Patient-Centered Medicine
Transforming the Clinical Method

THIRD EDITION

MOIRA STEWART, JUDITH BELLE BROWN, W WAYNE WESTON, IAN R MCWHINNEY, CAROL L MCWILLIAM AND THOMAS R FREEMAN
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Preface to the Third Edition

The principles underpinning the patient-centered clinical method remain constant but the components have changed: there are now four components instead of six. “Being Realistic,” one of the previous components, was considered not to be part of clinical care and so its material on time and teamwork was moved to other parts of the book. “Prevention and Health Promotion,” the second of the previous components to be changed, was considered to be incorporated into each patient-clinician interaction and therefore has become part of the other components. Conceptual clarity has been achieved regarding where Health Promotion fits in patient-centered care and where Prevention fits (see Chapter 1). The teaching and learning chapters comprise an up-to-the-minute compendium of the relevant education literature and methods. The research chapters illuminate patient-centered concepts through stories of lived experiences, and they also provide clear, positive, and uplifting messages about the important impact of patient-centered clinical care.

This book is divided into five parts. Part One contains an introduction to the patient-centered clinical method, including its evolution and relationship to other models of care. In addition, common misconceptions about the meaning of patient-centeredness are elucidated. The second chapter in this part is a historic perspective written by Ian R McWhinney.

Part Two describes the four interactive components of the patient-centered clinical method. Chapters 3–7 elaborate in detail Components 1–4, respectively. The clinical reader will notice the cases illustrating each of the four components of the patient-centered approach that are embedded in Chapters 3–7. Those most interested in the application of patient-centeredness in everyday practice might enjoy reading the cases first. As McWhinney (2001: 88) has wisely noted, “An actual case brings things alive for us in a way that aggregated data cannot do.” Taken together, the cases represent a typical series of patients in the practice of a busy doctor. All the cases are based on actual clinical encounters; however, the names, dates, and places have been altered to ensure the confidentiality of the participants.

Part Three, on teaching and learning, contains five chapters. Chapter 8 examines the experience of medical education. The parallel between the
learner-centered method of medical education and patient-centered practice is described in Chapter 9. Practicing, learning, and teaching patient-centered medicine has many personal, professional, and systemic challenges, as Chapter 10 illustrates. Chapter 11 contains details on teaching strategies and practical tips for teaching the patient-centered clinical method. A particular teaching tool, the patient-centered case presentation, is described in Chapter 12.

Part Four of the book deals with two key health care contexts within which patient-centered clinical care is enacted. In Chapter 13 the context of teamwork is explored. In Chapter 14 the preoccupation with cost restraint in health care is dealt with by providing the news that patient-centered care saves money.

Part Five, on research, combines reviews of relevant literature with descriptions of important measures. Qualitative and quantitative methodologies are represented. Chapter 15 presents a description of qualitative findings that illuminate the patient-centered clinical method. Chapter 16 is a review of quantitative studies – in particular, a number of stunning systematic reviews. In Chapter 17 we present measures of patient perceptions of patient-centered care and their use in research and education. Chapter 18 describes a measure we have developed that uniquely assesses encounters according to the patient-centered clinical method.

In the final chapter, we summarize the key messages of this book and look to the future of challenge and reward in the practice, teaching, and research of the patient-centered clinical method.

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October 2013
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This book is dedicated to Joseph H Levenstein, MD, for his inspiration to us and his outstanding contribution to the practice of medicine. We are grateful to Dr Levenstein for introducing us to the patient-centered clinical method during his time as a visiting professor in our department in 1981–1982.

