Special Article

Perspectives on Patient-Doctor Communication

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Until recently, the content, structure, and function of communication between doctors and patients has received little attention and has been excluded from the realm of scientific inquiry; as a result, most clinicians have had little formal training in communication skills. In this paper leaders in doctor-patient communication present four approaches that are currently used as the basis for clinical training and research, summarize the progress made in forming a consensus, and outline the implications of these perceptions for practicing physicians.

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The average primary care physician will perform at least 200,000 medical interviews during a 40-year career, making it the most commonly performed "procedure" in clinical medicine. Most clinicians, however, have had little formal training in communication skills. Research over the past 20 years has shown that effective physician-patient communication is related to patient satisfaction, physician satisfaction, compliance, and medical outcomes,[1-4] and that patient dissatisfaction with medical care and malpractice claims are often related to miscommunication between doctors and patients.[5] Many practicing physicians, however, are unfamiliar with these developments and their relevance to clinical care.

In this paper, leaders in doctor-patient communication to discuss four approaches that have been developed and used as the basis for clinical training and research. Until recently, the different approaches to doctor-patient communication evolved in isolation; each developed its own terminology, teaching methods, and research base. This has led to some confusion on the part of practicing physicians who have tried to improve the way they communicate with patients. As the approaches have matured, their complementarity has become more apparent; it is now possible to develop a common language for understanding, teaching, and researching about patient-doctor communication.

Achieving a Harmony of Understanding

(Gabriel Smilkstein, MD)

> The physician enjoys a wonderful world of opportunity . . . to witness words being born. Their actual colors and shapes are laid before him carrying their tiny burdens which he is privileged to take into his care with their unspoiled newness. He may see the difficulty with which they have been born and what they are destined to do. No one else is present but the speaker and ourselves, we have been the words parents. Nothing is more moving.[6]
>
> —William Carlos Williams, MD

The relationship a physician establishes with a patient during a clinical encounter is the heart of medicine. The metaphor is appropriate, for the quality of this relationship influences the flow of knowledge and nurturing that leads to a harmony of understanding so necessary for successful medical therapeutics.

Family medicine has played a prominent part in

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advancing the art and science of medical communication. It is apparent, however, that our efforts, along with those of our colleagues from other specialties, have not been enough. Patients are telling us that there has been a deterioration in the physician-patient relationship,[7] and within the profession itself there are signs of dissatisfaction and demoralization.[4] Two common explanations given for the distancing between physicians and patients have been the increasing use of technology in patient assessment and management and the economic pressures felt by both physicians and patients. I believe there is also a competition in medicine between words and numbers—and the numbers seem to be winning.

Physicians do not listen well. Much has been written lately on the importance of listening to the stories that patients have to tell.[8–10] Often these stories reveal the many facets of pain that could never be revealed by the technological marvels of the laboratory and radiology departments. It is not only the stories themselves that are so revealing, but the way these stories are told. Computer-generated diagnostic programs will never be able to record the nuances of body positions, facial expressions, and voice changes that add so much to the observant physician's knowledge of the patient's state of well-being.

Engel's seminal writings on the biopsychosocial model[11] have served as a template for educational objectives strongly advocated by family medicine[12]—that is, the study of the patient within the context of family and community. Many teachers of family medicine embrace these principles; however, they are often frustrated in their efforts to translate the model's theory into practice.

As physicians, we need to "listen with both ears," that is, symbolically assigning one ear to receive biomedical and the other ear to receive psychosocial information. Often, medical education places so much emphasis on the biomedical that student physicians tend to listen only with a biomedical ear, and "judgments bearing on social aspects of the patient's life are commonly made with minimum information about people, relationships, and circumstances involved."[11] In contrast, a biopsychosocially oriented physician ". . . identifies and evaluates the stabilizing and destabilizing potential of events and relationships . . ."[11] in a patient's life.

Often stabilizing forces can be equated with social support and destabilizing forces with stressors. The balance between these forces permits a qualitative estimate of the patient's risks and vulnerabilities. Depression and anxiety are related to poor physical health through associated neuroendocrinological and immunological changes.[13,14] Thus, the conduct of the medical interview is critical to optimizing biological outcomes as well as psychological and social well-being.

These introductory remarks were intended to communicate the following:

- Patients are saying that physicians are not listening very well.
- Listening requires the simultaneous intake of biomedical, psychological, and social data.
- Priorities must then be set regarding both assessment and management of these data. We must examine both stressors and social support resources. By listening with both ears, physician and patient will be able to achieve a harmony of understanding and thus establish an environment that allows for optimal healing.

In the following sections, four approaches to doctor-patient communication are juxtaposed. It is our hope that common themes and complementarity among the approaches will lead to a deeper understanding of the doctor-patient relationship.

