

Assessing the Quality of Patient Centred Consultations

Teresa Pawlikowska^{1*} and Ludmila Marcinowicz²

¹Health Professions Education Centre, RCSI, Dublin, Ireland

²Department of Family Medicine and Community Nursing, Medical University of Bialystok, Poland

*Corresponding author: Teresa Pawlikowska, Health Professions Education Centre, RCSI, 123 St Stephen's Green, Dublin 2, Ireland, Tel: +353 087 949 2722; E-mail: tpawlikowska@rcsi.ie

Rec date: Sep 07, 2015; Acc date: Nov 26, 2015; Pub date: Dec 4, 2015

Copyright: © 2015 Pawlikowska T, et al. This is an open-access article distributed under the terms of the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are credited.

Abstract

The consultation is key to health care delivery, and the pursuit of excellence in consultations enables health care practitioners to activate their knowledge in the service of patients. Effective consulting, alongside increasing patient involvement in the assessment of the quality of their own care is a contemporary imperative.

There are many ways to approach the assessment of quality, and patient centred outcomes are valued, but sometimes difficult to define and operationalize. Bearing in mind the emphasis in nursing on holistic patient centered care it seems appropriate to focus on this concept. The Patient Enablement Instrument (PEI) offers an approach to investigate consultations between patients and health care professionals on a patient centred model.

Keywords: Patient enablement instrument (PEI); Patient; Health care

Context

There is a burgeoning deficit of health care professionals world-wide [1], it is therefore important to understand how they can best deliver patient care. The consultation is the pivotal interchange of delivery between health care professional and patient, so it is vital to optimise its quality. Increasing patient involvement in their own care, and its evaluation, is an also an important feature of health service development. Donabedian [2] has conceptualised effectiveness into technical and interpersonal aspects: the latter will be the main focus here.

According to Nelson [3], best practice in nursing is a "directive, evidence-based, and quality-focused concept" used in educational, administrative, clinical and theoretical/conceptual domains. Moreover best practice is more than just evidence-based because good quality care is optimized according to contemporary standards and values, and in this way is also contextualized.

A systematic review by Köberich and Farin [4] defined patient-centered nursing care as "the degree to which the patient's wishes, needs and preferences are taken into account by nurses when the patient requires professional nursing care." They consider patient-centered nursing care as "a process influencing nursing-sensitive patient outcomes that is affected by several nurse- and context-related factors (such as nurses' attitudes towards patient-centeredness and the organization of nursing care)".

Kitson et al. [5] contrasted the perspectives of those active in the delivery of health care: health policy stakeholders and nurses perceive patient-centered care more broadly than medical professionals. They found that doctors tend to focus on the relationship with the patient and the decision-making process within the consultation. This narrative review of key health policy, medical and nursing work on patient-centered care, identified patient participation, the relationship

between the patient and the healthcare professional, and the context of care delivery as core themes.

Evidence has accumulated that robust primary care "helps prevent illness and death ... (and) is associated with a more equitable distribution of health in populations, a finding that holds in both cross-national and within-national studies" [6]. McWhinney [7] defined primary care as working with undifferentiated problems, patient-focused, and stressed the importance of the doctor-patient relationship.

Contemporary definitions of the role of general medical practitioners according to the European Academy of Teachers in General Practice (EURACT) [8] focus on a bio-psychosocial, person-centred approach and promote patient empowerment. So core values in primary health care include a holistic patient-centred approach. There has been much debate over the definition of patient-centeredness and its measurement, but Stewart [9] defines essential components as: exploring the patient's reason for the visit, "including their information needs and concerns", seeking an integrated understanding of the patient's world, finding common ground on defining the problem and how to manage it, attending to health promotion and prevention, and enhancing the on-going patient-doctor relationship.

The Importance of Communication

The consultation is the pivotal exchange in health care delivery. Silverman reports that during their working life doctors perform 200,000 consultations [10]. Striving for quality in such a fundamental area is therefore a professional imperative. Nurses are now taking on more diverse roles- including nurses specialised in the management of chronic disease, nurses specialising in triage of patients in primary care centres, and nurses who are able to prescribe independently. As health care delivery becomes more complex there is a need to reflect on how best to deploy this highly trained workforce to deliver the appropriate care to patients.

