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Patient-Centred Interviewing Part II: Finding Common Ground

SUMMARY

Developing an effective management plan requires physicians and patients to reach agreement in three key areas: the nature of the problems, the goals and priorities of treatment, and the roles of the doctor and patient. Often doctors and patients have widely divergent views in each of these areas. The process of finding a satisfactory resolution is not so much one of bargaining or negotiating but rather of moving towards a meeting of minds or finding common ground. This framework reminds physicians to incorporate patients' ideas, feelings, and expectations into treatment planning. (*Can Fam Physician* 1989; 35:153–157.)

RÉSUMÉ

L'efficacité du plan de soins exige que les médecins et les patients s'entendent sur trois éléments importants: la nature des problèmes, les buts et priorités du traitement et les rôles réciproques de chacun. On constate fréquemment des divergences de vue entre les médecins et leurs patients. La recherche d'une solution satisfaisante n'implique pas nécessairement une négociation mais plutôt un cheminement pour en arriver à un terrain d'entente. Ce cadre conceptuel rappelle aux médecins de ne pas oublier d'incorporer dans le plan de soins les opinions des patients, leurs sentiments et leurs attentes.

Key words: interviewing, physician-patient relationships, patient management

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BY USING a patient-centred approach, doctors can begin to explore and understand patient's ideas, expectations, feelings and the effects of their illnesses on functioning. By this means the patient's perceptions of the problem are defined. At the same time, by using conventional clinical methods, including history taking, physical examination, and laboratory tests, physicians establish a medical definition of the patient's problem. The next task is to reach mutual understanding. This requires that two potentially divergent viewpoints be brought together in a reasonable management plan. Once agreement is reached on the nature of the problems, the goals and priorities of treatment must be determined: What will be the patients' involvement in the treatment plan? How realistic is the plan in terms of the patients' perceptions of their illnesses? What are the patients' wishes and their ability to cope? Finally, how do each of the parties, patients and doctors, define their roles in this interaction? How does their relationship influence these decisions?

Many authors describe the clinical encounter as a process in which doctor and patient negotiate to define what is important and what should be done.[1–3] Like and Zyzanski,[4] for example, define negotiation as the "process whereby two or more parties attempt to settle what each should give and take, or perform and receive, in a transaction between them." The emphasis here is on the potential conflict between the points

of view of doctor and patient. This perspective is contractual rather than a true meeting of minds and is flawed by a simplistic "either/or" stance rather than a more holistic "both/and" perspective. We prefer to describe this process as a mutual task of finding common ground between doctor and patient in three key areas: defining the problem; establishing the goals of treatment; and identifying the roles to be assumed by doctor and patient.

Defining the Problem

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 difficult for a doctor and 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 patient's world. People may develop quite magical notions of what is happening to them when they become ill. It seems better to them to have an irrational explanation of the problem than no explanation at all. Thus the quack who offers help will be preferred to the cryptic physician who offers little. Some patients will even blame themselves for the problem rather than see the illness as simply random or impersonal.

Problems develop when patient and doctor have different ideas of the cause of the problems. For example:

- The patient says he is disabled by a back problem, and the doctor thinks he is malingering.
- The doctor has diagnosed hypertension, but the patient insists that his blood pressure is probably only elevated because he is nervous in the doctor's office and refuses to see it as a problem.
- The parent of a six-year-old child thinks there is something seriously wrong because the child has frequent colds: six a year. The doctor thinks this number is within normal limits, and that the parent is overly protective of the child.

We often get into difficulty in defining patients' problems by inappropriate use of the traditional medical model. In using this model, we run a risk of applying improper treatment for problems that do not fit this model. For example, common problems of living may be mislabelled "chronic anxiety disorder" and treated with long-term anxiolytics as if they were some sort of infectious affliction that could be eliminated with chemicals. The analogy to antibiotic use for infections is striking. We need to be reminded of the aphorism: "If your only tool is a hammer, you see every problem as a nail."

