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EDITORIAL

Looking London Talking Tokyo?

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SUMMARY
Patient disagreement and dissatisfaction with their healthcare providers may be reflective of ineffective communication during the doctor-patient interaction. Such disagreement and dissatisfaction has significant repercussions for the therapeutic relationship. We explore factors that may result in such inadequate communication. While acknowledging that gaps in communication may persist despite the best efforts of both the patient and the physician, we consider strategies to bridge these gaps.

Key Words
Physician-patient disagreement; physician-family disagreement; shared decision-making; physician patient relationship, Person-centred-care

INTRODUCTION

In more innocent times, we memorised the essential amino acids (histidine, methionine, valine, isoleucine, phenylalanine, leucine, lysine, threonine, tryptophan) in high school biology as "Hi Mr. VIP, Looking London Talking Tokyo" (LLTT). How times have changed! Urban Dictionary now defines LLTT as either an extreme case of strabismus or "when you get so messed up you can't make heads or tails of the conversation"!

LLTT has, of course, formed the basis of much melodrama—from Kalidas's "Shakuntala" to Shakespeare's "Romeo and Juliet". Medical literature is no different. PubMed (tapping out past the 1970s) is strewn with decades-old accounts recognising LLTT between medical professionals and their patients.[1,2] Indeed, when both parties bring their fallibilities—experience, expression, and expectation—are we surprised the clinician-patient dialogue sounds uncannily like the album by Extreme—"III Sides to Every Story: Yours, Mine, The Truth"?

There may be many contributors to this state of affairs. Regardless of the quality of the doctor-patient interaction, the patient is the one with the symptoms (adequately managed or not from the interaction), the diagnostic label, and the one who consents to being at the receiving end of both potential benefits and harms any recommended treatment entails. As Sir William Osler, one of the founders of Johns Hopkins University School of Medicine, said, "It is much more important to know what sort of a patient has a disease than what sort of a disease the patient has". Medical training is excellent for identifying what disease the patient might have, however, it teaches little about the patient with the disease. Medical (and popular) literature, is replete with the poignance of individuals confronting their own diagnoses, be it medical professionals (*When Breath Becomes Air* by Paul Kalanithi), writers (*The Diving Bell and the Butterfly* by Jean-Dominique Bauby) or indeed, persons from any background. But disease and suffering are stunningly equal opportunity, and to the disease process erudition, scholarship, background, and eloquence count for little.

Medical (and specialist) training is an exercise in becoming proficient at synthesising increasingly complex information into recognisable patterns to direct diagnosis and assess response to therapeutic interventions in a logical and stepwise framework. Sufficient technical knowledge and years of hands-on experience are assumed. Communication training does not feature prominently—if it makes an appearance at all—in the medical curriculum. Despite what we are told is best practice, how realistic is it to expect lucid "non-jargon" explanations for complex abstract technical data without the crutch of the accompanying terminology from someone who is expected to use nothing but technical language with their peers and superiors? How is LLTT from the "IT person" "resetting the cache" after a "security vulnerability" caused "stack buffer overrun" any different to the "blood disease specialist" looking for the "specific JAK-STAT mutation" to advise "directed therapy"?

In the ideal world of person-centric care, the medical practitioner-patient and/or the medical practitioner-family consultation would be a dialogue, resulting in shared understanding, mutual learning, and trust, which forms the bedrock of a successful therapeutic relationship. In the real world, time pressures and role responsibilities within modern healthcare systems mean that many of these interactions skim the surface at best, often getting reduced to a monologue with witnesses—LLTT in action.

Both sides of the doctor-patient relationship come with baggage that is rarely acknowledged: cultural differences in explanatory models of health and illness; differences in cultural values; cultural differences in patients' preferences for doctor-patient relationships; and perceptual biases and linguistic barriers all impair the likelihood of an effective and satisfying doctor-patient relationship.[3]

Physicians need to be conscious that their own demographic characteristics and perceptions might influence the quality of counselling delivered to their patients. Patient-doctor gender concordance/discordance is associated with their agreement/disagreement on advice given during the consultation. For instance, regarding advice given on weight loss, the probability of disagreement was significantly increased (OR: 2.87, 95% CI = 1.29–6.41) when consultations consisted of female patient and male general practitioners (GP).[4]

Physicians' perceptions of patients' health literacy, based on their socioeconomic position or health outcome, may be a contributing factor. A recent French general practice-based study reported that 71.8 per cent of patients estimated their own health literacy level higher than that estimated by their doctors. The "synthetic disagreement" variable was dramatically different for patients who were workers versus patients who were managers (OR 3.48, 95% CI 1.46–8.26), and the gap between doctors' answers and those of their patients widened from the top to the bottom of the social ladder.[5]

Finally, well-reported variability in interpretation of diagnostic testing[6] and lack of reliable reproducibility in clinical judgement[7] mean doctors are hardly infallible—and our patients know it! To quote Australia's famous Rhodes scholar and former Prime Minister Tony Abbott, "No one—however smart, however well-educated, however experienced—is the suppository of all

wisdom".

