Reflections on the doctor–patient relationship:
from evidence and experience

Moira Stewart

INTRODUCTION

As an epidemiologist/researcher in a Department of Family Medicine, I have been privileged to work beside GPs for 25 years. In the research that I do on doctor–patient relationships, quality of care, clinical outcomes and integrated health services research, I have witnessed magical moments in clinical encounters of patients with GPs, witnessed the mystery of general practice, and witnessed patients' evolution from health to illness and back. I have observed countless times how doctors help patients put the fragments of their lives back together into a whole.

Having watched whole-person medical practice, I have thought about the various elements that it requires. One is an openness on the part of the doctor to learning about all of the dimensions of a patient's problems. Another is a willingness to meet the patient at an emotional level, not only in order to have an understanding of the problems, but also to facilitate a healing of the whole person. I have learned, therefore, that this way of being a doctor requires engaging at both the cognitive level (the doctor will learn more about the patient), and the emotional level (the doctor will feel the patient's pain and suffering), but also tapping into a doctor's intuition, the creative side, which puts together complex webs of different types of information (cognitive, emotional and intuitive) into a new insight, not singly, but in communion with the patient.

The team of GPs with whom I work, believe that practising medicine that heals, encompasses a change of heart as well as a change of mind. These doctors began their enquiry into the essential features of such medical practice through observation, reflection and several years of teaching. It was the observation of patients and their responses that is similar to James Mackenzie's legacy. In the 19th century, Sir James Mackenzie made discoveries regarding pain and heart sounds based on meticulous and ongoing observations of his patients in general practice. Furthermore, Sir James Mackenzie was emotionally engaged with his patients. In the words of his biographer, he 'cared about his patients and suffered with them'.[1] As well, Sir James Mackenzie recognised the important contribution of the patients' context to their health and disease and was an advocate against the wrongs of industrialisation.

Throughout this lecture, I will be describing several 20th century discoveries in general practice based on the observations of GPs. My lecture is designed to appeal to the straightforward factual side of all of us (by presenting results of research designed to test the benefits of a more open relationship between doctors and patients) and, also, to appeal to the creative, intuitive side of us (by presenting stories, quotes and paintings illuminating doctor–patient relationships). I will be stressing the opportunities that GPs have, to focus intellect, intuition and advocacy in patient care. By the end I hope that the reader will feel validated, refreshed and inspired to continue the incredibly valuable work of general practice.

THE DOCTOR–PATIENT RELATIONSHIP IN AN INTEGRATED CLINICAL METHOD

Doctor–patient relationships evolve over time and are built on regular consultations as well as other shared experiences, such as childbirth, hospitalisations or home visits.[2] The goals of care at these encounters over time encompass the conventional goals of diagnosis and cure but also the broader goals of

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Box 1. The six interactive components of the patient-centred clinical method.[3]

- Exploring both disease and the patients' illness experience
- Understanding the whole person
- Finding common ground
- Incorporating prevention and health promotion
- Enhancing the patient-doctor relationship
- Being realistic

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Figure 1. Robert Pope's painting 'Sparrow'.

Figure 2. Robert Pope's painting 'Visitors'.

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support and healing. I contend that for both conventional goals and the broader goals, a reformulation of a time-honoured clinical method is necessary.

Described by a team of reflective GPs, the six components of the patient-centred clinical method are shown in Box 1.

To illuminate, in more detail, these six components I will quote both James Mackenzie and artist Robert Pope. A Canadian artist stricken with cancer, Pope represented his experience through paintings and prose.[4]

The first component of this clinical method suggests that the GP assess the two conceptualisations of ill health — disease and illness. That is, in addition to assessing the disease process by history and physical examination, the GP actively seeks to enter the patient's world to understand his or her unique experience of illness: the patient's feelings about being ill, their ideas about their illness, how the illness is impacting on their function and what they expect from the doctor.

Each person's illness experience is unique. Artist Robert Pope described his illness experience in his painting, *Sparrow* (Figure 1).

