

The Patient-centred general practice consultation



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Curriculum Vitae

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He has received numerous rewards and honours amongst which are the Louis Leipoldt Medal for the most outstanding article in the *S Afr Med J* (1971) and the Noristan Gold Medal for contributions to medical science (1976).

He has served on various academic and medical committees and was Vice-President of WONCA (1978-'80). He is serving on the committee of the SA Academy of Family Practice/Primary Care as well as on the Faculty of General Practitioners of the College of Medicine of South Africa. He has 34 publications to his credit.

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Summary

What happens between the doctor and the patient in General Practice? Are the patient's needs met? Dr Levenstein discusses the vital importance for the GP of having a model to work from during a consultation which is patient-orientated and not doctor-centred. This will help the doctor to ascertain the real reason for the patient's visit, to understand his problems and to enter into his world. Simplified examples of doctor-patient interactions are given to illustrate how the model operates by paying attention to the patient's expectations, his feelings and his fears.

INTRODUCTION

It has long been accepted that what happens between doctor and patient is the cardinal feature of General Practice (GP). The interaction which occurs between the two is central to the type of health care delivered and whether or not the patient's needs are met. There is clarity about the problems that may emerge from the consultation; ie physical, psychological, social, familial, minor, major, serious, undifferentiated and fragmented, for example, and the opportunities that these offer for different types of care and intervention, particularly on a continuing basis. This relative certainty exists only when the problems have been defined and categorized.

Less unanimity exists on the clinical method the General Practitioner (GP) uses while searching for and identifying problems. Several workers have made contributions, in one way or another, to facilitate the emergence of these problems. Balint has pointed out the need for self-awareness of the doctor and deeper diagnoses,¹ other authors have voiced the need for certain attitudes that need to be displayed by the physician; also the stages a consultation should go through,² and more recently Pendleton has defined 'tasks' which have to be completed.³

However, there is little on the clinical method the GP should use while 'searching for' and identifying these problems. In fact, great play has been made of the fact that GPs vary markedly in their 'approach' and 'style' towards patients. This is understandable if one remembers that all have been trained in the traditional medical model to deal with a totally different situation.

There is a great need amongst GPs for a model to work from during a consultation.

The lack of a distinctive model for General Practice hampers the progress of the discipline in several ways. For example, as GPs are using different models it is understandable that morbidity studies in the discipline are often at great variance with one another. Furthermore, in the teaching of the discipline the absence of a model makes the learning, teaching and evaluation of the consultation extremely difficult and the wide variation of trainers' models makes the exercise highly subjective.

CONTENT OF GENERAL PRACTICE

It is agreed that the content of practice for the GP differs vastly from his specialist colleagues. Using the traditional concept of the severity and chronicity of conditions, general practitioner studies have shown that 8-30% of conditions are 'chronic', only 6-17% are 'serious' and 51-77% are 'minor'.⁴ In fact, some general practitioners regard the bulk of their work as 'trivial', 'unnecessary' and 'inappropriate'.⁵ Furthermore, it is recognised that a large part of this so called 'trivia' is psycho-social in its genesis and there is even argument as to the relevance this has to the work of a doctor.⁶

PATIENTS' REASONS FOR ATTENDANCE

The crisp point remains, that whether he likes it or not, the GP will be confronted by patients who feel 'minor' disturbances in their normal well-being. Patients are not able to distinguish, usually, what is organic and what non-organic at the early undifferentiated stage of their illness. These so called 'minor' deviations from the patients' norm should have a major significance in the GP's world if he wants to detect the earliest signs of illness and institute preventive care on all levels and at all stages successfully.

The interaction between GP and patient determines whether the patient's needs are met.

Nor do patients believe that their illnesses are trivial. There is abundant evidence showing that, for whatever reasons, patients are highly selective as to what they present to their doctor, and the medical services only deal with a fraction of symptoms in the community.⁶ Studies have shown that only 10-33% of illness incidents reach the doctor and that even the seriously ill do not seek care.^{6,7,8} Thus the patient that presents in our consulting rooms has already selected himself and attends for a whole host of reasons which he obviously regards as important. More pertinently, if we, as doctors, do not ascertain the reasons for the pains and anxieties of patients, it is understandable that they will seek help elsewhere from those that they perceive might do so, such as the practitioners of alternative medicine.

Patients do not believe their illnesses are trivial.