Yet research continues to show that doctors fail to determine why their patients really consult [11,12]. Studies have shown how quickly doctors still interrupt patients [13], how they fail to elicit about half of their complaints and concerns [14] and how important unvoiced agendas are in problematic consultations [15]. Evidence has accumulated that doctors often consult in a directive doctor-centred style [16,17] and are not patient-responsive [18]. Patients crave information [19] and doctors consistently overestimate the time they spend giving it [20]. Patients also want to be involved in decisions regarding their care [21]. Problematic communication has led to malpractice claims and dissatisfaction [22].

Qualitative studies show that patients can themselves act to facilitate their medical consultation via their subjectivity in the doctor-patient relationship. A synthesis of studies that focused on doctor-patient relationships in consultations identified several different ways in which patients participate in a medical consultation, e.g. facilitating the visit (concordance, respecting of doctor's time and creating a relaxed atmosphere during the visit) [23]. Further exploration and assessment of this important dynamic in care delivery is therefore needed, the possibilities are explored next.

Pragmatic Process and Outcome Measures

Time is used as a crude measure of consultation quality and studies have shown that longer consultations are associated with improved problem recognition [24]. Studies have now shown that a "patient-centred" approach to the medical consultation does not always take longer - it is the interplay of factors that is important [25]. Mechanic [26,27] has pointed out the complexity of potential "active ingredients" in consultations which impact on time and quality (variability in problems, patients, doctors, the system). Our understanding of effectiveness needs to be further developed.

Patient satisfaction surveys have flourished and many are now available. Baker [28] defined satisfaction as "the patient's judgment of the quality of care". Both Ware [29] (in the US) and Baker [28] (in the UK) found that technical and interpersonal aspects of care are important for satisfaction. Patient satisfaction studies confirmed that remarkably few patients express dissatisfaction, which may be because satisfaction becomes a composite of overall attitude to health care and specific feelings [30-32]. Framing may be influenced by methodological approaches. A recent review has pointed out that there are a number of features of such patient surveys which may limit the usefulness of them as quality measures of patients' care experiences [33].

In a study exploring satisfaction qualitatively and quantitatively, there was a downward drift over time which could be linked to increasing patient expectations and staff demoralization [34], so repeated and widespread surveys could become problematic [33]. Calnan [35] has investigated patient satisfaction with general practice in the UK (95%), Greece (87%), Yugoslavia (85%) and Russia (62%): all nominated the doctor-patient relationship and professional skills as important. Another of his surveys reported that despite patient satisfaction being high, 38% of respondents felt unable to discuss personal problems with their GP, which casts doubt on satisfaction denoting quality of care. Satisfaction surveys have limitations, as patients seem inclined to report satisfaction and the results of such surveys fail to provide detail needed for assessment of individual consultation quality. Patients may report satisfaction with their consultation, but have they been helped?

In a review of the effectiveness of care provided by nurses and doctors in patients with chronic diseases (e.g. heart disease and diabetes) the meta-analysis showed that care provided by nurses and doctors showed no significant difference in the need for a repeat consultation, improved physical functioning, attendance at follow-up visits or attendance at an emergency department. Interestingly dissatisfaction was significantly lower with care received from nurses compared with doctors [36]. Spanish nurses trained specifically in the resolution of acute health problems of low complexity have been found to deliver care comparable to that provided by general practitioners. Nurses were also found to prescribe fewer drugs than general practitioners. However overall satisfaction with the visit was similar for both health care professionals [37].

There are growing numbers of countries that are introducing nurse prescribing. A systematic review [38] reported that nurses prescribe for a wide range of patients in comparable ways to physicians. Patients were generally more or equally satisfied with the care provided by nurses compared to the traditional care provided by physicians. However more robust studies in this area are needed to draw definitive conclusions.

It may well be that nurse and doctor consultations differ in ways which have consequences both within and outside of the consultation itself that are context dependent. Mohammed et al. [39] looked at factors influencing the duration of out of hours telephone consultation in primary care in the UK and found that nurses had a longer consultation length compared with doctors, however another element which influenced consultation duration was also whether or not mental health was an element of the consultation.

