The possibilities of patient-centered medicine*

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IN his paper, The Structure of the Training cum Research Seminar and its Implication for Medicine, Michael Balint spoke about two classes of pathological conditions: Class I comprises conditions in which a localizable 'illness' can be found. In this class scientific examinations can identify a fault either in the body or in one of the part functions in the body. In this way of thinking, the prime aim is to find a localizable fault, diagnose it as an illness and then treat it. This is what we call 'illness-orientated medicine.'

In contrast, there is another way of medical thinking which we call 'patient-centred medicine'. Here, in addition to trying to discover a localizable illness or illnesses, the doctor also has to examine the whole person in order to form what we call an 'overall diagnosis'. This should include everything that the doctor knows and understands about his patient; the patient, in fact, has to be understood as a unique human-being. The illness which can be described in terms of a 'traditional diagnosis' is either an incident like a broken leg, or a part like accident proneness which makes better sense if understood in terms of the whole.

The question which has recently been occupying our minds is: How does a practising doctor avoid a split in himself? How can he avoid being a general practitioner to some of his patients and a competent psychotherapist to others? Or, expressed in our new terminology: How can he avoid practising 'illness-orientated medicine' with some patients and 'patient-orientated medicine' with others.

Before proceeding it is necessary to state the problem in a slightly different way: What was our aim when, in 1950, we started advertising in the medical press in London that we proposed to hold seminars on the psychological problems in general practice? Did we, in fact, have in mind to teach our doctors to be minor psychotherapists? Did we aim in establishing this sort of split?

If this were so, why are we so worried about it now, because clearly if this had been our aim, we could not have expected our doctors to remain whole doctors with one professional activity as they were bound, it would seem, to do 'psychotherapy' with some patients and 'general practice' with others. Leaving on one side their patients,

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requirements, the size of their practices alone would not permit them to do minor psychotherapy with all their patients. Furthermore, if they wished to become psychotherapists they could take the necessary training and leave general practice altogether. No, there was never any doubt in our minds that the aim of the seminars was to study the emotional problems found in general practice in the hope that if it were found to be necessary the general practitioner's whole medical approach might be changed; which means that new skills would have to be evolved.

In the later 1950's we thought that we had made some progress, but nevertheless, we began to be anxious about the problem of the split doctor. Our doctors told us that although they had not altered their way of treating all their patients their whole work had nevertheless changed since they joined our seminars. They could not tell us how, but they felt themselves to be different kinds of doctors, even different kinds of people since they started work with us. They insisted, nevertheless, that their ordinary 'surgeries', i.e. the time they spent in their consulting rooms, were much as they had been before they started; and we found this puzzling.

We had already tried several times to discover how the doctors decided to choose one patient for psychotherapy rather than another. No answer could be found. The doctors realized that their choice was often irrational. That many people who needed investigation did not get it and that the most needy were not always chosen for special attention. Why was this?

When, therefore, in 1962, I was asked to lead a group of experienced general practitioners at the Tavistock Clinic I brought the subject up for discussion. This was with a group of doctors who had already had some experience in the training scheme and were ready to undertake some kind of research. Quite early in our work we decided to study randomly selected patients in contrast to our usual practice of studying only those patients whom the doctors selected specially for discussion.

During this study we made various discoveries.*

Here is the gist of what we found:

First, it seems as if our doctors felt compelled to identify with two professions when they joined our seminars; the profession of the general practitioner and the profession of the psychiatrist and psycho-analyst. All the participants were practising doctors but they felt that their work and ours as practising psychiatrists and psycho-analysts was utterly different. They wished us to remember this. It was important to them to preserve their identity as general practitioners; there were times when they strongly identified with us, but there were times when they did not wish to do so.

Secondly, they saw us, on the one hand, as trying to turn them into psycho-analysts, without the time or the opportunity to do so and on the other forbidding them to practise anything remotely resembling psycho-analysis. They wanted to show us how exacting our demands were on them and how frustrating and unrealistic. They thought that when we expected them to do more than they did we did not realize how good they were anyway.

