dramatic change of the medical focus has brought with it a range of essentially unintended consequences. In this *Guest Editorial* we want to discuss the challenges of modern medicine and draw the attention of the reader to a recently published volume [7] which has been written to show how a person-centred consultation might overcome the crisis of medicine.

Cost-driven political interventions are inefficient tools for overcoming the crisis

A disease-oriented medicine generally leads to substantial healthcare costs and hence places a high financial burden on the population. Politically, mostly economically driven interventions have proven to be unsuccessful in reducing expenditures. Often, they even have a contrary effect. Restrictions imposed on consultation time lead to less appropriate decision-making processes resulting in more and not less technical medical interventions which, paradoxically, lead to rising costs [8,9]. But political interference does not appear to influence the socially anchored drivers of medical decision-making processes on either the doctor's or the patient's side, where the ambition remains to do all that is possible given the uncertainty and fear of missing a crucial examination, diagnosis, treatment or prevention.

Bringing together technology and humanity, with the patient as a person at the centre of medicine

To attenuate the current crisis we need, beyond purely financial considerations, a good understanding of, and public discourse about, the complex interacting correlations of the scientific, societal and personal elements which form the basis of today's crisis. We should

foster a new way of handling medical encounters and decisions. We need to return the patient to the centre of focus and care as an autonomous person and bring the exciting scientific medical technologies to the individual patient in a spirit of accompaniment, trust and with empathy [4]. We need to practise a solution-oriented and person-centred approach from the very beginning of every single medical encounter [7].

Professional attitude and particularities of a solution-oriented and person-centred consultation

The consultation - a reliable interactive process between patient and doctor

We see the consultation as a complex-adaptive interaction between doctor and patient, where the doctor takes responsibility for a constructive person-centred and solution-oriented therapeutic process. We know that this interaction mutually influences doctor and patient and leads to emerging solutions which normally are not foreseeable.

We regard the interaction between doctor and patient as a conference of experts and essentially equals within their respective fields of competence. Here, we refer to the patient being an expert in his illness, which is to say expert in his unique experience of the symptom / problem / situation. He knows its history, developing process, and its interrelation with his social and professional context, the significance he gives to it, his stressors, resources and goals. Alongside the patient the doctor is the professional expert, holding the medical and scientific knowledge of the disease. She knows - with a biopsychosocial perspective - how to translate the patient's subjective narrative into "objective" medical terms. She knows about possible medical and non-medical interventions, their scientific evidence and significance [7]. Finally, she has (it is anticipated) the communicative competence to assess, together with the patient, the person-centred relevance of a particular intervention and to engage in shared decision-making as we will discuss later.

Creating a common reality as the foundation for the therapeutic process

We both - doctor and patient - construct a common reality. We are aware that the patient and the physician construct their own reality and understanding of the circumstances that have led to the consultation. These realities can be very different. The patient constructs his reality from his "inner pictures" based on raw experience, fantasy or allegoric imaginations, beliefs, his partial medical knowledge, and information gathered from his family, friends, neighbours, the media, or "Dr Google". With all this he has the tendency to build up, in a subjective and entirely human way, a catastrophic reality with uncertainty and fear. We, the doctors, create our reality based on our physiological, anatomical and medical scientific knowledge, professional capabilities and experiences. But also according to our personal beliefs and values as well as our own medical experiences if existent. We transfer the patient's subjective narrative into "objective" medical terms which are also impregnated by uncertainty and fear. We are aware that we depersonalize the patient's illness through this medical transfer. Bringing together these sometimes very divergent realities, and constructing a common reality out of them, is, we contend, the starting point for all the decisions which will follow [7].

Dealing with uncertainty, fear and ambivalence

Doctors are aware of the relevance of uncertainty and fear, which interweave all things in life, but become acutely obvious in a situation of critical health. They penetrate all medical occurrences; from the initial appearance of a symptom through the choice of examinations, interpretation of their results, assessments / hypotheses / diagnoses and therapeutic interventions, to the clinical outcome. Uncertainty and fear are present on both the doctor's and the patient's sides. We can never fully overcome them. To cope with uncertainty and fear together, and to attentively and cautiously go through this challenge of choosing between promises, seductions and reality, is one of the cornerstones of a successful person-centred therapeutic process. Let us, then, take a look at some common situations of uncertainty [7,10,11].