> *'One haunting memory of my illness is spring. From my window all I could see were the tops of horse-chestnut trees, covered with beautiful blossoms. These blossoms seemed to say to me all I was feeling. They became for me encouragement to persevere, a symbol of recovery. This image also shows the sparrow. I have tried to contrast a number of opposites: outside and inside, the horizontal man with the vertical bird and trees, passiveness and activity, illness and health. The man and the bird share the same vulnerability and strength.'*[4] (Page 37.)

The second component of the clinical method is the integration of these concepts of disease and illness with an understanding of the whole person in context, that is, an awareness of the multiple aspects of the patient's life such as personality, developmental history, life cycle issues, the proximal context, such as family, and the distal context, such as community and physical environment.

Sir James Mackenzie learned, according to his biographer, that:

> *'Signs and symptoms were certainly important, but they had to be interpreted against the wider back-cloth – of the patient as a person and his response to an environment of home and work, of climbing hills and stairs – the whole art and process of living. It was the whole man, then ... that had to be studied.'*[1]

Sir James Mackenzie integrated his broad understandings through the writing of two novels, the second of which chronicled, in Dickensian detail, the

dire poverty of urban Lancashire in the 1870s and 1880s. Called *Only a Working Lass* and later *Mary Helen* the novel followed the growth and development of Trade Unions.[1] Mackenzie's involvement in the creation of unions is a testament to his appreciation of the impact of the patients' context on their health and healthcare.

Pope's painting, *Visitors* (Figure 2) describes this second component of patient-centred medicine, understanding the whole person.

> *'As I began to heal, my art began to change. The fragmented views of isolated individuals … began to shift to a more holistic social vision. I began to include more people within the frame of the picture. This painting is like a psychological ecosystem, where the worlds of health and sick meet. The patient is seen in the context of his community. The focus is on the response of the patient's community which is both positive and negative. The emotions are varied, ranging from concern to indifference, from pessimism to support. Many of the people are brightly painted, like flowers. The image is framed by two opposing forces. On the right, the man aggressively gesturing downward can be interpreted as having a negative meaning. The gift of a book from the woman on the left can be seen as a positive gesture and, ultimately, a symbol of hope. The mood may be somber, but I feel this is an optimistic work, expressing faith in the continuity of our human community.'*[4] (page 64.)

The third component is a mutual task of doctor and patient, the task of finding common ground. This component has been found in our research to be the most important in predicting positive patient outcomes[5] and therefore now holds place of prominence as the central task of patient-centred medicine. It focuses on three key areas, the patient and doctor mutually: defining the problem; establishing the goals of treatment and/or management; and identifying the roles to be assumed by patient and doctor (Figure 3).

The fourth component highlights the importance of using each contact as an opportunity for prevention and health promotion. These activities may be as broad as the advocacy Sir James Mackenzie incorporated into his professional life. His biographer comments on Mackenzie's two influences:

> *'One medical and personal and the other social … one effort is directed solely toward the individual patient, while the other is concerned with stirring the public conscience.'*[1]