As health care shifts toward meaningful diagnostic co-production and shared decision-making, in-depth understanding of variations in patient reasoning and mental models must inform clinical practice. Patients and support persons use multifaceted reasoning in their assessment of diagnostic accuracy. In a recent study, adults who had presented acutely to an emergency department or urgent care centre were sent follow-up questionnaires exploring patient-reported (dis)agreement with diagnostic accuracy, focused specifically on whether the explanation they received regarding the health problem was true and also whether the explanation described what to expect of the health problem. Thirty-two per cent of respondents used only corroborative reasoning in assessing the accuracy of the explanation of the health problem (alignment of the explanation with either test results, patients' subsequent health trajectory, their medical knowledge, symptoms, or another doctor's opinion); 26 per cent used only perception-based reasoning (perceptions of diagnostic process, uncertainty around the explanation received, or clinical team's attitudes); and 27 per cent used both types of reasoning. The remaining 15 per cent used general beliefs, non-explicated logic (only about accurate diagnoses) and combinations of general reasoning with perception-based and corroborative.[8]

Yet, disagreement between the clinician and patient can have significant prognostic implications and may affect satisfaction with the overall healthcare experience. In sarcoma patients, a Canadian study reported patient-physician disagreement was common on the level of function (43.4 per cent) and pain (45.7 per cent). Yet, baseline physician-patient agreement was associated with better 12-month outcomes.[9] Similarly, in patients with unresectable metastatic colorectal cancer in the QUACK II study, there was low agreement between physician-reported and patient-reported dyspnoea, pain, fatigue, and insomnia, with underreporting by physicians ranging from 12.5 per cent (nausea/vomiting) to 56.7 per cent (fatigue). The 2-year overall survival rate was more favourable for patients with high agreement than for those with low agreement (71.2 per cent vs. 46.5 per cent, p=.016), and the agreement status was an independent factor of survival (HR 2.31, 95% CI 1.13–4.71, p=.022). In patients reported as asymptomatic by the physician, the presence of patient-reported symptoms resulted in a trend toward poor prognostic outcomes for appetite loss, dyspnoea, diarrhoea, and constipation. These findings highlight the importance of monitoring patient-reported symptoms to ensure more accurate clinical outcomes.[10]

Patients with sensitive health topics (medical uncertainty, psychiatric comorbidities, tumour diagnosis, social issues, non-adherence, previous conflicts between patient and treating team, and treatment failure) often provided more cues but reported lower overall satisfaction (87.7±14.6 vs 90.2±12.1, p=0.006) with their healthcare experience. Sensitive topics were associated with less subjective (77.8±22 vs 81.2±19, p=0.013) and objective knowledge (68.7±25.8 vs 72.6±24.9, p=0.021). While duration of discussions and debriefings was longer for patients with sensitive topics (14.5±5.6 minutes per patient with complex issues versus 11.3±4.6 minutes per patient without complex issues, p<0.001), patients with sensitive topics felt more uncomfortable and unsettled during the ward round, with discussions causing them to worry. They also felt less confident with the physician team (91.9±14.4 vs 89.5±16.8, p=0.02). Patient satisfaction correlated with physician- patient interactions during rounds (eg, respectful treatment, physician

compassion, observing privacy). Not surprisingly, poor satisfaction was reported when physicians disagreed with patients, when patients disagreed with physicians, when the overall ward round was longer or when patients lacked (subjective or objective) knowledge about their own medical care or had reduced capacity to understand the disease, the current treatment measures, or future care plans. Regardless of the presence of sensitive health topics, physicians applied more patient-centric communication techniques when patients mentioned emotions.[11]

Lower patient satisfaction may simply reference interpersonal skills and non-clinical aspects of the doctor-patient interaction, with non-surgical patients more likely to reference the amount of time spent with the physician (12.9 per cent to 6.6 per cent, p=0.026), wait time (11.9 per cent to 0.0 per cent, p<0.001), and bedside manner (41.2 per cent to 22.8 per cent, p<0.001), while patients who had undergone a surgical procedure were more likely to reference disagreement with the physician's decision or plan (35.3 per cent to 17.5 per cent, p<0.001), and uncontrolled pain (21.6 per cent to 5.2 per cent, p<0.001).[12]

Empathy is crucial to physician-patient communication. Mindfulness, compassion-based strategies, stress reduction using cognitive-behavioural techniques, relaxation techniques, and psycho-educational treatment have all proven effectiveness in improving empathetic communication between healthcare professionals and their patients.[13]

Verbal and non-verbal recognising behaviours—alert presence during the consultation, actively listening, understanding, accepting, and confirming—may leave space for disagreement or seeking independent opinions without jeopardising the therapeutic relationship in the long term.[14]

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