We also dedicate this book to the late Ian R McWhinney, MD, who invited Joseph to come to Western University as a visiting professor and provided him and all of us with an intellectually stimulating and nurturing environment in which to co-create the ideas in this book.
PART ONE

Overview
1 Introduction

Moira Stewart, Judith Belle Brown, W Wayne Weston, Thomas R Freeman, and Carol L McWilliam

In the 1980s, when the patient-centered clinical method was first being conceptualized and used in research and education, it was at the periphery of medicine (Brown et al., 1986, 1989; Levenstein et al., 1986; Stewart et al., 1986, 1989; Weston et al., 1989). Indeed, many educators and researchers viewed patient-centered medicine as a “soft science” – caring and compassion were acknowledged to be important aspects of humanitarian care but few people were aware of the pivotal role of patient-centered communication in modern scientific medicine. In the first edition of this book, we described the full patient-centered clinical method, with the goal of placing it at the epicenter of clinical practice and medical education (Stewart et al., 1995).

Since that time we have learned much by presenting the patient-centered clinical method to many groups of medical students, residents, graduate fellows, community physicians, and medical school faculties across North America, Europe, Turkey, the United Arab Emirates, Argentina, Brazil, Australia, New Zealand, Japan, and Southeast Asia. The patient-centered clinical method now forms the basis of many educational curricula internationally, at both the undergraduate and the graduate level (Stewart & Ryan, 2012). Furthermore, the patient-centered clinical method serves as the guide for the summative evaluation of postgraduate training in several countries (Brown et al., 1996; Tate et al., 1999). Research, focusing on the patient-centered clinical method, has exploded in the past decade. International studies reinforce not only the patients’ desire for, and satisfaction with, patient-centered care but also the positive impact of such care on patient outcomes, health care utilization, and costs of care (Dwamena et al., 2012; Epstein, 2005b; Stewart et al., 2011). These studies support an emerging international definition of patient-centered care.

There is still much work to be done! The current context of health care sometimes discourages patient-centered practice. For example, a recent study by Neumann et al. (2011) has found that empathy declines over the years of medical education. Those of us who had hoped that such findings were a thing of the past have had a wake-up call. Further, Cassell (2013: xii) says we “still do not know how to do it nor how to teach it.” It has been 10 years since the second edition of this book. Our hope, in launching this third edition, is
that it will aid those engaged in improving care through the patient-centered clinical method, by providing constructive information and encouragement.

THE PATIENT-CENTERED CLINICAL METHOD

The Department of Family Medicine at Western University, Ontario, Canada, began work on the patient-doctor relationship at its inception with the arrival in 1968 of the inaugural Chairperson, Dr Ian R McWhinney. His work elucidating the “real reason” the patient presented to the doctor (McWhinney, 1972) set the stage for explorations of the breadth of all patient problems, whether physical, social, or psychological, and depth, the meaning of the patient’s presentation. The research of his PhD student Moira Stewart was guided by these interests and began to focus on the patient-physician relationship (Stewart et al., 1975, 1979; Stewart & Buck, 1977). In 1982, Dr Joseph Levenstein, a visiting professor of family medicine from South Africa, shared with us his attempts to develop a model of practice and stimulated the department. The patient-centered clinical method evolved further through the work of the Patient-Doctor Communication Group at Western University.

In this book the patient-centered model and method is described and explained. A program of conceptual development, education, and research, which has been underway for the last 3 decades, provides the material. Although the program took place in the context of family medicine, its messages are relevant to all disciplines of medicine and to other health care professions, such as nursing, social work, physiotherapy, and occupational therapy. The overarching framework is the model. The way of implementing the framework reflects the clinical method. This book presents both a framework and its implementation, the patient-centered clinical method.

Patient-centered care presupposes several changes in the mindset of the clinician. First, the hierarchical notion of the professional being in charge and the patient being passive does not hold here. To be patient-centered, the practitioner must be able to empower the patient and share the power in the relationship, and this means renouncing control that traditionally has been in the hands of the professional. This is the moral imperative of patient-centered practice. In making this shift in values, the practitioner will experience the new direction the relationship can take when power is shared. Second, maintaining an exclusively objective stance in relation to patients produces an unacceptable insensitivity to human suffering. To be patient-centered requires a balance between the subjective and the objective, a bringing together of the mind and the body.
We have changed the conceptual framework and hence the diagram in significant ways since the first edition of this book. First, there are now four components, not six. The previous component “Being Realistic” was thought to be not so much a component as a comment on the context within which the patient-centered clinical method is enacted. The issues considered as part of “Being Realistic” – time and teamwork – are handled in other, later chapters. As well, the previous component “Incorporating Prevention and Health Promotion” was always conceived as occurring as part of the processes within the other components. Therefore, we have incorporated prevention and health.

