The Patient-Centred Clinical Method.
1. A Model for the Doctor–Patient Interaction in Family Medicine

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This article describes a patient-centred clinical method appropriate for family medicine. The method is designed to attain an understanding of the patient as well as his disease. This two-fold task is described in terms of two agendas: the physician’s and the patient’s. The key to an understanding of the patient’s agenda is the physician’s receptivity to cues offered by the patient, and behaviour which encourages him to express his expectations, feelings and fears. The physician’s agenda is the explanation of the patient’s illness in terms of a taxonomy of disease. In the patient-centred clinical method, both agendas are addressed by the physician and any conflict between them dealt with by negotiation. This is contrasted with the disease-centred method in which only the doctor’s agenda is addressed. Further articles will describe the patient-centred method in operational terms.

The task of the physician is twofold: to understand the patient and to understand the disease. In the process of differential diagnosis there is a well-tried clinical method for understanding diseases, but no equivalent method for understanding patients. For three reasons this lack is especially serious for family medicine. As Carmichael¹ has pointed out, a large proportion of the problems presented to family physicians are not diagnosed in the usual sense of the term. For many presenting symptoms, the proportion of patients who remain without a specific diagnosis is large. In these patients, a pathological diagnosis is not a realistic goal. The physician must have some other way of reaching an understanding of the illness. The key to this understanding, we will suggest, is an understanding of the patient.

The second reason relates to the different criteria of success between family practice and other fields of medicine. For a family physician, a precise pathological diagnosis may be indicative of a failure rather than a success. Thus, the intellectual achievement of making the precise diagnosis may be marred by the fact that earlier signs of the abnormality, although not as yet differentiated into a classical disease entity, have gone unnoticed. Thus an opportunity of preventing the disease may have been missed. These early deviations from the normal may only be significant if a patient is assessed in relation to his own norms, rather than by an objective standard. The family physician should, for example, take notice of a marathon runner complaining of dyspnoea occurring earlier on in his usual run as it may be indicative of oncoming illness. While the runner’s exercise tolerance is obviously far greater than that of most people, this occurrence is obviously of significance to him. Vague symptoms, such as tiredness and headaches may be the earliest evidence of a breakdown in health. Early signs of stress in a family, such as an underachieving child, a young girl neglecting her contraception, a mother who cannot cope with her baby, or a father who appears aggressive or despondent, may all be opportunities for preventing child

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abuse, suicide or alcoholism. Thus, the family physician's goal is, wherever possible, to identify emerging problems so that end-state pathology does not develop.

The fact that some of these goals are difficult to achieve does not make them any the less desirable. The undifferentiated illness encountered by the family physician provides him with his opportunity for prevention. His clinical method, therefore, must be effective in identifying problems at an early stage in their evolution and in conveying to patients that such problems are a legitimate reason for seeking help.

The third reason relates to management, described by Stephens as 'the quintessence of family medicine'. Management in family practice is tailored to individual needs. Although technological aspects of management may be standardized, there are numerous individual variations, even in patients with the same diagnosis. Thus, even when there is a clear-cut pathological diagnosis, the family physician still needs to know the patient as an individual, with a unique experience of life, if his management is to be fully effective. The development of an integrated clinical method, designed both to understand the patient and his disease, is a challenge of family medicine.

In this series of papers, we give an interim report on our work in developing and testing a clinical method appropriate for family medicine. Like other writers, we call this the 'patient-centred' method. We emphasize that a patient-centred method must include the process of differential diagnosis—its aim must be both to understand the patient and to diagnose his illness, if possible, in terms of physical pathology.

The two-fold purpose of the process is best expressed in terms of the doctor’s and the patient’s agendas (Figure 1). When a patient consults a physician, he has a certain agenda in mind. We have chosen to define this in terms of his expectations, feelings and fears. The doctor also has his agenda, which in general may be stated as the correct diagnosis of the patient’s complaints and the implementation of preventive procedures that are appropriate for the patient’s age, sex and risk factors. For individual patients he may have a more specific agenda based on previous knowledge of the patient and his family.

In the patient-centred method, the physician’s aim is to ascertain the patient’s agenda and to reconcile this with his own. In this initial phase of our study, we have concentrated on developing a method by which physicians can understand the patient’s agenda. In the family medicine
In the latter method, the doctor pursues his own agenda and makes little attempt to understand the patient’s. While adopting the same terminology, we stress again that the patient-centred method includes the disease-centred whenever this is appropriate.

