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A person-centred revision of "the plan" section in the standard consultation

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In this newsletter, "the plan" section of the standard consultation is explicitly structured to be more person-centred. It has been well-established that a consultation culminates in "the plan" preceded by enquiries and an assessment. This process of consultation has been captured by the acronym "SOAP" (subjective ; objective ; assessment ; plan) whereby the subjective and objective inquiries culminate into an assessment (including a formulation and differential diagnosis) after which a plan is formulated (1,2). This "SOAP" model intends to serve multiple purposes including the broad structuring of the actual consultation, clinical note keeping, continuity of healthcare, critical thinking, problem-solving and communication among physicians (2,3).

The planning section has conventionally captured, in biopsychosocial domains, further investigative and treatment interventions, as well as reviews and referrals when indicated (4). The planning section, however, is typically formulated as the clinician's plan and has thus been rather unilateral in presenting the clinician's perspective.

Although the planning section may at times implicitly incorporate the patient's contributions, the patient's voice does not necessarily feature explicitly in the planning section and may be absent all too often. In contrast, the planning section of the consultation and its corresponding clinical notes may be made explicitly person-centred and reflect co-production (5) and shared-decision-making advocated by, for example, the UK's General Medical Council (6).

This may be done calling this section of the consultation a "Co-produced Plan", structured as consultative actions (and clinical notes under headings) as follows:

1. Co-decide(d) bio-psycho-social tests and investigations
2. Co-decide(d) bio-psycho-social treatments, assistance, heath education and counselling
3. Incorporate(d) that which matters to the patient in that individual's context (including values, preferences, concerns, expectations, strengths, and aspirations)
4. Co-decide(d) referrals to other/specialist services.
5. Co-decide(d) arrangements for review and follow-up

"Co-decide" here should be taken as an engaging interpersonal communicative process, rather than an impoverished role allocation whereby the clinician picks (the potential interventions) and the patient has to choose. Instead, shared decision-making should account for both the common and the uncommon ground, both shared and conflicting values, in a creative interpersonal process that yields the best decisions for the person in that individual's specific circumstance even if not the best by medical values (5).

I urge clinicians and medical educators, revise "the plan" section of the consultation and the clinical notes by which to foster a routine that is more person-centred and that lives up to the requirements of shared decision-making and co-production.

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