**FIGURE 1.1** Exploring health, disease, and the illness experience
promotion as a portion within the chapters on each of the four remaining components.

We incorporated health promotion within Component 1. Health promotion conducted in interactions between patients and clinicians includes exploring the patient’s perceptions and experience of health. Its incorporation into Component 1 has the added advantage of making explicit that part of the dialogue between patient and clinician that focuses on the patient’s health and strengths. In addition to the explicit focus on a patient’s function, which has always been an integral part of the patient’s illness experience (in the patient-centered conceptual framework, the four dimensions of the illness experience are feelings, ideas, function, and expectations), the new attention to health (strengths and resilience) strengthens care designed for persons over a lifetime. It aligns with literature in nursing on health promotion and resilience; with literature in occupational and physical therapy highlighting functional strengths, not only functional deficits; and, finally, with new literature on the nature of healing that balances and integrates a patient’s function, strengths, and disease into one vision of healing (Cassell, 2013).

Reflecting these considerations, Component 1 is now called “Exploring Health, Disease, and the Illness Experience.” As well, the diagram depicting Component 1 has changed (see Figure 1.1), now having three intersecting circles (one for health, one for disease, and one for the patient’s illness experience). Most important of all is the bottom of the new diagram, which stresses the integration of the relevant aspects of health, disease, and illness experience into a synthesis completely unique for each patient. This integration has always been part of our diagram but it has not always been stressed as much as it will be in the chapters of this current book. We have increased this emphasis here in order to underline that health care does not have two or three goals (such as treating diseases, assisting in mobilizing strengths, or caring for the patient) but, rather, one overarching goal, the holistic health of the patient.

Returning for a moment to the way we have incorporated prevention and health promotion into the remaining four components of the patient-centered clinical method, we included the one-on-one health promotion in Component 1 because it focused on exploring the dimensions of health with the patient. The activities of health education and disease prevention, being actions not explorations, are included in Component 3, “Finding Common Ground.”

In this book, therefore, we describe the four interacting components of the patient-centered clinical method, summarized in Box 1.1 and illustrated in Figure 1.2.
Box 1.1 The Four Interactive Components of the Patient-Centered Clinical Method

1. Exploring Health, Disease, and the Illness Experience:
   - unique perceptions and experience of health (meaning and aspirations)
   - history, physical, lab
   - dimensions of the illness experience (feelings, ideas, effects on function and expectations).

2. Understanding the Whole Person:
   - the person (e.g., life history, personal and developmental issues)
   - the proximal context (e.g., family, employment, social support)
   - the distal context (e.g., culture, community, ecosystem).

3. Finding Common Ground:
   - problems and priorities
   - goals of treatment and/or management
   - roles of patient and doctor.

4. Enhancing the Patient-Clinician Relationship:
   - compassion and empathy
   - power
   - healing and hope
   - self-awareness and practical wisdom
   - transference and countertransference.

The first three interactive components encompass the interactions between patient and doctor. The fourth component focuses on the ongoing relationship that forms the foundation on which the interactions occur. Although components are used for ease in teaching and research, patient-centered clinical practice is a holistic concept in which components interact and unite in a unique way in each patient-clinician encounter.

The goal of the first component of the patient-centered clinical method is to explore disease and patients’ perceptions of health and illness. In addition to assessing the disease process by history and physical examination, the clinician actively seeks to enter into the patient’s world to understand both the perceptions of health (its meaning to the patient and his or her aspirations or life goals) and the unique experience of illness (the patient’s feelings about being ill, his or her ideas about the illness, how the illness is affecting his or her functioning, and, lastly, what he or she expects from the clinician).

