

are limits to how much most people can alter their interviewing techniques, 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 interviewers were asked to change their question-asking or responding techniques for feelings, the difference in the number of feelings expressed 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 technique 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.

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Patient-Centered Clinical Interviewing

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The task of the physician is twofold: to understand patients and to understand their diseases. In the process of medical history taking, we have a well tried clinical method for understanding diseases; we have no equivalent method for understanding patients. For three reasons, this lack is especially serious for primary care and family medicine.

First, as Carmichael (1980) has pointed out, a large proportion of the problems presented to primary care physicians is not diagnosed in the usual sense of the term. In these patients, a pathological diagnosis is not a realistic goal; the physician must have some other way of understanding the illness. The key to this understanding is an understanding of the patient.

The second reason relates to differing criteria of success in primary care and other fields of medicine. For primary care physicians, the focus is on preventing disease, not diagnosing it. More to the point, their role is to care for patients in the face of the effects on functioning of their diseases or life-problems. This role can only be fulfilled if physicians understand patients and their world.

The third reason relates to management, described by Stephens (1982) as "the quintessence of family medicine." Management in pri-

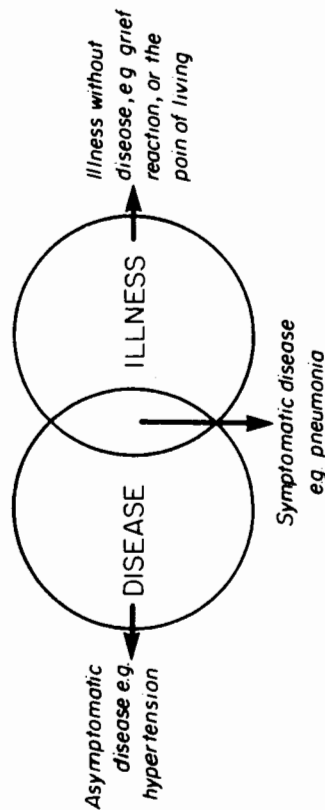


FIGURE 8.1 Two Modes of Ill Health: Disease and Illness

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; Marinker, 1981; Mishler, 1984;) 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.

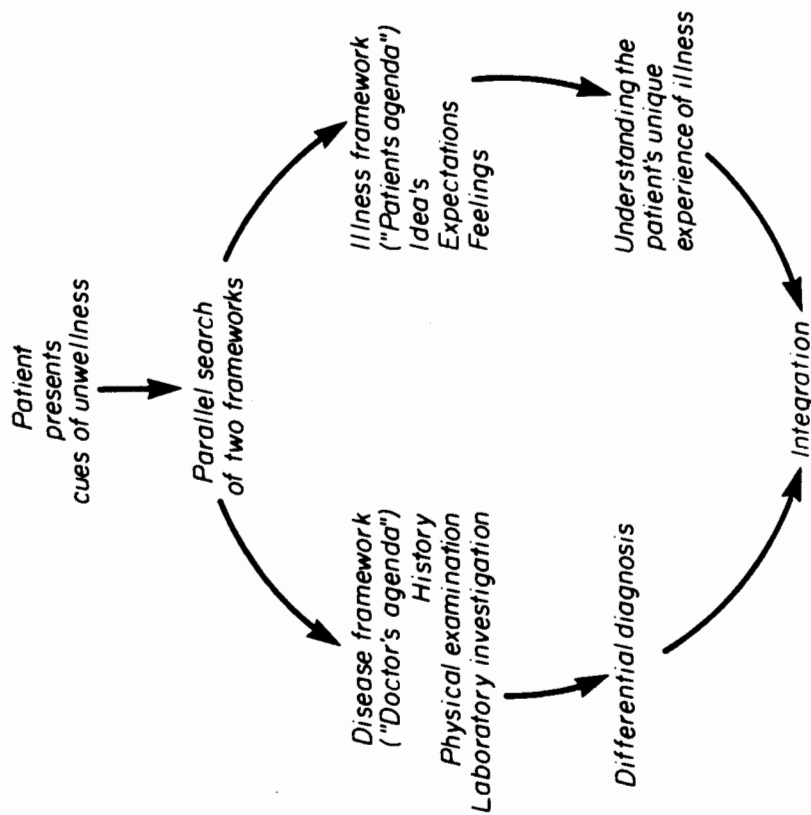


FIGURE 8.2 The Patient-Centered Clinical Interview

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 Levenstein (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?"