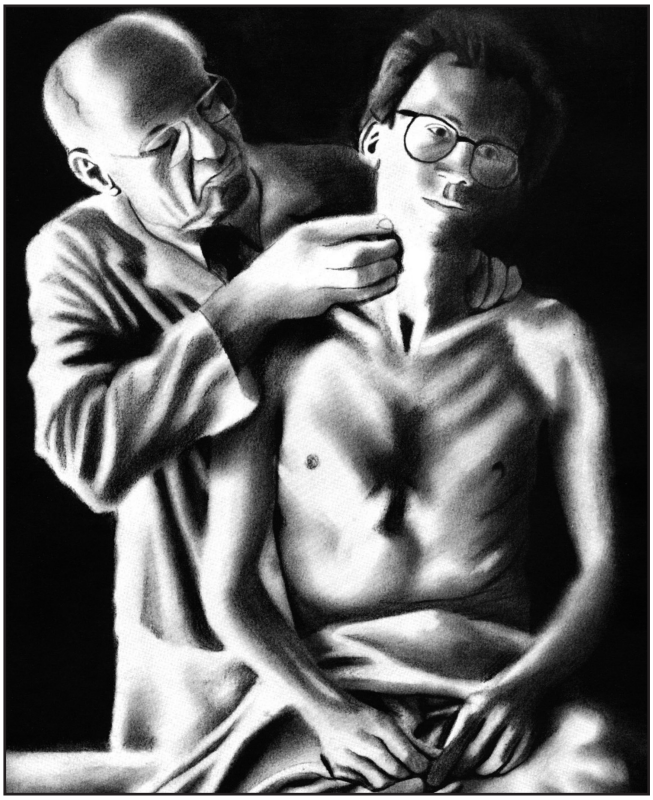

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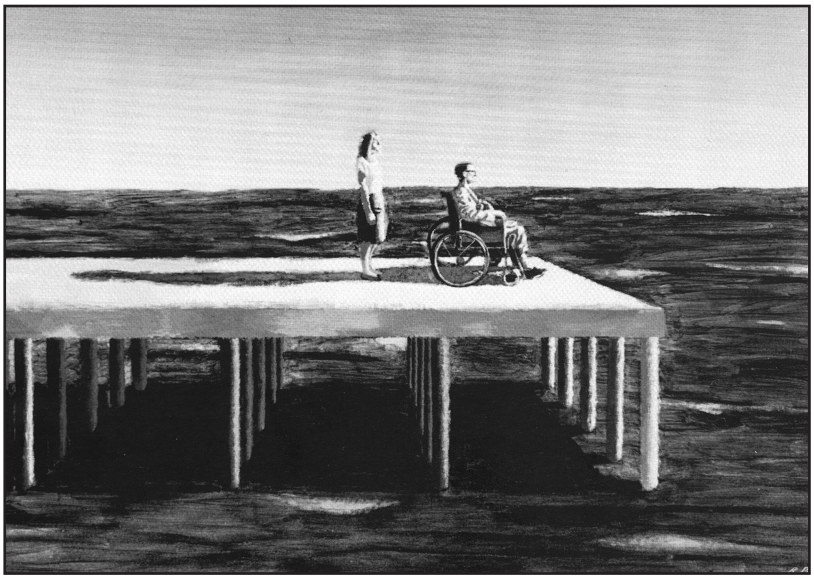
Figure 3. Robert Pope's painting 'Self portrait with Dr. Langley'.

When these activities of prevention and health promotion focus solely on one patient, they include immunisations and screening, but they also encourage self-confidence, self-healing and healthy practices as illustrated by Robert Pope's painting in Figure 4.

> *'The wharf becomes a stage. The man and his companion are … participants in a drama of healing.'*[4] (Page 130).

The fifth component is the use of each contact

Figure 4. Robert Pope's Painting 'Healing'.



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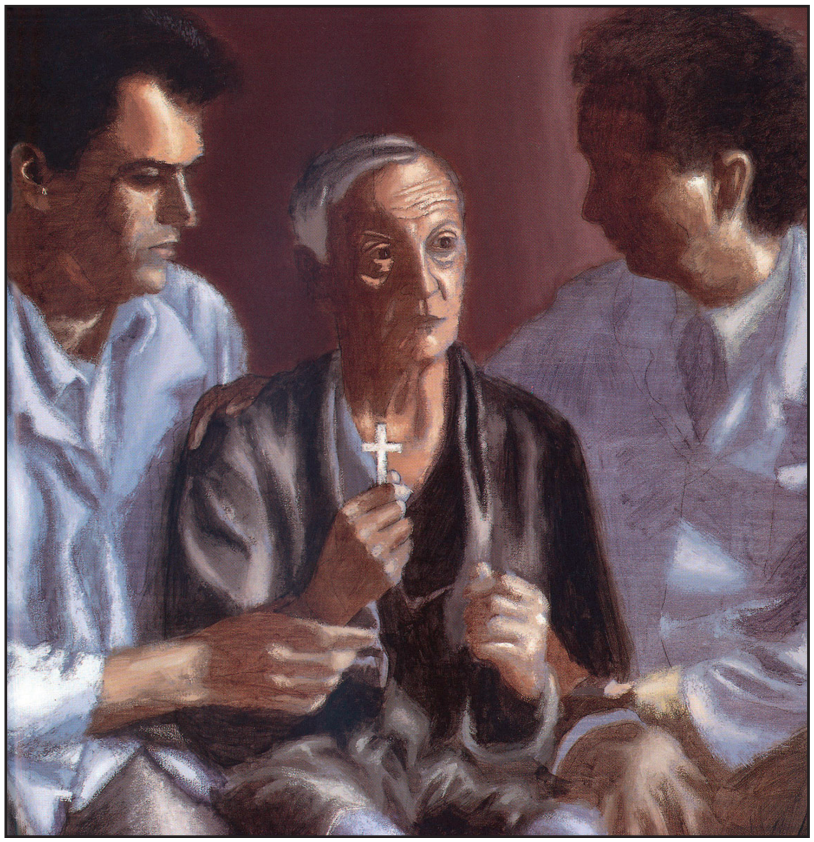

