are limits to how much most people can alter their interviewing tech-
niques, but since there are several ways of achieving similar ends, there
may be methods to suit most interviewers and most clients.

CONCLUSIONS

These studies are examples of the most difficult research strategy in
doctor-patient communication literature: the experiment. When inter-
viewers were asked to change their question-asking or responding
techniques for feelings, the difference in the number of feelings ex-
pressed by informants was not large. However, explicitly asking for
feelings or responding more actively to their expression, elicited more
emotions from interviewers after 15 minutes of an interview, if they
were less emotionally expressive individuals.

When the physician wants feelings to be aired, the preferred tech-
nique depends on the patient. With those who tend to show emotion
freely, the doctor needs only to be attentive, but with those who are
more inhibited, the physician needs to question directly about feelings
and to be more actively responsive when they are expressed.
mary care 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 physician still needs to know the patient as an individual, with a unique experience of life, if the management is to be fully effective. A patient-centered method must include the process of differential diagnosis: it must aim to understand the patient through patient-centered interviewing and to diagnose the illness, if possible, in terms of physical pathology.

The twofold purpose of the process is best expressed in terms of the distinction between disease and illness. Disease is an abstraction; the thing that is wrong with the body-machine; illness is the unique experience of a person who feels ill. See Figure 8.1.

Several other authors have described a similar distinction between disease and illness (Cassell, 1985; Kleinman et al., 1978; Marier, 1981; Mishler, 1984a) and we think this indicates that the differentiation has face validity. Our contribution to the growing appreciation of this conceptual distinction is to make explicit how physicians can apply these concepts, in practical terms, in their day-to-day practice. See Figure 8.2.

A patient consulting a physician has a certain agenda in mind. We have chosen to define this in terms of ideas, expectations, and feelings. The doctor also has an agenda: the correct diagnosis of the patient’s complaints. For individual patients the physician may have a more specific agenda based on previous knowledge of the patient and the family.

FIGURE 8.1 Two Modes of Ill Health: Disease and Illness

Patient presents
cues of unwellness

Parallel search
of two frameworks

Disease framework
("Doctor’s agenda")

| History |
| Physical examination |
| Laboratory investigation |

Illness framework
("Patient’s agenda")

| Ideas |
| Expectations |
| Feelings |

Differential diagnosis

Understanding the patient’s unique experience of illness

FIGURE 8.2 The Patient-Centered Clinical Interview

In the patient-centered method, the physicians aim is to ascertain the patient’s agenda and to reconcile this with their own. In the disease-centered, or doctor-centered method, physicians pursue their own agenda and make little attempt to understand the patient’s. The patient-centered method includes the disease-centered whenever appropriate.

The term “patient-centered medicine” was introduced by Balint et al. (1970) who contrasted it with “illness-centered medicine.” An understanding of the patient’s complaints, based on patient-centered thinking, was called “overall diagnosis,” and an understanding based on disease-centered thinking was called “traditional diagnosis.” The clinical method was elaborated by Stevens (1974) and Tait (1979). Byrne
and Long (1984) developed a method for categorizing a consultation as doctor-centered or patient-centered, their concept of a doctor-centered consultation being close to other writers' "illness" or "disease"-centered methods. Wright and MacAdam (1979) also described doctor-centered and patient-centered clinical methods. A patient-centered clinical method has much in common with the psychotherapeutic concept of client-centered therapy (Rogers, 1951).

Byrne and Long, in their analysis of 1,850 general practice consultations, suggested that many physicians develop a relatively static style of consulting that tends to be doctor-centered. "The problem is that the doctor-centered style is extremely seductive." Clinical teaching in medical schools tends to emphasize a doctor-centered approach (or disease-centered, as we prefer to call it). According to this model, physicians ascertain the patient's complaints and seek information that will enable them to interpret the patient's illness within their own frame of reference. This involves diagnosing the patient's disease and prescribing an appropriate management. 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, physicians use a method designed to obtain objective information from the patient.