PATIENT-CENTERED INTERVIEWING: THE PATIENT'S AGENDA

The essence of the patient-centered method is that the physician tries to enter the patient's world, to see the illness through the patient's eyes by behavior that invites and facilitates the patient's openness. The physician seeks to allow patients to express all the reasons for their attendance, so that the physician can understand each patient's ideas, expectations, and feelings about the illness.

Each patient brings to the doctor's office ideas about the nature and cause of the problem. Furthermore, each patient comes with expectations of the visit, not necessarily made explicit. Also, each patient has feelings about the problem or problems. Sometimes these feelings may be the major factor in the illness, as when the patient fears cancer.

Obviously each patient's accounts of symptoms and their underlying meanings reflect their 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 understanding each patient as an individual. Entry into the patient's world is a difficult art, requiring empathy, nonjudgmental acceptance, and genuineness. It also requires skill in certain techniques, which we are convinced can be learned and taught. Moreover, physicians cannot be patient-centered unless they know themselves and are prepared to change their own attitudes and behavior.

The key to the patient-centered method, as its name implies, is to encourage 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 ideas, expectations, and feelings.

Failure to take up a patient's cues causes doctors to cut off patients and thereby miss an opportunity to gain fuller insight into their illnesses. It can also be frustrating for the patient, since the doctors are giving precedence to their own priorities.

These concepts have been compiled into a set of specific definitions for assessing that part of patient-centered care referring to the patient's agenda.

One feeling, fear, is an almost universal feeling in the doctor-patient interaction. To a greater or lesser extent, the patients are confronting the unknown, and it is rare that they would not have some fears and fantasies about their illness, management, or its effect on their lives. As with other feelings, fears may have their source in the "here and now," or in past events, or may reflect the patient's personality and life experience.

Prompts

Prompts are signals from patients that their ideas, expectations, or feelings have not yet been acknowledged or sufficiently explored. Prompts may be verbal or behavioral or may arise from the content of the consultation. For our purposes, we define prompts as either statements that are out of context, or restatements of a problem that has already been mentioned, as with the patient coming for an annual physical examination who mentions his sore knee and, later, since it has not been dealt with, says at the end of the visit, "And what about my knee, doctor?"

PHYSICIAN BEHAVIORS

Facilitating behavior is any verbal comment by the physician that encourages the patients' expressions of their ideas, expectations, or feelings. **Facilitating behaviors** may include open-ended questions, open-ended statements, reflections, and confrontations. In analyzing physician behavior we document whether the doctor acknowledges or cuts off the patient's expression of ideas, expectations, feelings, or prompts. **An acknowledgment** is defined as a verbal indication that the physician has heard the patient.

We define all statements not acknowledged by the physician as **cut-offs**: the physician blocks the patient's further expression of ideas, expectations, or feelings by changing the subject, using closed-ended or rhetorical questions, or not acknowledging a prompt. For example, patients may present an expectation such as "I'm having trouble sleeping" and doctors, working from their own agenda, might reply, "How has your appetite been?" Even if a patient's expression is acknowledged, it can be subsequently cut off. For example, patients may present an expectation such as, "What do you think of these warts?" and

DEFINITIONS OF TERMS

Ideas

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 for fear they might sound foolish or because, traditionally, the patient's role is more passive and it might sound presumptive 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 are the individual's stated reasons for the visit, and often relate to a symptom or a concern, for which is anticipated an acknowledgment or a response from the physician. The presentation of the patient's expectations may take many forms, including a straightforward statement of the problem, a question, or a request for service. While a statement of expectations normally initiates an office visit, it may occur at any stage of the interaction. For example, a patient may say, at the end of the visit, "By the way, doctor, I've also got a pain in my knee."

