

Revisiting, reassessing, and reinterpreting 2 big ideas for family medicine

2025 Dr Ian McWhinney Lecture Series

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Dr Ian McWhinney's life and work, and his ideas about principles, emotion, sharing power, caring for patients without a diagnosis, and creating a new clinical method can inspire us in the midst of today's challenges in family medicine. They can also help diffuse confusion and reduce feelings of alienation or lack of belonging, thereby helping to overcome feelings of burnout in the profession.

In the 2025 Dr Ian McWhinney Lecture Series on September 17 at Western University in London, Ont, I considered and discussed 2 of Dr McWhinney's many big ideas: first, the importance of recognizing the early signs of illness, and second, the clinical method. Below, I reimagine, reassess, and reinterpret them for today's context and realities. I wonder if McWhinney's ideas were shaped by his own experience of an undiagnosed illness affecting many aspects of his life, especially one in his early 40s: "[I] ... had a mysterious illness that caused me great concern at the time ... mild throat infection ... fleeting pains in my joints, paresthesia in both legs up to the knees ... pronounced fatigue ... sadness ... lost 10 pounds." The doctor found no abnormalities and was unable to give a diagnosis. The symptoms "waxed and waned" for the next 18 months and no explanation was found for the "profound loss of energy ... and severe malaise."¹

McWhinney's first big idea started in 1964 when he published the book, *The Early Signs of Illness: Observations in General Practice*.² He was practising in Stratford-upon-Avon in England and noticed family practice was different from other disciplines in medicine. One crucial difference was that family medicine was community based and not hospital based; 22 of 1000 people saw a family physician each month, but less than 1 person was admitted to hospital.³⁻⁵ Therefore, problems presented by the 22 patients were vastly different than those of the hospitalized patient.

A key feature of those early signs of illness was that approximately 33% of patient symptom presentations did not culminate in a diagnosis.⁶ Early signs of illness might have been present for long periods of time, and many were never slotted into a diagnostic category; even after diagnosis, sometimes symptoms continued. McWhinney saw this as an unrecognized aspect of the work of family physicians.

Even today, it can be a tremendous source of frustration for family physicians looking for evidence and guidelines about symptoms on which to base their

decisions and conversations with patients. What is the evidence regarding symptoms? Much of it arises from research conducted using the International Classification of Primary Care in Canada, the Netherlands, and elsewhere. In Canada, the DELPHI Electronic Medical Record database produced research on symptoms in general and on 3 types of abdominal pain in particular,⁷ and produced a handbook suitable for teachers who want an evidence-based guide for caring for symptoms.⁸ In the Netherlands and elsewhere, key research revealed that persistent symptoms tend to exist as elements of symptom clusters; symptoms are chronic in 25% of patients; there is a mismatch between family physician and patient perceptions of care; and family physicians only rarely suggest follow-up visits.⁹

McWhinney grappled with his second big idea in 1968 when he came to Canada and started the Department of Family Medicine at Western University. We will call it "beyond diagnosis." The evolution of this idea is explained in the next paragraphs and through key writings over 2 decades: McWhinney in 1972,¹⁰ Stewart et al in 1979,¹¹ Levenstein in 1984,¹² and Weston et al in 1989.¹³

McWhinney was influenced by the writings of Hungarian psychoanalyst Michael Balint and his idea of a "deeper diagnosis," a "diagnosis of the person."¹⁴ McWhinney sought to illuminate patient presentations in dimensions to complement and go beyond the usual diagnoses of disease. His 1972 article in the *New England Journal of Medicine*¹⁰ entitled "Beyond diagnosis—an approach to the integration of behavioral science and clinical medicine" outlines his classification of illness behaviour. Patients present to family physicians to discuss their limit of tolerance of discomfort from their complaints; their limit of tolerance of their anxiety about their complaints; and symptoms presenting as signals of problems of living.

This idea morphed into the types of patient issues raised over the entire visit: symptoms or complaints, discomfort, feelings, and problems of living that I revealed in a paper from my doctoral thesis.¹¹ You can see McWhinney's big idea is moving from 1 deeper diagnosis to a multifaceted description of the problems of the whole person.

To this milieu came the catalyst, Dr Joseph Levenstein from South Africa, where he had done fascinating work in his teaching practice. He was a visiting professor in the Department of Family Medicine at Western University in 1982. Levenstein brought his ideas of patient feelings, fears, and expectations.¹² The idea evolved further into

the patients' illness experiences: feelings, ideas, functions, and expectations.¹³ This evolution occurred over the years after Levenstein left his visiting professorship, when McWhinney asked Dr Wayne Weston to facilitate monthly discussions, to which department members brought cases to hone the ideas grounded in clinical practice. The team made crucial additions after the illness experience: attention to the patient as a person, as well as finding common ground,¹⁴ and the importance of the ongoing patient-clinician relationship.