The second component is the integration of these concepts (health, disease,
and illness) with an understanding of the whole person. This includes an awareness of the multiple aspects of the patient’s life, such as personality, developmental history, life cycle issues, and the multiple contexts in which he or she lives.

The mutual task of finding common ground between patient and clinician is the *third* component of the method and focuses on three key areas: defining the problem, establishing the goals of treatment, and identifying the roles to be assumed by patient and clinician.

The *fourth* component emphasizes that each contact with the patient should be used to build on the patient-clinician relationship by including compassion, empathy, a sharing of power, healing, and hope. To enact these skills requires both mindfulness and practical wisdom, as well as an appreciation of unconscious aspects of the relationship such as transference and countertransference.

**THE PATIENT-CENTERED CLINICAL METHOD IN RELATION TO OTHER MODELS OF PRACTICE**

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; and 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 those aspects of a situation that are most important for understanding and effective action. The dominant model in medical practice has been labeled “the conventional medical model.” No one would question the widespread influence of the conventional medical model, but it has often been challenged for oversimplifying the problems of sickness (Reiser, 2009; Schleifer & Vannatta, 2013). Engel (1977: 130) describes 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 behavior, it also demands that behavioral aberrations be explained on the basis of disordered somatic (biochemical or neurophysiological) processes.

Balint and colleagues (Balint et al., 1970; Hopkins & Balint Society, 1972) introduced the term “patient-centered medicine” and 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.” Stevens (1974) and Tait (1979) elaborated the clinical method. 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 a doctor- and patient-centered approach to care.

The patient-centered clinical method we describe joins the work of Rogers (1951) on client-centered counseling, Balint (1957) on person-centered medicine, Newman and Young (1972) on the total person approach to patient problems in nursing, and the “Two-Body Practice” in occupational therapy (Mattingly & Fleming, 1994). In addition, there are strong similarities between our work and that of Pendleton et al. (2003), who defined, independently, a similar model of practice. Their approach of defining their model as a set of tasks for the physician to perform in the consultation appealed to us and we incorporated this idea into our own model. We refer to the elements of our method as components, rather than tasks, to avoid the misconception
that the method is a rigid, linear technique. The practice of medicine cannot be reduced to technique but rather is embedded in a way of thinking about the clinical tasks of medicine that need to be explained clearly and pragmatically (White, 1988).

Epstein et al. (1993) have described, compared, and contrasted a number of approaches to patient-doctor communication, including the biopsychosocial model (Engel, 1977; Frankel et al., 2003), the three-function model (Cole & Bird, 2009), the family systems approach to patient care (Doherty & Baird, 1987; McDaniel et al., 2005), physician self-awareness (Balint, 1957), and the patient-centered clinical method presented in this book. Epstein et al. (1993: 386) conclude that “on a theoretical level, the complementarity of the approaches is more powerful than their difference.” In our view, where they are similar is in their attempt to broaden the conventional medical approach to include psychosocial issues, the family, and the clinician him- or herself.

Two other frameworks for improving care and education have become prominent in the past decade and can be compared and contrasted with the patient-centered clinical method: shared decision making and narrative medicine.

The central tenet of the shared decision-making framework is that power must be more equally shared between patient and practitioner, and we agree (Légaré et al., 2003, 2010; Elwyn et al., 2012; Stiggelbout et al., 2012). Shared decision making and the patient-centered clinical method are most aligned in Component 3, “Finding Common Ground.” The approaches are most different in the following three aspects. First, the patient-centered clinical method stresses an emotional engagement with the patient that goes beyond sharing information about experiences, beliefs, and values. Second, the patient-centered clinical method stresses the need for a unique approach to each patient, and even each visit with each patient, using the structure as a guide only, with the main injunction being to follow the patient’s lead. The shared decision-making approach, while similar in its attempt to balance the formulaic and the idiosyncratic, has chosen a more standardized approach. Further, its goal is to increase shared decision making. Third, the patient-centered clinical method seeks to integrate its approach into clinical practice, hence its name as a clinical method.