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Figure 5. Robert Pope's painting 'Mr. S is Told He Will Die'.

with the patient to build on the doctor–patient relationship and its dimensions of compassion, empathy, trust, spirituality and sharing of power. To accomplish these goals, requires self-awareness as well as an appreciation of the unconscious aspects of the relationship. Pope's painting shown in Figure 5 illustrates these concepts. This painting depicts a poignant moment when the patient is told, very gently, and with close and comforting touch that he is dying. The artist shows the patient's religiosity and the doctors' non-verbal gentle embrace.

What drove Sir James Mackenzie on?

> *'Perhaps the answer lay in a single word: compassion. Mackenzie cared about his patients and suffered with them.'*[1]

A colleague of Mackenzie's is quoted as saying: 'I never knew how far it was love of truth or how far love of humanity that quickened his spirit'.[1] He was extremely frustrated when science did not provide the tools to help patients.

The sixth component is being realistic, reminding practitioners that each of us has limitations and that time and teamwork can assist in the multifaceted work in general practice.

FROM MANY PERSPECTIVES, ONE IDEA

In my view it is remarkable that the same six components described are identified repeatedly from different perspectives. We have seen the perspective of the artist who is ill and of Sir James Mackenzie's biographer. Next, we will address three additional perspectives — the perspective of GPs, of patients and of research literature.

GPs reflecting on their practice in order to teach better created this description of the six components in the first place. In the 1980s Dr Joseph Levenstein from South Africa was challenged to provide an answer to a student who asked 'What do you do (when it goes well) with each patient?' He closely observed his practice by listening to 1000 audiotaped interviews, thereby discerning the crucial elements of the consultations that went well. His powerful use of intellect and intuition led to the idea that patient's feelings (especially fears) and expectations needed to be attended to. Following Levenstein's visiting professorship in our Department of Family Medicine at The University of Ontario, our department members reflected on their own practice, read widely[6–10] and then described the six components of patient-centred medicine.[3,11–15]

Having described the perspective of GPs reflecting on their practice, let us turn to the patient's perspective. Strong agreement exists between the definition of patient-centredness that arose independently from observation studies of patients in the UK and the components described above.[16] Little *et al*'s statistical factor analysis resulted in three factors: their first factor contained items on exploring the illness experience, which they called communication; their second factor focused on finding common ground, which they called partnership; and their third factor was on prevention and health promotion, which they called health promotion. Three items that did not load on any factor pertained to understanding the whole person. In summary, four of the six components were very similar.

Little *et al*'s[16,17] series of studies in the UK indicate that more than 75% of patients want a patient-centred approach. Furthermore, the skeptical authors asked the research question, 'Do patients want all components of patient-centredness?'. They found that patients highly valued all aspects of patient-centredness. Furthermore, research in Canada has shown that it is the patients' perception of the consultation that is related to a positive patient health outcome and efficiency of medical care.[5]

Let us turn to the perspective of research and consider the results of several decades of formal study of the effects of doctor–patient relationships on patient and practitioner outcomes as summarised in reviews by myself,[18] Griffin *et al*,[19] Di Blasi[20] and a Cochrane review.[21]

In general, positive relationships between a doctor and patient are beneficial to both the doctor and the patient. Benefits to doctors include higher doctor satisfaction,[22] better use of time[5,23–39] and fewer complaints from patients.[40–47]

Benefits to patients include higher patient satisfaction,[48–50] better patient adherence[51–67] and improved patient health.

