



EDITORIAL

## **Hearing What the Patient Is Thinking: Implications for Care and Education**

I sat listening to Mrs Wong, straining to follow her words and phrasing. Her major concerns sounded like some effects of hypertension. She answered my questions about previous illnesses, but I was unsure exactly what she was saying about the treatments and how she responded. I noted her excessive weight and high blood pressure. I explained what I thought was the matter. I'm not sure that she understood me or agreed with me. She does piece work at home. I asked about her family; they favour traditional medicine. I discussed her management of weight reduction and exercise, plus anti-hypertensives. I suggested they may parallel herbal medicine. She nodded. I wrote the prescription, explained the diet sheet, and arranged follow-up. She smiled weakly.

As she left, I regretted knowing so little of what she was thinking. I didn't know whether she'd have the prescription filled or not, or whether I'd ever see her again. I suspected she wouldn't change her diet or start exercise. She's likely to fall into the scandalously high 50% who don't do "what the doctor ordered". I feel embarrassed because that must be at least half my fault! Did I do enough to understand her? Did I give her what she wanted?

### **She and I Were Different**

We commonly assume that other people think like us, but we rarely check that assumption. She and I were different, but which differences would affect her compliance and her health? I'm old and she was middle-aged. She grew up in China and I in Australia.

Differences between her and me (or between any ill person and a health worker) gives us somewhere to start. As a male doctor with a female patient we were only one of four patterns of difference we could set out in a  $2 \times 2$  table to include female:female, male:male and female:male consultations. Unfortunately, we know little about different levels of understanding, agreement and compliance in each combination. Our age difference can be set out in another  $2 \times 2$  table, perhaps with many gradations in the age range from intern to elderly. Both sex and age differences can affect what happens in the consultation when the malady is in the genital or anal areas. What factors

within age difference affect our projections about each other and our mutual respect? Should I have explored our possible cooperation, rather than her compliance to my regimen?

How could I have made clearer contact with that “other mind”? Even though that’s what clinical practice is all about, I found that I had no serious framework for exploring what she was thinking.

## **What Does She Believe Is Wrong?**

I’d asked her what she thought brought this illness about, but she looked puzzled and shook her head. I know that her cultural beliefs about what causes illness are likely different from mine. I’ve been taught to look for external, non-human etiological factors causing the disease, of which the illness is the surface manifestation. Her beliefs from traditional medicine may centre on internal “balance” of how her organs are functioning, seeking adjustments that will achieve bodily “harmony”. That view of equilibrium coincides with natur-  
opaths who accept illness as “part of life”.

The medical profession remains untaught and unaware of the range of patients’ health beliefs and superstitions (beliefs we think aren’t true) such as astrology, faith healing or magic because patients don’t tell doctors about them. Patients don’t change their beliefs just because a doctor says a treatment is worthless, but go ahead and use it anyway. Some assign culpability to themselves, self-blaming for some real or imagined act of omission or commission. Some project the blame on an external agent (perhaps human or even divine). Over a third believe that interpersonal relations could be stressful enough to cause serious physical illness.

Don’t dismiss these pejoratively as quaint beliefs and customs because you don’t believe them. Instead, rethink the “validity” of “release of repressed memory”, or of a Freudian interpretation of mental illness, or of what evidence sustains retrospective constructions of the psychohistory of a patient’s life events through psychoanalysis. Only when doctors deconstruct their own assumptions can they comprehend their patients’ assumptions. But few medical curricula teach medical anthropology!

## **What Was Going On “In There”?**

I don’t need to know everything my patient believes. But I do need to know what’s important to her, what “content areas” affect her choice of management. That’s “private” evidence “*in there*”. Only Mrs Wong knew what she was experiencing—headaches, occasional giddiness and one blackout. To transmit that experience, she had to describe those bodily sensations in words. Patients differ in that vocabulary, in how much they wish to tell, and in what they want

done about it. If together we had clarified our different beliefs about this illness, I may have understood better how her motivations (and those of other stakeholders, such as her family) would affect her compliance.