Because of the difficulties inherent in all of this, we felt that we must examine the situation further and it was for this reason that when this seminar had to be terminated Michael Balint and I assembled a dozen of our most experienced general practitioners (this time at University College Hospital) and asked them if they would like to co-operate with us in a research into how much 'patient-orientated medicine' can be done in the ordinary run of their practices. This time we did not want to examine randomly chosen cases. We wanted the doctors themselves to choose the cases where they felt one brief five- to ten-minute consultation had started a 'patient-orientated medicine' and we wanted

*A Study of the doctor/patient relationship using randomly selected cases. *J. Coll. gen. Practit.*, (1967), **13**, 163.

to follow up the cases that the doctors chose over a long period. We called this a research into six-minute psychotherapy; but, of course, we did not want to impose a strict time limit on our doctors but to make a distinction between this kind of psychological understanding and therapy and the traditional long interview kind.

Now I want to report something about this research. Many of the attitudes found in the first research seminar were repeated here. At the beginning it seemed that sometimes our doctors wanted to show us how little they did rather than how much. In the usual way, when the same doctors reported on cases the emphasis was on the doctor–patient relationship; and on the way they felt about the patient and why they were finding difficulties in helping him; whereas, when they reported on their 'six-minute cases', they did so rather in the traditional manner; they based their understanding of the patient more on traditional medicine (although it might sometimes be from the psychiatric point of view). That is, they discussed their findings in terms of dependency or some similar cliché and less on the patient's active communication at the time of the interview and how this could be understood and used for therapy. These were cases where the doctor did not want to have long interviews and was right in making this decision; but they could not see that something important for the patient had happened and perhaps even some help had been given to him in the short contact in the consulting room. Other participants in the group might see this but the general practitioner in charge of the case seldom did. They thought at these times that a formal proper course of psychotherapy with 50-minute interview might be of use, but that nothing else would. They ignored the usefulness, which they knew well theoretically, of their unique setting insofar as it gave them the opportunity to see their patients for short times over a number of years.

About a year after this research group started work we all realized that we were in difficulties. This became particularly clear when we were listening to the reports on the follow-ups of our original cases. During the discussion on these cases it appeared that very good and conscientious and respectable work had been done, but still the therapeutic results were somewhat disappointing. For instance, although the doctors had understood very well and worked competently with the patient's illness in terms of the present and the past and had seriously tried to identify the area of the patient's life where conflict was most acute and had tried to formulate the iatrogenous and the autogenous illness the work seemed rather flat and undynamic. These ideas, which we had worked out in our seminars over the years, seemed less useful here than usual: perhaps we did not yet know how to use them in the new setting which we were examining—i.e. in the 'six-minute interview'. Or, were they, in fact, being forced onto the patient?

One doctor said that so far the emphasis had been on what the doctor had tried to get from the patient, rather than on what the patient had tried to get from the doctor; that the doctors seemed to have enjoyed acquiring the skills of detective inspectors. They had learned to spot the patterns of human behaviour underlying the patient's presenting complaints and ferret out his carefully hidden secrets and fears, but they had often failed to shed much light on what the patient tried to get from his doctor when the treatment started. This doctor thought that the shift in our work should be from an overall picture of the patient to the patient's immediate needs. Another doctor thought it might help if we defined different therapeutic aims. The first aim he called the 'big bang aim' where the doctor tries to make the overall diagnosis as comprehensive as possible and then to influence the patient in the major area of his life situation. His success should then be the equivalent of a 'big bang result'. He called the second aim a 'steady state aim' where the doctor tries to maintain the *status quo* or restore the balance of control which the patient appears temporarily to have lost. The third which he called the 'little bang aim' was to search modestly into the limited areas of mutual understanding between the patient and the doctor. The doctor should try to be on the same wave-length as the patient and to capitalize such little gains as could be made

each time so that on subsequent visits work could proceed with a little more done each time. This doctor felt that this latter type of aim the 'little bang aim' seemed to be the most promising and realistic for general practitioners during their office hours.