The latter is what most people consider to be the central task of medicine — to help patients get better. Characteristics of a doctor–patient consultation that are similar to what we define as the patient-centred clinical method, influence the following patient outcomes: resolution of symptoms,[5,17] headache,[68] sore throat,[69] and anxiety distress.[70]

Griffin and colleagues'[19] recent systematic review found that most of the 35 interventions improved the relationship between the patient and the doctor. In addition, slightly more than half of the interventions improved patients' health including: patient interventions, such as encouraging patients to ask questions and having patients write down what their concerns are; and interventions with doctors, such as teaching doctors how to better explore the patients' ideas, concerns and expectations, helping doctors provide clear information about disease and its treatment, and enhancing doctors' attention to emotion in the consultation.

Despite methodological limitations pointed out by the reviewers, the message of this research synthesis is a resounding one: the impact of patient-centred medicine is positive both for the doctor and for patients. The evidence reviewed above repeatedly revealed the following dimensions of the doctor–patient relationship to be beneficial:

- facilitation of the patients' expression of feelings, ideas and expectations;
- clear information to the patient;
- mutually agreed upon goals;
- an active role for the patient; and
- positive affect, empathy, warmth and encouragement.

To conclude this segment of the paper, we have seen that reflective practitioners, patients and a body of research converge on a definition of the patient-centred care; three perspectives suggesting a collective truth.

ROLE OF THE PATIENT-CENTRED CLINICAL METHOD IN DIAGNOSIS AND CURE

Two examples illustrate the importance of patient-centred components in the two central tasks in conventional medicine, diagnosis and cure. A real case shown in a teaching videotape shows a young woman patient, coughing and looking tired in a round-shouldered way (Colorado University School of Medicine, 2000). The medical student conducts a thorough enquiry but asks closed-ended questions finding out that the cough has been going on for some time, that the patient is tired, that she has phlegm, that it hurts when she coughs. The diagnoses was bronchitis and an antibiotic prescribed. The preceptor later embarked on a broader approach, one that I would call patient-centred; the patient was asked two broad questions which dramatically changed the differential diagnosis. With regard to her illness experience she was asked how the illness affected her daily life and she responded, 'I cannot sleep with the coughing, the nights are so difficult with drenching sweats and, actually I coughed so hard once one night there was blood in the handkerchief'. As well she was asked, 'What do you think this is?' and she responded that because she worked with immigrants each day, she wondered if it was something she had acquired from them.

Tuberculosis! The point of telling this story is to emphasise that correct diagnosis relies on a history that encompasses all the dimensions of human life.

The second example concerns cure. When one thinks about treating hypertension and diabetes, one immediately thinks of appropriate drug treatments. However, one rigorous intervention trial has shown that when patients are encouraged to participate more fully in their visits with their GP, their diastolic blood pressure is 83 mmHg versus 95 mmHg before and 91 mmHg both before and after in the control group.[71,72] While the study did not elucidate the mechanism, there is both biological and psychological plausibility for a process revealed by seminal qualitative studies suggesting that when doctors listen, patients begin to trust in the relationship, they feel better and become more active partners in care. They feel and become more empowered to mobilise their own resources, finally leading to an hypothesised improvement in physiologic health status.[73,74]

THINKING OUR WAY

At a first encounter for a confusing series of symptoms and feelings, the GP has two main roles: first, to sort out or understand the process of health to illness and disease, and even to act to prevent these processes; and second, to walk with the patient throughout and to help make meaning of the process of health proceeding to illness and disease.[75]

The pain, panic and symptoms, at the early stage of the health-to-illness pathway are likely coming from both the body and the mind of the patient. It is in this confusing, complex stage of illness, that

general practice resides. The responses of the GP and the patient at this point in the pathway must rely on mutual trust — trust by the GP in the inherent truth of the patients' experience and trust by the patient that the GP will figure it out, prevent the worst from happening or, at the very least, remain steadfast in helping to make sense of things.[75] Here, empathy with the patient is only the first step in the doctor's work. Empathy must lead to insight and then to a recommended action[76] in partnership with the patient.

