Why connection matters
understanding patients' illness by understanding their reality

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It is much more important to know what sort of a patient has a disease than what sort of a disease a patient has.

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BHMA Essay Competition 2015

On the construction of reality and its medical implications

L. Berger and Thomas Luckmann will be remembered forever for having authored the world-famous book “The social construction of reality. A treatise in the sociology of knowledge”. In this jewel of sociology they argue that there is not just one reality but many. According to their theory, reality is nothing but a social construct, an idea that is created billions of times a day by every single living individual. Reality therefore represents no more and no less than the totality of its creator’s perceptions and interpretations of what is.[1]

In medicine knowing the patient is key. However, even more important is to understand the reality they live in. In other words, it is impossible to know a patient without knowing their reality, that is their life. In 1977 this idea was put on paper by the psychiatrist George L. Engel, calling for a new biopsychosocial model of human health. He also considered his patients to be more than just their illnesses and asked his colleagues to give particular attention to their patients’ lives in their entirety.[2] Since then the biopsychosocial model has experienced a story of unprecedented success. Although the theory has been criticized for many reasons and despite being far from flawless, its core however, that lives and not just illnesses matter, has never really been challenged.[3, 4]

Finally, narrative medicine (a term coined by the general practitioner Rita Charon) has emerged to offer a conceptual framework to put the daily experiences of doctors and patients into words. When told, their stories echo not only the different realities in which patients and doctors live, but they also accentuate the longitudinal aspect of human health and illness.[5–7] This is of uttermost importance since most doctors (and in particular clinicians) might otherwise just catch a glimpse of what is actually happening - a snapshot in time that obscures more than it reveals. It is the luxury of the general practitioner to accompany his patients over many years, to see them flourish and wither, like a biographer of human life.

Something that all three concepts, that is reality as social construct, the biopsychosocial model and narrative medicine, share is their determination in understanding the different dimensions of human life. For a doctor it is impossible to heal a patient by just focussing on a disease. In fact, curing a patient from a specific disease is much easier than healing somebody, in terms of helping a patient to remedy a disturbance in any sphere of his complex life. Therefore, being a doctor is more than just being a medical specialist, it is also being a psychologist, being a social worker and (perhaps most importantly) being an attentive listener.

For doctors it is crucial to connect to their patients and to be granted entry into the very personal and unique reality of their patients. Nothing is more rewarding than learning more about another human being. At the same time it gives access to non-medical aspects of life which would otherwise remain carefully hidden from peeking eyes. It is nowadays considered almost a universal truth that social circumstances can make us ill.[8, 9] In 2008 the United Nation’s Commission on Social Determinants of Health published its very extensive final report which also stressed on the importance of social, economical and environmental factors and their impact on human health.[10] However, it is only the trusted doctor who can see behind the curtain and understand the complexities of her patient’s life. All those who have failed to really connect to their patients and to establish a relation of mutual trust can only assume what remains hidden in the dark.

Though appearing impeccable in theory, application of these three concepts in daily practice can present major challenges. Possibly the greatest danger comes from intergroup bias, that is systematic preference of individuals that belong to the same group as the reference person.[11] In doctor-patient relationships, that would be the doctor who favours patients that live in close

proximity to his reality over those whose reality of life is more distant. Assuming that doctors form only a very small group of the overall population (and therefore their realities represent only a small and probably very skewed part of society), there is considerable risk that they might jeopardize patients' health. This is especially worrisome as discrimination itself poses just another hazard to patients' health.[12] However, doctors who are aware of this bias might be able to mitigate it by means of frequent introspection and questioning of their own actions.

"He took me seriously...

Marianne, a 29 year old woman describes her first encounter with her new general practitioner: *"He listened to what I was saying, and he took me seriously. So I felt that it was I who was important".*[13] In the same study, other patients gave similar accounts when asked about what matters in a doctor-patient relationship. "Being taken seriously" might seem to be quite an elusive description of interpersonal relationship at first, but it actually gets right to the heart of it. It is all about recognizing the patient and accepting them as they are. Building a trustful relationship is a bidirectional process which requires an attentive doctor who is willing to listen and to impartially accept what is being said and a patient that wants to share her reality. However, sometimes communication fails. This can especially be the case if the doctor gives a psychosomatic diagnosis which might be experienced as humiliating by the patient.[13]

"Being taken seriously" can mean very different things to various persons, all depending on the reality in which they live to apply Berger's & Luckmann's theory again. Therefore the doctor that affronts her patients has most likely not succeeded in connecting with them and as a consequence does not know how to avoid the pitfalls of those very distinctive relationships. However, communication will thrive when the doctor starts to explore the reality the patient lives in. It needs to be treated like a precious flower, one wrong gust of words can take its life, but when watered with attentive curiosity it will blossom in a previously unknown beauty. It is the essence of being a good doctor to learn about all those little peculiarities everyone keeps hidden in the attic of one's mind. Knowing them enables the doctor to bring up more delicate topics which had been hitherto carefully avoided to allow both doctor and patient to connect to each other.

Epstein & Street coined the term "shared mind" to describe exactly this process of decision-making whereby two individual minds (the doctor's and the patient's) converge to one "shared mind" which finally decides. It is of course still the patient who takes the decision, but she has been supported by the collaborative efforts of her doctor. It is he who attunes to his patient's reality, who reinforces and complements her cognitive faculties, and who can provide sense in times of information overload.[14]

However, today's fast-paced world and economic constraints put these cherished relationships under pressure. Regularly, personal continuity of care is balanced against speed of access.[15] Though patient satisfaction and valued doctor-patient relationships have so far been postulated to be closely linked to continuity, this association might not be as strong as previously assumed. Recognition, that is respecting and accepting a patient as a person and remembering past encounters might be more important than a regular "own" doctor.[13, 16] Indeed, familiarity between doctor and patient does not seem to influence content of consultations in primary care which might be a sign of great communication skills on the side of primary care physicians.[17] Nevertheless, attending to psychosocial aspects remains crucial to establish a trustful connection and to empower patients.[18] In the end, content appears to beat both length of consultation as well as duration of the relationship, that is continuity.[13, 18]

The concept of patient-centered medicine has evolved as the logical progression of the biopsychosocial model and has superseded the paternalistic communication style. In patient-centered medicine the focus of attention, which traditionally lies on the disease, has shifted towards the patient's experience of being ill. It is no longer for the nearly omniscient doctor to explain the concept of disease to the patient, on the contrary, it is now his turn to listen to the patient's subjective narrative on being ill.[19, 20]

Conclusion

It is not treating patients what makes a "medical specialist" a doctor. It is quite the contrary, adapting to their patients' reality – and accepting it without bias - is what makes them doctors and what allows them to connect with their patients. And it is this connection that makes patients feel taken seriously and that gives doctors the chance to not only cure symptoms but to work on the root of any problem. However, those who do not get involved with their patients will never understand the plurality of human life as they will rest confined to their own reality, which in this case would be more of a cage. To heal one must be ready to immerse oneself in the different worlds of one's patients and only those who can endure those varieties of being a human being and the different realities in which we all live will re-emerge as true doctors.

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