The Three-Function Model of the Medical Interview (Steven A. Cohen-Cole, MD)

This section describes specific skills that can be developed to optimize communication between physicians and patients. The three functions—gathering information, developing a therapeutic relationship, and giving information—are understood in the context of a dyadic doctor-patient relationship.

The three-function model of the medical interview, originally developed by Julian Bird for the purpose of educating medical students,[15] represents a comprehensive foundation for understanding doctor-patient communication. A heuristic device, the model highlights three core functions of the interaction between doctor and patient: (1) gathering data to understand the patient; (2) development of rapport and responding to the patient's emotions; and (3) patient education and behavioral management. Each of the three functions carries high face validity, as students and practitioners readily understand and usually accept the importance of each of the three functions. By organizing many dimensions of the medical interview into three core functions, the model serves the purpose of simplifying complex processes for the purpose of education, research, and clinical practice. This section describes each of the core functions and reviews some of the basic skills used in the medical interview (Table 1).

The first function of the interview is to gather data to understand the patient and his or her problem. The basic skills used to gather data accurately and efficiently are familiar to medical practitioners and to teachers and

Table 1. The Three-Function Model of the Medical Interview

Functions	Objectives	Skills
I. Collect information	A. Accurate data collection B. Efficient data collection C. Determine the nature of the patient's problem	A. Open-ended questions B. Open-to-closed cone C. Facilitation D. Checking E. Survey of field F. Negotiate priorities G. Directions H. Summarizing I. Elicit patient's ideas about etiology
II. Respond to patient's emotions	A. Develop and maintain rapport B. Reduced interference C. Patient satisfaction 1. Adherence 2. Fewer lawsuits D. Relief of distress E. Detection, management of psychiatric illness F. Physician satisfaction G. Improved physical outcome	A. Reflection B. Legitimation C. Support D. Partnership E. Respect
III. Educate and influence behavior	A. Achieve patient understanding of illness and treatment options B. Involve patient actively in treatment process C. Achieve high adherence to treatment plans (medication and/or life-style change)	A. Education about illness 1. Elicit patient's ideas 2. Provide basic diagnosis 3. Respond to emotions 4. Check patient's baseline information 5. Provide details of diagnosis 6. Check understanding and elicit questions B. Negotiation and maintenance of a treatment plan 1. Check baseline information 2. Describe goals and plans 3. Check understanding 4. Elicit patient preferences and commitments 5. Develop plan 6. Affirmation of intent 7. Maintenance and prevention of relapse C. Motivation of nonadherent patients 1. Check adherence 2. Diagnose adherence problems 3. Elicit statement of commitment 4. Negotiate solutions 5. Affirmation of intent and follow-up

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students of the interview: (1) open-ended questioning; (2) the use of an open-to-closed cone of questioning to progressively narrow the focus of the narrative; (3) facilitation (eg, "Tell me more about your pain."); (4) clarification (eg, "When you say *dizziness* do you mean that you feel the room spinning?"); (5) checking (eg, "If I have heard you correctly, this episode began Monday evening and has worsened over the past 2 days, is that correct?"); and (6) surveying for new problems (eg, asking "What else bothers you?").[16]

The second function of the interview concerns the development of rapport and responding to the patient's emotions.[17] Although physicians have traditionally understood the importance of doctor-patient rapport and the importance of the emotional dimension of the interview, attempts to formulate pragmatic teaching approaches have been difficult. By collapsing the entire range of emotional issues into a discrete, equally compelling function of the interview, teachers and learners are better able to conceptualize and develop skills relating to emotional issues.

Some physicians and students may question the core relevance of this function to the practice of medicine. For such "biomedical" practitioners or students, it is often helpful to point to key objectives of this function (Table 1): increasing the efficiency of data gathering; increasing patient satisfaction (thereby decreasing nonadherence and lawsuits); recognition of psychiatric distress; humanization of the doctor-patient encounter; improving physical outcome; and increasing physician satisfaction.[16]

Many different basic and higher-order skills can be used to improve doctor-patient rapport and doctors' capacity to respond to patients' emotions. However, there is a specific set of five verbal interventions that can serve as a core set of basic skills for this function: reflection, legitimation, support, partnership, and respect. Each of these skills has been operationally defined; each can be demonstrated and practiced using live patients, role-play, or simulated patients. The virtue of defining a core set of basic skills lies in the ability to focus students' and practitioners' attention on a relatively simple group of interventions that can be mastered and which, when used skillfully, can actually change the nature of the doctor-patient interaction. Using a pragmatic approach often demystifies and renders acceptable complexities and subtleties that have led many physicians to reject explicit attention to emotional issues as unscientific, "soft," and "touchy-feely."

