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Why we need a new clinical method

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The clinical method that has served us well for over a century is reaching the end of its useful life. This is tacitly acknowledged by the widespread attempts to improve communication by teaching interviewing skills. I do not think, however, that the problems will be solved simply by improving our interviewing skills – important as that is. The problem is more deep seated than that: it requires a change in the context in which the skills are used.

What must come about, I think, is the biggest transformation of medical thought since the 19th century. The transformation involves four changes:

1. A re-definition of the clinical task;
2. A new perception of the meaning of illness;
3. A re-definition of medical knowledge;
4. A change in the way physicians perceive themselves.

The origins of our clinical method

The method originated in France at the turn of the 19th century. Up to that time, medicine lacked a clinical method and a nosology that were universally accepted as useful. Sydenham (1), it is true, had demonstrated the predictive power of a nosology based on observations of the natural history of disease; however, the nosologies of his 18th century successors did not have this power; they were "uncorrelated catalogues of clinical manifestations... lacking the prognostic or anatomic significance that would make the results practical or useful" (2).

All this changed in early 19th century France when clinicians began to turn their attention to the physical examination of the patient. New instruments such as the Laennec stethoscope revealed a new range of clinical information. At the same time, clinicians began to examine the internal organs after death and to correlate physical signs with postmortem appearances. According to Foucault, "the constitution of pathological anatomy at the period when the clinicians were defining their method is no mere coincidence: the balance of experience required that the gaze directed on the individual and the language of description should rest upon the stable, visible, legible basis of death" (3). The result was a radically new classification of disease based on morbid anatomy, far more powerful than the nosologies of the 18th century. English physicians, who had displayed little enthusiasm for the botanical classifications of the 18th century, became so convinced by the French clinico-pathologists that, according to Crookshank, "to interpret in terms of specific diseases [became] almost the only duty of the diagnostician" (4).

This change was not merely an advance in medical knowledge; it was a change in the way sick people were perceived. The change involved "a reorganization of the elements that make up the pathological phenomenon (a grammar of signs has replaced a botany of symptoms), a definition of a linear series of morbid events (as opposed to the table of

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On September 2, 1991, Professor Ian R. McWhinney was given the degree of Doctor Honoris Causa at the University of Oslo.
In connection with this very special event, the Department of General Practice, Oslo, held a seminar at which Ian McWhinney gave the following address.

nosological species), a welding of the disease on to the organism" (3). The transformation was the beginning of the modern era in medicine. Certain social changes were necessary for it to become possible: "a reorganization of the hospital field, a new definition of the status of the patient in society, and the establishment of a certain relationship between public assistance and medical experience, between help and knowledge". The reorganization of hospitals and medical schools in the wake of the French Revolution prepared the ground for "a mutation in medical knowledge" (3).

The emergence of the clinical method we know today has been described by Tait (5), who studied the archives of the clinical records of St. Bartholomew's Hospital in London, England. In the early 19th century, case notes were an unstructured account of the patient's complaints and the physician's superficial observations. By the 1830's the stethoscope was being used, and notes on physical signs in the chest began to appear. The first part of the record to gain a regular structure, around 1850, was the postmortem report. By 1880 the structured method for recording the results of history-taking and physical examination had begun to resemble its modern form. Thus, the process that had begun in late 18th century France culminated a century later in a fully defined clinical method.

Advances in investigative technology have greatly increased the precision of the method, and advances in microbiology, physiology, and biochemistry have increased the method's power to make causal inferences. The method's aim, however, is still to interpret symptoms and signs in terms of physical pathologic findings. This is both its greatest strength and its severest limitation.

Strengths of the method

The method which emerged towards the end of the 19th century had four great strengths. It had great predictive power. In this it far surpassed any of its predecessors, paving the way for the technological innovations of the 20th century. It simplified a very complex process: provided a framework and structure where previously there had been none. It gave the clinician a clear injunction: "Take the history and conduct the examination and investigation in this way and you will either arrive at a diagnosis or exclude pathological change". Finally, it provided criteria for validation. The pathologist told the clinician whether his diagnosis was right or wrong.

