Collaborative care

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From the off, I would like to acknowledge my lack of direct experience and knowledge of your specific context, experience and approach in many of the medical situations that I will be writing about. At the same time, I would also like to acknowledge the experience and specific interest in the relational qualities that are found at the core of something such as counselling. The conditions that are found to enhance relationships and collaboration, both personally and professionally.

What I hope to offer is something of the meeting point of both of our experiences; your medical knowledge and expertise, and my belief and experience of the conditions that support others through a different type of healing — relational. The ways that we might enhance both our endeavours to support patients through their treatment. The meeting point that is best practice and the acceptance and understanding of patients, which are likely to enhance this very process.

Can I really accept that someone is choosing to smoke 20 cigarettes a day, or is comfortable with their obesity and continues to over eat? Whatever the objective facts may be? And maybe this brings the crux of the dilemma — holding objective facts alongside patients subjective experience and choice.

One of the most divergent points that our professional roles may find is that you will have a physical and medical representation with a specific treatment plan that is based on the science of best practice and treatment. Whereas, for myself, despite there still being basis in scientific research, I am mostly dealing with a different manifestation of the human condition – emotional and relational difficulty. And whilst these may seem worlds apart on one level, I believe there is value and enhancement to be found in the conditions that therapy uses to support people through processes of self-discovery, growth and, ultimately, healing.

There is little doubt about the importance and place of treatment protocols, care plans and clinical guidelines. Alongside this, I believe that there is also another aspect which may be just as essential, but a little more abstract – the relationship and process between yourself and the patient.

The wound management and best practices for treatment will guide the core of what is offered to patients, but the environment and relationship that this happens within will likely have significant impacts; not only on the patients experience, but also their overall treatment and recovery. We could even argue that this is the aspect of the treatment that we actually have most impact and choice over. The variables that surround the fixed.

Connecting conditions

Before moving on to look at how we might deal with the specifics of difficult conversations with patients, it feels important to look at the general relational qualities that may best enhance the patient's experience and engagement with you and the treatment as a whole.

It may even be helpful to think when you have best engaged and responded with a professional in your own experience. What were the qualities present in that professional that helped you feel unguarded, open to suggestion and at ease? Or in case it may be easier, what were the qualities present at times when you have felt particularly guarded, closed and disconnected from another?

Of course, I bring my own bias, but I also feel that my offering is bolstered by consistent personal (and professional) experiences, as well as hearing similar from many others too. Namely, that two of the most effective qualities that we can offer in relationship to another person are empathy and acceptance. That we try to understand another person's experience and point of view, as best as possible, alongside the ability to accept their choices and personhood in its own right.

So often, we can get lost in our own perspective or even things we see as objectively 'right' or 'wrong'. This can lead to judgements about the person and their choices, as well as increasing the chance of disconnection and difficulty in the relationship between you.

It is important to say that neither of these qualities require you to agree with the patient's choices, or even be championing of them. Instead, we are aiming to (at least momentarily) put our own views and values aside, and be able to understand and accept another person's view and approach, whatever that might be. Acknowledging that they are a separate person to ourselves with a whole lifetime of different experiences, personal history and priorities.

This can sometimes feel threatening to us. We tend to find comfort in trying to hold on to our views and values, having them confirmed wherever possible. But to risk letting go of these,

and opening ourselves up to a completely different reality, is confronting to say the least. So, in offering these suggestions, I am under no illusion that they are straight forward or natural.

Enhancing empathy

A helpful way to try and enhance our empathy for others is to try and think of ways that we may fall victim to the same pitfalls that we may judge in others. A quite generic example of this could be maintaining a healthy diet. I would posit a guess that the majority of adults have a good sense of what a healthy diet should consist of, but this clearly does not equate to the majority of us actually following this in reality.

This could easily be replaced by the number of hours sleep we should get a night, the number of daily steps, the recommendations of work life balance, or any representation of the delightful "shoulds" that we get given on a daily basis from the world around us. I would imagine it is a given that we all fall short on some number of these on a fairly regular basis.

I suppose what I am trying to illustrate here is that we all have our (perfectly valid) reasons for living differently to what we feel we "should". Our own versions of the "yes, buts" or justification for the choices we make. And although we probably judge this differently in others, the patients who are smoking 20 cigarettes a day or eating diets that do not do themselves or their recovery any favours have exactly the same justifications than we do for the ways we also live sub-optimally (as well as the likely guilt and shame that often accompany these).

Even in these shortcomings, we can often get lost in validation and justification of why ours is different to theirs, or "I know I…but they should really…"

And so, our question and approach may be reframed from "how do I make my patient do something differently?", to "how can I best meet them in their choices and decisions, however we may view them?" A movement from "you should…" to "help me understand why you…"

And this is where we come back to the conditions of empathy and acceptance that we explored earlier. Rather than try and change someone in ways that they probably already know would be beneficial, how can we work collaboratively with them to represent each of our points of view and work towards some kind of attainable middle ground?

