

Overview of the Patient-Centered Clinical Method

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Models of Medical Practice

Many colleges and academic associations of medicine have defined the knowledge, skills, and attitudes of the effective doctor. But these fall short of describing, in practical terms, the uniqueness of the doctor's clinical method. As medical professionals, we need a way to explain, clearly and pragmatically, the clinical tasks of medicine (White, 1988). Models of practice are valuable in several ways. First, they guide our perceptions by drawing our attention to specific features of practice. Second, they provide a framework for understanding what is going on. Third, they guide our actions by defining what is important. A productive model will not only simplify the complexity of reality but also focus our attention on aspects of a situation that are most important for understanding and effective action. The dominant model in medical practice today has been labeled the "conventional medical model." No one would question the widespread influence of the conventional medical model, but it often has been attacked for oversimplifying the problems of sickness (Odegaard, 1986; White, 1988). Engel (1977) described the problems with the conventional medical model this way:

It assumes disease to be fully accounted for by deviations from the norm of measurable biological (somatic) variables. It leaves no room within its framework for the social, psychological, and behavioral dimensions of illness. The biomedical model not only requires that disease be dealt with as an entity independent of social behaviour, it also demands that behavioral aberrations be explained on the basis of disordered somatic (biochemical or neurophysiological) processes. (p. 130)

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In the past few years, a number of alternative conceptual frameworks have been recommended (Carmichael & Carmichael, 1981; Cohen-Cole, 1991; Foss & Rothenberg, 1987; Kleinman, Eisenberg, & Good, 1978; Pendleton et al., 1984). Engel's biopsychosocial model has attracted much attention. Engel (1980) uses systems theory as a basis for understanding human sickness. The patient is conceptualized as being composed of systems (tissues, cells, molecules) and, in turn, as being part of several larger systems (dyads, families, communities, nations). This model is valuable in reminding us to consider the personal and social dimensions of illness, in addition to biological aberrations. Yet, the model does not explain when or how to include these other dimensions. All of these conceptual models have been informative, have moved the practice of medicine forward, and have served as antecedents to our current work. However, an effective model of practice will need to be explicit about when and how to go beyond the conventional medical model.

Several authors (Hurowitz, 1993; Illich, 1976) have challenged an expanded model of medicine as unrealistic and arrogant: It is inappropriate to medicalize all human suffering and to expect physicians to find solutions to problems that have their origins in poverty, greed, racism, or ignorance. At the end of a 100-hour week, this argument has a certain appeal! But the debate ignores the reality of practice—that patients present to their doctors when they feel ill, no matter what the cause. At least, the physician must identify the source of the patient's distress and recommend appropriate resources for additional help. Furthermore, even treatment of organic disease may be ineffective if the patient's context is dismissed (e.g., family strife, unemployment, cultural differences).

Other authors have pointed out the importance of acknowledging a distinction between the physician's theoretical understanding of the

patient's disease and the patient's firsthand experience of feeling unwell (Cassell, 1985b, 1991; Fabrega, 1974; Levenstein, 1984; Levenstein et al., 1986; Levenstein et al., 1989; McWhinney, 1989b; Mishler, 1984; Reiser & Schroder, 1980; Stephens, 1982; Stetten, 1981). This distinction highlights patients' need for more than a scientific formulation and treatment of their problems. Patients generally want to feel understood and valued and to be involved in making sense of their health problems. In addition, many of them want to be involved in decisions about management.

A model of medicine will need to integrate the conventional understanding of disease with each patient's unique experience of illness. The patient-centered model presented in this book is an attempt to meet this need (Levenstein, 1984).

The patient-centered model is valuable in several ways:

1. It defines what doctors do when they are functioning well in helping their patients. It is not simply a model for curriculum or course planning, but rather a conceptual framework to guide the practitioner "in the trenches." Because the model is explicit about the behavior of an effective doctor, it provides a vocabulary and a focus for teaching and learning. The model provides more than a moral exhortation to be more caring; it provides a description of the specific behaviors that need to be learned, as well as guidelines about when and how to use them with patients. We call this description of specific behaviors "the method" that operationalizes the model.
2. The model is a reasonable representation of reality; it simplifies the complexity of the doctor's job without distorting it. Because the model grew out of medical practice, in particular, Dr. Levenstein's practice (Levenstein, 1984), rather than being imported from other disciplines, it has immediate applicability for experienced physicians.
3. The model applies to the majority of "ordinary" interactions between doctors and their patients.
4. The model provides a framework for research. By defining effective doctoring in discrete and measurable terms, specific components of practice can be evaluated.

