Time for a change

New perspectives on the doctor-patient interaction

— Ronald J Henbest

Ronald J Henbest, BSc, MD, CCFP, MCISc (Family Medicine)
Department of Family Medicine,
The Medical University of Southern Africa
PO Medunsa
0204 Tvl

Curriculum vitae

Ronald J Henbest was born in Edmonton, Alberta (Canada) where he qualified in 1974 with a BSc in Maths and Psychology and in 1978 with an MD from the University of Alberta. He then completed two years postgraduate study (residency) in Family Medicine with the Department of Family Medicine at the University of Western Ontario (Canada) and obtained his CCFP from the College of Family Physicians of Canada. Ron joined the Department of Family Medicine at Medunsa in 1980. He has a particular interest in the doctor-patient interaction and its importance for healing. He returned to the University of Western Ontario in 1984 to take their Master of Clinical Science Degree in Family Medicine (MCISc), which emphasizes patient care, teaching and learning, and research. His thesis on Patient-Centred Care involved the development of a method for measuring patient-centredness and testing it against patient outcomes. Ron is involved in both the undergraduate and postgraduate teaching programmes in the department, is married to Judy and they have a little son, Benji.

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Summary

Several models for the doctor-patient interaction are presented. Seven common themes are identified: primacy of the person, significance of the subjective, importance of the interpersonal relationship, whole person medicine, deeper diagnosis, real reasons for coming, and the person of the physician. These models can be seen as part of a paradigm shift – a shift from thinking in terms of disease, to caring for people.

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The importance of the doctor-patient interaction, especially for family/general practice, has been increasingly recognized during the past sixty years[1-14]. The task of the doctor has been described as twofold: to understand the patient and to understand the disease.[15] There is a well-tried clinical method for understanding disease in the traditional medical model, consisting of history, examination, investigations, differential diagnosis, further investigations, diagnosis and treatment. There is no equivalent method for understanding patients.

The need for a new model for patient care can be seen to have begun with the recognition by general practitioners of a lack or deficiency in their medical training. Consider for example, the reflections of Sir James Mackenzie, in 1919, about his experience of starting general practice some forty years earlier: "After a year in hospital as a house physician, I entered general practice in an industrial town of about 100 000 inhabitants. I started my work fairly confident that my teaching and hospital experience had amply furnished me with complete knowledge for the

pursuit of my profession ... I was not long engaged in my new sphere when I realized that I was unable to recognize the ailments in the great majority of my patients."[16] Sir Francis Peabody, in an article published in 1927, identified not only that there was a lack in the medical education of his day, but spelled out what that lack was: "The most common criticism made at present by older practitioners is that young graduates have been taught a great deal about the mechanism of disease, but very little about the practice of medicine – or, to put it more bluntly, they are too 'scientific' and do not know how to take care of patients."[17]

Thinking in terms of disease, to thinking in terms of caring for the person

The lack of a model is particularly important for family practice for five reasons. First, patients most often present with symptoms or problems, not diseases, and a large proportion of the problems presented to the family doctor cannot be readily explained by any disease category.[18] Second, there is a need to be able to assess the quality of care in family practice and it would seem that the criteria of good patient care differ between family practice and other fields of medicine. For example, a precise pathological diagnosis may be considered a failure rather than a success when it means that appropriate preventive measures were missed.[14]

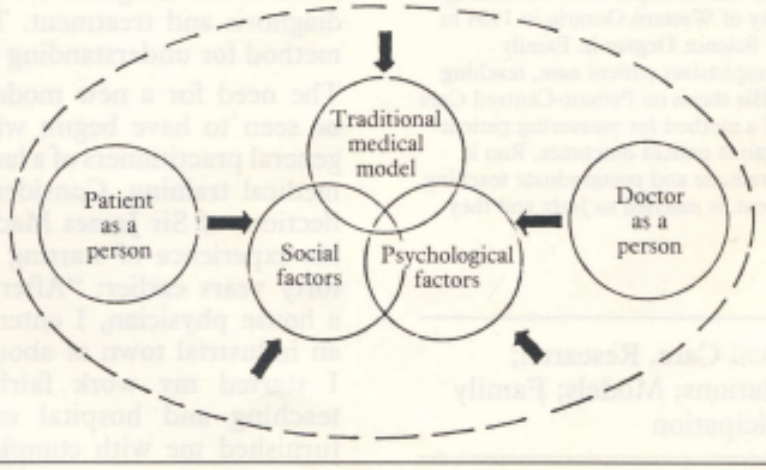
Third, the family doctor seeks to individualize patient management according to individual patient needs and this requires a knowledge of the patient and his or her unique experience of life. Stephens[19] refers to this individualization of management as the "quintessential skill" of clinical practice. Fourth, in the teaching of the discipline of family practice, the absence of a model makes the learning, teaching and evaluation of the consultation difficult. Fifthly, in the absence of a model, family practitioners find it difficult to communicate to others what their work is really about.