A review [40] found that more patients returned for consultations with nurses (41%) than with physicians (33%). It also showed a higher mean number of visits with nurses; however this failed to reach statistical significance. The number of robust trials in this field was relatively small so that firm conclusions are difficult and this area needs to be further explored.

Working from the evidence that patient satisfaction with nurse practitioners in primary care is high, clinical outcomes appear similar to those of GPs and nurses spend significantly longer consulting, Seale et al. [41] discovered in an observational study that nurses talked more about the practical detail of treatments and that they were more likely to discuss socio-emotional issues, the course of the illness and side-effects (spending twice as long for the entire consultation).

Focusing on telephone triage, a pragmatic cluster randomised controlled trial, incorporating economic evaluation and qualitative process evaluation, showed that nurse-led computer-supported telephone triage reduced the rate of overall GP contacts by 16% and GP face-to-face contacts by 20%, [42]. By contrast, nurse contacts increased. The introduction of the nurse-led telephone triage was associated with a redistribution of primary care workload at similar cost to usual care.

So although nurses and doctors can work in the same areas of health care it seems that their interactions with patients may differ and that capturing the complexity of the interaction, context and consequences is challenging but important for contemporary health care systems. Regardless of this both nurses and doctors profess a patient centered approach to their consultations.

The Patient Enablement Instrument

The development of the Patient Enablement Instrument (PEI) aims to operationalize patient-centred consulting in terms of a patient-reported outcome. It represents over 20 years work by Howie [24] and was developed from literature review and patient focus groups: six questions were discriminatory (Figure 1).

The Patient Enablement Instrument (PEI)				
As a result of your visit to the doctor today, do you feel you are ...				
	Much better	Better	Same or less	Not applicable
able to cope with life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
able to understand your illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
able to cope with your illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
able to keep yourself healthy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Much more	More	Same or less	Not applicable
confident about your health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
able to help yourself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Scoring: Much better/more = 2, Better/More = 1, Same or less = 0, Not applicable = 0
Total score: Maximum 12, minimum 0, per consultation

Figure 1: The Patient Enablement Instrument (PEI)

These 6 PEI questions that patients complete after their consultation have been used principally in primary care. Enablement builds on theories that adjustment and coping are important modifiers of patient outcome, and predictors of how patients feel and perceive life [43,44]. Although enablement correlates with satisfaction measures, it represents a distinct concept [45]. GPs who were more enabling were those who had longer consultation times, so both were regarded as useful measures of consultation quality [24].

The PEI was derived from qualitative research with patients concerning what mattered to them in terms of the outcome of their consultations by Howie [24] and the final 6 questions which comprise the PEI were those questions with that performed most robustly with patients in those original development studies where Howie found Cronbach's alpha to be 0.92-0.93 [24]. He then also compared the PEI with the Medical Interview Satisfaction Scale (MISS) and the Consultation Satisfaction Questionnaire (CSQ) and found that rank correlations were 0.48 ($p < 0.01$) and 0.47 ($p < 0.01$) respectively. Correlations of PEI scores with individual component scores on the CSQ were lower (0.14-0.53) as were correlations with MISS components (0.21-0.53). Internal consistency was also lowered when items from the CSQ or MISS were added to the PEI (i.e. Cronbach alpha was lower relative to the original 6 item PEI alone at 0.91 in this study) [45]. These results have been found consistently in international studies in Poland [46] and China [47]. More recently a Swedish analysis focused on internal reliability, test-retest reliability and internal construct validity: Cronbach's alpha was 0.90, kappa to be 0.65-0.75 [48].

It is known that continuity (how well the patient knows their GP) improves enablement (and is under attack by contemporary service development). Studies relate enablement and empathy [49] which is supported by analysis of verbal interactions in consultations [25] where

socio-emotional interactions support enablement. Receiving a prescription when one is expected [46,50] is associated with enablement. Mead et al [51] used a modified PEI (part of the General Practice Assessment Questionnaire GPAQ 12 [52] in the UK, (190,038 consultations, 1031 practices) and found patients' evaluation of communication skills was associated with enablement [52]. Patients with chronic illness and frequent attenders report lower enablement, and patients consulting in other languages report higher enablement [46]. Howie's study reported PEI as independent of case-mix [50], but Mercer [53] and Pawlikowska et al [46] have found that those with psychological problems are more difficult to enable.

