Studies about the patient-centred approach

MOIRA STEWART

A patient-centred approach requires that the physician attend to the patient's cues in seeking both to understand the patient's illness experience and to find common ground with the patient in order to embark on a mutually acceptable treatment. The patients' illness experience is defined in terms of their ideas about their problem, their expectations of the visit and the treatment, their feelings and the effects of their condition on function. There are three important aspects to finding common ground: agreement between the doctor and patient about the nature of the problem; agreement on the goals of treatment; and agreement on their roles in the relationship. Our research program has attempted to answer important and practical questions about the patient-centred approach. First, is it worthwhile? Does it make a difference? Second is the issue of efficiency. We ask: Are patient-centred visits long? Third is the issue of consistency. Are patient-centred physicians consistently patient-centred? Finally, how do students learn the patient-centred approach?

Stewart M. Studies about the patient-centred approach. Huisarts Wet 1991; 34(7): 302-5.

Moira Stewart, PhD, Associate Professor, Centre for Studies in Family Medicine, Department of Family Medicine, The University of Western Ontario, London, Ontario, Canada.

Introduction

The concept of the patient-centred approach has been evolving at The University of Western Ontario over the past eight years. It grew out of the work of Rogerian counselling and the Balint movement. The patient-centred approach, as described in this paper, was first proposed by *Levenstein* and *McWhinney* and later expanded by *Weston*.[1-3] The key aspects of a patient-centred approach are for the physician: to gain an understanding both of disease and their illness; and to find common ground with the patient about the treatment.

Understanding disease and illness

The basis of this conceptual model is a distinction between two modes of ill health: disease and illness. Disease 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 (*figure 1*).

In the patient-centred method the physicians' aim is to ascertain the patient's illness experience and to reconcile it with the search for disease. In a disease-centred approach, physicians would pursue their search for disease to the exclusion of any attempt to understand the illness experience. The patient-centred approach, on the contrary, includes both the search for disease and the search for the illness experience. The parallel search of the two frameworks is depicted in *figure 2*.

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 illness being explored first and the disease second. Under usual conditions, however, the physician follows the patient's cues to unwellness and weaves back and forth between the illness and the disease throughout the encounter. Readers will be well versed in the principles of the search for disease through differential diagnosis. What, though, are the principles for understanding the illness experience?

We propose four dimensions of illness experience that physicians should explore:

- *Patients' ideas about what is wrong.* What are the patient's ideas about their illness? What meaning do they attach to the illness experience? Many persons endure illnesses as irreparable loss; others may view it as an opportunity to gain valuable insight into their life experience. Is the illness seen as a form of punishment or as an opportunity for dependency? Whatever the illness, knowing its meaning is paramount for understanding the patient.
- *Patients' feelings, especially their fears, about their problems.* What are the patients' feelings? Do they fear that the symptoms they present may be the precursor of a more serious problem such as cancer? Some patients may feel a sense of relief and view the illness as an opportunity for respite from demands or responsibilities. Patients often feel angry or guilty about being ill.
- *Patients' expectations of the doctor.* What are their expectations of the doctor? Does the presentation of a sore throat carry with it an expectation of penicillin? Do they want the doctor to do something or just listen?
- *The effect of the illness on functioning.* What are the effects of the illness on function? Does it limit patients' daily activities? Does it impair their family relationships? Does it require a change in lifestyle?

Finding common ground

To reconcile the illness agenda of the patient and the disease agenda of the physician requires finding common ground. The physician and patient must reach a mutual understanding. This requires that two potentially divergent viewpoints be brought together in a reasonable management plan.