Over decades, the team defined 4 interactive components describing a process of care over time, and starting each visit with attention to the patients' illness experiences. These ideas came to be called the patient-centred clinical method (PCCM), which includes exploring health, disease, and the illness experience; understanding the whole person; finding common ground; and enhancing the patient-clinician relationship.¹⁵

The first component is the continuation of McWhinney's preoccupation with patient presentations (ie, what the patient says when you ask, "How can I help you today?"). The patient may express cues to their disease, such as "I have had these headaches for the past few weeks" or to their health (eg "I am no longer a healthy person" or "I want to be more active"). Hearing the patient's words about their headache, the clinician will listen for cues about the patient's illness experience, feelings (eg, "I am worrying because of my uncle's brain tumour a while back"), ideas (eg, "I wonder if the headaches are related to stress"), function (eg, "I am annoyed the headaches ruin each afternoon so I cannot do what I want or need to do"), and expectations (eg, "I need the pain to stop and I would like to know how serious this is").

An example of taking just 20 seconds to explore patients' functions comes from my own life and wonderful orthopedic surgeons. I fell at age 71 years. It was no joke. I fell on the ice and lay on the street at dusk, alone, for maybe 6 minutes until a jogger helped me up and escorted me home. I had, in 1 second, lost my independence, ability to take care of myself, and confidence in my body. After urgent care diagnosed a painful and disabling broken arm on my dominant side, I experienced a week of ebbing confidence before I had an appointment at the orthopedic outpatient clinic. The orthopedic fellow took the lead¹⁵:

Fellow: "Tell me about yourself?"

Me: "I am a professor and I do research."

Fellow: "OK, so what does your day look like?"

Me: "I should tell you that I am retired."

Fellow: "What do you do each day now that you are retired?"

Me: "Well, I play music."

Fellow: "What kind of music?"

Me: "Percussion in big concert bands."

Fellow: "What does that mean? I have never done

that myself. Show me, with your good arm, what the motions are that you do on your drums?"

Me: Mimic playing a drum with my left hand.

Fellow: "I can tell you that, with your injury—seeing the x-ray scan—you will be drumming again within months."

In that brief exchange, the orthopedic fellow took a huge weight off me and my broken arm and shoulder. She started the conversation with the patient experience, not the diagnosis. She looked at function and addressed fears and expectations. My case demonstrated how the patient-centred approach is relevant to all of medicine, not just family practice.

The second component of the PCCM is understanding the whole person. Clinicians listen for issues of the whole person, such as personality, stage of life, and of context, such as family, work, finances, and spirituality. Two family physicians from the Netherlands, Drs Peter Lucassen and Juul Houwen, published a case about the person and the context¹⁵: Friya, age 61 years, presented to a physician with stomach and chest symptoms in the context of the recent loss of her son in a car accident. This could have led the physician to think her symptoms were related to grief, but the physician knew Friya as someone who rarely complained and, on the basis of familiarity with the patient, ordered a blood troponin test and referred her to a cardiologist. An acute myocardial infarction was diagnosed. "Personal contact and knowledge of living conditions, ways of responding, and important events in the patient's life ... removes some of the inherent uncertainty."¹⁵

The third component of the PCCM is finding common ground. This is where important information gathered about a patient is brought together in mutual discussion and agreements are forged on these 3 elements: the nature of the problem, goals for treatment, and roles the doctor and patient will play in enacting a treatment plan. We know patient-physician agreement is essential to positive patient outcomes¹⁶ and that finding common ground is the most influential of the 4 components of patient recovery.¹⁷

The fourth component of PCCM is the patient-clinician relationship. We live in a contrarian time in which human relationships are seen as transactional, like business relationships, buying and selling commodities. This is counter to the notion of health care as a unifying and integrating force in society. What are the health care relationships that can unify and integrate? There are many such elements in the patient-clinician relationship. Here, I will cover 3: constancy and continuity, compassion, and sharing power.

Regarding constancy and continuity, author Polly Morland writes about a female family physician in the rural United Kingdom in her book, *A Fortunate Woman: A Country Doctor's Story*.¹⁸ She stresses intertwining the present and past in the journey of the patient and doctor.¹⁸ This can be complex, as internist Dr Eric Cassell

wrote: “Constancy to the patient is necessary ... not difficult when things are going well.... It requires self discipline ... when things are going sour ... errors ... wrong diagnosis, patient’s behaviour is difficult.”¹⁹

Accompanying a patient over time, which is the definition of continuity, is a strongly held value in family medicine. Rigorous research has demonstrated the importance of continuity of care to absolutely crucial outcomes, including both lower patient mortality and higher physician satisfaction.^{20,21} Enshrining continuity in your practice is not a mere nicety but the essential bedrock on which the all-important long-term edifice of the relationships with your patients is built.