The elucidation of all the reasons for the patient's attendance has been found to be crucial to the success of any interaction. Following on Balint's seminal work,¹ Byrne and Long, in their analysis of thousands of consultations of British doctors, found that the single most common reasons for a dysfunctional consultation, was the doctor's failure to ascertain the reasons for the patient's attendance.⁷ Hull observed that more than half of 335 women expressed reservations as to whether they told the doctor why they had consulted.⁹ There is little doubt that it is the psycho-social aspects of the visit that are the ones missed by the doctor who is acting from his own frame of reference. He is desirous of diagnosing and excluding differentiated organic disease in a world where little exists. His doctor-centred approach, which assumes that all can be categorised, diagnosed and managed by his knowledge of disease, is frustrated by the patient's own needs and concerns and reasons for attendance.

PSYCHO-SOCIAL ASPECTS OF ILLNESS

Assuming that we are missing all the psycho-social aspects of illness does not necessarily prove that these are relevant. What evidence exists that they are? Firstly, it has been shown that purely physical lesions per se may only be presented when psycho-social factors intervene. Zola underscored the fact that individuals often make appointments to see their doctors after disagreements with

their mothers, difficulties at work and even after unfortunate incidents at gatherings.^{10,11} Thus at the very outset the patient's presence can be a mix of physical and psycho-social factors which are part and parcel of the patient's illness and reasons for attendance.

At a more complex level, life crises such as bereavement, divorce and major geographic dislocation have been shown to be associated with serious disease, such as coronary artery disease¹², cancer¹³, strokes¹⁴, rheumatoid arthritis¹⁵, streptococcal diseases¹⁶ and depression¹⁶. Furthermore, psycho-social factors have been shown to have had profound influence on the outcome and the aetiology of an illness. Whether a patient went on to chronic brucellosis with all the clinical parameters that are used to measure it, was determined mainly by a disturbed or troubled life situation or by gross traumatic events or circumstances in early life.¹⁷ Similar observations were made in studies on the outcome of such varied conditions as Asian Flu¹⁸ and constrictive peri-carditis¹⁹.

The relationship of the family and marriage to illness has also been explored. Here it has been shown that there is higher morbidity and mortality in the bereaved²⁰, increased disease such as influenza, pneumonia, syphilis and cirrhosis in unmarried persons²¹, and increased mental illness in dysfunctional families²² to quote just a few examples.

Life crises are associated with serious diseases.

OUTCOMES

The outcome of illness is affected by the intervention of doctors. Egbert et al showed, in a carefully controlled study, that merely by providing explanation and information, the amount of post-operative pain experienced by patients decreased dramatically.²³ By providing emotional support to mothers whose children had operations, the children's physical and psychological recoveries were hastened²⁴. In a study conducted by Querido on patients admitted to surgical, medical and psychiatric wards, it was determined that a wide range of social and emotional factors determined outcome to a greater extent than did clinical parameters²⁵.

What happens between doctor and patient is the cardinal feature of general practice.

More specifically, with regard to outcome, Stewart showed that patient-centred interviews, in a general practice setting, were associated with a higher level of patient satisfaction and compliance.²⁶ Patient compliance was found to be better when they had had some involvement in their health care²⁶ and compliance was found to be evident only when patients were involved in the decision making process.³ These are all highly pertinent observations when one realises that two-thirds of patients fail to take their doctors' advice.³ Patient satisfaction was far higher, in a careful

study conducted by Pendleton, when the doctor dealt with patient concerns and expectations and communicated warmth, interest and concern.³

PATIENT-CENTRED APPROACH

There appears to be a need for a clinical approach which will take into account all the aspects of a patient's illness within appropriate time constraints. This is particularly so in the area of undifferentiated illness in the general practice situation.

It is argued that in General Practice the crucial activity is to ascertain all the reasons for the patient's attendance. This inevitably involves a host of physical, psychological and social components which, however, do not constitute the only aspect of consultations since doctor-initiated activities (such as preventive and educational intervention as well as the diagnosis and management of clearcut organic disease) are also part of any 'model'. It is nevertheless essential that the GP reveal the patient's unique situation, since this has an effect on the outcome of his patient's illness and treatment, his vulnerability to serious illness, his compliance with management and his own personal satisfaction.

The most common reason for an unsuccessful consultation was the doctor's failure to find out WHY the patient came.