Questions we should be asking were not so much—Is this man getting upper respiratory infections because his wife is bullying him? Or, Does that boy want to stay off work because he is frightened of his homosexuality? But more, Why is this girl complaining of eye-strain today? Does she want me to see something for her or instead of her? Does she want more than eye-drops? Why is she sitting still; the last time she came she fiddled around restlessly? Or, of another patient: Why did he ask me whether it was all right to have the repeat prescription again? He had it for a year without any bother, and so on, and so on.

Now, of course, all this seems quite obvious. We all know that these observations are often the ones that count: but it is apparently so much easier to think about more organized 'problems' such as dependency and castration anxiety, and furthermore we did not know whether these kinds of observation would be useful in ordinary consulting hours, or where they would lead. Would they inevitably force the poor overworked doctors to arrange yet another out of hours interview, which would then have to be followed up by many, many more, i.e. a usual long-term psychotherapy would result?

I will now report one sample case which followed these discussions to show the kind of thing that slowly emerged.

The reporting doctor was Dr C and his patient was Mrs Grace R, aged 56. She had been on our doctor's list for more than 15 years and had been seen by either our doctor himself or by one of his partners five or six times a year during this period. The patient was a machine operator and was married for the second time to a retired stoker at a power station, aged about 68. Dr C said that he had decided to report the case because, although he had known the patient for so long, she had never become alive to him before this interview and he thought also that he would almost certainly see her again fairly soon. This is really what should be our criteria. He had spent the usual few minutes with this patient, who had come to see her doctor complaining of headaches. Dr C said that he supposed that the traditional diagnosis was tension headaches. The patient attributed them to the noises at work. The doctor said that he knew very little about Mrs Grace R, although he knew a great deal about her previous illnesses. He gave us a long list of these in traditional terms; for instance, she had had an appendicectomy, osteoarthritis of the knee, cystitis, 'flu, irregular menses and back pain. She had also had severe headaches two years ago which had then been accompanied by vomiting and vertigo. The contact with the patient over all these illnesses had been good although very superficial. In fact, it was only at this interview, that our doctor learned that this was the patient's second marriage and that her husband was 12 years older than she was. When speaking of her husband the patient said that he was only interested in football and bed. When Dr C asked the obvious question, she said Oh no, that wasn't what she meant at all. They had not had intercourse for five years or more. She added that she never really enjoyed it and was quite relieved when it was given up and that she was glad that she never had any children because they only grew up to be cannon fodder. She then paused and added that her husband wanted her to give up work for sometime but she felt that she must do something and that she could never sit still.

Dr C's overall diagnosis was that the patient was an unhappy woman, who had attempted to deny the more frustrated feminine parts of herself, but had solved part of her problem by marrying a rather passive older man. She was fighting off depression by activity and she was unfeminine rather than masculine. His therapeutic decision was to bring out her feelings into the open if he got the chance and to see why she had to drive herself to breaking point all the time. He gave the patient a certificate for a week so that she should not go back to work. This would involve her coming to see the doctor again in order to get a certificate to re-start work.

During the discussion which followed this presentation one of the doctors said, "I find that when there is a history of psychosomatic disturbances like dysmenorrhoea and so on, by the time that they are 50 or 60 I wonder if there is any point in going through it—there is so much, it would take so long—I find that my time is so short that I tend to give it to the younger people—this woman would really leave me feeling like making some sort of collusion because it would take so much time to go through all this, and would it be worth it?"

I think most doctors would sympathize with this opinion: There is so much to do with so many patients to see. Also, our doctor knew nothing about the patient's past so if he wanted to link up the past with the present he would have to start at the beginning. However, another member of our group did not altogether agree. She said, "Although I agree that I would not want to go through the whole thing, stage by stage, year by year, this is all the more reason that it should be a 'six-minute' case".