First agreement must be reached on the nature of the problems needing attention. It is a universal human characteristic to try to explain personal experiences in order to give people a sense of having some control by labelling those experiences. Most patients want a 'name' for their illness or at least an explanation of their problem that makes sense to them. Without some agreement about the nature of what is wrong, it is

Figure 1 *Disease and illness*

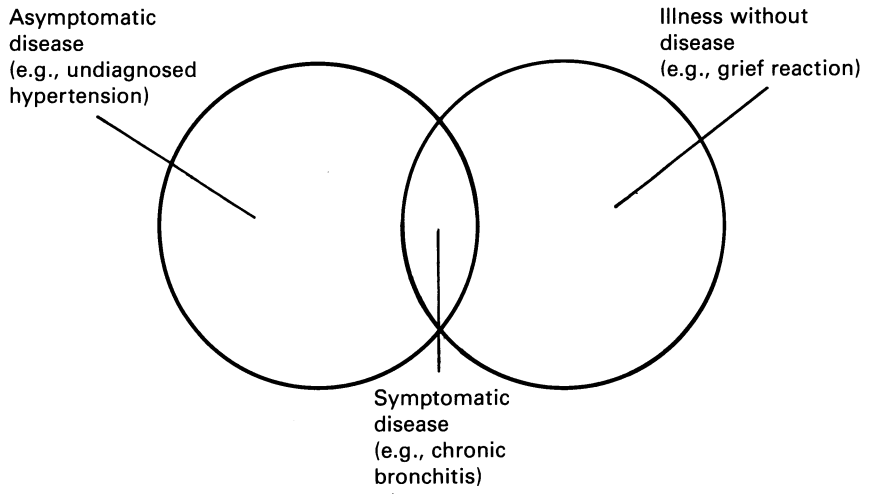
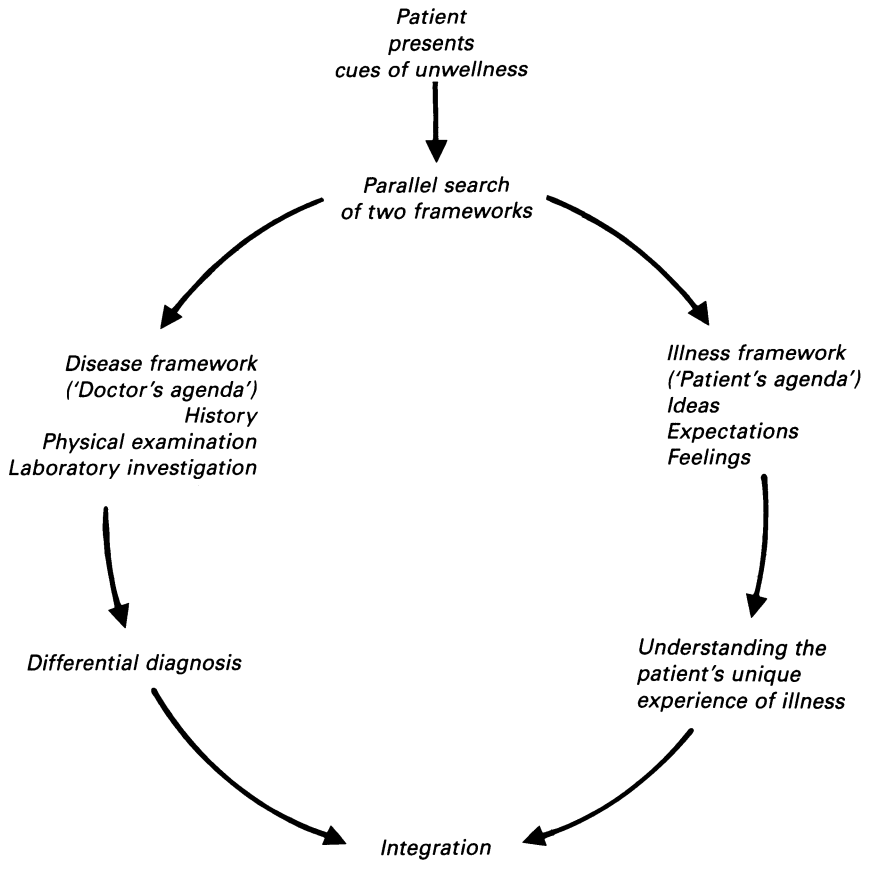


Figure 2 *The patient-centred clinical interview*



difficult for a doctor and a patient to agree on a plan of management that is acceptable to both of them. It is not essential that the physician actually believe that the nature of the problem is as the patient sees it, but the doctor's explanation and recommended treatment must at least be consistent with the patient's point of view and make sense in the patients' world.