An example

The socially isolated, lonely patient who has suffered chronic pain for 20 years may need his pain to legitimize his disability pension (his only income) and to provide an occasion to sit down with someone who cares about him and his suffering. He long ago accepted this situation as the best of a bad job. The physician may realize that the pain which he experiences as physical pain is a metaphor for his intolerable life pain, but he does not need to inflict this insight on the patient if the latter cannot bear it. It may be sufficient that the physician's insight allows him to care more deeply for the patient and to avoid unnecessary investigation to find a disease that is not there. If the physician responds to the patient's cues and follows his lead in discussing his personal life and his feelings, he will help the patient to tell his own story at his own pace and will avoid the risk of pushing the patient beyond his limits of tolerance.

In their book *Getting to Yes*, Fisher and Ury[5] describe two common and erroneous approaches to negotiating differences. The first is "hard bargaining": participants are viewed as adversaries, and the goal is victory. This approach generates bad feelings and mistrust. The second approach is "soft bargaining": the emphasis here is on building and maintaining the relationship and the goal is agreement. The risk of this approach is a sloppy agreement. Fisher and Ury recommend an alternative, which they call "principled negotiation". Four basic tactics make up this approach:

- First, separate the people from the problem. It is better to see the problem as being "out there" and the participants as working together to attack the problem, not each other.
- Secondly, focus on interests, not positions. People tend to stake out a position and defend it as if it were personal territory. Often the underlying interests are forgotten in the battle.
- Thirdly, generate a variety of possibilities before deciding what to do. Having too much emotional investment in one approach inhibits creativity.
- Finally, use objective criteria to judge the solution rather than pitting one personal opinion against another.

Defining the Goals

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. For example:

- The patient has a sore throat and expects to receive penicillin but instead is urged to gargle with salt water.
- The patient is concerned about innocent palpitations but is found to have high blood pressure. The doctor launches into a treatment of the hypertension without explaining to the patient the benign nature of the cardiac symptoms.
- The patient demands muscle relaxants for chronic muscular pains, but the doctor wants to use "talking" therapy to resolve the "underlying" problems.

If physicians ignore their patient's expectations, they risk not understanding their patients, who in turn will be angry or hurt by this perceived lack of interest or concern. Some patients will become more demanding in a desperate attempt to be heard; others will become sullen and uncooperative. Patients may be unwilling to listen to their doctors unless they believe that they have first been listened to themselves. Hearing fully their patients' distress often challenges doctors to use their imagination and feelings to enter into their patients' inner lives: to experience empathically their patients' pain, confusion, hopes, and fears. This experience may be both threatening and emotionally draining for physicians.

Inexperienced physicians are often uncomfortable with the conventional

biomedical responsibility of making the correct diagnosis and are hesitant to add another dimension to a task which seems already difficult enough. Physicians are sometimes concerned that patients may ask for something they disagree with; because they are not comfortable with confrontation and saying no, they may prefer to avoid an issue. Perhaps they hope that the patient will get the message, indirectly, that any ideas not raised by the doctor are unimportant. Students often point out that if they ask patients for their ideas and expectations, they will be told, "You are the Doctor!", a remark that may leave the student feeling foolish and unable to respond.

Timing is important. If the physician asks for a patient's expectations too early in the interview, the patient may think that the doctor is evading making a diagnosis, and may therefore be reluctant to say much. On the other hand, if the physician waits until the end of the interview, time may be wasted on issues unimportant to the patient. The physician may even make suggestions which will have to be retracted. Physicians need to express their questions clearly and sincerely. For example, a physician might say, "Can you help me to understand what you hope I might do for you today?" It is important that neither the physician's words nor tone of voice suggest any accusation that the patient is wasting the doctor's time on something trivial or silly. Often, it is helpful to pick up on a patient's comments that suggest, or hint at, their ideas, expectations, or feelings. For example, "I have had this chest cold for three weeks now and none of those cough medicines you recommended has helped!"

The doctor should avoid becoming defensive in trying to justify previous advice. Instead, it is more helpful to pick up on the patient's frustration and the implied message that something must be done: "You sound fed up with the length of time this illness has dragged on. Are you wondering if it is something serious? Are you wanting a particular means to clear it up?"