Thus, the development of an integrated method for the understanding of both the disease and the person is an important challenge for family medicine. The old model of the biomedical approach has been found wanting; a new model is needed to take its place. In this paper, I present several attempts to describe this new model and then discuss what these models have to say to us in terms of seven inter-related themes.

Heuristic Problem Solving in an Open System

Stevens,[8] in 1974, proposed a model for general practice called, "Heuristic Problem Solving in an Open System", which is shown in Figure 1. Steven's model presents the consultation as an open system, represented by a dotted line forming an oval around five small circles. The three central circles he labels traditional medical model, social factors, and psychological factors. The other two circles are placed one at each end of the oval and labeled: patient as a person, and doctor as a person. Arrows indicate that factors outside the consultation influence what goes on inside the consultation, and also that both the person of the patient and the person of the doctor influence the consultation process.

Figure 1
Heuristic problem solving in an open system[8]



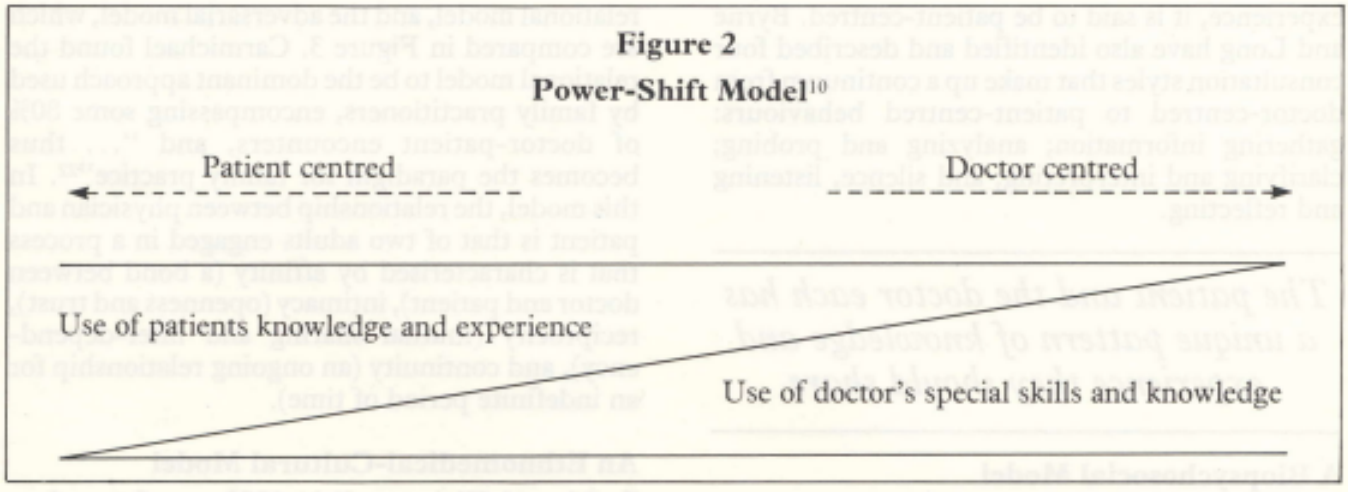


Figure 2
Power-Shift Model[10]

This model includes the notions of patient and person-centred medicine; divergent thinking; hypothesis testing by Bayes Theorem; tolerance of ambiguity; unorganized, undifferentiated illness; alternating search strategies; open-ended interviewing style; adult-adult relationship; the Rogerian triad of genuineness, accurate empathy and non-possessive warmth; learner directed learning; and the consultation as a unique situation.

A Power-Shift Model

Byrne and Long[10], in 1976, presented what they described as a power-shift model, shown in Figure 2. According to this model, the patient and the doctor each have a unique pattern of knowledge and experience that they bring to the consultation. To the extent that use is made of the doctor's special skills and knowledge, the consultation is said to be doctor-centred; to the degree to which use is made of the patient's knowledge and

experience, it is said to be patient-centred. Byrne and Long have also identified and described four consultation styles that make up a continuum from doctor-centred to patient-centred behaviours: gathering information; analyzing and probing; clarifying and interpreting; and silence, listening and reflecting.