As McWhinney has pointed out, there are essentially two types of models in medicine: *doctor-centred* and *patient-centred*.²⁷

- In the former the doctor attempts to interpret the patient's illness in terms of his own explanatory framework. The interview is dominated by the doctor who, it is assumed, has all the necessary knowledge and skills — the individual patient's participation is almost irrelevant. The objective is to fit the patient's illness into a precise classification linking the symptoms and signs with organic pathology and identifying single external causes such as micro-organisms. The power of the doctor-centred reductionist model needs no explanation as to its effectiveness in the diagnosis and exclusion of clearcut organic disease.
- In the patient-centred model, the doctor sees each patient as a unique individual with a unique illness.²⁸ He endeavours to enter and 'tune in' to the patient's world and facilitate the expression of his perceptions of illness. The doctor, furthermore does not place a value judgement on the patient's illness, recognising that whatever its nature, it is causing pain and anxiety to the patient. Bearing in mind the multi-causal factors of illness, he listens carefully to the patient and attempts to enter the patient's world using empathy, non-judgemental acceptance and congruence. It is accepted that the doctor cannot be patient-centred unless he is aware of self and his attitude and behaviour are appropriate to such an approach.

GENERAL PRACTICE MODEL²⁸

It is obvious that both models have relevance to GP. However, the most important objective of any interaction is to establish the reasons for the patient's attendance — the components of his illness. In the short time available, attention must be paid to detail of the patient's presentation since all that he says and does in this concentrated time (which has perhaps followed hours, even years of indecision) must surely be relevant. The reason for his attendance can be expressed in terms of his **expectations**, his **feelings** and his **fears**. Every patient who seeks help has expectations explicit and implicit of the doctor. Furthermore, he has feelings related to his illness which can be the result of several factors. Although fears are feelings, they are such a universal component of illness that they are given a separate heading.

The doctor can facilitate the expression of the patient's reason for attendance or he can 'cut-off' the patient. This can be effected by ignoring him or failing to take up what he is expressing, both verbally or non-verbally, thereby ignoring the context of the patient's presentation or repeatedly rejecting what the patient is trying to communicate to him.

To illustrate these features of the model, a few simplified examples of doctor and patient-centred interviews are presented.

In the patient-centred model, the doctor sees each patient as a unique individual with a unique illness.

DOCTOR-CENTRED INTERVIEW

Expectation

Patient: I would like a check-up.
Doctor: Good. I see you haven't been for some time.

Feelings

Patient: I thought it was about time.
Doctor: Once a year is about right. Have you got any complaints?
Patient: Not really . . .
Doctor: Have you been ill or off work at all?
Patient: (Sighs): I never miss a day . . .
Doctor: So, there is nothing really significant . . . ?
Patient: Only the odd ache and pain which, I suppose, is normal. Also the long hours at work make me tired. I really need a holiday.

Fears

Doctor: I'm sure I'll find nothing wrong.
Patient: I hope not!
Doctor: You look in the pink of health.

PATIENT-CENTRED INTERVIEW

Expectation

Patient: I would like a check-up.
Doctor: Fine, is there any particular reason why you came today?

Feelings

Patient: Well, it has been some time and the wife insisted . . .
Doctor: Why is that?
Patient: Well, I haven't been myself lately.
Doctor: In what way?
Patient: It's nothing really.
Doctor: Nothing . . . ?
Patient: I suppose it's the pressure at work . . .
Doctor: Yes . . .
Patient: It's getting so much that I have been taking it out on the family. I am impossible to live with . . .
Doctor: You sound pretty down?
Patient: I suppose I am. I really must get my priorities right.
Doctor: What do you mean?
Patient: Perhaps we can talk about it some other time.

Fears

Patient: . . . I really hope it is nothing serious.
Doctor: What is?
Patient: These shooting pains across my chest.
Doctor: Tell me about them.
Patient: Well, they come at the oddest times and they're getting more frequent.
Doctor: How long do they last?
Patient: About a few seconds, just on the left side of my chest under my nipple.
Doctor: Well, what did you think it may be?
Patient: Well, I was worried about my heart . . .

In these examples a marked difference is noted. In the doctor-centred (DC) interview the patient's expectation is accepted at face value and the doctor sees the whole transaction from his world, namely, to diagnose or eliminate organic disease. He ignores the 'trivia', he allows nothing to flow from the patient, controlling the interview from start to finish. We know very little about the patient's unique world and his underlying feelings.

The patient's real reason for a consultation is crucial to the success of any interaction.

By contrast, in the patient-centred (PC) interview, the doctor makes every effort to 'tune in' to his patient's world. He listens and subtly creates opportunities for the patient to express all his reasons for attendance. This is accomplished effortlessly by allowing the patient to dictate the interview and its pace. He allows as much as possible to flow from the patient which is the key to the patient-centred model. Everything the patient says is regarded as significant and the patient is allowed the opportunity to elaborate on his own unique circumstances.

EXPECTATIONS

The consultation is initiated by the patient who states his expectation, which is the spontaneous, conscious reason for his presence. In this instance it was for a physical examination which the patient anticipates the doctor will acknowledge and/or act upon. The patient invariably requires his expectation to be at least acknowledged or the interaction will become totally dysfunctional eg . . .