Thus, the goals of treatment must take into account the expectations and feelings of both physicians and patients. If the hidden agendas are not recognized, it may be difficult to reach agreement. What physicians call "non-compliance" may be the patients' expressions of disagreement about treatment goals; in this sense the patient always has the last word. The following two examples illustrate some problems in defining goals:

Examples

Mrs. C. has metastatic breast cancer, and her pain is poorly controlled. Her physician may believe that a course of chemotherapy would help. The patient, however, may consider this treatment too aggressive and the potential side-effects unacceptable. In this case the physician may place a higher priority on slowing the progress of the disease, whereas the patient would rather concentrate on symptom control.

Another patient, Mrs. Y., is a young mother with three small children. She presents with tennis elbow. The doctor may recommend that the patient reduce her activities for several weeks to allow the inflamed area to heal. The patient, on the other hand, may consider this impossible because of her responsibility for child care. She wants analgesics to relieve the pain so that she can get on with her jobs.

In these two examples the physician and patient must work together to find a treatment plan that is acceptable to both. This may require that the goals and priorities of each be reexamined. It is often helpful for the doctor to explain the nature of the problem clearly and to outline the pros and cons of different approaches. It is important to acknowledge the patient's concerns first so that the patient is aware that the physician is taking these into account.

Defining the Relationship

Sometimes there is profound disagreement about the nature of the problem or the goals and priorities for treatment. When such an impasse occurs, it is important to look at the relationship between the patient and the doctor, and at their perception of each other's roles. Doctors, as in the example of the 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 physician 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.

One of the major differences between family medicine and other medical disciplines is the duration of the doctor-patient relationship over time. This allows the physician to see the same patient with different problems in different settings over a number of years, and also to see the patient through the eyes of other family members. The physician's commitment is to "hang in" with the patient to the end. Patients need to know that they can count on their doctors to be there when they need them. This ongoing relationship colours everything that happens between them. If there are difficulties in their relationship or differing expectations of their relationship, they will have problems in working together effectively. For example:

- The patient is looking for an authority who will tell him what is wrong and what he should do; the physician, on the other hand, wants a more egalitarian relationship in which doctor and patient share decision making.
- The patient longs for a deep and meaningful relationship with a parental figure who will make up for everything the patient's own parent never gave; the doctor wants to be a biomedical scientist who can apply the discoveries of modern medicine to patients' problems.
- The physician enjoys a holistic approach to medicine and wants to get to know patients as people; the patient seeks only technical assistance from the doctor.

Commonly, physicians react in one of two ways to problems in their relationships with patients. First, they tend to blame the patient, who is often characterized as a "crock". This response is often chosen to justify ignoring complaints that are not "legitimate" (i.e., organic). Patients can be rejected in a variety of ways: they may be subjected to unnecessary and sometimes dangerous or punitive investigations; they may be given pills instead of time; they may be referred

inappropriately to a variety of specialists. They therefore become dissatisfied with physicians, continue to present numerous unresolving complaints, do not comply with treatment and switch doctors frequently.

Alternatively, it is common for doctors to blame themselves. They feel that they must have done something wrong: that if only they knew more or were more skilled in interviewing or therapy, they could save these people from themselves. The rescue fantasy that led many physicians into medicine is severely tested by these patients. Many physicians take courses to improve their patient-management skills, hoping to find "The Answer". Only after repeated failure with a variety of approaches are they able to come to terms with their limitations.

A third, more effective and satisfying, reaction is to realize that the problem is not one-sided. As Pogo said, "We have seen the enemy, and they are us!" On realizing this, physicians can give up their need to be perfect and instead be prepared to do their best, to be "good enough", to be real persons to their patients rather than needing to find someone to blame for the limitations of medicine.

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 that continuity of care is so important. Mayeroff[3] emphasizes this principle:

> Caring assumes continuity and it is impossible if the other is continually being replaced. The other must remain constant, for caring is a developmental process.

The final two examples illustrate the key concepts of finding common ground: defining the problems, the goals, and the roles of the patient and doctor.