Weaknesses of the method

At the same time it had four weaknesses. At first, these were not obvious, but have become more and more apparent with the passage of time. It dealt with abstractions we call diseases. These are very powerful abstractions – the method depends on them – but they are far removed from the experience of the patient. The method aimed to understand the meaning of the illness on only one level – the level of physical pathology. It excluded from consideration its personal meaning for the patient. It excluded the subjective experience of patients: their fears, beliefs, perceptions, expectations, feelings; and it excluded the subjectivity of the physician who is assumed to be a detached observer.

The method was a true product of the Enlightenment: thoroughly rational and objective in intent, if not always in practice.

Why weaknesses are now becoming apparent

For a time, this clinical method seemed to work very well. It certainly dominated medicine at the time when I was a student in the 1940's. It went something like this. The method either produced a clinico-pathological diagnosis or excluded one, in which case the illness was called "functional". It was tacitly agreed that "functional" was equivalent to "psychogenic". In keeping with the mind/body dichotomy, diseases were divided into organic and psychogenic, with an intermediate category called psychosomatic. It was considered desirable to explain all the patient's symptoms with one diagnosis. The division between mind and body became institutionalized in medicine by the separate development of internal medicine and psychiatry.

As the years have passed, however, this method has become less and less appropriate for the clinical task. I believe there are several reasons for this. There are so many illnesses in which the personal experience of patients, especially their ability to function in their environment, is as important, if not more important, than the clinical diagnosis: for example, chronic disease, chronic symptoms without physical pathology, and problems of the aged.

Technology has given us so many new diagnostic tests, some of them risky and uncomfortable, that we are often faced with a conflict between two values: diagnostic precision and patient welfare. There is a temptation to do *one more test* when what is needed is a better understanding of the patient.

The discomforts of modern therapy also make it especially important to know the patient's expectations and feelings.

On the societal level there is an increasing resistance to accepting the authority of the professions or to tolerating impersonal service. It is a paradox that this has developed at a time when medicine has never been more technically successful. Finally, the increasing mechanization of medicine has tended to direct the attention of physicians away from patients towards the machines and their outputs.

The increasing mismatch between our clinical method and public expectations is evident in the public dissatisfaction with our performance. Books and articles by patients and their families are appearing, many of them highly critical of the care they have received. Litigation is increasing, and more people are turning to alternative medicine.

A reformed clinical method

The key problem with our clinical method is that it is doctor-centred. Its purpose is to interpret the patient's illness in terms of the physician's frame of reference – an interpretation which often bears little relation to the patient's actual experience. The process is dominated and controlled by the doctor. In a study of primary care internists in Detroit, the average time between the beginning of the interview and the doctor interrupting and taking over control was 18 seconds (6).

What are the requirements of a patient-centred clinical method? First, an understanding of the meaning of the illness for the patient should be as important for the physician as reaching a clinical diagnosis. Second, to attain this, the process must allow expression of feeling by the patient. The desired outcome is a common understanding, an agreement between doctor and patient about the meaning of the illness at all levels, from the microbiological to the personal and social. Of course, this outcome may not be possible, at least in the short term. The doctor and patient may see each other's interpretation of the illness as wrong and there may be no common ground or room for reconciliation. The patient may want something the doctor is not prepared to give – a prescription for a narcotic for example. However, if both have had an opportunity to express themselves, at least the disagreement is open rather than hidden. In general practice, one consultation is a small episode in a continuing relationship. As we all know, mutual understanding often takes time to grow.

How can we develop a reformed clinical method which will have the same strengths as the traditional method: simplicity, a clear injunction, and criteria for validation? Let me give you our answer to this:

1. At every consultation the doctor should ascertain the patient's understanding of the illness, his feelings about it, especially his fears, its impact on his life, and his expectations about the outcome and about treatment.
2. The doctor should attempt to find a common ground of understanding with the patient.
3. Validation is provided by the patient, who says whether or not they have been given the opportunity to express themselves and whether the doctor has understood them.