We had a follow-up from Dr C on his patient four months later. He reported that he had seen his patient twice since last reporting. The first time was one week and the second two weeks after the original interview. Since then he had not seen her; that is to say, she had not been seen for about three and a half months. He told us that the first interview had lasted ten minutes and the second 20. He said, "This was *force majeure* as you will see". At the first interview the patient said she was better and then, encouraged by Dr C, tried to understand what it was that made her drive herself to work. While doing this she began to reminisce about her early life. How, when she was 17, she had come to London from Yorkshire and how hard it had been; how she had trained as a nurse and then married. This marriage, she said, had never been a success and she finally got a divorce. She said she had had many jobs in factories since then and talked on freely and expanded on these various themes. Our doctor then brought her back to the way she pressed herself; always seemed to overwork. He did not feel that much progress had been made in his understanding of any of this, but the patient had spoken much more freely and a much less superficial atmosphere had been created.

At the second follow-up interview a week later the patient came into the doctor's room looking radiant; he hardly recognized her. She said her headaches had gone and our doctor proceeded to find out what had happened. The patient then told him that coming down on the bus (to see the doctor) she had suddenly realized that her husband must be lonely without her and that he was very good to her. She recounted how he got up in the morning and made her tea and cut her sandwiches and how he was alone from early in the morning until quite late in the evening. She then suddenly realized that he must love her. This, she said, was an absolute revelation to her and as she spoke her face lit up. Dr C said there was quite an amazing feeling in the interview and he said to her "Didn't you feel that he loved you before?" and she said "Well, yes, but it hadn't meant much to me"; and then said: "I will tell you something that I haven't told anybody else in my life", and went on to say that the first thing she remembered was when she was five, that she was living with her parents and one evening her mother put on a dress to go to a dance and her father came in and tore the dress off her. She did not know why, but her mother went out of the room and then came back and smacked her and said that it was all her fault. The next memory she had was two years later when there was a baby brother born and she thought how funny he looked; and then soon her mother left and she was put in an orphanage. She then paused, but went on to say that she knew it sounded silly and like something in a novel, but that in fact you go on and on hoping that somebody is going to visit you and then gradually, as the years go by, nobody visits you and you realize that nobody is going to visit you so you say to yourself "it doesn't matter if nobody visits me I'll get on myself", and she did. Then, when she was 14 somebody did come to visit her. She thought to herself "I know why they have come, they want me to work for them". And, indeed, she was taken out of the orphanage and put into domestic service. Dr C said you could see in her face the gradual feeling of being left, peering in vain through the gates for someone to come. She said, love and affection was something foreign to her and it had just come to her head that her husband cared for her. She thought she would go back to work and then gradually give it up.

What happened here? Naturally enough, the group of doctors was very interested

to discover what had brought about this change. Various ideas were put forward. The doctor who had spoken in favour of not trying to be too ambitious with this patient because it would take too long, said laughingly, "Can I just to be beastly say that you could not have done that in ten minutes". Dr C answered, "But I did not need 50 minutes". It had been done, in fact, in ordinary office hours. Dr C thought he had enabled the patient to feel that someone wanted her. The seminar thought that if Dr C had not prodded the patient slightly she would have withdrawn when her headache was better, but they realized that it was the doctor's observation before he reported the case that started the treatment. His prodding only consisted of asking her "Why do you push yourself to work so much?" The rest had followed. In this case the doctor made no attempt to make links between the past and the present; the patient was allowed, as our doctor expressed it, to reminisce, and made what links were useful to her; the doctor did not interfere. But we must remember that many worrying aspects of the case were left on one side. For instance, although it had been felt that the patient might be depressed and that there might be hidden menopausal problems and in addition the fact that she had no children would be likely to give her more and not less trouble as time went on—none of these were touched upon. But, whereas this unfinished job might cause uneasiness to the specialist, it did not worry the general practitioners because they knew that the patient would be seen again and again over the years and so a watch could be kept.