The term ‘patient-centred medicine’ was introduced by Balint and colleagues, who contrasted it with ‘illness-centred medicine’. An understanding of the patient’s complaints based on patient-centred thinking was called ‘overall diagnosis’, and an understanding based on illness-centred thinking was called ‘traditional diagnosis’. The clinical method was elaborated by Stevens and by Tait. Byrne and Long developed a method for categorizing a consultation as doctor or patient-centred, their concept of a doctor-centred consultation being close to the ‘illness’ or ‘disease’-centred methods of other writers. In their book, Clinical Thinking and Practice—Diagnosis and Decision in Patient Care, Wright and MacAdam also describe doctor and patient-centred clinical methods. The concept of a patient-centred clinical method has much in common with Rogers’ psycho-therapeutic concept of client-centred therapy.

The findings of Byrne and Long in their analysis of 1850 general practice consultations, suggest that many physicians develop a relatively static style of consulting and that this tends to be doctor-centred. As they remark: ‘The problem is that the doctor-centred style is extremely seductive’. Our observation is that clinical teaching in medical schools tends to emphasize a doctor-centred approach (or disease-centred, as we prefer to call it). According to this model, the physician ascertains the patient’s complaints and seeks information which will enable him to interpret the patient’s illness in terms of his own explanatory frame of reference. This involves diagnosing the patient’s disease and prescribing a management plan appropriate to the diagnosis. One of the criteria of success is a precise diagnosis, such as myocardial infarction, stroke, carcinoma of the colon, child abuse, attempted suicide or alcoholism. In pursuit of this goal, the physician uses a method which is designed to obtain objective information from the patient.

While there is substantial agreement on the need for family physicians to be patient-centred, little has been done to define what this means in operational terms. It could be argued that the physicians’ styles are so different, and clinical situations so varied, that no single method could cover all possible doctor—patient interactions. We do not accept this view. The method of differential diagnosis is designed to apply to any clinical situation. We see no reason why family medicine should not develop an equally rigorous patient-centred method which can also be applied to any situation. Indeed, we believe it is essential for our discipline that we do develop such a method.

In these articles we describe a patient-centred method developed by one of us (J.L.) in his own practice, and further developed and tested during visits to the University of Western Ontario in 1981 and 1982. We believe this method answers the question, ‘What is the minimum that can be expected of any family physician at any patient visit?’

THE PATIENT-CENTRED METHOD—THE PATIENT’S AGENDA

The essence of the patient-centred method as it relates to the patient’s agenda is that the physician tries to enter the patient’s world, to see the illness through the patient’s eyes. He does this by behaviour which invites and facilitates openness by the patient. The central objective in every interaction is to allow the patient to express all the reasons for his attendance. The doctor’s aim is to understand each patient’s expectations, feelings, and fears. Every patient who seeks help has some expectations of the visit, not necessarily made explicit.

Every patient has some feelings about his problem or problems. Sometimes his feelings may be the major factor in the illness, as when a perfectly tolerable symptom is mentioned only because the patient fears cancer. Although fear is an aspect of feeling, it is such a universal component of illness that we feel justified in giving it a separate heading.

Understanding the patient’s expectations, feelings and fears will be specific for each patient. Obviously each patient’s account of his symptoms and their underlying meanings reflect his own unique world. Categorization may help the physician, but the classification of clinical phenomena, be it physical, psychological or social, comes from the doctor’s world, not the patient’s. It is not a substitute for the understanding of each patient as a unique individual.
Entry into the patient’s world is a difficult art, requiring of the physician human qualities of empathy, non-judgemental acceptance, congruence and honesty. It also requires a skill in the practice of certain techniques, and it is our conviction that these techniques can be learned and taught. Moreover, the physician cannot be patient-centred unless he has self-knowledge and is prepared to make the changes in attitude and behaviour needed for such an approach.

The key to the patient-centred method, as its name implies, is to allow as much as possible to flow from the patient. The crucial skill is to be receptive to cues offered by the patient. By attentive listening, the doctor is able to respond to these cues, thereby helping the patient to express his expectations, feelings and fears.

Failure to take up a patient’s cues results in the doctor cutting off the patient and thereby missing an opportunity to gain full insight into his illness. It can also result in frustration for the patient, since the doctor is giving precedence to his own priorities. The following example, based on recent experience, will serve to illustrate the method:

A 68-year-old male patient, who had recently been operated on for a benign stricture of the sigmoid colon presented for a routine follow-up office visit. The patient, a retired Roman Catholic priest, had very recently taken up residence in a retirement home for ageing clergy. All these facts were known to the doctor. The interaction has been reconstructed in two ways to illustrate the disease- and patient-centred methods.