Following is a brief description of basic skills used to develop rapport and respond to patients' emotions. *Reflection* refers to the physician's explicit recognition of a patient's emotion, whenever it emerges. For example: "Mrs Smith, I see this problem is disturbing to you," or "Mr Earnest, I realize that my keeping you waiting so long must be frustrating for you." *Legitimation* refers to explicit statements by the physician that validate the patient's emotional response: for example, "I think anyone would find this information quite distressing." *Supportive comments* point out that the physician wants to help: "I am going to do whatever I can to help you overcome this problem." *Partnership* connotes cooperation between the physician and his or her patient: "Let's talk about this problem and together try to develop some solutions." Lastly, *respect* refers to the physician's explicit recognition of a patient's accomplishments: "I am impressed by the way you're handling your work and home life, in spite of the medical problems you've been having."

The third function, patient education and behavioral management, refers to the importance of providing diagnostic information and therapeutic recommendations to patients in a manner that they can understand and put into action. When this function of the interview is successful, physician and patient will agree on a course of action and patient adherence will be maximized. Few students and physicians ever receive instruction on the communication techniques that have proven effective for accomplishing these goals. The skills related to these objectives are listed in Table 1. Patient education is best served by eliciting baseline understanding, delivering information in small, discrete bundles, and checking for understanding. Negotiation of a treatment plan is facilitated by eliciting the patient's preferences and obtaining a statement of commitment. Adherence management is best served by accurate assessment of adherence problems and eliciting the patient's preferences and ideas for changes.

The three-function model is a teaching tool, which also proposes a way of looking generically at doctor-patient communication processes. While the originators of the model have emphasized the basic skills components for the purpose of educating medical students, the conceptual underpinnings of the model extend into the most complex and subtle dimensions of medical practice. For example, the organizational framework separating the medical interview into the three tasks of information collection, rapport development, and behavioral management can be applied to other situations, such as family interviewing. Thus, family systems approaches could also be considered along lines of information collection (though techniques needed will clearly surpass those needed in dyadic interviewing), rapport development (again, techniques need to be expanded to develop rapport not only with each family member but also the family as a whole), and behavior management (more complex interventions are often required).

The Patient-Centered Clinical Method

(Ian R. McWhinney, MD)

This section develops a philosophical and moral basis for a reformed clinical method. Practicing the method requires an open-ended inquiry into the patient's concerns and the patient's needs for comfort, for information, and for being understood.

The patient-centered clinical method, as developed by the group at the University of Western Ontario,[18,19] is a total clinical method designed to replace the one that has dominated medicine for over a century. It is historically justified, theoretically grounded, empirically tested, and morally based. Its historical justification is that it represents an evolutionary transformation of a method that has roots in the Hippocratic tradition and in the Enlightenment.[20] The transformation is needed because in recent times the method has moved more and more away from the experience of the patient toward increasing levels of abstraction.

A transformed method should aim to preserve the strengths of the old method—predictive power, a clear injunction to the clinician, and clear canons of validation—while remedying its defects. In the patient-centered method, the injunction to the physician is: "Understand the meaning of the illness for the patient as well as interpreting it in terms of the medical frame of reference. Based on a shared understanding, try to find com-

mon ground with the patient about the problem and its management."[21] Just as the pathologist provides the ultimate validation for the clinical diagnosis, the patient validates the patient-centeredness of the process. Note that these are not separate and distinct processes: the meaning of the illness for the patient may have an important bearing on the full understanding of the clinical problem, and vice versa.

Practicing the method requires physicians to understand and respond to patients' feelings and fears, perceptions and expectations, and the reciprocal relationships between the illness and the patient's life. It is this requirement that makes different and challenging demands on us; it also makes our work engaging and rewarding.

First, we have to set aside temporarily the interpretive frames of reference that can get in the way of our understanding. In his account of experiences as a cancer patient, Arthur Frank[22] writes, "Caring has nothing to do with categories; it shows the person that her life is valued because it recognizes what makes her experience particular." Every patient is unique. Second, we have to open ourselves to the patient's expression of feelings, some of which may be very disturbing to us. The old clinical method protected us from this by regarding the doctor as a detached observer, separated from the patient by an invisible barrier. Third, we have to master the process of active listening, partly a skill, partly an attitude of mind, partly a personal attribute. Active listening requires intense concentration on the patient's expression in all its manifestations and nuances, verbal and nonverbal, searching for the meaning behind every word, gesture, and movement. Understanding on this level is person-to-person and is based on trust and commitment. It also implies a shift in the power balance between doctor and patient. If patients are to be granted the opportunity to express themselves, they need more control over the process than has hitherto been the case.

Although learned techniques are necessary, the patient-centered clinical method is, like its predecessor, an attitude of mind and a moral position rather than any particular technique. It is an attitude of openness rather than "buttoned-upness," receptivity rather than dominance, commitment rather than detachment. Like ail applied sciences, it is an art, requiring intensive preparation and engagement by the physician. It has rules and strategies, but these do not and cannot specify the whole art.