A wide variety of issues impact on the consultation, given the influence of case-mix, the individuality of patients, doctors and their relationships, it is clear that any quantitative measure of effectiveness based on the analysis of small numbers of consultations, will be unlikely to yield a reliable measure. Large numbers (of the order of 50 - 60 per practitioner) of unselected consultations are needed for the effect of diverse influences to accumulate, so the PEI requires such conditions [46,54,55] which is both its strength and its challenge.

Patient enablement (the PEI) provides us with a way to investigate effectiveness in health care practice, which is sensitive to patient, health professionals and consultations [56]. Hitherto the majority of studies have been in primary care settings as it encapsulates general practice core values and a patient-centred approach. As, in contrast to medicine, nursing tends to emphasize the acceptance of patients' beliefs and values and addresses how patient-centered care is promoted, the Patient Enablement Instrument seems to provide a sensitive approach to assessing nursing consultations. So far the patient enablement instrument has not been extensively tested in nurse-patient consultations, on theoretical grounds it should provide a useful tool.

Hitherto the majority of studies with the PEI have been in primary care settings as it encapsulates general practice core values and a patient-centred approach. As, in contrast to medicine, nursing tends to emphasize the acceptance of patients' beliefs and values and addresses how patient-centered care is promoted, the Patient Enablement Instrument seems to provide a sensitive approach to assessing nursing consultations. The CARE instrument [57] has been developed from the PEI with an emphasis on empathy and Bikker et al. [54] have recently used this to demonstrate that it can be used to discriminate between practice nurses sufficiently for quality improvement. Therefore this approach shows promise in terms of a patient driven assessment of the quality of routine consultations. The Patient Enablement Instrument (PEI) can therefore be used to assess consultation quality in a number of countries, both in doctor- patient and nurse- patient consultations

References

1. World Health Organization (2013) A universal truth: No health without a workforce. Geneva, Switzerland.
2. Donabedian A (1988) The quality of care. How can it be assessed? JAMA 260: 1743-1748.
3. Nelson AM (2014) Best practice in nursing: a concept analysis. Int J Nurs Stud 51: 1507-1516.
4. Köberich S, Farin E (2015) A systematic review of instruments measuring patients' perceptions of patient-centred nursing care. Nurs Inq 22: 106-120.
5. Kitson A, Marshall A, Bassett K, Zeitz K (2013) What are the core elements of patient-centred care? A narrative review and synthesis of the literature from health policy, medicine and nursing. J Adv Nurs 69: 4-15.