GPs use their minds to come to insights that bring together disparate categories of knowledge. They turn the insights into action by testing them with patients, offering them as illumination of a new path for the patient to follow, potentially a path out of illness back to wholeness and health.

But to take these ideas one step further, Willis[77] and McWhinney[78] challenge us to understand that, in the spirit of Sir James Mackenzie, observation and reflection on many such individual patients is the integrated science, the clinical research, of general practice. As Willis said:

> *'Not only must doctors remain scientists in order to serve their patients … I also believe they have a unique contribution to make to science itself.'*[77]

As Mackenzie's biographer puts it: this science, this research 'is a means to an end not an end in itself'.[1] Such science is fueled by the passionate desire to help individual patients but it relies on careful observation and inspired interpretation using the doctors' faculties of emotional and intellectual intelligence. In James Mackenzie's case:

> *'He placed different interpretations, removed misunderstandings and confusion and gave new meaning … because his findings were based on vast numbers of clinical observations in health and disease.'*[1]

'The great field for new discoveries is always in the unclassified residuum'.[79] Difficult-to-classify problems are the topic of the following example of discovery in general practice, employing the method of observation, interpretation, intuition, action and reflection.

The example concerns a patient like Wendy aged 25 years, married with two children, aged 3 years old and 10 months old. Her husband has just recently been laid-off from his job as a plumber and is trying to start a new plumbing business. Wendy has always been in good health until 2 months after the birth of her second child, when she developed the 'worst flu of her life'. Still, many weeks later she has recurring 'muscle pains, severe headaches, lack of sleep, memory loss and lack of sexual desire'. She now feels unable to look after her children. Her parents, successful professionals, unhappy with her choice of husband, want to send Wendy to the big famous clinic several thousand miles away for tests. Her husband disagrees and begins to spend more time away from home.[80]

After a process of observation, interpretation, intuition, action and reflection on a number of cases such as this, the GP began to try a new approach: first, immediate recognition of the patient and the family's suffering; second, simultaneously a rigorous, not delayed diagnostic search for cause; and third an immediate naming and tentative explanation of what the problem is, chronic fatigue syndrome.[80] After careful consideration of the magnitude of this problem, the common characteristics of the patient's illness experience, the issues of the person and family, and society's stigma against such sufferers, the GP revealed his message: 'to realise that the central issue in the illness is the crash.'[80] Just as if the patient has been a victim of an automobile accident (a car crash) and was bedridden, the doctor and the family must respond by providing 'refuge', shelter, 24–hour care and comfort, immediately.

The process described of observation, interpretation, intuition, action and reflection may be leading to new discoveries in general practice.

FEELING OUR WAY

In order to practice and to learn from practice, in the manner described above, one needs to strive constantly to obtain a balance between science and caring. Let us now consider the emotional side of general practice.

Patients live in an emotional world and experience overwhelming, crushing losses in their hearts as well as their bodies. Author, Alistair MacLeod tells about the depth of caring of his male characters, Scottish immigrants living on the unforgiving soil of Cape Breton Island, 'You know' says the narrator of his short story entitled *Vision* 'the future scar will be forever on the outside while the memory will remain, forever, deep within'.[81] By associating memory with blood and body, MacLeod suggests that emotion is biologic and can never therefore 'be connected to that which is ephemeral or casual'.[82]

Maybe, nonetheless, we believe that we will be wounded ourselves if we care too much or maybe any emotion is rejected because it is too threatening to our own defenses. We may not want to accept the facts that Annie Dillard repeats like painful drips of water-torture, when she provides example after example, of the messiness of life and the inevitability of death.[83]

Practitioners may respond to such inevitabilities in a variety of ways. Some may become like the doctor described by Winckler who said to a man whose wife was dying 'There is nothing more I can do', when on the contrary, 'whatever the trouble is, there is always something we can do',[84] if only not to flee and not to leave such patients even more alone than they already are.