The method is based on the experience that patients provide cues to their feelings, fears, and expectations which, if responded to appropriately, will lead to their expression. The appropriate response is behavior that encourages patients to tell their stories. If meaning does not emerge in this way, key questions[23,24] can unlock the gates of expression. In her account of experiences as a multiple sclerosis patient, Kay Toombs[25] writes: ". . . no physician has ever asked me what it is *like* to live with multiple sclerosis or to experience any of the disabilities that have accrued over the past seventeen years . . . no neurologist has ever asked if I am afraid. . . ."

The old and new methods represent different valuations of knowledge. Kay Toombs gives an example from her experiences. Some time after the diagnosis of multiple sclerosis, she developed disabling muscle pain. A muscle biopsy showed a myopathic process, but made little contribution to diagnosis or treatment. When she commented that not much had been gained by doing the biopsy, her doctor replied, "Oh, but we have! Now we *know* something is wrong." For Toombs, to be unable to carry out the most mundane of activities was to know something was "wrong." Both types of knowledge were based on facts. The knowledge based on the biopsy, subject to the usual errors associated with all tests, was actually less reliable than the knowledge gained from Toombs's personal experience: yet it was automatically valued more highly by the physician.

Developing, validating, and teaching the patient-centered clinical method has involved developing a vocabulary of cues and responses, together with criteria by which patient-centeredness can be measured. A cue, for example, is an expression that invites exploration of the patient's expectations, ideas, feelings, or fears. The physician's response may be a facilitation, encouraging further expression by the patient, or an acknowledgment, which indicates that the message has been received and will be dealt with later. A cut-off is the physician's failure to respond to a cue. A prompt is the patient's repeat of a cue that has been cut off by the physician.

Using these definitions, a method has been developed for an observer to score the patient-centeredness of an interview based on the proportion of cues responded to or cut off by the physician.[26] The outcome of the interview can be assessed by asking the patient whether his or her expectations, ideas, feelings, and fears have been understood. Empirical studies have shown a relationship between these and other criteria of patient-centeredness and resolution of symptoms, control of hypertension and diabetes, patients' satisfaction, and resolution of concerns.[1,2,27,28] These studies justify the method according to utilitarian criteria. The equally important justification, however, is its moral underpinnings[29]: the willingness of the physicians to share their power, show their human face, and respond to suffering irrespective of its cause.

In teaching the method, defining its objectives in the terms described above helps students to understand the nature of the task. Having a vocabulary of cues and

responses allows practitioners to develop a framework for self-evaluation of their communication skills, and allows learners and teachers to review taped interviews and identify points at which different responses could have led to a better outcome.

A Family Systems Approach to Patient Care

(Thomas L. Campbell, MD)

This section describes how the individual patient is part of a complex social unit, and how physicians can communicate more effectively with patients by taking into account patients' families and social networks.

A family systems approach to health care was developed from family therapy and systems theory in an effort to integrate the family and social context into clinical medical practice. Many individuals in the field have made major contributions to the development of this approach, including Doherty and Baird[30,31]; McDaniel, Campbell, and Seaburn[32]; Christie-Seely,[33] Medalie,[34] Ransom and Vandervoort,[35] Crouch and Roberts,[36] Sawa,[37,38] and others. Although a family systems approach offers new ways to think about clinical problems and work with patients and their families, it has more similarities to than differences from the other methods discussed here. It is based on many of the same principles and builds on these other approaches. For example, a family systems approach assumes that the health care provider has excellent interviewing and communication skills, such as those described in the three-function model, but extends these skills to interviewing couples and families. Similar to the patient-centered clinical method, a family systems approach focuses on the illness experience of the patient, but also attends to the family's experience. One method of physician self-awareness, the family of origin approach, is based on family systems theory. Each of the approaches described in this paper is based on a biopsychosocial approach that emphasizes a holistic and integrated approach to patient care. In this section, I will highlight some of the unique contributions and characteristics of a family systems approach.

BASIC TENETS OF A FAMILY SYSTEMS APPROACH

A family systems approach has three basic tenets[32]:

TENET 1. A family systems approach is based on the biopsychosocial approach with the family as the most relevant context that influences illness.

This tenet assumes that the family context will be important in dealing with most clinical problems. The assumption is based on research demonstrating that family and social relationships have a profound effect on patients' physical and mental health.[39,40] Furthermore, patients' health beliefs and health behaviors develop and are sustained within families. Families, not health care providers, provide the day-to-day care for patients' illnesses and are deeply affected by the illness of a family member.[41] Caring for families is part of the mission of family medicine and leads to better patient care and outcomes. A family system approach provides the theory and methods to care for families.

In the family systems approach, "family" does not refer simply to the traditional nuclear family that represents a minority of American families. For clinical purposes, the family is best defined as the patient's most intimate social relationships, or as those people who are biologically, legally, or *emotionally* related.[32] Thus, a family systems approach considers the patient in his or her intimate social context, whether that is a two-parent family, a homosexual couple, or a group home for the developmentally disabled.