We know that not every patient is responsive to our sort of approach and we know that some patients are responsive at certain times and not at others. Or, we could put it another way; we know that some patients when entering the doctor's offices are wondering at the back of their minds whether they can ask him something or discuss something with him; and that others are not. And, some of them may even be hoping that the doctor will not observe some frightening secret. Both observations are, or may be, useful to the doctor.

One of our aims now is therefore to look for diagnostic criteria, which will tell us what to expect and what to do. We know that these criteria cannot be in terms of such clichés as oral dependence, castrating mothers, immature egos, sexual inadequacy and so on, or what really amounts to 'illness-centred medicine', but in terms of observable signs of a patient's preparedness or wish to talk or communicate or to remain silent. Conditions which can seldom be described *usefully* in our usual terminology.

In general practice where the doctors see their patients over long periods there may be opportunities for them to notice changes in the patient or for them to recognize some signs which make them think that the patient may want to communicate. This thought, this idea, in the doctor's mind then has to be examined. Clearly, it does not necessarily mean that the doctor is right. But, he should be responsible to the thought in himself and be willing to look further in a receptive way. The sign might not be a depressed patient who had been undepressed before, or anything as traditional as this, because in our experience the kind of 'little bang work' that we are attempting often starts in quite a different way.

To give an example: One patient, Lucy H, aged 73, was a constant attender at Dr F's surgery. She attended at least once a month and had been on the doctor's list for five years. On this occasion she too came complaining of headaches. Dr F reported that over the years he had made many attempts to discuss her problems with her, with very limited success, and with no apparent benefit to her. He felt he made no contact with this patient and said "There seems to be an inability to relate her symptoms to her problems". But this time (and Dr F does not know why) after a little coaxing the patient spoke about feeling lonely and soon expressed quite strong resentment because she thought that her four sons neglected her. She showed some anger and Dr F felt in touch with her for the first time. When leaving, to our doctor's immense surprise, the patient thanked him. A fortnight later Lucy H returned for some pills. Once again she talked about her misery and anger and her need for human contact. Dr F was glad to be in contact with this patient and felt things had gone quite well. However, after this

interview, the patient disappeared and Dr F learned that she had visited his partner instead. She told him (the partner) that she did not like being questioned. Her headaches, though, were better.

During the seminar discussion on this case, many doctors thought that Lucy H had changed doctors because Dr F had tried too hard. One doctor said "When they create a sense of guilt in us we need to be omnipotent and it is that that drives them away". And another doctor said "If we do well, we must do better and they cannot stand it". Some months later we had a follow-up on this case and were told that Lucy H has come back to Dr F after a two months absence and a routine had now been established between them. Each interview started with a discussion of the patient's symptoms and the uselessness of the pills previously prescribed by the doctor and then a talk ensued about the patient's loneliness and fear and her wish to be of some use to somebody. Strangely enough, Dr F does not feel himself to be threatened or burdened by this patient. She seems a bit livelier and better, but has not given up her symptoms and Dr F does not mind spending ten minutes every two or three weeks with her. He feels the patient is starved of attention, which, although no doubt, is due to her complaining and aggressive behaviour to her family, is the patient's illness and can be treated if the patient is left to make use of the doctor in the way that I have described.

Another aspect of our work is to study a technique of responding to these little shifts. How can we use them? If we start, how far should we go? Sometimes in our experience, the doctors would like to go further but the patients prefer to stop. Perhaps this is because the doctors proceed too much in the traditional manner, looking for a traditional general problem like impotence, or a castration anxiety, or resentment and in so doing fail to follow the patient. At other times the patient shows signs of wanting to go on but the doctor is reluctant fearing dependence or domination by his patient. A patient may only want one 'dynamic' interview and may then be able, or even prefer, to go home and manage on his own; but we do not know which cases want which treatment and it is one object in our research seminar to study these things by very long term follow-ups.