Towards acceptance

Another helpful way which may further enhance our understanding and acceptance of our patients, is to remember, that just like ourselves, they are doing the best they can, with their specific history, experiences and contexts. We can often lose sight of this when we get lost in judgements or the seemingly objective rights and wrongs of patient's choice and behaviours.

Of course, this is made all the more difficult in a medical role, where there may seem more justification in the things we judge as good or bad, and with solid evidence. We know what will help or hinder their wound healing, we know what enhances or detracts from personal health and this can make the quest of acceptance and understanding all the more difficult.

But what we are trying to hone here is a move from the objective to the subjective. That whilst there may be objective truths about hygiene, diet and health, we are first trying to understand the patient's subjective experience of these things before we can move towards representing our own.

An important distinction to make here, is that acceptance and understanding are very different from agreement and encouragement. This process is not to simply become agreeable with anything the patient is saying or doing. But more so, that we make room to be able to understand a patient's behaviours and motivations, as well as accepting that it is their choice and is probably happening for very good reason (even if we personally disagree with it).

There is undoubtedly still place and room to share our preferences, recommendations and knowledge, but the way we may do this could significantly increase the likelihood of these very things landing well with our patients.

In fact, the usual result of telling others what we think they should do is that they actually dig their heels in even deeper. The more we push against the many habits and ways of life that they have, the more force that they have to use to uphold them in the face of this. In addition, this will also likely have a significant impact on the relationship as a whole and how everything else that is offered lands, even if seemingly unrelated.

Lead with curiosity

A valuable place for us to start is to try and understand the patient, before we aim to be understood ourselves. The reason for this, is that it gives us a good grounding, helps the patient feels prioritised and respected, and also can help us in how we ultimately offer our suggestions and recommendations further down the line.

What this can also help create is a sense of collaborative decision-making and flexibility (where possible!) The sense of the

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patient feeling involved, that there is room for movement, and consideration given to their preferences and needs, will greatly enhance the relationship and engagement with treatment going forward.

If you think back to the little task I gave you at the start of the article, you can think of the example you chose in terms of someone you felt open and connected to or closed and disconnected from. We can then think about how much you might imagine wanting to listen to them (or not), or being willing to take on their advice and offerings.

In the areas that are possible, what we are moving towards here, is a malleable, collaborative and personally tailored treatment plan. And even if the treatment plan looks exactly the same regardless of the person, the fact we have tried to understand, and worked with the patient and their preferences, will make all the difference (even on the non-negotiables).

The difficult edges

Of course, this is a natural part of the treatment anyway; that we hear the patient's experience, receive any updates about relevant reactions or responses and build a picture to inform treatment going forward. But maybe the more important focus for this article is the more challenging aspects of this. The areas we judge negatively or disagree with, the areas we struggle to hear or accept, and the potential labels and pigeon holes we put patients in as a result (further reducing our openness to their varied and human experience).

These are the areas where acceptance and understanding are likely most important, but also most difficult. The greatest areas of struggle in relation to offering acceptance and understanding to another are the areas that we hold more rigidly for ourselves. Whether that be areas that we struggle with personally or our personal values and beliefs that we feel are unquestionable (for example, not missing appointments).

And again, this is not to say we suddenly become okay with patients missing appointments; naturally, it is essential part of their care and recovery. But our approach, instead, becomes focused on trying to understand why they are choosing this behaviour. This also involves loosening our binary, objective position (at least momentarily!) We try to really understand their internal process about non-attendance from their point of view; does it feel like a choice? What is their reasoning behind it? What might make it easier for them? Was there something specific that caused it? Ultimately, we are saying "help me understand your choice and process, from your perspective."

And this brings us to the final piece of the puzzle. By establishing a foundation of understanding and acceptance, and continually enhancing our relationship through our interactions, we arrive at a point where we can better share our recommendations and perspectives.

As I have argued, this is likely to be made much more likely, and enhanced, by the relationship we have created prior to this and patients experience of being valued, respected and understood. As I mentioned earlier, this acceptance and understanding do not mean we have to abandon our best practice or recommendations, but now we may be able to offer these in a more collaborative and welcome way.

Rather than coming from a place of offering a binary prescription, we now have a way to offer things in context with what the patient has shared previously; tailoring our delivery, checking out how the offering lands for them and why, and being curious with them about the possibility and impact of the suggestions that we offer. Ultimately creating a fuller, more collaborative picture.

I can sometimes think of empathy as trying to paint a picture that only the patient can see and is describing to us. The more we ask them about each colour, brush stroke and shape, the more we can imagine exactly what it looks like to them. Not only does this process greatly enhance the relationship we have with the patient in its own right, but it also helps inform how and where we may best offer our own brush strokes on the canvas to create a shared picture of care.

This whole process involves continually refining our understanding and offerings to align with the deeply unique perspectives, preferences and behaviours of each of our wonderfully diverse patients.