TENET 2. In the therapeutic triangle of relationships among the doctor, patient, and family, the family is considered an essential partner in medical care.

Doherty and Baird have written about the "illusion of the dyad in medical care," suggesting that the family is involved in most of what takes place between the doctor and patient whether present in the office at the time of the visit or not.[31] They propose a "triangular perspective" in which the family is an important resource in assessment and treatment planning. After seeing a physician, patients usually discuss the visit with other family members and often seek a second opinion from them. Involving the family in the therapeutic relationship from the start helps to avoid problematic and frustrating interactions with patients and family members.

TENET 3. Most disorders or problems are assumed to result from a complex interaction between multiple factors at different levels of the system, rather than any simple cause and effect at one (eg, biomedical) level.

It is often impossible to find simple causes for clinical problems, so a family systems approach to these cases focuses on the interactions that maintain symptoms and problems and ways to change those interactions. This general systems principle emphasizes the notion of circular causality and feedback loops.[42] For example, in caring for an obese patient who suffers from depression and marital problems, it is not usually helpful to try to determine whether the obesity caused the depression and

Table 2. Interviewing Patients Using a Family Systems Approach

When interviewing an individual

1. Focus on the symptom as a pathway to explore relevant biomedical and psychosocial dimensions of the problem.
2. Intersperse biomedical and psychosocial questions as much as possible.
3. Inquire about how the family (or intimate others) are involved in the problem.
4. Assess what level(s) of the biopsychosocial model is the most relevant and helpful to intervene.
5. Decide how to involve the family in the treatment process.

When a family member comes in with the patient

1. Join with the family member first, if you have a prior relationship with the patient.
2. Clarify the reasons for the family member coming in and what his or her role is.
3. Ask the family member's observations and opinions of the problem or symptom.
4. Solicit the patient's and family's assistance in the treatment plan.
5. Maintain alliances with all family members. Do not take sides, especially in chronic family conflicts.

marriage problems or vice versa. Instead, all are assumed to influence each other; intervening with each problem (weight reduction program, antidepressants, and couples therapy) is likely to be the most effective treatment plan.

INTERVIEWING TECHNIQUES AND COMMUNICATION SKILLS

A family systems approach is not an interviewing technique, but there are some principles that apply to interviewing an individual patient and family (Table 2). Using a family systems approach does *not* mean always seeing more than one member of the family. Most of family practice involves seeing individual patients.

The first two interviewing principles, using the symptom as a pathway for exploration of the problem and interspersing biomedical and psychosocial questions, are common to any biopsychosocial approach. The last three principles are more specific to a family systems approach. A few useful questions for inquiring how the family is involved in the problem include: "Has anyone in your family had a problem similar to this one?"; "Who else in the family is concerned about this problem?"; and "What have others (family or friends) said or done about the problem?" Each of these questions helps to put the symptom in a family context. Early in the interview, the physician usually makes an assessment as to which areas are likely to be the most relevant for inquiry and necessary for implementation of an effective treatment plan. Part of this process involves deciding how and when to involve other family members. For some problems, involving the family may not be necessary. In other situations, it may be helpful to speak to a family member who has accompanied the patient to the physician's office and is sitting in the waiting room. For many serious problems, such as the diagnosis of a serious chronic or life-threatening illness, it is important to invite other family members to the next appointment.

The family genogram is an essential tool for a family systems approach.[43] It gives the practitioner a quick picture of the family, including information about family structure and functioning, life-cycle stages, and patterns of family relationships. A "skeletal" genogram, giving basic information about the immediate family, can be constructed in several minutes and is useful to obtain on all patients. Detailed genograms are helpful in more challenging cases, especially those involving vague, unexplained symptoms or psychosocial problems.

Since meeting with families is an important part of a family systems approach, basic skills in interviewing more than one person are necessary. Some of the basic principles for family interviewing are listed in Table 2. More detailed descriptions of how to conduct a family conference are available.[32] It is crucial to welcome family members and include them early in the interview. Since family members may not know the physician, it is important to spend time establishing a relationship ("joining") with them. Clarifying why they are present is helpful. If the visit was initiated by the patient or family member, one can ask, "How is it that you happened to join (the patient) today?" If the visit was initiated by the physician, a useful question to the family member is, "What is your understanding of why you were invited here today?" Asking the family members' opinions or observations about the presenting problem and how they might be helpful communicates the physician's desire to include family members as important allies and resources.

When there are conflicts within the family, it is particularly important, but often difficult, to maintain alliances with all family members. It is often tempting to side with either the identified patient to "protect" him or her from the family or with the family if they happen to agree with the treatment plan and the patient does not (eg, stopping smoking, taking medication). Except in rare circumstances, such as when there is a danger of abuse or self-harm, taking sides in a family disagreement dramatically reduces the physician's effectiveness in dealing with the problem. Instead, the physician can elicit each person's experience without necessarily agreeing with it or invalidating the viewpoints of other family members. These viewpoints can then be taken into consideration when developing a treatment plan that is likely to be successful.