The Disease-Centred Method

Doctor Hello Father Smith, how are you today?
Patient Fine—except for my headaches...
Doctor ... and your operation, how’s that going?
Patient Fine.
Doctor Bowels working?
Patient Yes.
Doctor Appetite?
Father A bit poorly.
Doctor Have you lost any weight?
Patient No.
Doctor Well, obviously your loss of appetite hasn’t affected anything, so it can’t be too bad? Any nausea or vomiting?
Patient None.

Doctor Any pain at the operation site?
Patient Not really.
Doctor Are you eating the bran we recommended?
Patient No.
Doctor You must please stick to our recommendations. We don’t want any recurrences.
Patient (sighing) Yes.
Doctor Good, well the operation seems to have been a success and there don’t seem to be any complications. Have you any other complaints?
Patient I have this headache.
Doctor Is your vision affected?
Patient No.
Doctor Any weakness or paralysis of your limbs?
Patient No.
Doctor Where are your headaches?
Patient At the back of my head.
Doctor Do they throb?
Patient Yes.
Doctor How long do they last?
Patient About four hours.
Doctor What takes them away?
Patient I just lie down.
Doctor How often do they come?
Patient About twice a week.
Doctor How long have they been there for?
Patient Ever since I’ve been at the home.
Doctor Good, well you needn’t worry—it can’t have anything to do with your operation. They are tension headaches. Perhaps we can give you some paracetamol for it. The home you have just moved into seems to have beautiful gardens.

The Patient-Centred Method

Doctor Hello Father Smith, how are you today?
Patient Fine, except for my headaches.
Doctor What about your headaches?
Patient Well, I’ve been getting them about
twice a week at the back of my head and they bother me so I can't do anything, and I have to lie down.

Doctor You can't do anything? What's that like for you?

Patient It's frustrating, they're interfering with the writing I want to get done and nobody seems to understand . . .

Doctor Understand?

Patient All the other priests are so old and decrepit in that place. All they can talk about is their aches and pains. I'm ashamed to say they make me sick.

Doctor Why are you ashamed?

Patient Well, I shouldn't really talk that way about them, they mean no harm . . . I feel so guilty about it.

Doctor What do you mean guilty?

Patient I feel that my anger is unjustified, I'm so frustrated that no one understands that I wish to write.

Doctor It must be frustrating . . .

Patient Yes, it is and my headaches—my headaches make it worse.

Doctor When did they first start?

Patient Ever since I've been at the home.

Doctor Why do you think that is?

Patient I . . . don't know, I haven't really thought about it . . . do you think it's tension? . . . I mean the people at the home . . . is it possible?

Doctor What do you think?

Patient Well the whole situation at the home does trouble me.

Doctor Would you like to talk about it more?

Patient No, not now, perhaps later.

Doctor Well, feel free to discuss it anytime you like.

Patient Mmm, mmm, I will.

Doctor Well, how are things going after your operation?

Patient It seems okay.

Doctor What do you mean, it seems okay?

Patient Well I don't seem to be eating well and I can't stand that bran. In fact I have no appetite for food.

Doctor What do you think that could be due to?

Patient I wonder if it's due to the tension I'm feeling?

Doctor Mmm, mmm.

Patient I will really think about what we've said and come back to see you again.

Doctor Fine, anything else today?

Patient Fine, everything is fine, except I get a funny feeling on my scar.

Doctor A funny feeling?

Patient Yes, it seems a bit numb . . . I hope it's not serious.

Doctor It's probably a little nerve that supplies the skin that was cut during the operation. Nothing to be concerned about.

Patient I'm glad it's only that. I was quite worried.

Doctor Anything else you'd like to discuss?

Patient No, everything else is fine.

Doctor Good, would you like something for your headaches?

Patient Thank you, but I don't think it's necessary.

Doctor I'd like to see your wound in a month's time, but we can get together earlier if you'd like to.

Patient Fine, I'll be in touch, Doctor.