Each analytic, therapeutic and preventive intervention has its statistical sensitivity and specificity with, in consequence, its own "number needed to treat" and "number needed to harm". Doctors are aware of this and inform the patient (or should) comprehensibly. Together with the patient we withstand the seduction to overestimate the benefits and underestimate or even neglect the often noteworthy risks of each possible intervention. We take into account the risk caused not only by undertreatment, but also by over-testing, over-diagnosis and over-treatment, which can do more harm than good.

We are aware that the interpretation of each analytical result and the expected effect of each medical intervention are based on statistical mean values derived from rarified clinical trials conducted in homogeneous study populations. Thus, their significance and effects can never be directly transferred to an individual patient. Furthermore, even if an intervention has a statistically significant success rate, it does not have to be relevant to a patient with his unique personal characteristics and his specific context. [4,7].

We know that many medical innovations are of marginal utility and often entail disproportionately excessive costs. When considering the use of such interventions we reflect together with the patient and possibly also his family, to determine whether it would make sense for the patient to choose this treatment. We look at his needs, weighing hope, promise, risk, not forgetting the resulting costs for the healthcare system. Such decisions are a real challenge. On the one hand, a new medical intervention might be a real advancement

with the potential of healing or at least prolonging the patient's life, or it might allow a better control of the patient's disease, reducing his suffering and thus improving his quality of life. On the other hand, it might endanger the patient's life or prove worthless under scientific scrutiny of its promised benefit in comparison to already existing interventions. So, we never know for sure if a novel treatment represents a real breakthrough, or if it will soon disappear due to inefficiency or even danger. We take into account that the provider's commercial interests might be the motivation behind seductive promotions. This so called "disease mongering" tries to present uncomfortable, but non-pathological conditions, as diseases, and often leads to requests for dubious examinations and therapies [7,12].

Empowering the patient for shared decisions between benefit and risk

We want to empower the patient to take part in a shared decision-making process by reviewing with him all of these uncertainties and inherent ambivalences. Here, we inform him comprehensibly and comprehensively about which medical and non-medical interventions could be employed or omitted. During these discussions we take into account the patient's actual knowledge and adapt our choice of words and depth of information carefully with direct reference to his emotional state and cognitive capabilities. We reconsider if an investigation would be able to give answers to the patient's questions around the symptom / problem / situation and contribute to a solution, or if it would lead to more uncertainty triggering unwanted additional procedures. We reflect carefully on the benefits, risks and accuracy of each considered examination, analysis and therapeutic intervention, in order to guarantee the best result for the patient with his individual needs, expectations, resources and goals. Also, we keep in mind the benefit-to-cost ratio in line with our social responsibility not to waste money and professional workforce that could otherwise be used for more effective activities and the wellbeing and better health of all people [13,14].

Solution and person-centred communication with the patient

Communicating empathically and skilfully with an authentic interest in the patient

We communicate with the patient on a factual, emotional and interactive level using active listening and solution-oriented questioning and with an authentic interest in his personal narrative of his symptom / problem / situation. It is reassuring for the patient to be heard and understood by the doctor. We formulate our questions skilfully to obtain answers to our medical questions on the one hand and, on the other, to encourage the patient to reflect on his situation, thus enabling him to participate in finding a solution and widening his view of himself and his situation in a therapeutic way (reframing). We approach the patient with a respectful and empathic attitude, reassuring him that he is recognized and valued by the doctor. We reach an agreement for our collaboration and set ground rules. This establishes a mutual commitment with defined liabilities and responsibilities for both patient and doctor and helps to prevent or resolve potential hang-ups and conflicts. Together, all these elements build and maintain a sustainable doctor-patient relationship, create mutual confidence, and provide to both doctor and patient a better orientation within a sometimes chaotic situation. For sure, good relationship and confidence in each other are the foundation of an efficient and successful cooperation in a field of uncertainty and fear for both the doctor and the patient [4,7,10,11].