While there is substantial agreement on the need for family physicians to be patient-centered, there is no definition of what this means in operational terms. It could be argued that 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 medicine should not develop an equally rigorous patient-centered method that can also be applied to any situation. Indeed, we believe it is essential for primary care to develop such a method.

In this chapter we describe patient-centered interviewing developed by Levinestein (1984) in his own practice and further developed and tested during visits to the University of Western Ontario in 1981 and 1982. Together with diagnosis, such interviewing exemplifies the patient-centered clinical method. We believe this method answers the question, "What is the minimum that can be expected of any primary care physician at any patient visit?"
DEFINITIONS OF TERMS

Mood

Most patients have their own thoughts about what is wrong with them, what might be causing it, and what might be its implications. Often patients are reluctant to express ideas of their own accord, and it might sound presumptuous or insulting to offer a diagnosis to the doctor. Physicians often need to encourage patients to express these thoughts.

Expectations

Each patient visiting a physician has some expectations of the visit. These expectations can be the result of the patient's own research, word of mouth, or a previous experience with the physician. In general, the calendar of the physician is the patient's expectation. The presentation of expectations is made explicit or implicit at any stage of the interaction, for example, if the patient with hypotension comes for a follow-up visit, there is an implicit expectation that the blood pressure will be taken.

Feelings

Feelings reflect the emotional content of the patient's illness. They may be the predominant aspect of the interaction between patient and doctor. Feelings may be generated by the illness itself, or they may be created by the patient's belief about the illness. Feelings may be explicitly or implicitly expressed. Feelings can be negative or positive, and they can have a significant impact on the course of the interaction. Feelings may reflect the patient's, life experience, personality, or defense mechanisms. They may arise directly from the stated expectations, or, as in the case of the patient who has requested a second opinion, from the course of the interaction.
doctors, preoccupied with their agenda, reply "Warts, mm, well, let's set up this chest X-ray."

A return occurs when a physician has cut off a patient but subsequently returns to the patient's ideas, expectations, feelings, or prompts. A return is considered as an acknowledgment of the patient's problem and is not counted as a cut-off. For example, the physician who previously cut off the patient's mention of warts may say, "Let's have a look at those warts now. In what way do they concern you?"

**AN ILLUSTRATIVE CASE**

The following example, based on recent experience, illustrates the definitions.

A 68-year-old male patient, who has recently had surgery for a benign stricture of the sigmoid colon, presents for a routine follow-up office visit. The patient, a retired Roman Catholic priest, has recently moved into a retirement home for aging clergy. These facts are known to the doctor.

**The Disease-Centered Interview**

Doctor: Hello, Father Smith, how are you today?
Patient: Fine—except for my headaches… (expectation)
Doctor: …and your operation, how's that going? (cut-off)
Patient: Fine.
Doctor: Bowels working?
Patient: Yes.
Doctor: Appetite?
Patient: A bit poorly.
Doctor: Have you lost any weight? (exploring the disease framework)
Patient: No.
Doctor: Well, obviously your loss of appetite hasn't affected anything, so it can't be too bad. … Any nausea or vomiting? (cut-off)

**Patient-Centered Clinical Interviewing**

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. (prompt)
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. (prompt)
Doctor: Is your vision affected? (exploring the disease framework)
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 you been having them?
Patient: Ever since I've been at the home. (prompt)
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 them. The house you have just moved into seems to have beautiful gardens. (cut-off)

Patient: Yes.

Doctor: It really is good of the church to care for its elderly and it must be comforting to have company.

Patient: Yes.

Doctor: Well good. Come and see me in a month’s time and we’ll see how things are going. Take care.

The Patient-Centered Interview

Doctor: Hello, Father Smith, how are you today?

Patient: Fine, except for my headaches. (expectation)

Doctor: What about your headaches? (facilitating behavior)

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? (facilitating behavior)

Patient: It’s frustrating, they’re interfering with the writing I want to get done and nobody seems to understand… (feeling)

Doctor: Understand? (facilitating behavior)

Patient: All the other preses 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. (feeling)

Doctor: Why are you ashamed? (facilitating behavior)

Patient: Well, I shouldn’t really talk that way about them, they mean no harm… I feel, so guilty about it. (feeling)

Doctor: What do you mean guilty? (facilitating behavior)

Patient: I feel that my anger is unjustified, I’m so frustrated that no one understands that I wish to write. (feeling)

Doctor: It must be frustrating… (facilitating behavior)

Patient-Centered Clinical Interviewing

Patient: Yes, it is and my headaches—my headaches make it worse. (prompt)

Doctor: When did they first start?