I could have found out more about how she's handling the existential impact the illness was having on her life. That would tell me how well she *could* comply with the regimen within her personal, real world. Nurses (but few doctors other than general practitioners/family physicians) are aware of the "burden of illness" and the "burden of treatment" on their patients' daily living—eating, sleeping, working, making love.

Patients vary widely in their coping strategies. Some become skilled managers of their diabetes or asthma or renal dialysis, using their doctor as co-worker. Some become "victims" from "learned helplessness". Some are passive, with resigned acceptance. Some are angry or despairing. Some "catastrophize", turning every problem into a disaster ("*I can't live with this pain*") and demand high levels of medication.

### **What Factors "Out There" Affect Her Decision?**

Along with those factors "*in there*" subjectively within the patient are local circumstances "*out there*" that may affect what's practicable. Some relate to whether the family is dependent on the patient (especially a mother of small children) or supportive of her. The workplace can be helpful or dismissive. Community health services vary widely in their range and availability. Health care costs (and insurance gaps) can interfere with full care.

No patient is identical with another (or with figures collated from a group). Nor are the details of their disease, its history, its distribution around the body, its severity, its persistence, its response to treatment and its impact on the patient in producing disability or impairment or handicap. *No patient is like a textbook!* Nor are the circumstances of money, family, support, work and local facilities the same from person to person. Nor is the stigma of some maladies that they won't admit, or which make them reluctant to seek health care early. Yet each of these factors could affect the choice of treatment, compliance or cooperation with the management plan, and how things turn out.

### **How Can We Study Better What the Individual Patient Is Thinking?**

We lack a framework for careful and rigorous "*study of the individual*". That applies to the "*patient as (sick) individual*" and to the "*doctor as (informed, reasoning) individual*". We can begin by examining the evidence about the individual that we can look for in everyday practice. If we can agree on this "content", we can then examine the "processes" we use in making judgements and decisions from that content.

With Mrs Wong's diagnosis I was dealing with two sorts of evidence. Some was "*out there*" in what I could see in her blood pressure and her weight, the "objective" evidence of disease. Some was what was happening "*in there*" within her body and her mind as she experienced the symptoms and worried about their implications, her "subjective" evidence of illness. She had shared some of that subjective evidence verbally. But much was left unsaid, such as what she felt or feared about the illness, and about my advice and me. And I was dealing with a third batch of evidence, what I was thinking "*in here*" during the consultation as I matched her against my experience of other patients.

With the decisions on Mrs Wong's management, I was dealing with what she wanted "*in there*" according to how she understood what was wrong and what she thought should be done. She was dealing with what I thought about the same issues. And both of us were dealing with the local circumstances "*out there*" that modified what was practical for us to do.

### **What Was Going On in My Mind?**

I was also dealing with what was going on "*in here*" in my own mind. That "self-talk" was private to me, unless I expressed to her what I was thinking. Or to my students as we discussed what evidence I was looking for, and how I fitted that into my judgement and decision-making. Notice that, educationally, students are also an "other mind" problem. As with what my patient is thinking, I must connect with what my students are thinking. In both instances, we're seeking the important "content", so that our judgements and decisions turn on that evidence.

### **Who Decides What's Done?**

Clinical practice is inescapably multidimensional. Any mix of these "*it depends*" variables in the individual circumstances might determine the management decision. Every clinical decision balances trade-offs between desirable and undesirable outcomes of the disease and of its treatment. But who decides which of these ("*out there*", "*in there*", and "*in here*") factors are important, the doctor or the patient (or other stakeholders), or some combination?