Narrative medicine, in common with the patient-centered clinical method, stresses the patient’s particular story (Components 1 and 2 of the patient-centered clinical method) revealed in the context of an ongoing patient-practitioner relationship (Charon, 2006; Launer, 2002). The two approaches also seek to enhance the clinician’s comfort in engaging patients at
an emotional level. Narrative medicine in Component 3, “Finding Common Ground,” is a process of the patient and clinician co-constructing the patient’s story to promote both understanding and change. One difference is that narrative medicine separates itself from the tasks of conventional medicine, in contrast to the patient-centered clinical method, which attempts to integrate its work with the medical tasks.

These models in general, and the patient-centered clinical method in particular, set out to make the implicit in patient care explicit. While models help clarify the basics, they never completely capture what happens in reality. The tacit knowledge of the doctor and patient are not captured in the models, which are, by definition, oversimplifications. Stewart (2001: 445) stated that while models do help in teaching and research they “fail to capture the indivisible whole of a healing relationship.”

VALUE OF THE PATIENT-CENTERED CLINICAL METHOD

In order to convince colleagues, education committees, and policy-makers of the value of transitioning to a patient-centered approach, one needs to be able to answer the essential questions: Does it work? Do patients want it, and why? Is it more costly?

The series of studies by Little et al. (2001a) in the United Kingdom indicate that, whereas only a minority of patients want an X-ray or medication, more than 75% of patients want the elements of a patient-centered approach. Furthermore, the patients wanted all components of patient-centeredness.

We do not find this surprising, given the following data. Recent studies show that adult patients come for medical care with not one condition but multiple conditions at the same time. A focus on one disease will not satisfy these patients. Twenty-three percent of all adult patients have two or more chronic conditions, and of the 65-year-old patients more than 65% have two or more chronic conditions (Barnett et al., 2012). Furthermore, this is only part of the picture – one must add acute conditions. Also, until recently we have not known how frequently patients express their illness experience in their medical visits; such expressions are remarkably common. Figure 1.3 shows that 89% of adult patients expressed ideas about their problems; 72% expressed an expectation about their care; 57% expressed problems with functioning; 55% expressed family, life cycle, or context issues; and 42% expressed concerns, fears, or anger (data from the study called Patient-Centered Care and Outcomes). With this complex of issues being present at each visit with a health professional, a single disease focus will not likely meet the patients’ needs.
Does patient-centered medicine work? What evidence is there that it positively affects important outcomes? In our view, this is one of the great strides that has been made over the last decade. Chapter 16 shows that the results of several key systematic reviews are very positive. Education interventions to improve patient-centered practice are effective in changing physician behavior. Such interventions are also having more of an impact on patient health outcomes than was the case with previous systematic reviews.

In the context of severe economic restraint, health care costs are an overriding concern for health care managers and policy-makers. Chapter 14 provides Canadian data on patient-centered care in relation to health care costs; as well, there are US data to demonstrate that patient-centered care results in lower costs for diagnostic tests and subsequent use of services (Epstein et al., 2005b).
INTRODUCTION

CHALLENGES TO THE PATIENT-CENTERED CLINICAL METHOD IN THE TWENTY-FIRST CENTURY: THE NEW CONTEXT OF CARE

There are a remarkable number of changes in our society that challenge the practice of patient-centered care. However, some changes can improve the interaction between patients and doctors – for example, emphasis on patient autonomy, interest in ethnic diversity, and increased attention by the public on prevention and health promotion activities. These changes enhance the abilities of patients to become more involved in their own health care.

Paradoxically, being patient-centered actually saves costs to the system, as is shown in Chapter 15; however, this news is not widely known and may not feel like good news for a clinician feeling conflicted between the patient’s expressed expectations and his or her need to contain costs.

An emerging trend of decreasing continuity of care, because of pressure either from overworked clinicians or from policy-makers, is likely to be deleterious to the future of patient-centered care. The positive outcomes of continuity of care are well known (Freeman, 2012) and it is a key prerequisite to patient-centered care.