These, in brief, are the injunctions and the ultimate validation criteria. They do not tell the physician how to achieve these objectives, any more than the traditional method told the physician how to feel for an enlarged spleen. These are skills that have to be acquired, and the key skill for the patient-centred method is that of active listening. I will return to this later, but let me just make the point here that it is not simply a matter of learning a technique. Becoming an active listener requires a personal change on the part of the physician.

Now I want to turn to the question: does the patient-centred method work? Is it effective and is it efficient?

Outcome studies of the patient-centred method

The ultimate test of a clinical method is whether or not it helps people to recover from illness. We already have some evidence that indicators and measures of "patient-centredness" are associated with recovery from headache (7), and from undifferentiated symptoms (8), and with better control of diabetes and hypertension (9). Patient centredness is also related to greater patient satisfaction and reduced concern about the presenting problem (10).

Is it efficient?

Whenever the patient-centred method is discussed by family physicians, the question of time is always raised: "Does it not take a lot more time to practice in this way?" The evidence we have so far is that a patient-centred consultation is, on the average, very little longer than a doctor-centred one. One rather paradoxical finding has been that the longest consul-

tations were those in between. It is interesting to speculate on why this might be so. My own view is that being patient-centred should be more efficient in the long run, even if it takes more time at the earlier visits. The earlier one is able to reach an understanding of the patient, and *with* the patient, the less likely is one to follow false trails.

Why this is a revolution

Let me now return to my first theme of the magnitude of this transformation. I mentioned four changes. The clinical task is no longer only to make a diagnosis of a disease, but to understand a patient's individual experience of illness. How much we are failing to do this is described in many recent narratives of illness, for example, Arthur Frank's "At the Will of the Body" (11). This involves a new perception of the meaning of illness: an existential as well as a mechanistic meaning. It follows that we have to redefine medical knowledge. We have to learn about the experience of illness as well as about its mechanism. This involves listening to our patients and researching the response of people to trauma, challenge, illness, and disability. This has as much to do with health as it has to do with disease. None of us can avoid challenge, traumas, and disabilities. Health is a measure of how we respond to these challenges. Learning about how people in general respond can help us to imagine the experience our patients are living through, always recognizing that each one responds in his or her own way.

Finally it involves a change in the way we perceive ourselves. The old method protected us – set up a barrier between doctor and patient. We were even told: "Don't get involved." But no one was ever healed by an uninvolved physician. The question is, how to become involved? There are right and wrong ways. Psychoanalysis has taught us about the risks involved in transference and counter-transference. We have tended not to use these terms in general medicine, but they are part of all continuing doctor-patient relationships, especially in general practice. Avoiding the traps of involvement – of filling our own needs through our patients – requires self-knowledge. It can never be only a matter of technique. Encouraging patients to express themselves may also expose us to some very disturbing feelings. We have to learn how to deal with these. Avoidance is no longer acceptable.

This brings me back to the question of active listening. I believe this is the essential quality required for the practice of patient-centred medicine. There is all the difference in the world between active and passive listening. In active listening, we are listening to the other person with intense concentration and total attention. We are listening not only to the literal meaning of their words, but their expressive meaning. Active listening is a discipline: a discipline of the body as well as the mind. One can tell by their posture whether a person is listening actively. It involves responding actively too, in ways that will unlock the gates of expression. Kirsti Malterud (12) has written with much insight about this in her work on doctor-patient communication. Techniques can help us in this, and she has demonstrated how key questions can help to unlock the gates. We should all examine our techniques, and develop questions which have this power for us.

Learning to practice patient-centred medicine is a process that changes us. One of the things that convinces me of its rightness is the number of doctors who have told me how practice has taken on new meaning for them since they started to work in this way. When I spoke about this three years ago, a student asked me if I thought practising in this way – since it exposes one's vulnerability – would lead to "burn-out". My response was that the opposite is true. It is the medicine of detachment, defensiveness, and suppression of feeling that more often leads to alienation and exhaustion.

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