Can anything be said at this stage about any new skills that we have developed during the past year? My idea would be that the skills are rather in the way that the doctor allows the patient to use him, rather than in the way the doctor responds to the patient by his interpretations and theories. This should not surprise psycho-analysts because many of us think of the way that the patient uses the analyst, perhaps more than and certainly in addition to the way that the analyst understands and interprets the patient's free associations. We do not think much of a description of a psychoanalytic treatment which talks only about the doctor's interpretations and nothing about the atmosphere in which he works with that particular patient and the way in which the patient relates to or uses him.

So too, with traditional medicine; the traditional family doctor is used in a particular way which is very good and reliable because both doctor and patient know the rules. But if our doctors are prepared to watch their responses to their patients demands and communications and the subtle ways in which their patients change in their use of them, they may learn to be 'used' in different or more varied ways. In my experience what has prevented them from doing this in the past is not because it involved them in a new way of thinking but because they feared that if they let the patient loose, so to speak, they would be overwhelmed; patients would get too close to them and would become unbearably dependent and demanding. I do not want to suggest that there are no such patients; but they are not so difficult to deal with, if the doctor has a clear idea of what he is being asked for. Nor do I want to suggest that all doctors should give their patients what they ask for; quite the contrary; but the better the doctor understands the more likely he is to take appropriate action.

The doctor, as always, has the responsibility to be aware not only of his patients'

communications and demands but of his own immediate response to them before he can decide what action is appropriate.

It may be, therefore, that our doctors are beginning to feel that they are not endangered if they allow their patients to tell them what they want in their own time and in their own way and they find that they are not turned into psychotherapists if they do this.

May I return to where we started? Are we any nearer to answering the question now as to whether the doctor can avoid a split in himself? Whether he can avoid being a 'general practitioner' to some of his patients and a 'competent psychotherapist' to others? Or, to formulate it in other words: practising 'illness-orientated medicine' with some of his patients and 'patient-centred medicine' with others. I have described how, in trying to answer this question, our research seminar has examined selected patients who have been seen during the doctor's ordinary consulting hours. The patients who have been chosen by the doctors were those with whom they have felt that they had opened the way towards 'patient-centred medicine'; often when, in the doctor's opinion, the patients needed both a general practitioner and a psychotherapist.

I have described some cases where the doctor has succeeded. We do not yet know, however, how often success can be achieved: nor what dangers the doctor has to face.

At the time of writing this paper the majority of the group think that the shift of emphasis in our research was from expecting the doctor to be a sort of detective inspector to a study of the varieties of response open to the doctor; or to put it in other words to the variety of ways the doctor can be used. This may be one of the changes which will lead us to understand the possibilities and techniques of 'patient-centred medicine' and thus to undo the split in the doctor.

Disappointing results of health check. *The executive council.* 1969. **20,** 56.

Members of the Finance and General Purposes Committee of the Norfolk Executive Council have had for consideration a memorandum which had been prepared giving the final report of two practitioners on the health check they had conducted in November, 1967.

The memorandum indicated that the health check had cost about £160 and had attracted 437 persons out of approximately 3,000 who might possibly have come for the check. Details were given of the kinds of check undertaken and the arrangements which have been made. The doctors felt that the results on the whole were rather disappointing as the persons who came tended to be the people who knew already that they had some underlying disease and who were being treated or those who were well but who were conscious of their health and who would in any case have consulted the doctors at the first sign of disease. The people that the doctors particularly wanted to attend came only in very small numbers. The doctor had acquired a certain amount of interesting information from the check but they reported that they had discovered the enormous difficulty in running periodic health checks. However the check had involved a lot of reading and it was felt that the doctors' vision had been widened. In conclusion it was suggested that from the patients' point of view and the expenditure of public money it does not seem that this kind of health check is an economical and viable project.