Not all expectations are made explicit. For example, if a patient with hypertension comes for a follow-up visit there is an implicit expectation that the blood pressure will be taken.

Feelings and Fears

Feelings reflect the emotional content of the patient's illness. They may be the predominant aspect of the illness, as in a grief reaction, or be a contributory factor, as in the anxiety of a breadwinner with a myocardial infarct. Patients may not necessarily articulate feelings explicitly; they are frequently under the surface, or even unconscious, often emerging during the process of the interaction. Feelings may reflect the patient's life experience, personality, or defence mechanisms. They may arise directly from the stated expectations, as when a patient who has requested a checkup discloses during the course of the interview that she is anxious about the effects of dyspareunia on her marital relationship.

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: 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 home 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: Its 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 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. (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: 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)

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. (feeling)

Doctor: Anything else you'd like to discuss? (facilitating behavior)

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.

In the disease-centered method, the physician's utmost priority is to check out any possible postoperative problems. Anything unrelated to it is of secondary importance. He thus single-mindedly 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 ideas or feelings. He misses subtle cues throughout. In discussing the patient's social context, the doctor preempts any expression of feeling by the patient by using value judgments to describe his circumstances—none but the most assertive patients would contradict him.

From the physician's viewpoint, disease-management is fine: there are no postoperative complications and he has treated the patient's tension headaches with Paracetamol. However, the patient's world has not entered into it at all.

The physician using the patient-centered method allows the patient to guide the interview. He recognizes that the patient's expectation of the visit is that his headaches will be dealt with and, by using open, nondirective, facilitative verbal (and nonverbal) behavior, has elicited several ideas and feelings related to the patient's life. He picks up subtle cues and encourages the patient to expand. He also concentrates on the one aspect ostensibly related to the postoperative course, i.e., loss of appetite. However, it appeared to have an entirely different connotation when explored in the patient's context.

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.

RECONCILING THE TWO AGENDAS

At some stage the physician must apply the disease framework to arrive at a diagnosis. There is no necessary sequential order, with the patient's agenda being explored first, the doctor's agenda second. The patient may provide cues at any stage of the process. Under usual circumstances however, physicians must begin with the patient's agenda, since the understanding gained may determine how the physicians follow their own agenda. If, for example, they discover that the patient's reason for attendance is to obtain a certificate of sick leave for an illness that is already subsiding, they may not need to apply the disease framework at all.

We believe it to be quite common, even in family medicine programs, for physicians to use the disease framework first in all cases, moving to the patient's agenda only if the former does not yield a clear pathological diagnosis. We are convinced, however, that the patient-centered method, integrating the doctor's and the patient's agendas, should be universally applied in primary care.

In some cases, there will inevitably be a conflict between the patient's expectations and the physician's assessment of those needs. If the patient's main concern is itchy feet, and the physician finds a blood pressure of 230/140, the doctor will obviously try to convince the patient that the hypertension is a more pressing concern than the presenting problem. A conflict of this nature will normally result in negotiation followed by an agreement. The patient's expectations must be addressed, but only after more urgent problems have been dealt with.

Of course, physicians may not be willing or able to meet the patient's expectations. For example, they may be unwilling to prescribe penicillin for a cold. Even in this case, however, physicians will be able to deal with the situation more effectively if they know that this is what the patient expects.

In observing many doctor-patient interactions, we conclude that a failure to apply the patient-centered method correctly leads to a dysfunctional interview and an unsatisfactory outcome.

CONCLUSIONS

1. The patient-centered clinical method is an important concept for students and practitioners. The key concept is the distinction between the disease

framework (What is the diagnosis?) and the illness frame-work (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 Arntson deal with another part of the training process, the relationship between the community-based preceptor (the clinical