Second goals and priorities of treatment must be shared. When a doctor and patient meet, each has expectations and feelings about the encounter; if these are at odds or inappropriate, there may be difficulties. Physicians need to elicit the patients ideas, expectations and feelings at an appropriate time in the encounter and using questions which are clear and sincere. The goals of treatment must then take into account the ideas, expectations and feelings of both physicians and patients. If hidden agendas are not recognized, it may be difficult to reach agreement. What physicians call 'non-compliance' may be the patient's expressions of disagreement about treatment goals; in this sense the patient always has the last word.

Third, it is imperative that physicians and patients understand each other's perception of their role in the relationship. Doctors of a cancer patient may see themselves wanting to bring about remission, and may expect the patient to assume the role of a passive recipient of treatment. Patients, however, may be seeking a physicians who expresses concern and interest in their well-being, and who is prepared to treat them in the least invasive manner, viewing them as autonomous individuals with a right to have a voice in deciding among various forms of treatment. This is not such a dilemma for doctors when the various forms are equally effective, but physicians are understandably concerned when the patient chooses a treatment that they consider harmful.

Different patients want different kinds of relationships with their doctors. Physicians are often admonished to be more humane, less paternalistic, and more accepting of the rise of consumerism in medicine. These criticisms sometimes ignore the patient's best interests or even fail to take into account whether this approach is what the patient wants. We advocate that physicians

be sensitive to patient's cues about what they want to talk about, and to what extent they can, and wish to, handle their own condition. This step in understanding takes time and is one of the reasons why continuity of care is so important.

A research program at The University of Western Ontario has involved faculty and graduate students. Our goals were to answer four questions:

- Does it make a difference?
- Are patient-centred visits long?
- Are physicians' scores consistent from consultation to consultation?
- How do students learn the patient-centred approach?

In the course of this research we developed a scoring system of doctor-patient encounters which has been demonstrated to be reliable and valid.[4]

Difference

Are patient-centred consultations associated with better outcomes than consultations not scored as patient-centred?

Patient-centred consultations are associated with subsequent patient satisfaction, patient compliance, reduction of concern, symptom reduction and physiologic status. *Stewart* conducted a study of 140 adult patients with a combination of chronic illnesses and self-limiting conditions visiting 24 family physicians, and found that patients expressing feelings were more likely to be satisfied and compliant 10 days later than those not expressing or not so encouraged by their physician. In particular, there were significant associations of the proportion of patient expressions which were feelings and opinions with patient satisfaction. Also, there was an association between physicians' encouragement of expressions of feeling and both patient compliance (self-report) and patient satisfaction (with personal qualities of the physician).[5]

Henbest & Stewart conducted a study of 73 adult patients with one new symptom visiting six family physicians. They showed that high scoring consultations (on patient-centredness) were related to:

- decreased patient concern about the presenting symptom;
- patient's perception that the presenting problems were fully discussed;
- patient perception that his/her reasons for visiting had been fully understood by the doctor.[6]

A study of 272 patients presenting to family physicians with a new complaint of headache found that a good outcome at one year was associated with the patients' assessment that they had the opportunity to discuss their problem fully at the first visit. Bass (The Headache Study Group) reports a study of 193 patients with new episodes of common symptoms (non-respiratory). After controlling for demographic, psychological and social variables, the only element that was related to the resolution of the symptom was doctor-patient agreement about the nature of the problem.[7]

It is important to note the results of other investigators here as well. *Greenfield et al.* in the United States have conducted experiments in which diabetic and hypertensive patients were educated to be more assertive in expressing their expectations and asking questions of the physician. The experimental patients showed better functional status and physiologic outcomes (blood glucose and blood pressure readings) than control patients. Audiotape analysis of the doctor-patient interaction showed that patients who were more controlling, showed more emotion (particularly negative emotion) and improved their effectiveness in eliciting information from the doctors showed bet-

Samenvatting

Stewart M. Onderzoek naar de 'patient-centred' benadering. Huisarts Wet 1991; 34(7): 302-5.