6. Starfield B, Shi L, Macinko J (2005) Contribution of primary care to health systems and health. *Milbank Q* 83: 457-502.
7. McWhinney IR (1984) Changing models: the impact of Kuhn's theory on medicine. *Fam Pract* 1: 3-8.
8. European Academy of Teachers in General Practice (EURACT). (2005) The European definition of general practice/family medicine.
9. Stewart M, Brown J, Weston W, McWhinney I, McWilliam C, Freeman T (2003) Patient-centred medicine, Transforming the Clinical Method. 2nd ed. Abingdon: Radcliffe Medical Press Ltd.
10. Kurtz S, Silverman J, Draper J (2013) Teaching and Learning Communication Skills in Medicine. 3rd ed. Abingdon, Oxon. UK: Radcliffe Publishing Ltd.
11. Marvel MK, Epstein RM, Flowers K, Beckman HB (1999) Soliciting the patient's agenda: have we improved? *JAMA* 281: 283-287.
12. Barry CA, Bradley CP, Britten N, Stevenson FA, Barber N (2000) Patients' unvoiced agendas in general practice consultations: qualitative study. *BMJ* 320: 1246-1250.
13. Marvel MK, Epstein RM, Flowers K, Beckman HB (1999) Soliciting the patient's agenda: have we improved? *JAMA* 281: 283-287.
14. Stewart MA, McWhinney IR, Buck CW (1979) The doctor/patient relationship and its effect upon outcome. *J R Coll Gen Pract* 29: 77-81.
15. Barry CA, Bradley CP, Britten N, Stevenson FA, Barber N (2000) Patients' unvoiced agendas in general practice consultations: qualitative study. *BMJ* 320: 1246-1250.
16. Byrne P, Long B (1984) Doctors talking to patients. Exeter: The Royal College of General Practitioners.
17. Marcinowicz L, Pawlikowska T, Oleszczyk M (2014) What do older people value when they visit their general practitioner? A qualitative study. *Eur J Ageing* 11: 361-367.
18. Levinson W, Gorawara-Bhat R, Lamb J (2000) A study of patient clues and physician responses in primary care and surgical settings. *JAMA* 284: 1021-1027.
19. Wensing M, Jung HP, Mainz J, Olesen F, Grol R (1998) A systematic review of the literature on patient priorities for general practice care. Part 1: Description of the research domain. *Soc Sci Med* 47: 1573-1588.
20. Makoul G, Arntson P, Schofield T (1995) Health promotion in primary care: physician-patient communication and decision making about prescription medications. *Soc Sci Med* 41: 1241-1254.
21. Elwyn G, Edwards A, Wensing M, Hood K, Atwell C, et al. (2003) Shared decision making: developing the OPTION scale for measuring patient involvement. *Qual Saf Health Care* 12: 93-99.
22. GMC: The state of medical education and practice in the UK report: 2014, GMC London 2014 downloaded from www.gmc-uk.org 28th August 2015.
23. Marcinowicz L, Pawlikowska T, Konstantynowicz J, Chlabicz S (2014) New insight into the role of patients during medical appointments: a synthesis of three qualitative studies. *Patient* 7: 313-318.
24. Howie JG, Heaney DJ, Maxwell M (1997) Measuring quality in general practice. Pilot study of a needs, process and outcome measure. *Occas Pap R Coll Gen Pract* : i-xii, 1-32.
25. Pawlikowska T, Zhang W, Griffiths F, van Dalen J, van der Vleuten C (2012) Verbal and non-verbal behavior of doctors and patients in primary care consultations - how this relates to patient enablement. *Patient Educ Couns* 86: 70-76.
26. Mechanic D (2001) How should hamsters run? Some observations about sufficient patient time in primary care. *BMJ* 323: 266-268.
27. Druss B, Mechanic D (2003) Should visit length be used as a quality indicator in primary care? *Lancet* 361: 1148.
28. Baker R (1990) Development of a questionnaire to assess patients' satisfaction with consultations in general practice. *Br J Gen Pract* 40: 487-490.
29. Ware JE Jr, Snyder MK, Wright WR, Davies AR (1983) Defining and measuring patient satisfaction with medical care. *Eval Program Plann* 6: 247-263.
30. Hopton JL, Howie JG, Porter AM (1993) The need for another look at the patient in general practice satisfaction surveys. *Fam Pract* 10: 82-87.
31. Calnan M, Katsouyiannopoulos V, Ovcharov VK, Prokhorskas R, Ramic H, et al. (1994) Major determinants of consumer satisfaction with primary care in different health systems. *Fam Pract* 11: 468-478.
32. Rodriguez HP, Rodday AM, Marshall RE, Nelson KL, Rogers WH, et al. (2008) Relation of patients' experiences with individual physicians to malpractice risk. *Int J Qual Health Care* 20: 5-12.
33. Anhang Price R, Elliott MN, Cleary PD, Zaslavsky AM, Hays RD (2015) Should health care providers be accountable for patients' care experiences? *J Gen Intern Med* 30: 253-256.
34. Lewis JR, Williamson V (1995) Examining patient perceptions of quality care in general practice: comparison of quantitative and qualitative methods. *Br J Gen Pract* 45: 249-253.
35. Calnan M, Katsouyiannopoulos V, Ovcharov VK, Prokhorskas R, Ramic H, et al. (1994) Major determinants of consumer satisfaction with primary care in different health systems. *Fam Pract* 11: 468-478.
36. Lassi ZS, Cometto G, Huicho L, Bhutta ZA (2013) Quality of care provided by mid-level health workers: systematic review and meta-analysis. *Bull World Health Organ* 91: 824-833I.
37. Iglesias B, Ramos F, Serrano B, Fàbregas M, Sánchez C, et al. (2013) A randomized controlled trial of nurses vs. doctors in the resolution of acute disease of low complexity in primary care. *J Adv Nurs* 69: 2446-2457.
38. Gielen SC, Dekker J, Francke AL, Mistiaen P, Kroezen M (2014) The effects of nurse prescribing: a systematic review. *Int J Nurs Stud* 51: 1048-1061.
39. Mohammed MA, Clements G, Edwards E (2012) Factors which influence the length of an out of hours telephone consultation in primary care: a retrospective database study. *BMC Health Services Research* 12: 430.
40. Martinez-Gonzalez NA, Rosemann T, Djalali S, Huber-Geismann F, Tandjung R (2015) Task-shifting from physicians to nurses in primary care and its impact on resource utilization: a systematic review and meta-analysis of randomized controlled trials. *Med Care Res Rev* 72: 395-418.
41. Seale C, Anderson E, Kinnersley P (2005) Comparison of GP and nurse practitioner consultations: an observational study. *Br J Gen Pract* 55: 938-943.
42. Campbell JL, Fletcher E, Britten N, Green C, Holt T, Lattimer V et al (2015) The clinical effectiveness and cost-effectiveness of telephone triage for managing same-day consultation requests in general practice: a cluster randomised controlled trial comparing general practitioner-led and nurse-led management systems with usual care (the ESTEEM trial). *Health Technol Assess* 19: 1-212.
43. Lazarus R (1976) Patterns of Adjustment. McGraw-Hill, New York.
44. Cox T (1981) Stress. Macmillan, London
45. Howie JG, Heaney DJ, Maxwell M, Walker JJ (1998) A comparison of a Patient Enablement Instrument (PEI) against two established satisfaction scales as an outcome measure of primary care consultations. *Fam Pract* 15: 165-171.
46. Pawlikowska TR, Nowak PR, Szumilo-Grzesik W, Walker JJ (2002) Primary care reform: a pilot study to test the evaluative potential of the Patient Enablement Instrument in Poland. *Fam Pract* 19: 197-201.
47. Lam CL, Yuen NY, Mercer SW, Wong W (2010) A pilot study on the validity and reliability of the Patient Enablement Instrument (PEI) in a Chinese population. *Fam Pract* 27: 395-403.
48. Rööst M, Zielinski A, Petersson C, Strandberg EL (2015) Reliability and applicability of the Patient Enablement Instrument (PEI) in a Swedish general practice setting. *BMC Fam Pract* 16: 31.
49. Mercer SW, Reilly D, Watt GC (2002) The importance of empathy in the enablement of patients attending the Glasgow Homoeopathic Hospital. *Br J Gen Pract* 52: 901-905.
50. Howie JG, Heaney DJ, Maxwell M, Walker JJ, Freeman GK, et al. (1999) Quality at general practice consultations: cross sectional survey. *BMJ* 319: 738-743.