Patient: I would like a check-up.

Doctor: You have a mole on your cheek.

Patient: That's nothing; it's been there for years. I need a check-up.

Doctor: I think we must take that out under local anaesthetic.

Patient: I haven't got time. I'm very busy at work. I must have an annual check-up.

Doctor: It doesn't take long to cut it out.

Expectations may, on occasion, be implicit such as in a doctor-initiated interaction for a blood pressure check, for example. Mostly, the expectation is 'physical' in nature and relates to organs or systems or to symptoms emanating from them. The expectation can be couched in the form of a request, a demand 'Give me a check up, a question: 'Can I have . . . ?' or a statement: 'It is time for my check-up'.

The doctor should at least meet the patient's expectation on a reality level. This can be in the form of acknowledgement, by obtaining clarification, asking appropriate questions, performing examinations and instituting investigations with the ultimate objective of making a diagnosis and instituting treatment, if appropriate. Some interactions lend themselves only to the meeting of expectations such as emergencies, episodic care, etc.

FEELINGS

The emotional content of the patient's illness can be reflected by the patient's feelings. These may reflect the predominant part of the illness or be one of its constituent parts. Feelings are not often explicitly articulated by the patient. They are often under the surface and may even be in the unconscious only surfacing during the process of the interaction. They may arise directly out of the stated expectation or may be indicative of the patient's personality, his past, events in his life, or his defence mechanisms. Feelings can be the psychological component of the illness or arise from the effects of the illness.

By merely providing explanation and information, the pain experienced by patients decreased dramatically.

In the PC interview the patient's feelings are facilitated and developed: 'I haven't been myself lately — I suppose it's the pressure at work — it's getting so much I am taking it out on the family', to accepting the interpretation that he is 'down'. Feelings or emotions need not be directly expressed, although this may often occur or develop. The patient, for example, does not say: 'I am hopeless, useless or depressed. He says: 'I am impossible to live with'.

Often patients need *permission* to reflect their feelings . . .

Patient: It's nothing really.

Doctor: Nothing . . . ?

Patient: I suppose it's pressure at work.

In the DC interview there was no flexibility and feelings were not explored or allowed to develop — this was just another physical examination. Explicit feelings were ignored, including the patient sighing and stating that work made him tired. Possible feelings were not allowed to emerge, for example:

Doctor: Have you got any complaints?

Patient: Not really . . .

Doctor: Have you been ill or off work?

The doctor perceived this from his world in organic physical terms and *assumed* that that was all the patient wanted.

The doctor should build bridges between himself and the patient to facilitate trust and communication.

FEARS

Fears are almost universal to any doctor-patient interaction. To a lesser or greater extent the patient is dealing with the unknown and it is rare to find a patient who has no anxieties or fantasies about his illness, its possible management and the effect it may have on his life. Fears, being feelings, can have their source in the here and now, in past events or be part and parcel of the patient's personality or circumstances. In the PC interview the patient's fears were expressed. 'I hope it's not serious . . .' 'These shooting pains across my chest'. In the DC interview we haven't the vaguest idea what the patient is worried about, although the patient states that he hopes 'the doctor will find nothing wrong'.

DOCTOR FACILITATIVE BEHAVIOURS

The doctor in the PC model must allow the interview to be dictated by the patient. To do this he must use verbal and non-verbal facilitative techniques of one or other type. The questions must be open, non-directive, allowing the patient to expand. As the objective is to follow-up all the patient presents, reflective questions and silences can be extremely useful. Interpretations, observations and even confrontations can also be used to allow the patient to develop his feelings further and thereby a deeper understanding of his illness. To enter into the patient's world is a difficult art requiring the qualities of empathy, non-judgemental acceptance, congruence and honesty. The most crucial attribute of all is a knowledge of self.

Feelings are not often explicitly articulated by the patient.

In the PC interview the doctor gets the patient to elaborate his own perceptions using all these techniques. He is building bridges between himself and the patient to facilitate trust and communication.

The doctor, in facilitating all aspects of the patient's illness, does not run the risk of invading the patient's privacy. He does not probe or dig, but merely invites the expression of the patient's feelings or opinions. If the patient does not wish to proceed, the doctor can get the message and 'drop' the subject. The doctor acts only on what the patient gives him.

Patient: I suppose I really must get my priorities right.

Doctor: What do you mean?

Patient: Perhaps we can talk about it some other time.