De 'patient-centred approach' is een aanpak voor consultvoering die is ontwikkeld aan de Universiteit van Western Ontario door met name *McWhinney* en *Levenstein*.[1 2] Kenmerkend voor deze benadering is het integreren van 'the patient's agenda' – zowel zijn ziekte of aandoening, als de wijze waarop hij deze ervaart – met 'the doctor's agenda': het medisch referentiekader. De eerste stap bestaat uit het vaststellen van het probleem dat besproken moet worden. Daarbij hoeft de arts in beginsel niet dezelfde kijk op het probleem te hebben als de patiënt, maar hij moet wel goed begrijpen wat deze ervan denkt. Vervolgens moeten arts en patiënt het eens worden over de doelen en prioriteiten van het te volgen beleid. In de derde plaats moeten arts en patiënt hun wederzijdse verwachtingen op elkaar afstemmen.

Het artikel behandelt een aantal resultaten van onderzoek – vrijwel allemaal afkomstig van de 'Ontario-school' – naar effecten, mogelijkheden en beperkingen van deze methode.

- *Maakt de methode iets uit?* Werken met de 'patient-centred method' leidde bij de patiënten tot 'zich meer begrepen voelen', grotere tevredenheid, reductie van angstgevoelens, en een gunstiger beloop van de aandoening.
- *Gaan consulten door die aanpak niet veel te lang duren?* Naarmate een dokter meer 'patient-centred' werkte, nam de duur van de consulten toe tot de optimale score;[4] vanaf dat punt daalde de consultduur dramatisch. De verklaring voor dit fenomeen luidt dat dokters die wel proberen 'patient-centred' te werken maar er niet erg bedreven in zijn, langer zitten te worstelen om toch te slagen.
- *Passen artsen de methode consistent toe?* In een onderzoek onder zes huisartsen werden grote verschillen gemeten, maar naarmate artsen meer patient-centred' werkten, vertoonden ze een grotere 'range' in gedrag; wellicht een bewijs van échte patient-centredness.
- *Is de aanpak aan te leren?* In het onderwijsprogramma blijkt dat te lukken, maar het is moeilijk en kost soms veel tijd. Als didactische werkvormen worden daarbij peergroup-review, analyse van video-opnamen, rollenspellen en individuele begeleiding gehanteerd.

Hoewel de besproken resultaten hoopvol stemmen, moet er nog veel onderzoek worden gedaan, met name naar de effecten van 'patient-centred' werken op de tevredenheid van de arts, en naar de lange-termijn effecten.

ter functional status, blood glucose control and blood pressure control.[8 9]

We conclude that important patient outcomes are enhanced by communication between doctors and patients which is characterized by full expression of the patients problems leading to a mutual understanding.

Duration

Are patient-centred visits long? We studied this question in our study of 24 family physicians and 133 visits. As the patient-centred score increased, length of the visit also increased until the score reached the optimum (a score of 4). At this point, the length of the visits decreased dramatically (replicated on three of our patient-centred measures).

For example, when the patient-centred score for eliciting feelings was lowest at 1, the visits averaged 7.8 minutes; score of 2, 9.8 minutes; score of 3, 12.0 minutes; score of 4; 10.4 minutes. When the score for facilitating by the physician was low at 1, the visits averaged 7.8 minutes; score of 2, 10.9 minutes; highest scores of 3, 8.5 minutes.

We interpret these findings to mean that physicians who are struggling with the patient-centred concepts, but not fully utilizing and integrating them, engage in longer interviews compared to doctors who have mastered the approach or doctors who have very low scores on patient-centredness.