The patient and the doctor each has a unique pattern of knowledge and experience they should share

A Biopsychosocial Model

Engel[20], in 1977, proposed a biopsychosocial model in an attempt to reconcile the psychosocial and biological perspectives in medicine. His approach was to; "... include the psychosocial approach without sacrificing the enormous advantages of the biomedical approach." In addition to disease, this model takes into account: "... the patient, the social context in which he lives, and the complementary system devised by society to deal with the disruptive effects of illness, that is, the physician's role and the health care system"[21]. The biopsychosocial approach is basically a systems approach that draws on the concept of hierarchically arranged systems in nature.

A Relational Model

Carmichael[18], in 1980, described three conceptual models of family practice: the clinical model, the relational model, and the adversarial model, which are compared in Figure 3. Carmichael found the relational model to be the dominant approach used by family practitioners, encompassing some 80% of doctor-patient encounters, and "... thus becomes the paradigm for family practice"[22]. In this model, the relationship between physician and patient is that of two adults engaged in a process that is characterised by affinity (a bond between doctor and patient), intimacy (openness and trust), reciprocity (mutual sharing and inter-dependency), and continuity (an ongoing relationship for an indefinite period of time).

An Ethnomedical-Cultural Model

Smith and Kleinman,[23] in 1983, put forward an ethnomedical cultural model as an expansion of the biopsychosocial approach described earlier by Engel[15]. Central to this model is the notion of ethnomedical beliefs, which Smith and Kleinman define as: "assumptions, expectations, attitudes, or interpretations that concern the body, its normal functions, the self, the family and social network, causes and consequences of sickness, pathophysiology, help seeking and treatment choice, compliance, satisfaction, and many related issues"[24]. They point out that all patients (not just those of another culture) have ethnomedical

... to enter the patient's world and to see the illness through the eyes of the patient

Figure 3
Comparison of conceptual models in family practice[18]

	Clinical	Relational	Adversarial
Percentage	15%	80%	5%
Orientation	Values and goals	Rights and duties	Privileges and sanctions
Objective	Cure/control	Care/comfort	Certify
Relationship	Provider/recipient	Participants	Antagonists
Evaluation	Outcome	Process	Structure
Characteristics	Authority Activity Objectivity Rationality	Affinity Intimacy Reciprocity Continuity	Entity Brevity Animosity Legality

beliefs, as do all physicians, and that the ethnomedical orientations of both patients and doctors may either facilitate or impede care. A useful shorthand conceptualization provided by Smith and Kleinman is that of the explanatory model which includes the patient's (and his family's) thoughts, fears, and expectations about the illness and its treatment. This model is aimed at understanding the meaning of symptoms for the patient in as comprehensive a manner as possible.

Seven Tasks

Pendleton et al[25], in 1984, described seven tasks of the consultation that together provide a comprehensive framework for both understanding and conducting the consultation. These tasks are: (1) to define the reason for the patient's attendance, (2) to consider other problems, (3) to choose (with the patient) an appropriate action for each problem, (4) to achieve a shared understanding of the problems with the patient, (5) to involve the patient in the management of the problems, (6) to use time and resources appropriately, and (7) to establish or maintain a relationship with the patient which helps to achieve the other tasks.