This example also serves to show how the doctor's facilitating behaviour helps generate management options. In this instance the patient elects to cope with the generated problems himself. It is obvious that this interview may have developed out of the patient asking for help, referral and/or stating that his marriage was in ruins, his job in jeopardy, etc.

PATIENT CUES

As everything that emanates from the patient is significant, the patient may be cueing or prompting the doctor consciously or unconsciously by his verbal or non-verbal behaviour. In the DC interview, several cues are missed, for example: 'Not really', (asking for permission to express feelings) and '(Sighs): I never miss a day' (reflecting on the hopelessness of the situation).

Sometimes, what a patient doesn't say, can be a cue to the doctor.

Often the patient gives the doctor another chance by cueing him again. In the DC interview the patient, not having been let in, eventually mentions 'the odd ache and pain'.

In the PC interview the doctor picks up every cue allowing the patient to turn a simple interaction into a rich unique mosaic of the patient's current situation in life, instead of a dull frustrating ritual.

Patient detail is thus of the utmost significance. These details are the cues to the doctor. Cues can arise from the circumstances of the consultation; a low user, for example, consulting for something trivial, should alert the doctor to find out the other reasons for attendance. Appearance and non-verbal behaviour also may 'cue' the doctor. Sometimes, what a patient doesn't say can be a cue!

Doctor: How's the family?

Patient: Well, my wife and Margaret are fine.

Doctor: You haven't mentioned Geoff.

Patient: Don't talk to me about Geoff. He is driving us all mad. He has dropped out . . .

CUTTING-OFF

Failure to take up what the patient presents or 'cues', whether this be an expectation, feeling or fear, results in the doctor cutting-off the patient and thereby missing an opportunity to gain full insight into the patient's illness. It can also result in frustration for the patient, since the doctor is placing his own priorities above those of his patient. He is operating from his own world and imposing it on the patient.

Again we see how in the DC interview the patient is not allowed to expand on any of his statements. The doctor

does not even acknowledge some of the patient's feelings and keeps returning to his own perspective:

Patient: (Sighs): 'I never miss a day'

Doctor: So there is nothing significant.

A further stark example of cutting-off is given where the doctor fails even to take up the patient's expectation (See heading 'Expectations').

CONTINUING CARE

While this paper concentrates only on the reasons for the patient's attendance, it is obvious that the data contained in any one interaction can be used to build up a total picture of the patient and his family and at future consultations, where appropriate, be reflected on again. It is but a fragment in an ongoing process and the patient in this example may well 'wish to talk about getting his priorities right' on a subsequent occasion.

Patient details are cues for the doctor.

The PC general practitioner model does not exclude the reductionist medical model where the latter is appropriate, such as in the diagnosing or elimination of a clear-cut organic entity or suspicious symptom. The formal medical model can be interspersed at any appropriate stage in the interaction. Also, the PC interview must be seen in the context of the the job definition of the GP, namely to initiate preventive care and to see to continuing care for all physical, psychological and social problems of patient and family. In making management decisions the GP is called upon to apply his knowledge and skills to a lesser or greater extent. With this model he involves the patient in the process of diagnosis and management alternatives.

Patient compliance is better when patients are involved in their own health care.

Furthermore, there are occasions when the urgency of a problem may require the doctor to impose his value system and priorities on the patient, eg a conflict between the patient's expectations and feelings and the physicians assessment of his needs. An example of this may be where a doctor suspects an acute myocardial infarction and the patient insists he only has heartburn and is too busy to go to hospital.

CONCLUSION

It is concluded that the patient's reasons for attendance should be facilitated and that these, globally, fall under the headings of expectations, feelings and fears. Furthermore, all that is offered, verbal and non-verbal should be taken up and not cut-off. The doctor should exhibit facilitative behaviours and endeavour to be aware of self. By following this model a dysfunctional interview could be avoided.

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CONGRESS QUOTES

by Saville Furman.

- *Most patients are scared of dying of cancer, but most of them will die of cardio-vascular disease.*

(DR R MATISONN)

- *Rheumatic Heart Disease should be labelled "Owen or PW's heart" as it is not a medical, but a socio-political problem.*

(DR R MATISONN)

- *The single most effective thing we can do for our patients that have had a myocardial infarct, is to stop them smoking.*

(PROF JE ROSSOUW)

- *Ischaemic Heart Disease patients that stop smoking reduce their risk factors by 50%.*

(PROF JE ROSSOUW)

- *ON ALTERNATE MEDICINE. We must keep an open mind, but not so open that our brains will fall out.*

(BASIL JAFFE)

- *I regard pharmacists as "Doctors of Medicine". They shouldn't be selling pantihose — they should guide our patients.*

(PROF H GRANT-WHITE)