The doctor using the disease-centred method assumes that the expectation of the visit is to check out any possible post-operative problems. This is the physician's utmost priority and anything unrelated to it or anything not of organic significance is of secondary importance. He thus relentlessly pursues his objectives. When he finally does discuss the headaches he does so in a closed-ended way, not allowing the patient any opportunity to express his own feelings or fears. He misses subtle cues throughout. In discussing the patient's social context, the doctor pre-empts any expression of feeling by the patient by using value judgements to describe his circumstances. None but the most assertive patients would contradict him.

The first interview could certainly have been said to have been appropriate from the conventional doctor's world. There are no post-operative complications and he has treated the patient's tension headaches with paracetamol. However, the patient's world was not entered into it at all.

The physician using the patient-centred method has allowed the interview to be guided by the patient. He has recognized that the patient's expectation of the visit is that his headaches will be dealt with and, by using open, non-directive, facilitative verbal (and non-verbal) behaviour, has elicited several feelings and fears related to
the patient’s life. He has picked up cues, albeit subtle ones, and allowed the patient to expand. He also concentrated on the one aspect ostensibly related to the post-operative course, that is, loss of appetite. However, it appeared to have an entirely different connotation when explored in the context of the patient’s world.

In short, while the doctor was aware of his own agenda, he understood that to learn about the patient and his illness, he had to do it through the patient’s world.

THE APPROPRIATE CONTEXT

In gaining an understanding of the patient’s expectations, feelings and fears, the physician is obtaining a picture of the context of the illness. In some cases, the context may be the key to understanding the whole illness, in others it may enlarge the management options, in others it may seem to have little practical significance. The question then arises: what is the appropriate context? Our answer is that the context should be large enough for the physician to offer to the patient the maximum number of management options, and the greatest opportunity for identifying emerging problems.

Is there a risk in this method of invading a patient’s privacy? Not, we believe, if the principles are followed. The physician does not probe or dig, he invites the expression of feelings and opinions. If the patient does not wish to respond, that is his prerogative and the subject is dropped. The doctor is only, in fact, acting on what the patient gives him.

RECONCILING THE TWO AGENDAS

Although the exploration of the patient’s agenda can be applied to all cases, it is obviously not sufficient in itself. At some stage the physician will need to apply his agenda, the disease-centred method, bringing the patient’s problems into his world by trying to arrive at a pathological diagnosis or applying appropriate preventive strategies. There is not necessarily a sequential order, with the patient’s agenda being explored first, the doctor’s agenda second. Cues may be provided by the patient at any stage of the process. Under usual circumstances however, the physician will need to begin with the patient’s agenda, since the understanding gained by it may determine how he follows his own agenda. If, for example, he has discovered that his patient’s reason for attendance is to obtain a sickness absence certificate for an illness that is already subsiding, he may not need to apply the disease-centred method at all.

We believe it to be quite common, even in family medicine programmes, for physicians to use the disease-centred method first in all cases, then move to the patient’s agenda only if the former does not yield a clear pathological diagnosis. Given the predominance of the disease-centred method in medical education, it is, not surprisingly, the approach used by residents at the beginning of their training. Our conviction is, however, that the patient-centred method, integrating the doctor’s and the patient’s agenda, should be universally applied in family practice. In some cases, there will inevitably be a conflict between the patient’s expectations and the physician’s assessment of his needs. If the patient’s main concern is his itchy feet, and the physician finds that he has a blood pressure of 230/140 mm Hg, the doctor will obviously try to convince him that his hypertension is a more pressing concern than his presenting problem. A conflict of this nature will normally result in a process of negotiation followed by an agreement. This does not mean that the patient’s expectations are not dealt with; at some stage, they must be addressed, but only after more urgent problems have been dealt with. It is, of course, possible that the physician may not be willing or able to meet the patient’s expectations. For example, he may be unwilling to prescribe penicillin for a cold. Even in this case, however, the physician will be able to deal with the situation more effectively if he knows that this is what the patient expects.

Our observations of many doctor—patient interactions lead us to the view that a failure to apply the patient-centred method correctly leads to a dysfunctional interview and an unsatisfactory outcome. This is supported by the finding of Byrne and Long6 that a failure to ascertain the patient’s reason for attendance leads to dysfunctional interviews. It is also in accordance with Stewart’s10 finding that patient-centred interviews are associated with a higher level of patient satisfaction and greater compliance with treatment.

The next questions we wish to address are: Can the patient-centred method be defined in precise operational terms? Can we develop a reliable method for scoring the ‘patient-centredness’ of interviews? Can a physician learn to apply the
patient-centred method if given the appropriate instruction? The remaining articles in this series deal with these questions.

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REFERENCES