A Patient-Centred Model

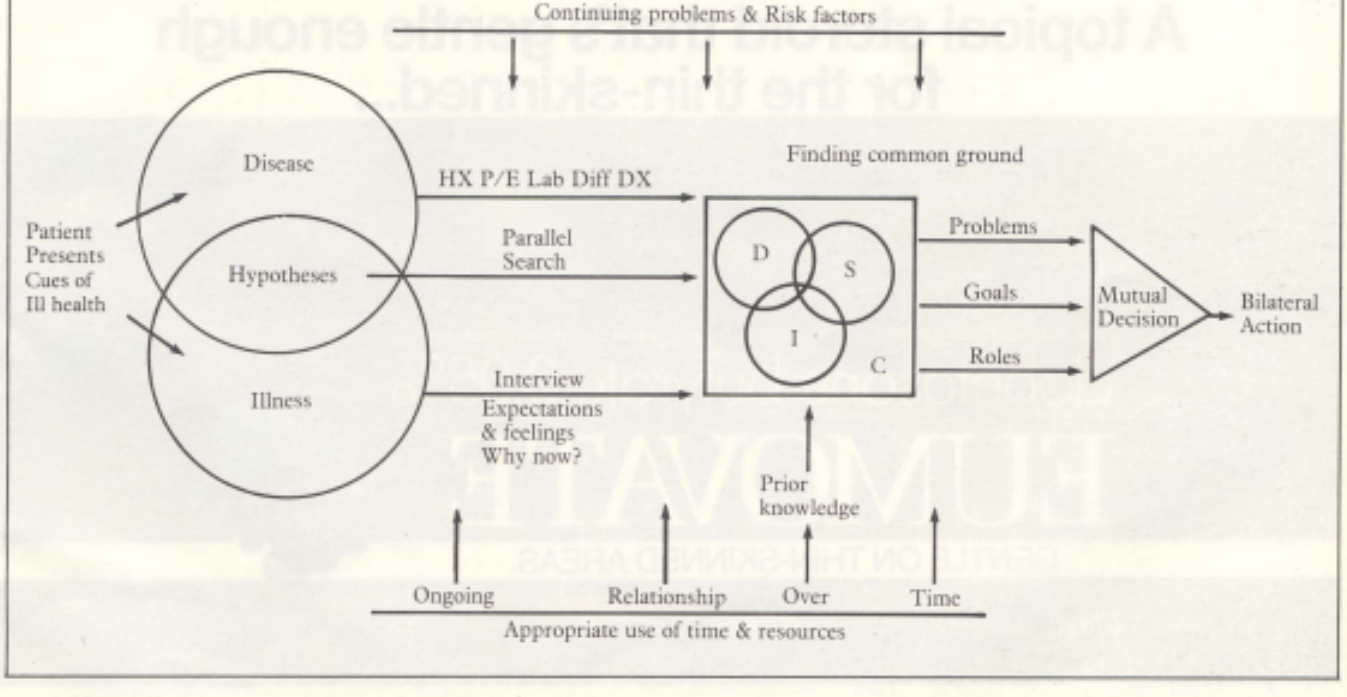
The final model to be described is that developed by the Department of Family Medicine at the University of Western Ontario, London, Canada based on work by Joseph Levenstein. This model, which is still in the process of being refined, has been described in two works: "The Patient-Centred Clinical Method: A Model for the Doctor-Patient Interaction in Family Medicine"[14] and, "The Clinical Method in Family Medicine: A Patient-Centred Approach"[26]. The method is described as follows: "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.

Allow the patient to express all the reasons for coming

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, feeling and fears."[27]

This model presents the aim of the consultation as being to attain an understanding of the patient as well as his disease. As is shown in Figure 4, the early portion of the consultation involves a parallel search of two agendas: the doctor's and the patient's. The doctor's agenda is to explain

Figure 4. The Patient-Centred Model of Care in Family Practice[26]



the presenting symptoms and signs by categorizing the problem in terms of a taxonomy of disease. The purpose of exploring the patient's agenda is to understand the patient's experience of unwellness and what it means to him in his world. The end result of this parallel search is an integrated understanding of the whole person. Weston[24] uses the mnemonic, DISC, (disease, illness, self, context) to help conceptualize this understanding of the whole person. The terms disease and illness are used to express two aspects of unwellness. Disease is used to refer to a pathologically changed part or function of the body; illness is used to refer to the person's experience of not being well, including his thoughts and feelings, and thus concerns the whole person (not just the diseased part). The final part of the consultation, referred to as finding common ground, includes reaching a common understanding regarding the problem, the goals of management, and the roles that the patient and doctor are going to play. Three ongoing additional tasks similar to Pendleton's are to (1) consider other continuing problems and risk factors, (2) develop an ongoing relationship which helps to achieve the other tasks, and (3) accomplish all of the above using time and resources appropriately for each visit as well as over the long term.

Disease: a pathologically changed function of the body.
Illness: the person's experience and feelings of not being well

Discussion

I have chosen not to discuss the advantages and disadvantages of each model, or even the applicability of the various models, but rather to show that these models, (instead of being fundamentally different, or in competition with each other) are really part of a whole, and that together they have an important message for us about patient care: a message that I would like to present as seven interrelated themes (Fig 5).