The Patient-Centered Clinical Method

The term "patient-centered medicine" was introduced by Balint and colleagues (Balint, Hunt, Joyce, Marinker, & Woodcock, 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 (1976) 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), with Newman and Young's (1972) total-person approach to patient problems in nursing, and with the two-body practice in occupational therapy (Mattingly & Fleming, 1994).

Byrne and Long (1976), 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" (p. 125). Clinical teaching in medical schools tends to emphasize a doctor-centered approach (or disease-centered, as we prefer). 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 criterion 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.

In this chapter, we briefly describe the patient-centered model and method developed by Levenstein (1984) in his own practice and further developed at The University of Western Ontario (Levenstein, McCracken, McWhinney, Stewart, & Brown, 1986; McCracken, Stewart, Brown, & McWhinney, 1983). The model consists of six interconnecting components, summarized in Table 2.1 and illustrated in Figure 2.1, each of which is described in more detail in Chapters 3 through 8:

1. Exploring both the disease and the illness experience
2. Understanding the whole person

TABLE 2.1 The Patient-Centered Clinical Method

The six interactive components of the patient-centered process:

1. Exploring both the disease and the illness experience
 - A. Differential diagnosis
 - B. Dimensions of illness (ideas, feelings, expectations, and effects on function)
2. Understanding the whole person
 - A. The "person" (life history and personal and developmental issues)
 - B. The context (the family and anyone else involved in or affected by the patient's illness; the physical environment)
3. Finding common ground regarding management
 - A. Problems and priorities
 - B. Goals of treatment
 - C. Roles of doctor and patient in management
4. Incorporating prevention and health promotion
 - A. Health enhancement
 - B. Risk reduction
 - C. Early detection of disease
 - D. Ameliorating effects of disease
5. Enhancing the patient-doctor relationship
 - A. Characteristics of the therapeutic relationship
 - B. Sharing power
 - C. Caring and healing relationship
 - D. Self-awareness
 - E. Transference and countertransference
6. Being realistic
 - A. Time
 - B. Resources
 - C. Team building

3. Finding common ground
4. Incorporating prevention and health promotion
5. Enhancing the patient-doctor relationship
6. Being realistic

1. EXPLORING BOTH THE DISEASE
AND THE ILLNESS EXPERIENCE

The first component involves physicians' understanding two conceptualizations of ill health with all of their patients: disease and illness (Levenstein, 1984; Levenstein et al., 1986; Levenstein et al.,