How to carry out a methodically structured consultation

Preparing the consultation - before seeing the patient

We start the consultation before we greet the patient. When preparing the consultation, we study the medical record. We reflect on the last consultation, considering medical facts, arranged procedures and their results, mandates for the patient and ourselves, intra- and interpersonal interactions with the patient, as well as on our own role.

Meeting the patient

Thus prepared we undertake the consultation with the patient. We welcome the patient with friendly attention and interest. Together we work out the reason(s) for the consultation, the background of the appointment and the goals. We set priorities and chart a way towards adequately person-centred solutions. Together we discuss and interpret the patient's situation on all biopsychosocial levels. We learn about how he sees and interprets the interacting effects between his situation and his familial, professional, social, as well as economic context. We hear about earlier actions the patient has undertaken to resolve his situation and thus potentially to obtain insight into his strengths, weaknesses, creativity, personality, social integration and resources. We give space to his individual needs, ideas, concerns, expectation, uncertainties, fear, inner pictures, and created reality. We show an interest in the meaning he gives to his symptom / problem / situation as well as in his personal values, beliefs and goals [4,7].

In this manner we allow the patient to widen his view of his situation (reframing). We find out if the patient needs any support and what kind it should be - medical or other; for example, a social worker, home care, financial help or "social prescribing". Passing through ambivalence we come to a shared decision about possible examinations, therapeutic or preventive interventions as well as follow-up encounters. We assess if any other persons or institutions

are already or should be involved, how the respective cooperation should be organized and who will have the lead. And we do not forget to summarize what we have worked out together and to clarify which are the doctor's and which are the patient's tasks and responsibilities on the way toward the determined goal. And we agree upon the first step that the patient will take and when we will meet again. We say goodbye to the patient with an honest gratitude for his trust, appreciating his courage to work on his situation and giving him a word of confidence and hope. Apart from the beginning and the end we organize the consultation flexibly by adapting the different interdependent steps "organically" to the evolving interactions of the consultation [7].

Concluding the consultation with reflection and evaluation

After the patient has left, we pause for reflection and evaluation. We write the medical record and reflect on what happened within the medical factual context as well as on the level of inter- and intrapersonal interactions and our personal and professional role. After concluding the consultation in this way, we prepare ourselves for the next patient. If there are remaining difficult personal impressions or feelings, we try to understand them. If we cannot then we discuss them within peer groups, for example, a quality circle or an intervision-group. If the emotional pressure continues, we talk to a personal supervisor, consult our own family doctor, or look for psychological help. Only by caring for ourselves and staying healthy are we able to care well for our patients.

Such a careful process will efficiently lead to a high quality person-centred and solution-oriented outcome for the patient and to satisfaction on both the patient's and the doctor's side. It also has a preventive beneficial effect on the doctor's health and protects against burnout. And, finally, it leads to optimized costs for the health system as a whole [7].

Realizing these methods within the constraints of our daily work, in often typically short consultations

We know that in a huge number of our consultations we undertake there are straightforward situations which can be resolved within a relatively short period of time. We are aware, however, that all the above-mentioned elements are at work below the surface. Keeping this complex background in mind also allows us to perform more efficiently in relatively short consultations with "trivial" or very concrete reasons for the encounter, or if we are operating under time constraints. In these situations, we have to decide which of the above described elements are relevant for the current encounter and thus which elements we will put our focus on [7].

The medical consultation - system and solution-orientated

As discussed above, we published our practice-based insights into a systemic solution-oriented and person-centred procedure in the form of a major new volume [7]. The scientific underpinning of the book is based on systemic solution-oriented psychology. One of us (PR) transferred it to the context of family medicine over 30 years ago. At that time, he was asked for support by family doctors due to his competences as a social worker with additional education in psychotherapy and his experience in process design and supervision. The family doctors were at a loss, because they experienced that, despite their medical knowledge, they could not meet the needs of their patients efficiently in their daily work.