Perhaps the first and most important theme that

Figure 5
Seven inter-related themes for patient care

1. Primacy of the Person
2. Significance of the Subjective
3. Importance of the Interpersonal (Doctor-Patient Relationship)
4. Wholeness of the Whole (person)
5. Deeper Diagnosis
6. Real Reasons
7. Person of the Physician

can be identified is that of the primacy of caring for the person, rather than the disease. Steven's model[8] clearly identifies the patient as a person, distinct, but of course related to the illness. Carmichael states that the measure of the quality of care in the Relational Model[16] is based on the care given rather than on outcomes. The Patient-Centred Model described by Levenstein et al,[14] has as its centre, the patient as a person.

A second, and closely related aspect of care that can be identified, is the significance of the subjective. Steven's model[8] incorporates the Rogerian[28] notions of empathy and non-possessive warmth. The patient-centred behaviours described by Byrne and Long[10] attempt to make use of the patient's knowledge and experience and include seeking and using the patient's ideas. Engel[20] speaks of a need for a model that accounts for the realities of human experience as well as disease abstractions. Smith and Kleinman's Ethnomedical — Cultural Model[23] places emphasis on both the doctor's and the patient's beliefs, and the Patient-Centred Model[14] focuses specifically on the patient's expectations, feelings and fears.

. . . too much about the mechanism of disease and too little on how to care for patients

The third aspect to be identified, very closely follows upon the first two. With the recognition of the primacy of the person and the significance of the subjective, comes the realization that the interpersonal relationship is of tremendous importance. Steven's model[8] assumes an adult-adult relationship requiring personal responsibility in both doctor and patient. Carmichael[18] also describes the relationship between doctor and patient as being adult-adult and as including affinity, intimacy, reciprocity and continuity. Pendleton's[5] seventh task defines a desirable doctor-patient relationship in terms of its effectiveness in achieving the other six tasks of the consultation. Rather than diminishing the importance of the doctor-patient relationship, this task makes clear that the whole of the consultation depends upon it. The Patient-Centred Model[26] also emphasizes the importance of the doctor-patient relationship over time.

A fourth aspect of care that can be identified is that of caring for the whole person in the context of his or her significant relationships. A consequent fifth aspect of this different perspective of care is that of attempting to arrive at a deeper (or more comprehensive) diagnosis. Both Steven's[8] and Engel's[20] models apply general systems theory to the consultation. Steven's model emphasizes the openness of the consultation in recognition of the important outside influences acting upon it, which include the patient's family, social contacts, and work situation. The importance of taking into account the social, psychological and behavioural dimensions of illness is also seen in Engel's model.[20] Pendleton's[25] first three tasks of the consultation aim at comprehensive care and include the identification and management of acute and chronic problems, and risk factors. In the Patient-Centred Model[14] the doctor attempts to understand the whole person in terms of the person, the disease, the illness and the context.

A sixth aspect that can be identified is that of the patient's real reason(s) for coming. Pendleton[25] considers it self-evident that the first task in any consultation is to define the reasons for the patient being there. Byrne and Long[10] found in their study that the most frequent reason for a consultation being dysfunctional, was the doctor's failure to discover why the patient had really come. The Patient-Centred Model[14] incorporates the notion of two agendas; the patient's agenda includes all of his or her reasons for coming, including expectations and feelings.

The seventh and final aspect that I shall discuss is, perhaps, more implied in these new models for patient care rather than having been stated explicitly: that of the person of the physician and his or her interpersonal skills. To practice the kind of medical care implied by the six inter-related themes described, requires certain personal qualities and interpersonal skills on the part of the doctor. As stated by Brennan, "The basis of adequate total person care in family practice lies not only in the physician's technical competence but also in his personal qualities of sensitivity and awareness. Especially important is the physician's sensitivity to the feelings of patients and his intellectual as well as his intuitive awareness of the inextricability of the psyche from the soma."[29]

In concluding I would like to state that these models represent a change in thinking about patient care, that is, a shift in paradigms[30] – a shift that began with the recognition that, ". . . an exclusive concern with the traditional medical model of specific agents, specific responses, and specific cures is no longer adequate to the doctor's practice".[31] The models described in this paper are but a small part of the very exciting medical literature of this century that has sought in many

ways to express both the need for a new perspective on patient-care, and what that perspective should be.[32]

I join with Cassell stating: "I believe that medicine is in the midst of fundamental and exciting changes, it is evolving towards a profession in which the primary concern of physicians is with sick (or well) persons rather than merely their diseases. Indeed, this is probably the most profound shift in medicine since the concept of disease as we know it, came into being in the 1830s."[33]

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