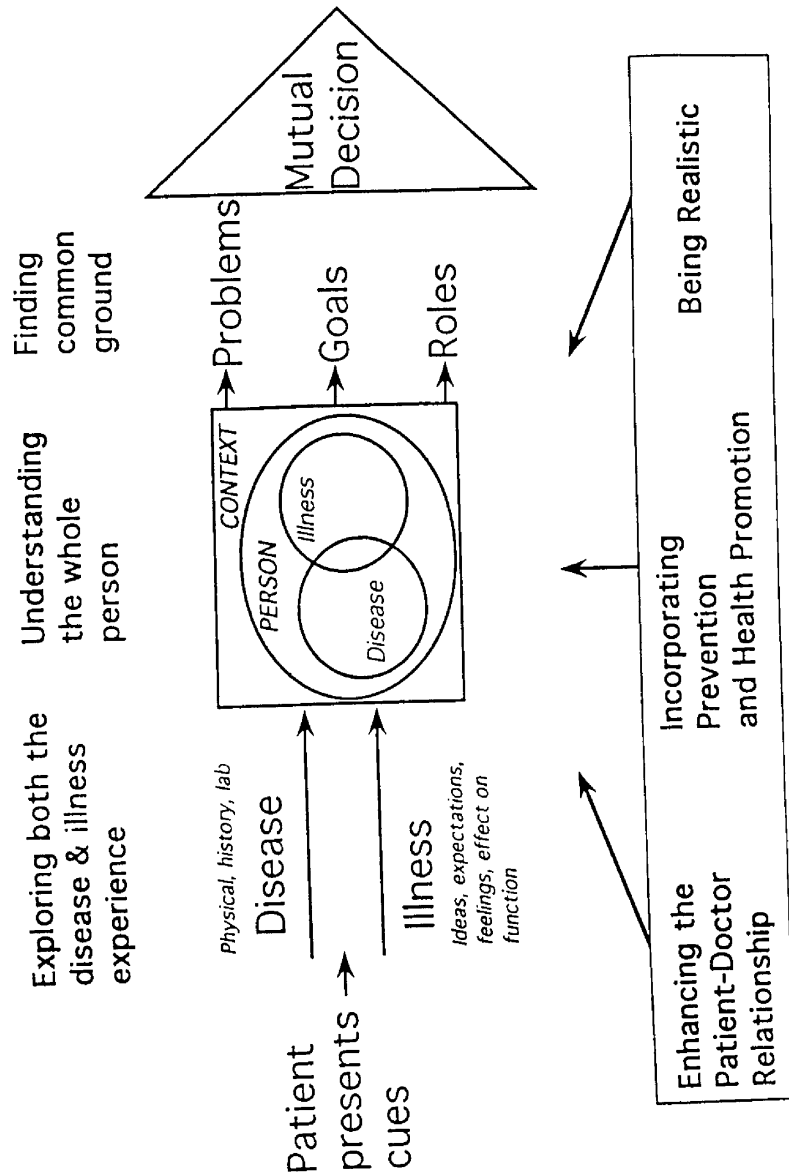


Figure 2.1. The Patient-Centered Clinical Method.

1989). *Disease* is a theoretical construct, or abstraction, by which physicians attempt to explain patients' problems in terms of abnormalities of structure and/or function of body organs and systems and includes both physical and mental disorders. *Illness* refers to patients' personal experiences of ill health. The diagnostic label explains what each individual with a disease has in common with all others, but the illness of each person is unique.

Effective patient care requires attending as much to patients' personal experiences of illnesses as to their diseases. The identification of disease is established by using the conventional medical model, but understanding illnesses requires an additional approach. A patient-centered method focuses on disease and on four principal dimensions of patients' illness experiences: (a) their ideas about what is wrong with them; (b) their feelings, especially fears about being ill; (c) the impact of their problems on functioning; and (d) their expectations about what should be done. The key to this approach is attention to patients' cues related to these dimensions; the goal is to follow patients' leads, to understand patients' experiences from their own points of view. This method improves patient satisfaction, compliance, and outcomes of both illness and disease and is applicable to the everyday work of physicians with "ordinary" patients.

Reaching a therapeutic understanding of patients' illness experiences requires skill in interviewing to enable the doctor to "enter into the patient's world," to understand the illness from the patient's point of view. Often this component will be straightforward; at other times, however, the doctor must be alert for any cues to the patient's ideas, expectations, feelings, or effects on function. Patients may prompt a doctor if he or she misses cues. Sometimes, it is only at the end of an interview that a crucial comment is made. These "doorknob" remarks may indicate that the doctor has missed earlier cues or that the patient finally has summoned up enough courage to raise a fearful or embarrassing issue before it is too late.

2. UNDERSTANDING THE WHOLE PERSON

The second component is an integrated understanding of the whole person. Over time, doctors accumulate a myriad of information about their patients that goes beyond diagnosing disease or attending to illness responses. They begin to know the whole person and, in doing

so, come to understand the patient's disease and experience of illness in the context of his or her life setting and stage of personal development. This knowledge of the person may include the family, work, beliefs, and struggles with various life crises.

Serious illness of a family member reverberates throughout the entire family system. The doctor who understands the whole person recognizes the impact of the family in ameliorating, aggravating, or even causing illness in its members. The patient's cultural beliefs and attitudes also influence his or her care.

An understanding of the whole person can enhance the physician's interaction with the patient at specific times—for example, when the signs or symptoms do not point to a clearly defined disease process or when the patient's response to an illness appears exaggerated or out of character. On these occasions, consideration of the patient's position in the life cycle may shed some light on his or her current experience. But even when the diagnosis is clear and uncomplicated, knowledge of the whole person can help the doctor answer the question "Why now?"