The second element of the relationship is empathy and compassion. Empathy can be considered that look of recognition and acceptance between doctor and patient. “Ah,” the patient responds, “I can relax here.” But that is not quite enough. Compassion is required. Compassion is the action that follows empathy.²² “Without compassion there is no health care,” according to Dr Brian Hodges, former president of the Canadian Medical Association.²³ One can imagine a scenario in which a cue is presented, followed by empathy, followed by a compassionate response—or not. Here is the way family physician Dr David Loxtercamp describes such a moment of choice by the patient and clinician²⁴:

At that moment of indecision, why would a patient risk self-disclosure or the doctor relinquish the safety of higher ground? Their choice often reflects a mutual leaning towards relationship: trust that here one’s true self can safely emerge; reassurance that their galloping fears will be calmed through the clinician’s touch, words, and familiar surroundings; companionship that ends the exile of illness.²⁴

Morland describes a similar thought in her book¹⁸:

That willingness to invest in the moment, that instinctive ability to occupy, reflect and respond to the here and now, both emotionally and intellectually sits at the heart of the doctor-patient relationship.... Building good relationships calls for both spontaneity and judgement. To knit it all together over time. It is a job that requires both heart and head ... in delicate balance.

The third aspect of the patient-clinician relationship is sharing power. Here is how my coauthors and I describe it in the book, *Patient-centred Medicine: Transforming the Clinical Method (4th Edition)*¹⁵:

Health care’s role in reducing disparities and in providing a glue that helps hold society together, has long been recognized. There are a variety of mechanisms helping this role: an ethical stance of sharing power, i.e. a belief that the patients have a right to share in

decisions about their life course; and a thoughtful and humble stance by the clinician seeking to marry medical expertise with personal humility in moving the relationship from patient dependence to mutual interdependence.

Regarding the patient-clinician relationship, I have concentrated on these last 2 elements—engaging at the level of emotion (ie, empathy and compassion) and sharing power—because these are the 2 features of the PCCM that McWhinney believed were foundational principles.

Turning now to the evidence on the impact of patient-centred care, the quintuple aim is widely accepted as the standard for evaluating a health care system.²⁵ We want to apply these aims to the question, “Does patient-centredness positively impact the 5 aims of health care: health outcomes, patients’ care experiences, costs, equity, and physician well-being?”

Does patient-centred care improve health outcomes? First, retired British general practitioner Dr Denis Pereira Gray demonstrated continuity of care—not precisely patient-centred care but a key tenet of it—decreases mortality.²⁰ Next, regarding clinical status measures, randomized controlled trials of patient-centred interventions showed lowering of blood pressure and the hemoglobin A_{1c} test at a clinically significant level. There is also evidence from 16 recent randomized controlled trials in which approximately half showed positive impacts of patient-centred care on physical health, functional status, quality of life, and other health status measures.¹⁵

Does patient-centredness improve patients’ care experiences? The results of the 16 trials are very positive with most showing significant impacts of patient-centred interventions on patients’ experiences of care, including patient centredness of care and communication, as well as their experiences of quality, continuity, and coordination of care.¹⁵

Does patient-centred care reduce costs? Yes. Cohort studies have shown lower costs after patient-centred visits in Canada and the United States.^{26,27} Randomized controlled trials show compassionate care in a Canadian emergency department lowered the number of repeat patient visits, leading to reduced hospital costs.²⁸ A people-oriented care model for older patients lowered costs in a European study.²⁹

Is patient-centred care a force for equity? Yes. It has been found that patient-centred care is a force for equity,³⁰ such that care is effective at all levels of deprivation, supporting its unifying potential.¹⁵

Does patient-centred care improve physician well-being by reducing physician burnout and dissatisfaction? Three

randomized controlled trials found patient-centred training had positive effects on physician burnout and dissatisfaction.¹⁵ These results lead to my conclusion that patient-centred practice in family medicine can be an antidote to physician burnout. I am convinced that, in really difficult times, returning to the principles that excited one's motivations at the beginning of a career, reflecting on the universal values of walking in another person's footsteps, staying constant, and being open and compassionate in relationships with patients, can be nourishing. I am not the only one. In a personal communication (January 15, 2022) your family physician colleague, Dr Keith Thompson, said:

We entered this decade ... suffering time constraints and finding ourselves distanced emotionally as we buried our noses into our EMRs [electronic medical records]. The "art of listening" became less important than the preventive care bonus code, updating the CPP [cumulative patient profile] properly, or ensuring the recent guidelines ... are being met.... Distanced emotionally, we now suffer distancing physically [because of the COVID-19 pandemic] and both patients and providers are suffering the consequences.... Hence my reach out to see if there might be some way of revisiting [McWhinney's *Textbook of Family Medicine*].... I am perhaps taking a risk here in being transparent but have felt devastated by this pandemic and its effects upon my sense of what Family Medicine should be for myself personally and my patients. So just tossing this onto the table, and honestly for me personally [working on McWhinney's principles] would be a redemptive and healing exercise as I feel as if having lost a limb lately and [I am] trying to put sense to all going on in our profession.

Morland brings her wisdom to this issue¹⁸:

It is the equilibrium that makes the work sustainable ... brings the richest rewards of the job. For being there, most days for your patients, is one of the key elements in building relationships, and strong, rooted relationships don't just help patients. They also help the doctor.

I began with 2 big ideas of McWhinney's and brought them up to the minute, supported by current research and illustrating how these foundational ideas are now evidence based and still relevant today.

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Competing interests

None declared

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