This was the beginning of a series of courses on systemic-solution-oriented performance in medical consultations. Since then, regular supervised group sessions on the basis of case reports from the participants were held. Their results and feedbacks about the doctor's experiences with patients confirmed the quality and effectiveness of this procedure and promoted its further development. The scientific foundation is furthermore combined with results from complex-adaptive systems theory.

To ensure good practice in person-centred and solution-oriented consultations we need to learn and train the respective skills continuously. Doctors who meet regularly for such a continuous education experience a joyful support for their personal wellbeing beyond their basic professional needs [7].

Structure of the book

Consultation in 7 steps

In our book we organise the consultation process into 7 steps: (1) Preparation, (2) Building a solution-oriented cooperation, (3) Taking a medical history of each problem / symptom / complex of symptoms, ideas of solutions, (4) Developing action: 'make an examination', 'create an appraisal and understand connections', 'discuss therapeutic possibilities', (5) Discuss preventive possibilities, (6) Arrange the closing of the consultation or the cooperation & (7) Evaluate the consultation [7].

Practical set of questions (*downloadable*)

For each step we suggest lists of effective practical questions, which on the one hand give answers to our medical questions and, on the other, stimulate the patient to reflect on his symptom / problem and involve him actively in the consultation process and the finding of a person-centred solution. This set of questions can be downloaded for its practical support during the consultation.

Extended reflections on all elements of the consultation

For each step, we reflect on what happens between doctor and patient. We look at factual, personal and emotional elements and interactions between the patient and his context, as well as at the many interactions between the doctor and the patient with their triggers and their impact on the common process.

Chapters on main topics, which interweave all parts of the consultation

We write about aspects that penetrate each step of the consultation such as: 'consulting room and atmosphere', 'active listening', 'art of questioning', 'clarifying the mandate', 'resources', 'bodily proximity and touch', 'ambivalence and internal conflicts in decision-making', 'uncertainty and medicine of marginal benefit', 'culture in which mistakes are dealt with', 'discussing options of therapies', 'discussing preventive possibilities', 'writing the medical record'.

The book also contains a chapter with an introduction to systemic-solution-oriented counselling and a chapter by Joachim Sturmberg, (a member of the editorial board of the *European Journal for Person Centered Healthcare*) on complex-adaptive systems theory.

Code for free streaming and download

As an additional resource the book includes free online access - for private purposes - to the documentary film trilogy "At the doctor's side" (2013, www.atthedoctorsside.ch, German spoken with English subtitles) by Sylviane Gindrat.

Conclusion

Modern medicine is in crisis, a crisis of care, compassion and costs [1,2,4]. We contend that a systemic, solution-oriented consultation, with both doctor and patient together approaching the symptom or problem, is a clear way forward in order to achieve effective solutions. With active listening by the doctor, and an effective exercise of the asking of questions, both patient and doctor create a common reality as a starting point for a targeted therapeutic process which is always tailored to the specific clinical circumstances and individual needs and possibilities of the patient. The consultation, if it is broadly structured in this way, considers and involves the patient as a person in all of his complex biography and with all of his personal resources. Such an approach initiates, we suggest, an individual, comprehensive and efficient healing process, with the generation of measurable clinical outcomes at reduced overall costs. Moreover, such an approach enables the doctor to feel a higher order of satisfaction - if not *joy*, in his work - which will contribute substantially to his own wellbeing, a factor of considerable significance in our current era of widespread physician burnout [15].

The clinical consultation is, we argue, ideally divided into seven discrete steps, each one of which may be explicitly described and scientifically justified. Indeed, our passion for this entirely person-centered approach to the consultation, and our experience of the effectiveness of this approach, led us to publish a book entitled "The medical consultation - systemic and solution-oriented", currently available in the German language, but with the possibility of translation into universal English in 2020. Our book reflects on the nature of the consultation in the context of family medicine. However, its content is surely relevant for any professional working with persons in any clinical context who has an ambition to treat patients as persons, and with a determination to move from professional competence, to clinical excellence [4].

Conflicts of Interest

Bruno Kissling and Peter Ryser are co-editors of the volume "The medical consultation - systemic and solution-oriented" [7].

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