The most effective and satisfying approach to patient care is likely to be one that integrates different approaches such as the ones described in this paper. A

family systems approach offers a practical method for treating patients within their family and social context, which represents one of the core principles in family practice. It is based on an extensive body of research demonstrating the importance of the family in health care, although more research is needed to prove the effectiveness of family interventions. The three-function model of interviewing, the patient-centered clinical method, and the physician awareness approach are all compatible with a family systems approach. One of the challenges of the future is to explore how best to integrate these approaches into patient care.

Physician Self-awareness (Ronald M. Epstein, MD)

This section develops a rationale for physician self-awareness and describes some methods used to enhance physician self-awareness.

My first career was in music. I played the piano, more recently the harpsichord. Thus Smilkstein's notion of a "harmony of understanding" has particular meaning to me. In many ways the interactions between doctor and patient resemble music-making (especially chamber music) and dance.

Being a musician, I spend part of the time regulating and tuning the instrument so that I can play. One cannot play music on an instrument that is out of tune, and a poorly regulated instrument makes music-making more difficult. Instruments vary; a skilled performer may find it difficult to play on an unfamiliar, but otherwise fine, well-tuned, and well-regulated instrument. For a keyboard player, as well as for other instrumentalists, it is necessary to keep one's fingers in shape as well; it is as important that the fingers be "in touch" as it is that the instrument be in tune. For singers and dancers the analogy is even more directly applicable to medical practice; as with physicians conducting medical interviews, their instruments *are* themselves.

There are several assumptions that underlie the importance of physician self-awareness in medical practice. I have begun with the idea that physicians themselves are diagnostic instruments and therapeutic tools. This idea borrows from the work of Michael Balint, who referred to the physician as a "drug," a potent agent of change.[44] Thus, the first assumption is that physicians themselves are therapeutic as well as the prescribers of therapy.

The second assumption is that medical decisions are based on cognitive as well as noncognitive factors,[45] including factors that are vague or opaque to the physician. Affective dimensions[45] and sociologic influences[46] partially account for large variations in the use of "standard" medical procedures from one physician to the next. For example, laboratory use is related to attitudes physicians have toward risk[47] and to personality factors.[48] Errors in medical diagnosis can be attributable to physicians' feelings about patients.[49] What physicians feel about their patients may be as important determinants of medical decisions as what physicians think and know about their patients.[50,51]

The third assumption is that the physician's own background and family have major influences on how he or she approaches the practice of medicine.[52,53] I will give a personal example:

> My maternal grandmother, with whom I was very close as a child, decided that I would become a doctor. When I was 5 years old, she told me that I would become a doctor so that I could take care of her when she was old. Surely, I would have a lucrative and prominent practice, keep patients waiting for a long time because I was so much in demand, and drive a Cadillac.
>
> Entering medicine was thus colored by my grandmother's expectations. She is now quite old. I am the only physician in the extended family, and several times a year I get calls from relatives to interpret what their physicians said and to communicate with them. The privilege of physicianhood thus carries a significant burden. I feel a strong sense of responsibility for patients, and find it difficult to leave them when I travel for conferences and vacation. Sometimes my overresponsibility interferes with patients doing things for themselves.

Similarly, for each physician, unique backgrounds, culture, stories, myths, and the roles they played in their families of origin shape their practice of medicine.

Fourth, the way physicians deal with issues in their own families and personal lives relates to the way that they deal with similar issues in their professional lives, as illustrated by the following example:

> A skilled and empathic resident was caring for a couple. The husband had a cluster of puzzling neurological complaints that eluded medical diagnosis. In the resident's own family, his younger brother received special attention after suffering a stroke during childhood. The resentments that grew culminated in his brother's prolonged disappearance, a parental separation, and the resident changing his name, all within a few months. The family pattern of dealing with stresses by cutting off communication was repeated with this patient. The patient was not responding well to treatments that were prescribed. The resident began to interrupt the patient during the interview and to break eye contact, and eventually suggested that the patient not come back for another appointment for a year.

Others have reported similar parallels between family and work environments, both in medical[52] and psychotherapy[54] training settings.

The fifth assumption is that greater self-awareness

will enhance physicians' use of their own potential strengths in clinical settings. Examples would be a physician who had been at risk for HIV infection in the past using his own experience to help counsel his patients who were still at risk, or a physician whose parents died at a young age developing a special sensitivity to the issues that face the recently bereaved. Conversely, awareness of recurring patterns and blind spots can help physicians accommodate and avoid further blocks to effective communication.