Patients may not get what they came for from the doctor because control over what's done is stacked in the doctor's favour. Doctors know more about diseases and treatments than patients, an asymmetry of knowledge and experience. Doctors can access the system, order investigations, prescribe drugs and arrange hospitalization, none of which the patient is permitted to do, an asymmetry of power. Doctors and patients each have

their motivations and purposes for the treatment, and these may differ, an asymmetry of values and goals usually left unspoken. The consultation is on the doctor's home turf to which the patient is a visitor, an asymmetry of context most vivid in the Accident and Emergency ward. The patient is under threat from the illness and the unknown and is seeking help. The doctor is not disturbed by this familiar situation and is offering help, an asymmetry of dependence on another.

Can we lower those barriers to patient participation? Theoretically, patients can choose the extent to which they become involved in negotiation. Patients frequently disagree with management plans, but typically do so covertly by non-compliance with the prescribed treatment rather than in overt argument with their doctor. The patient's choices are not stupid or illogical from their perspective. Patient and doctor function in their separate worlds of work and home. What makes sense to one may not to the other.

Patients rarely give their doctor feedback about poor communication that inhibits open discussion. But if doctor and patient don't listen carefully to each other, neither learns to work out what could be an optimal path to meet both their sets of goals in this illness under these circumstances. Whatever their differences, each must ensure that they understand and are understood. That responsibility rests with both doctor and patient. With clear interpersonal communication, "difference" between individuals ceases to interfere with high quality patient care.

All our actions have consequences. All medical actions have consequences for other people, especially for patients, but also for family, other health workers, "the system", and more. Our clinical practice includes these personal responsibilities to patients because of the consequences of our decisions for their lives. The patient is another human being who depends on our advice and on our power, since patients cannot access the resources (investigations, prescriptions, admission to hospital, certificates to be off work) that help them get better. Consequently, I have a moral responsibility to comprehend the impact that my medical decisions have on each patient's life. I slowly realize that this is the basis of the patient's trust in my advice and my actions.

Remember that practice is far more complex than knowing which treatment works best. Practice embraces:

- person management (in carefully understanding the patient's illness and the problems it creates in their life, their coping skills, and their family support);
- case management (in reasoning out the "best" evidence to diagnose the underlying disease, and judgement in choosing a management plan that optimizes the outcomes both patient and doctor are seeking);
- system management (in meshing patient care with local resource constraints, hospital administrative rules, government parsimony, health insurance companies, and even litigious lawyers hovering for prey); and

- self-management (in honestly perceiving how your own values, style and thoughtfulness assist or hinder the patient's achieving what they came to you for).

All of those management tasks call for closer understanding of each other's thinking. Instead of turning to the books to be told "what to do", you can begin to study clinical thinking "as it happens". You can become your own "unit of study" here as you observe what's going on between you and your patient, and simultaneously observe (and record) what's going through your mind at each point.

How carefully did you listen? What questions did you ask? Did you invite the patient to explain how they interpreted their illness? What diagnoses were in your mind? And in the patient's? How did you decide on your management plan? Did you ask the patient what they wanted done? What were the steps in your negotiation with the patient? Did you help the patient express their desires? Did you reach a mutually acceptable cooperative arrangement?

As such a "self-aware participant-observer" (SAPO for short), you can study clinical negotiation in operation. You, your patients, your students and your colleagues are all independent individuals, with different life and work experiences. As you explore your own thinking, you begin to gain glimpses into how those others may think. You are beginning your study of the individual, with yourself as your first "subject". And, of course, the more self-aware you become, the better equipped you will be as a role model and advisor for your students, so that you can help them grow into effective SAPO-clinicians.

How to do all this is covered under the title "*What's going through your mind?*" at the School of Medical Education web site on Clinical Education, at: [www.med.UNSW.edu.au/MedEd/KenCox.htm](http://www.med.UNSW.edu.au/MedEd/KenCox.htm) to which you are invited to contribute, argue, share, query or whatever, so that we can all learn from each other. (*Editor*: And consider sending a Letter to the Editor for publication in a future issue of EfH.)

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