Two aspects of the pervasiveness of information technology may have varied effects on patient-centered care. One is the empowering of patients to learn, in advance of coming to a health professional, about their symptom or condition. Practitioners can consider this a distraction and a time-consuming issue, but it can be reframed as a positive experience. The patient is certainly engaged and ready to learn. The Internet information brought by patients to their practitioners is a new kind of cue that sheds light on the level of the patients’ concerns and expectations. Using this information can be a mutual learning experience.

The second aspect of information technology is the use of electronic medical records (EMRs), which has been shown to have some negative effects on the interaction of patients with their health care professionals (Margalit et al., 2006; Noordman et al., 2010). Lown and Rodriguez (2012: 392) suggest that EMRs introduce a “third party” into exam room interactions that competes with the patient for clinicians’ attention, affects clinicians’ capacity to be fully present, and alters the nature of communication, relationships, and physicians’ sense of professional role. Screen-driven communication inhibits patients’ narratives and diminishes clinicians’ responses to patients’ cues about psychosocial issues and emotional concerns.
On the other hand, other authors have pointed out improvements in screening for health risks using EMRs (Adams et al., 2003) and better information exchange by being able to show the patient graphs or test results (Shachak & Reis, 2009).

Doctors are being directed to follow a plethora of clinical practice guidelines, with more being produced every day. This can be overwhelming, and particularly daunting, when the guidelines are unclear because of insufficient evidence, and at worst conflicting when two or more respected organizations produce differing guidelines. However, guidelines are just guidelines and their application must be geared to the individual needs and context of each particular patient. This is where being patient-centered can be extremely useful (Tudiver et al., 2001). The balance between patient-centered medicine and evidence-based medicine is also explored in the next section.

EVIDENCE-BASED MEDICINE AND THE PATIENT-CENTERED CLINICAL METHOD: THE CONFLUENCE OF TWO WORLDVIEWS

On superficial examination of the current literature of evidence-based medicine and the approach described in this book as the patient-centered clinical method, some could conclude that the two are in conflict with each other. This view is sometimes further simplified by saying that evidence-based medicine represents the “hard science” of medicine and the patient-centered clinical method is the “soft” side of it. This is to misrepresent both evidence-based medicine and the patient-centered clinical method, which, in truth, have significant areas of confluence.

The early writings describing evidence-based medicine make clear that it is not intended to replace clinical judgment. Clinical decision making is described as taking into account three elements: the evidence, patient particulars, and patient preference (Haynes et al., 2002; Sackett et al., 2000). Evidence-based medicine has made tremendous strides in describing and putting into practice a method for acquiring the best available evidence about an issue in health care. The concurrent improvements in electronic databases and retrieval systems make it possible to access this information at the site of care and to integrate with the EMR. Evidence-based medicine is, in essence, a robust and extremely useful method for framing questions and evaluating evidence. It is not itself a clinical method, although it does inform the clinician.

Research on the patient-centered clinical method has made clear that finding common ground between both the physician’s and the patient’s perspective is key to a successful clinical outcome. Evidence-based medicine assists the
physician in determining what elements might be appropriate for a part of the physician’s perspective. It is not a substitute for clinical judgment or clinical intuition, which arises out of a specific interaction between a particular patient and a particular clinician. The patient-centered clinical method describes a method for ensuring that the patient’s particulars and preferences are taken into account and an agreed plan arrived at. From this vantage point, the patient-centered clinical method incorporates or subsumes evidence-based medicine.

One could look at this in another way, however. It is increasingly apparent that the patient-centered clinical method is itself evidence-based. Taking into account the illness experience, the person and the context and arriving at common ground have together been demonstrated to improve patient health outcomes, patient satisfaction, and physician satisfaction. This burgeoning literature detailing the evidence to support this clinical method is covered in Chapter 16.

