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Case report

'Well doctor, it is all about how life is lived': cues as a tool in the medical consultation

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ABSTRACT

Introduction During consultations, the perspective of the patient and the family physician come together. In order to reach a shared view about the symptoms it is important to know the agenda of the patient. Cues (i.e. non-explicit remarks that can enclose a special meaning) can serve as a tool to clarify the agenda.

Case report In this article, we describe a patient with unexplained palpitations during vacuuming. During one of the following consultations she provided an important psychosocial cue which changed my perspective on her palpitations, resulting in a deeper understanding of her symptoms.

Discussion Recognition and exploration of cues is important for reaching mutual understanding of doctors and patients about the symptoms. Moreover, it enhances the therapeutic relationship and improves illness outcomes and patient satisfaction.

Conclusion Noticing cues in the medical consultation helps the doctor to understand the patient's real worries. It gives us, as doctors, a better understanding of the patient's perspective.

Keywords: cues, family practice, medically unexplained symptoms, patient-centered care

Introduction

An important task for family physicians (FPs) is listening to patients.[1,2] The patient's symptoms are discussed by the patient and the doctor together during consultation. Patients have their own ideas, worries and expectations about their symptoms and so has the FP, partly because of what he was taught in medical education, but mainly because of his experience.[3,4] During consultation the perspectives of the patient and the FP come together.

One of the most important tasks of the FP is to come to a mutual understanding with the patient: a shared view about the symptoms.[5] To reach this agreement, the doctor needs to know the agenda of the patient. This can be achieved by exploring the patient's expectations, cognitions and emotions.[5–7] Through this working style, the doctor enhances the patient's satisfaction, adherence and health.[8,9]

In daily practice it appears to be difficult to get to know the agenda of the patient.[10] In approximately half of all consultations the doctor does not reveal the reason for encounter and the worries of the patient.[9] In about 20% of all consultations the patient has an unvoiced biomedical or psychosocial agenda.[11]

During a consultation, patients often give cues. Cues are non-explicit remarks that can enclose a special meaning. They can point towards ideas, worries or expectations the patient has not shared

before.[3] Noticing and exploring the patient's 'cues' is helpful; it can serve as a 'tool' to clarify the agenda of the patient.[3,5] However, doctors appear to have great difficulty in detecting and responding to more indirect forms of communication such as cues.[12] The following case changed my (ToH) communication skills and illustrates the importance of noticing and exploring a cue.

Case

The first consultation

A 79-year-old woman visits me (ToH) with symptoms of fatigue and palpitations. The symptoms started while vacuuming; she frequently had to stop doing it just to recover for a while. She is very active, but the years seem to start counting. She asks me why she suddenly developed palpitations. She is worried because she never had them before. Further history taking does not give any indication for an underlying cause of the palpitations. Because she has palpitations during exertion, I want to exclude a cardiac problem. With the patient's approval I decide to make an electrocardiogram and test her blood to exclude cardiac and other causes for the palpitations.

The following consultations

The electrocardiogram is normal, the blood test reveals a hypothyroidism. This could explain her fatigue, but not her palpitations. I reassure her, and after discussing this we decide together that I will prescribe her thyrax. We settle a couple of appointments for follow-up consultations. During these consultations I adjust the thyrax dosage and also have a chat with her. Gradually I get to know her a little better. She tells me more about her history and background. I enjoy these consultations. With the thyrax the thyroid function normalises and the fatigue disappears almost completely.

A special consultation

Six weeks after the first consultation, she comes for a follow-up visit again. Her blood has been tested and her thyroid function is stable. She is happy and satisfied with this news. Then she brings up her palpitations again. She wants to know whether it is possible that they are caused by her thyroid problem. I ask her if they have increased since the start of the thyrax, which she denies. I explain to her that the palpitations are probably unrelated to her hypothyroidism and probably benign. She seems to accept this and says: 'Well doctor, it is all about how life is lived'.

'What a remarkable sentence' I think. I show my wonder and ask: 'Well then, how is life lived?' And in front of me, there and then a story unfolds that had been unknown to me. At the age of 16 she went into a convent. Initially she had a good time there, but this changed when a new mother superior was appointed with whom she could not get on. Mother superior allotted her all the nasty tasks and she degraded her to being a cleaner. For a long time she did not do anything but scrubbing floors. She was teased and cold-shouldered by her fellow sisters. Years of bullying followed. A couple of times she tried to bring up this subject, but the sisters did not seem to hear her. During this period she often had physical symptoms, as a result of which she could not perform her cleaning tasks. After living in the convent for 15 years she had to leave – cast out from the convent.

With astonishment I listen to her story and she says: 'Gosh, doctor, I have never told this to anybody' and 'maybe that is why I get these palpitations during vacuuming. I will think about it at home'. We talk some more and she leaves my consultation room noticeably relieved, with the words 'thanks for listening doctor'.

Half a year later

During the follow-up visit for her thyroid problem the woman is cheerful. I realise that it has been half a year since the day that she told me that special story. I ask her about her palpitations. She tells me that she has had them a couple of times since the last consultation, but she is hardly bothered by them any more. Vacuuming has become easier now and she feels better too. She says everything is fine now.