51. Mead N, Bower P, Roland M (2008) Factors associated with enablement in general practice: cross-sectional study using routinely collected data. *Br J Gen Pract* 58: 346-52.
52. National Primary Care Research and Development Centre, and University of Manchester, Safran/NEMCH (2008) General Practice Assessment Questionnaire. Manchester: NPCRDC.
53. Mercer SW, Watt GC (2007) The inverse care law: clinical primary care encounters in deprived and affluent areas of Scotland. *Ann Fam Med* 5: 503-510.
54. Bikker AB, Fitzpatrick B, Murphy D, Mercer SW (2015) Measuring empathic, person-centred communication in primary care nurses: validity and reliability of the Consultation and Relational Empathy (CARE) Measure. *BMC Fam Pract* 16: 149.
55. Pawlikowska TR, Walker JJ, Nowak PR, Szumilo-Grzesik W (2010) Patient involvement in assessing consultation quality: a quantitative study of the Patient Enablement Instrument in Poland. *Health Expect* 13: 13-23.
56. Howie JG, Heaney D, Maxwell M (2004) Quality, core values and the general practice consultation: issues of definition, measurement and delivery. *Fam Pract* 21: 458-468.
57. Mercer SW, Maxwell M, Heaney D, Watt GC (2004) The consultation and relational empathy (CARE) measure: development and preliminary validation and reliability of an empathy-based consultation process measure. *Fam Pract* 21: 699-705.

This article was originally published in a special issue, entitled: "**Nursing Knowledge Development and Clinical Practice**", Edited by Jolanta Lewko