A physician in his mid-30s came from a family characterized by longevity and generally excellent health. He had four living grandparents, and the only funeral that he had ever attended was for his great-grandmother, who had died 20 years previously at the age of 96. His family never spoke of death directly; instead, people "passed away" or were not mentioned. He was caring for a patient in his late 30s with AIDS. Both physician and patient were elder brothers, and they had each assumed a caretaking role in the family. Despite being sensitive and attuned to end-of-life issues with dying patients, the physician repeatedly forgot to discuss advance directives or living wills with the patient. On reflection, the physician realized how strongly he had identified with the patient, and how this had led him to avoid discussing some important but painful issues. Since that realization, the physician became more able to discuss end-of-life issues.

How are physicians to become more self-aware in a manner that is useful and transferable to the clinical setting? There are several approaches that have merit; individuals may need to choose a route that is most compatible with their personal style. There have always been practitioners who have gained insight through reflection, journals, psychotherapy, or focused case review. Videotape review alone or with an experienced critic can offer another route to self-reflection. Group approaches have the advantage of exposure to other physicians' issues, offering support and finding common ground. In recognition of the importance of self-awareness for physicians in training as well as physicians who are already in practice, three major methods have been developed (Table 3).

Most family physicians are familiar with the concept of Balint groups. In the 1950s Michael and Enid Balint developed an intensive, ongoing small-group format wherein practicing physicians would present difficult cases to a consulting psychiatrist.[44] Often, the physician's unrecognized feelings were a clue to the difficulties, and exploration of those feelings formed the focus of the group. The theoretical base is psychoanalytic, and is based on dyadic doctor-patient and group-leader–participant relationships. The Balint group has since become more heterogeneous; often the group leaders are family physicians, psychologists, and social workers,[58] and the participants are residents, fellows, academic faculty, or community-based physicians[59]; and sometimes the group has incorporated family systems concepts.[59]

Table 3. Self-awareness Groups, Their Origins and Focuses

Type of Group	Theory Base	Primary Focus
Balint group	Psychoanalysis (Freud; Balint[44])	Clinical cases that raise countertransference issues in medical practice
Family-of-origin group	Family therapy (Bowen[55,56])	Physicians' past and present family issues as they apply to clinician-patient relationships
Personal awareness group	Person-centered therapy (Rogers[57])	Interactions between group members and personal issues as they apply to all aspects of work

Family-of-origin groups are based on intergenerational family therapy as developed by Murray Bowen.[55,56] Families carry stories, traditions, attributes, and myths. The genogram, or family tree, is a graphic means for gaining access to some of those stories. Typically, each group member presents his or her family story with the aid of a genogram and sometimes photographs, memorabilia, or other materials. The group discusses how an individual's family-of-origin has given him or her particular strengths and insights.[60] By adopting an explicit focus on strengths rather than shortcomings, this approach helps establish trust while enabling participants to explore their difficulties and blind spots.[54] As the group evolves, clinical cases may occupy more of the discussion and are related to patterns in participants' families of origin.

Personal awareness groups based on the work of Carl Rogers[61] have been developed as part of intensive courses in medical interviewing. The format of the groups is the least structured of the three approaches. Difficult clinical cases and other aspects of the work environment are explored alongside here-and-now relationships between group members. The immediacy of feelings fosters affective education that participants generalize to their particular work settings.

Each of the three approaches makes an important contribution toward helping physicians become more self-aware and able to bring more of their strengths to clinical encounters. As with tuning and regulating musical instruments, the process of personal knowledge is not an end in itself. Ultimately, this awareness is for the purpose of being in tune and in touch with our patients.

Summary and Conclusions

The four approaches to doctor-patient communication that have been represented in this paper are among many that have made important contributions. On a theoretical level, the complementarity of the approaches is more powerful than their differences. The three-function model outlines specific tasks to be accomplished during a medical encounter, criteria for observing and critiquing physician behavior, and techniques to help physicians communicate more effectively. The patient-centered method provides a philosophical framework and paradigm of the doctor-patient relationship that ablates the artificial separation of human distress into "physical" and "psychological" phenomena; within this paradigm, specific communication strategies may be used. The family systems approach emphasizes the importance of the patient's life context in understanding and managing illness; in addition, this approach raises the question of to what extent is the patient the individual, the family, or the social milieu. The various approaches to self-awareness complement each approach to physician-patient communication by helping practitioners to be in tune and in touch.