Reflection on the case

During the first consultation I (ToH) collected data by asking open-ended questions, summarising and asking directive questions. Furthermore, I aimed at searching for a biomedical diagnosis of her palpitations. I looked at her palpitations from a biomedical point of view and wanted to exclude a cardiac cause. When I found a hypothyroid function with the blood test I mainly focused on the medical policy and management plan, without reconsidering the palpitations and without legitimising the patient's feelings.

Looking back on this case I realised that initially I hadn't dwelled on the fact that the palpitations came up especially during vacuum cleaning. Why of all times did she get them during vacuum cleaning? At this stage I should have shown my curiosity. Did she get palpitations because of the exercise or could it be linked to vacuum cleaning in particular? A better exploration of her cognitions and worries about the palpitations would have been helpful. However, the following consultations gave me the opportunity to ask questions regarding the patient's social situation and history and build the doctor–patient relationship. Thanks to the remark: 'Well doctor, it's all about how life is lived', I was capable of leaving my biomedical point of view. Together with the patient I found a deeper meaning in her symptoms.

Did my consultation skills change since this case? Yes, they certainly have. Through this case I became keener on picking up cues patients give during the consultation. Cues are an easy tool in doctor–patient communication and very useful in daily practice. Of course, I do not know for sure if there is a causal relationship between telling the story and her improvement. But the patient seemed to benefit from discussing the possible relationship, especially considering her relief at the end of the consultation.

Cues in the consultation

In primary care there is a tradition of paying attention to cues and their meaning. Recognition of cues and exploration of their meaning is important for the mutual understanding of the doctor and the patient. With the patient-centeredness movement at the end of the 1980s, paying attention to the significance of cues became in vogue again.[5]

Responding to patients' cues is one of the most important tools for a successful consultation.[13] Cues are described in different ways by different authors. Gask and Usherwood refer to verbal and non-verbal expressions of the patient that hint at psychosocial or social problems.[13] Levinson *et al* describe 'cues' as direct or indirect expressions with information about patients' life and feelings.[14] Balint uses the word 'offers' for expressions by the patient about the significance of their symptoms and for expressions about the reason for the encounter with the FP.[15] Branch and Malik describe cues as 'windows of opportunity' for the doctor to show empathy.[16] It is important to detect and respond to cues at the time they are offered by the patients.[13] Not addressing cues during clinical encounters may inhibit patients from further disclosures. Bertakis *et al* reported a significant relationship between the doctor's response to emotional cues and the patient's disclosure.[17] Moreover, cues enable better understanding of patients' life, cognitions and emotions.[18,19] Recognition and exploration of them has another advantage. It shows that the FP is listening carefully, wants to understand the meaning of the symptoms and is interested in the patient.[3] By picking up cues and exploring them, the FP enhances the therapeutic relationship and, as a consequence, improves illness outcomes and patient satisfaction.[17,20]

We know that doctors have difficulties recognising cues. Levinson *et al* examined how patients presented cues and how FPs reacted to them.[21] In more than half of the consultations, cues were present (average of 2.6 cues per consultation). Patients initiated 71% of the cues themselves and 29% were initiated by the FP asking open questions. In a majority of the consultations (79%), FPs missed the opportunity to react to the cues given in the consultation. Moreover, these consultations were of significantly longer duration. Butow *et al* found the same results in their study of verbal cues in cancer patients: oncologists did not consistently detect and address cues for emotional support. Consultations in which oncologists responded to higher proportions of patients' cues did not last longer than other consultations.[22] Cegala analysed videotaped primary care consultations of 16 doctors with 32 patients, and found that doctors rarely provide information in the absence of a direct patient question.[12] Moreover, patients' indirect cues of informational and emotional needs are far more common than direct patient questions. Thus, a focus on cues of needs in the clinical encounter is important.

Salmon *et al* studied consultations about medically unexplained symptoms and showed that most patients gave explicit cues about emotional or social problems.[23] Most FPs reacted to these cues by either blocking or facilitating a discussion about psychosocial issues. The FPs who blocked a discussion did not pay attention to the cues; they refocused on the symptoms and normalised the worries of the patient, or stressed patients' own responsibility. The FPs who facilitated a discussion about psychosocial issues did so by asking questions about the experiences of the patient and by exploring the problems of the patient. However, when the FPs gave an explanation of the symptoms, the FPs rarely took the psychosocial problems into account. Consequently, patients' concerns were not addressed and reassurance failed.

Conclusion

Most people interpret their symptoms in the context of their personal, family and life experiences. Active listening and noticing cues, as described in

this case report, can help FPs to get to know their patients.[1]

Discovering the patients' real worries and getting to know their stories gives us, as doctors, a better understanding of their own world.[24] In addition, mutual understanding leads to a higher satisfaction with care for both patient and doctor and it strengthens the doctor–patient relationship.[3,25,26] Remarkable words, strange clauses, sentences that you do not directly understand – ask for their meaning. It brings the patient's and the doctor's world closer together.

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CONFLICTS OF INTEREST

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