Consistency

The study of 73 consultations of 6 physicians showed significant differences in scores among the physicians but, more interestingly, showed wider ranges in scores the more patient-centred the physician was.[10] We think this may mean, if replicated elsewhere, that physicians who tend to have high average scores are in fact flexible in style whereas physicians who are not so patient-centred are consistently not patient-centred i.e. very small ranges in scores. This was supported by *Byrne & Long* who found that their subjects had doctor-centred styles of practice and were very consistent from patient to patient.[11]

Learning

We have many years of experience with residents, graduate students and community physicians taking Continuing Medical Education courses. All the teaching is conducted in small supportive peer groups which meet weekly over weeks or months. One study of residents showed that after two months in the Family Medicine program, with no specific course on the patient-centred method, they had significantly increased the number of expectations, feelings and fears expressed by their patients and used more facilitations.[12] However, the proportion of patient expressions which the residents cut-off actually increased somewhat, indicating that they had difficulties accepting and integrating the new data they were able to elicit from the patients. We acknowledge with our students the awkward and self-conscious stages of learning the patient-centred approach and now incorporate tape-review sessions, role-playing sessions, and coaching in the everyday practice setting to enhance the students' confidence and skills. We also acknowledge that until the skills are mastered at a high level the visits are likely to be of longer duration. We must provide a protective and supportive environment which permits the student enough time to move through these awkward stages to full integration of patient-centred interviewing into their practices.

Discussion

The research program as reported here has found that patient-centred interviews can be scored and studied in a relatively objective manner. We have found not only that a patient-centred approach affects patient satisfaction, compliance and recovery but that it is practical enough to be realistic for use in everyday practice. Furthermore, it is teachable and learnable, although not without an investment in time and continued supervision.

Important questions remain unanswered and important challenges lie ahead. While patient outcomes have been assessed by us and other investigators, it remains to be seen whether or not wide use of the patient-centred approach would increase physician satisfaction.

Finally, because continuity of care is a guiding principle of family medicine, future studies of the patient centred approach ought to address the natural history of doctor-patient relationships. One relevant question is: Does a doctor-patient relationship which begins as patient-centred evolve into a different, deeper and more therapeutic relationship than one which began disease centred?

References

1 Levenstein JH, McCracken EC, McWhinney IR, Stewart MA, Brown JB. The patient-centred clinical method. I. A model for the doctor-patient interaction in family medicine. Fam Pract 1986; 3: 24-30.

2 McWhinney IR. Are we on the brink of a major transformation of clinical methods. Can Med Assoc J 1986; 135: 873-8.

3 Weston WW, Brown JB, Stewart MA. Patient-centred interviewing. Part I. Understanding patients' experiences. Can Fam Physician 1989; 35: 147-51.

4 Brown JB, Stewart MA, McWhinney IR, McCracken EC, Levenstein JH. The patient-centred clinical method. Part II. Definitions. Fam Pract 1986; 3: 75-9.

5 Stewart MA. What is a successful doctor-patient interview – a study of interactions and outcomes. Soc Sci Med 1984; 19: 167-75.

6 Hernbest R, Stewart MA. Patient-centredness in the consultation 2: Does it really make a difference? Fam Pract 1990; 7: 28-33.

7 The Headache Study Group. Predictors of outcome in headache patients presenting to family physicians – a one year prospective study. Headache J 1986; 26: 285-94.

8 Greenfield S, Kaplan SH, Ware JE. Expanding patient involvement in care. Ann Int Med 1985; 102: 520-8.

9 Greenfield S, Kaplan SH, Ware JE. Patient participation in medical care: effects on blood sugar and quality of life in diabetes. J Gen Int Med 1988; 3: 448-57.

10 Henbest R, Stewart MA. Patient-centredness in the consultation 2: Does it really make a difference? Fam Pract 1990; 7: 28-33.

11 Byrne PS, Long BL. Doctors talking to patients. London: Her Majesty's Stationery Office, 1976.

12 Stewart MA, Brown JB, Levenstein JH, McCracken EC, McWhinney IR. The patient-centred clinical method – changes in residents' performance over two months of training. Fam Pract 1986; 3: 164-7. ■