There is an important need to develop a common language for talking about communication in the clinical setting. Each approach has adopted language from the school of psychology on which it is based. Some of those who are beginning to explore the literature on physician-patient communication may be left confused by the diversity of terms and constructs.[62] Thus, those trained in a patient-centered approach might speak about *establishing rapport*, whereas another, trained in family systems, might speak of *joining*. The two terms refer to similar activities of making contact with the patient and developing a relationship based on trust; however, the concept of joining also includes becoming a participant-observer in a family or culture. *Countertransference*, a psychoanalytic term that refers to a physician's unconscious process of interposing his or her own life issues in his or her relationship with a patient,[63,64] may be called *family-of-origin issues* in a family systems context.[56] A *biopsychosocial approach*[11] is philosophically very close to a *systemic view*,[42] such that those using the terms have difficulty distinguishing them. *Enmeshment* is a family systems term that describes the behaviors observed between individuals who have diffuse ego boundaries (a psychoanalytic construct). Other terms, such as *resistance*, are used differently by the different approaches, with some referring to resistance as a behavioral phenomenon (such as noncompliance), and others considering it more of an unconscious phenomenon.

The above comments are a first attempt at providing some translation between the approaches. Further elaboration of this effort will be the result of further collaborative work, such as the 1992 symposium from which this article was drawn, consensus conferences such as the one that was held in Toronto in 1991,[65] and collaborative training courses in physician-patient communication that are now offered through the Society of Teachers of Family Medicine, the American Academy on Physician and Patient (for further information, contact AAPP, 3000 Chestnut Ave, Suite 320, Baltimore, MD 21211), the Program for Biopsychosocial Study (contact Timothy Quill, MD, 220 Alexander St, Rochester, NY 14607), and others.

We do not yet know all of the important "active ingredients" of each approach. Nevertheless, clues may be gleaned from research on the doctor-patient relationship and also from those principles that are common to all approaches. Effective communication must be grounded in respect for the uniqueness and integrity of all humans. Thus, the teaching of communication goes beyond technique; there are always important philosophical and moral issues. The technique of interviewing from each of the perspectives includes providing the patient with a facilitating environment,[57,66] eliciting the patient's concerns,[17,67] allowing the patient to tell his or her story,[9,68] judicious use of open-ended and close-ended questions,[16] clarification and legitimation of the patient's concerns,[15] exploring the family and social contexts,[54] providing medical information in a manner that is understandable to the patient,[69] and reaching common ground with regard to the nature of the illness and its treatment.[21,70] More advanced skills include dealing with sensitive issues such as sexuality and death; discussing diagnostic test results and bad news[71]; dealing with substance abuse; communicating with patients with cognitive impairments; communicating through translators[72]; and conducting interviews with couples and families.[32,73]

The medical interview cannot be understood as an isolated encounter. Especially in primary care settings, patients and physicians develop relationships that have historical precedents and the expectation of continuity. Most of the research on physician-patient communication, however, has been conducted on single interviews, and has often focused on patient visits for new problems rather than on follow-up visits. For that matter, most interview research has focused on the early phases of the interview to the exclusion of later phases, especially information-giving and negotiating treatment plans.[65] Nor has the relation of reimbursement method and practice setting (health maintenance organization, private, clinic) to physician-patient communication been explored. Although the patient-centered method gives a philosophical overview of the basis of such long-term relationships,

more work is needed to define the skills necessary for fostering effective long-term strategies with patients in practice settings. We also need to create health care systems that will support physicians' efforts to communicate with their patients. This is particularly important for making this body of research more meaningful for physicians in practice, and for developing appropriate educational strategies that will prepare students and residents for the realities of clinical practice.

Time is of great concern to practicing physicians and health care organizations. Studies of family medicine residents show that patient-centered interviews take an average of 1 minute longer than physician-centered interviews.[19] Dealing with more complex psychological issues can add more time to the medical encounter.[74] On the other hand, patients whose concerns are heard and acknowledged have quicker resolution of symptoms,[1,2] presumably fewer return visits, and, perhaps, fewer malpractice suits (H. Beckman, R. Frankel. June 1993. Unpublished data). The costs and benefits of changes in communication style must be studied in economic as well as personal terms in order to achieve widespread change.

Finally, physician-patient communication should not lie isolated within the domain of "psychosocial medicine." It is clear that all aspects of patient care are affected by how physicians and patients communicate, including the diagnostic process, treatment choices, compliance with treatment, and patient satisfaction. As McWhinney notes (above), human suffering does not come neatly divided into physical and psychological components; instead, there is a web of factors and forces that contribute to illness, which include alterations in functioning, pain, and other psychophysical experiences, connections to fellow human beings,[75] and personal and social meanings of suffering. If the goal of medicine is the relief of suffering,[76] then communication, as Smilkstein said (above), is at the heart of *all* aspects of medicine.

Each of the approaches described above has matured to a point where communication between their adherents has yielded some consensus and collaborative work. It will be crucial to maintain a multidisciplinary approach, to maintain a rich diversity of perspectives and approaches, and not to assume that complex phenomena can be easily reduced into a unified theory and one style of practice. Current collaborative efforts between academic disciplines, between medical specialties, and between academia and community-based physicians are making training in communication skills more accessible and relevant to clinical practice. It is now critical to continue the work to develop a common language and common ground.

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