Patient: Ever since I’ve been at the home.

Doctor: Why do you think that is? (facilitating behavior)

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? (idea)

Doctor: What do you think?

Patient: Well, the whole situation at the home does trouble me. (feeling)

Doctor: Would you like to talk about it more? (facilitating behavior)

Patient: No, not now, perhaps later.

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

Patient: Mmm, mm, I will.

Doctor: Well, how are things going after your operation?

Patient: It seems okay.

Doctor: What do you mean, it seems okay? (facilitating behavior)

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. (expectation)

Doctor: What do you think that could be due to? (facilitating behavior)

Patient: I wonder if it’s due to the tension I’m feeling? (idea)

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? (facilitating behavior)

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

Doctor: A funny feeling? (facilitating behavior)

Patient: Yes, it seems a bit numb… I am afraid it may be serious. (feeling)
At some stage the physician must apply the disease framework to arrive at a diagnosis. There is no stage, however, where the patient does not play a meaningful role in the diagnostic process. The physician may provide cues at any stage of the process. Under usual circumstances, however, physicians must begin with the patient's accounts, and the reason for attendance is to obtain a clue to the probable disease. This is the starting point of the diagnostic process. We believe it to be quite common, even in family medicine practice, for physicians to use the disease framework that it will, however, be presented to the patient, and the patient will probably be a conflict between the patient's, the physician's, and the patient's expectations. The patient's understanding of the physician's assessment of the needs, the patient's, and the patient's expectations, and the physician's assessment of the needs, the patient's understanding of the physician's assessment of the needs, and the patient's understanding of the physician's assessment of the needs, and the patient's understanding of the physician's assessment of the needs, and the patient's understanding of the physician's assessment of the needs, and the patient's understanding of the physician's assessment of the needs, and the patient's understanding of the physician's assessment of the needs, and the patient's understanding of the physician's assessment of the needs, and the patient's understanding of the physician's assessment of the needs, and the patient's understanding of the physician's assessment of the needs, and the patient's understanding of the physician's assessment of the needs, and the patient's understanding of the physician's assessment of the needs, and the patient's understanding of the physician's assessment of the needs, and the patient's understanding of the physician's assessment of the needs, and the patient's understanding of the physician's assessment of the needs, and the patient's understanding of the physician's assessment of the needs, and the patient's understanding of the physician's assessment of the needs.
Framework (What is the diagnosis?) and the Illness Framework ("What is the patient's experience of illness: ideas, expectations, and feelings?").

2. Physicians need to integrate both frameworks and develop specific skills for eliciting the patient's own ideas, expectations, and feelings using facilitating behaviors and refraining from cutting off the patient.

PART III

Teaching and Evaluation

Particular communication skills can be taught by specific pedagogical techniques such as systematic practice with patients, review of interviews on videotape or audiotape, and discussion with tutors.

Maguire and colleagues address the important question of whether interviewing skills acquired during medical training are maintained after the training period has ended, and if these skills are used only with particular types of patients.

A series of well-designed and controlled studies are quite stunning. The improvements in skills attributable to training were evident four to six years later when these same physicians were established in their own practices. In fact, the impressive ratio of total performance scores of trained to untrained doctors was only slightly less than it had been immediately after training, demonstrating an inconsequential decay of skills over the many years. As well, the impact of interview training with psychiatric patients extended to interviews with physically ill patients.

These findings are the happy corollary of the usually discouraging observation that doctors become fixed in their-style of interviewing; the benefits of performance feedback are likely to persist throughout the doctor's professional life.

Schofield and Aronson deal with another part of the training process, the relationship between the community-based preceptor (the clinical