In summary, evidence-based medicine and the patient-centered clinical method are not ideas in conflict; rather, they are synergistic. The field of action between them is best understood as one of creative tension. Complexity science (Plsek & Greenhalgh, 2001: 627) calls the “edge of chaos” those circumstances in which there is “insufficient agreement and certainty to make the next choice obvious, but not so much disagreement and uncertainty that the system is thrown into chaos.” This calls for complex adaptive behavior. Such areas of human interaction are the genesis of humane moral action from which arises true value. The patient-centered clinical method explicitly addresses this domain.

COMMON MISCONCEPTIONS ABOUT THE PATIENT-CENTERED CLINICAL METHOD

Over the last 30 years, as the patient-centered clinical method has been disseminated to students, clinicians, educators, and researchers, we have observed many misconceptions about the model. These misconceptions have concluded that being patient-centered takes more time; it focuses primarily on the patients’ psychosocial issues versus their diseases; it requires acquiescing to patients’ demands; it means being rigid and following a standard approach; it expects sharing all information and all decisions with patients; and, finally, that the patient-centered clinical method is a set of tasks that do not need to be applied during each visit but, rather, that can be cherry-picked – that is, some used or some discarded.
In addition, the acronym FIFE (feelings, ideas, function, and expectations) can be very useful for students as they are learning to inquire about the patient’s illness experience. However, it can also be dangerous if it becomes an appendage to the conventional review of systems: “Any visual problems – blurred vision . . .?” “What do you feel about this?” “How are your bowels – any constipation; diarrhea . . .?” “Any ideas about what is causing this?” Thus “FIFEing” the patient, as we have heard students remark, becomes just another interviewing technique or an additional step in their review of systems and does not reflect a genuine interest in and concern about the patient’s unique illness experience and does not encourage attentive listening.

Having said that, sometimes patients’ expectations are very clear and straightforward. They want treatment for their athlete’s foot or completion of a medical form for insurance purposes. Thus it is not always essential to explore, in depth, the patient’s perceptions of health or his or her illness experience. What is essential is that doctors listen to patients’ cues and prompts in order to make appropriate and sensitive inquiries. In a similar vein, being patient-centered means taking into account the patient’s desire for information and for sharing decision making and responding appropriately.

The notion that patient-centeredness recommends a single style of practice is worrisome (Lussier & Richard, 2008). We find it difficult to present a diagram and an approach and, at the same time, avoid giving the impression that a standard approach is recommended. Nonetheless, a standard approach is not recommended; rather, the diagrams are a guide and the goal is different conversations with different patients.

The argument that a physician does not need to be patient-centered in all visits – for example, when a patient presents a straightforward problem – is supported by the description of visits as falling into types: routines, rituals, or dramas (Miller, 1992). Arguing in favor of the view that doctors are not patient-centered all the time is our own result that doctors with low average scores on patient-centeredness show small standard deviations for these scores, perhaps revealing a more rigid and inflexible approach. However high-scoring doctors show wide standard deviations, suggesting a flexibility in their clinical approach. Nonetheless, our contention is that physicians do not know whether the visit ought to be routine, a ritual, or a drama, unless they are patient-centered and ask brief and appropriate questions at the beginning of the visit. A brief patient–doctor dialog about a minor sore throat serves as an example.

Doctor: (While reaching for a tongue depressor) Is there anything unusually worrying about this sore throat?
Patient: No. (Pause)
Doctor: Do you think this is anything out of the ordinary?
Patient: No . . . I don’t think so.
Doctor: Anything else going on in your life that you want to tell me about today?
Patient: No. Things are great!

Only after such a 5-second interchange can a doctor be sure that this visit is going to be routine as opposed to a drama.

CONCLUSION
In this introductory chapter we have provided a historical perspective of the evolution of the patient-centered model, and of the clinical method that serves to implement the theoretical framework. The place of the patient-centered model and clinical method was examined in relation to other models of practice and current trends in health care. This chapter has briefly provided empirical evidence supporting the adoption of the patient-centered clinical method. In the final sections, challenges in practicing the patient-centered clinical method in the current context were explored, with attention given to some common misconceptions about the patient-centered clinical method.


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