Example One: A demanding patient

Mrs. A. came to the office after an urgent phone call, made that same day, demanding a repeat prescription for steroid eye drops. She had had a painful red eye two months earlier and had seen an ophthalmologist, by referral, who diagnosed acute iritis and prescribed steroid eye drops. When similar symptoms recurred a few days previously, she started using the drops again. By the time she was seen she no longer had any symptoms and her eyes looked normal. She was out of drops and was concerned about a flare-up, as she was leaving for a vacation in Bermuda that afternoon. The resident who saw her had been taught in medical school that family doctors should never prescribe steroid eye drops and insisted that she see an ophthalmologist. He was concerned that the patient's history was vague and was not convinced that she had a recurrence of her iritis.

The patient adamantly refused to "waste two hours" in emergency and preferred to take her chance without eye drops if he would not prescribe them. The resident, believing that he was in a no-win situation, was furious. If he gave her eye drops (which he was not even sure she needed) and she had complications, he would feel badly; on the other hand, if he refused, the patient might have a flare-up that would ruin her vacation and perhaps even permanently damage her eye. He feared that this type of "unreasonable" patient was likely to sue him either way. The staff physician who had known the patient for several years, realized that she rarely backed down. Even after explaining the doctor's concerns (the uncertain diagnosis and the potential harm of treatment or non-treatment), the patient remained adamant in her request. The physician decided that on balance, and under these restricted circumstances, the patient's interests would best be served by prescribing the steroid eye drops and cautioned her on what symptoms to look for.

Example Two:
A case of "severe" poison ivy

Mrs. M., a 38-year-old woman presented to the office with a small patch of poison ivy 3 cm in diameter present for 3 days on her left calf. She was angry with the doctor she had seen the previous day because he had refused to prescribe oral corticosteroids, and she stated that the rash had "tripled in size overnight". (His description of the lesion in the medical record stated that the rash was 3 cm in diameter when he had seen it.) She was to play in a golf tournament the next day, wanted to wear shorts, and wanted the rash to be gone; she demanded oral prednisone.

When the doctor explored her concern that the rash might spread, Mrs. M. reported that her son had had a bad case of poison ivy, initially treated with topical steroid, and then requiring prednisone. She could not be reassured that this was very unlikely to happen in her case, especially after three days.

The doctor had known this patient for many years and was aware of her troubled marriage and her great difficulty in trusting anyone. He also knew that she was often concerned about her appearance and hated getting older. Experience had taught him that any exploration of these issues was fraught with danger: Mrs. M. would almost certainly become angry and accuse him of not taking her concerns seriously. He decided to focus on her concerns until he was sure she knew he understood and was not taking them lightly. Then he directly addressed their difference of opinion about what was likely to happen and about appropriate management. He asked her to read the adverse effects of prednisone in the *Compendium of Pharmaceuticals and Specialties*. He promised to see her again early the next morning if the rash doubled or tripled in size again, and to reconsider oral steroids if that occurred. He made a point of carefully measuring the lesion, telling her its dimensions, and making sure that she noticed him recording this in his notes.

Reluctantly Mrs. M. accepted topical treatment and did not call back. Several months later, when seen for a separate problem, Mrs. M. mentioned that the poison ivy had become worse the next day but "not too bad".

In both these cases there was some disagreement about the nature or severity of the problems and appropriate goals or methods of treatment. There were also difficulties in the doctor-patient relationship that could easily have reached an impasse. By

clarifying their differences of opinion while, at the same time, showing respect for the patient's point of view, the physician was able to avoid a harmful power struggle and perhaps sowed the seeds for a more effective working relationship in the future.

Being Realistic

What can physicians realistically achieve in ordinary office visits? We do not suggest that all areas of patient concern be explored in every visit. In fact, one of the strong points of family medicine is the use of several visits over time to explore complex or deeply personal issues. Often, after a close and trusting relationship has developed, doctor and patient can get to the heart of a matter very quickly. Time and timing are two key factors. While it is not realistic to cover every aspect of the patient's story on every visit, physicians must be sensitive to the importance of timing and be able to recognize when a patient requires more time even if it means disrupting their office schedule. Timing also speaks to the issue of the patient's readiness to share certain concerns or experiences with the doctor. When a patient presents with multiple symptoms and concerns, the physician must learn how to establish which are the most pressing issues at that time, address them, and pave the way for the patient to return to the office to explore the remaining concerns. Physicians must learn how to create quickly an atmosphere in which patients feel heard and understand that the physician sees their problems as important and worthy of further exploration. ■

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