One patient, a senior public servant in Canada said when his wife had a stroke:

> *'If you've had this experience (you don't know if you can carry on) to be surrounded by love and affection is absolutely essential. I didn't understand it before.'*[85]

McLeod, a medical doctor says:

> *'I worked to keep my emotions and intuitions from influencing medical decisions because they were subjective and not measurable. I became adept at hiding the feelings of vulnerability and helplessness that I felt when my patients died, and those of anger and frustration with 'hateful' patients … As a result, I became increasingly isolated from my own emotions and needs; I shared less with my colleagues at work. I evolved a workaholic lifestyle with the subconscious expectation that others would figure out my needs and satisfy them because I was "doing so much". I did not take the risk of identifying and asking for what I needed. I hid behind a mask of pseudocompetence and efficiency. I let power, money, and position take the place of empowerment, love and meaning. But because they were substitutes for my primary needs, they were never enough.'*[86]

Caring has been defined as a process encompassing eight concepts. These eight have been raised before in this paper. They are: time; being there; talking; sensitivity; acting in the best interest of the other; feeling; doing; and reciprocity.[87] Caring implies that the doctor is fully present and engaged with the patient. The notion of the detached clinician who keeps a safe emotional distance is replaced by the notion that doctor and patient are interconnected in such a deep way that the doctor can fully immerse him or herself in the concerns of the patient.[88] Boundaries may be much more blurred than in the traditional, distanced, one-way relationship. However, the closeness restores the patients' sense of connectedness to the human race, a connectedness that may have been broken by their physical or emotional suffering.[89–91] In my view, this emotional re-connection should not be underestimated.

IMPLICATIONS FOR TEACHING DOCTOR–PATIENT RELATIONSHIP

We ask ourselves, why are the components of doctor–patient relationships not more widely embraced?[92] Current societal values do not, on the whole, support or nurture relationships. Our Western society, on the contrary, values individual accomplishment above community; values science over art; values analysis over synthesis; and values technological solutions over wisdom. In such a context, all of us suffer diminished capacity for spirituality and love. In medicine, these societal influences tip the balance so alarmingly that we and our students almost never see the alternative to individualism, science, analysis, and technology — almost never recognise the balance that must be sought. Willis argues that:

> *'the greatest challenge facing contemporary medicine is for it to retain … or regain its humanity, its caritas — without losing its essential foundation in science … to find a middle way.'*[77]

What can we do in education to counter the imbalance and to model the middle way? First, we will resist teaching the science of medicine separate from the art of medicine and the disease as separate from the person. As a possible solution to this great divide, we propose teaching the student to deal with the disease issues and the patients' illness experience in one integrated clinical method, such as the patient-centred clinical method described in this paper. I have argued that without such integration, the tasks of medicine cannot be accomplished.

Second, we will teach the value of relationships but, try to avoid the reductionist perspective of breaking down caring into minute skills and behaviours without also re-integrating the parts into a whole. The use of art, poetry and prose can serve such an integrative function.

Third, we will resist teaching in a way that reinforces the idea, that each patient is an 'island to himself' divorced from his or her context. Instead we will stress that each patient is surrounded by a web of caring (or uncaring) relationships that matter to a patient's health, healing and wholeness.

Fourth, we can engage patients as our allies in teaching by encouraging them to be experts in their meetings with students (that is, to participate fully, ask questions, provide written notes about their concerns and expectations) and to ask their perception of consultations with students in order to provide formal and formative feedback to students.[93]

Finally, like us, our students are overwhelmed,

fearful and defensive. We should want to teach in a way we would want to be taught, modelling the kind of relationship we encourage our students to have with their patients.[94] Just as the doctor does not abdicate his or her expert role when attending to the patient's voice, the teacher of medical students and trainees does not have to abdicate the role as teacher to listen more to the student's voice, enter more the student's world, and open up more your inner world to model the caring and the joy of the committed GP.

CONCLUSION

In the hands of GPs, I have watched the patients' confusion, fear and doubt transform to clarity, relief and assurance. There is still confusion all around but there is a time of insight, healing and new positive energy within the patient to engage the situation. Without the GP in this role, there would continue to be more confusion, fear and doubt. With the GP in this role, sick people recover, sick people find relief from suffering, some sick people fear less, and some sick people are filled with hope. This is general practice's precious gift to humanity.

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