Finally, understanding the whole person can deepen the doctor's knowledge of the human condition, especially the nature of suffering and the responses of persons to sickness.

3. FINDING COMMON GROUND

The third component of the method is the mutual undertaking of finding common ground. Developing an effective management plan requires physician and patient to reach agreement in three key areas: (a) the nature of the problems and priorities, (b) the goals of treatment, and (c) the roles of the doctor and the patient. Often, doctors and patients have widely divergent views in each of these areas. The process of finding a satisfactory resolution is not so much one of bargaining or negotiating, but rather of moving toward a meeting of minds or finding common ground. This framework reminds physicians to incorporate patients' ideas, feelings, expectations, and function into treatment planning.

4. INCORPORATING PREVENTION AND HEALTH PROMOTION

The fourth component incorporates prevention and health promotion into the context of the "ordinary" office visit. As disease preven-

tion and health promotion require a collaborative, ongoing effort on the part of patient and physician, the process of finding common ground on the multiplicity of opportunities for disease prevention and health promotion becomes an important component of every visit. Application of the patient-centered approach throughout this process constitutes health promotion as currently defined (World Health Organization, 1986a)—that is, "the process of enabling people to take control over and to improve their health" (p. 73).

Within such a supportive process, physicians and patients together monitor areas in patients' lives that need strengthening in the interests of long-term emotional and physical health. Physicians also need to monitor recognized problems and to screen for unrecognized disease. Finally, physicians need to collaborate with other health professionals to implement the program of health promotion and screening in practice.

This task requires that continuing and comprehensive care is the underlying philosophy of the practice and that a protocol for screening and health promotion, as well as a medical record system that supports the protocol (e.g., problem list, flow sheets, tickler files, computer reminder systems), be implemented.

5. ENHANCING THE PATIENT-DOCTOR RELATIONSHIP

The fifth component of the patient-centered method is conscious attention to enhancing the patient-doctor relationship. When doctors see the same patients time after time with a variety of problems, they acquire considerable personal knowledge of them that may be helpful in managing subsequent problems. At every visit, in the context of continuity of care, physicians strive to build an effective long-term relationship with each patient as a foundation for their work together and to use the relationship for its healing potential. Physicians (using personal self-awareness, as well as the basic tools of effective relationships: unconditional positive regard, empathy, and genuineness) attend fully to patients and their needs without always having to interpret or intervene. Physicians recognize that different patients require different approaches and use themselves in a variety of ways to meet the patients' needs (e.g., sensing a patient who has unquenchable need for support and is vulnerable to abandonment; recognizing and accommodating an assertive, involved patient). Physicians, at the very least, "walk with" the patients and, at most, use themselves and

their relationship to mobilize the strengths of patients for a healing purpose.

6. BEING REALISTIC

The sixth component involves being realistic. Doctors frequently have competing demands for their time and energy; they must learn to manage their time efficiently for the maximum benefit of their patients. Physicians must develop skills of priority setting, resource allocation, and teamwork. Doctors practicing in primary care settings are the providers of first entry into the health care system and, as such, must be wise stewards of the community's resources. Finally, doctors must respect their own limits of emotional energy and not expect too much of themselves.

Conclusion

Although the six interactive components of the patient-centered clinical method have been presented as separate and discrete, in reality the components are intricately interwoven. The skilled clinician moves effortlessly back and forth, following the patients' cues, among the six components. We have found this technique of weaving back and forth to be a key concept in teaching the method and one that requires practice and experience.

The First Component

Exploring Both the Disease and the Illness Experience

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The first component of the patient-centered clinical method was demonstrated and described to the authors by Dr. Joseph Levenstein (1984, 1986, 1989). The basis of this method is a distinction between two conceptualizations of ill health: disease and illness. Effective patient care requires attending as much to patients' personal experiences of illnesses as to their diseases. Diseases are diagnosed by using the conventional medical model, but understanding illnesses requires a different approach. *Disease*, on the one hand, is an abstraction, the "thing" that is wrong with the body-as-machine. *Illness*, on the other hand, is the patient's personal experience of sickness—the thoughts, feelings, and altered behavior of someone who feels sick.

In the biomedical model, sickness is explained in terms of pathophysiology: abnormal structure and function of tissues and organs.

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