Survive & Thrive: A Journal for Medical Humanities and Narrative as Medicine

Volume 9
Issue 1 *Open Issue*

Article 7

2022

How to Talk so that Doctors will Listen

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Cover Page Footnote

Thank you to the doctors who listened to me! And f*#k you to all the doctors who didn't.

How to Talk so that Doctors Will Listen

On Sept. 19th, 2008, Brian Sinclair, a double amputee, went to a medical clinic in Winnipeg, Manitoba. The clinic couldn't deal with his condition so they put him in a cab to the nearest ER with a doctor's note stating that his catheter was blocked (Canadian Broadcasting Corporation, 2013, October 21, para. 8 - 9).

At 3pm, Brian arrived at the ER. The triage aide instructed Brian to wait in the waiting room (Puxley, 2014, para. 11). As the afternoon turned to evening, Brian waited. As the evening turned to night, patients in the waiting room asked staff to check on Brian as he had vomited on himself and his skin was "very blue" (Puxley, 2013, para. 15); video footage shows that these requests appear to have been ignored ("Video Timeline", 2013). A family member of another patient reported that when he asked a nurse to check on Brian, the nurse "laughed it off" and said Brian was just there to watch TV (Puxley, para. 24). Night turned to morning, afternoon, evening, and night again. Eventually, a security guard – not a medical professional – decided to check on Brian. By then, Brian's body was stiff with rigor mortis. The security guard quietly allerted hospital staff (to avoid upsetting other patients). The staff thought the security guard was joking (Pritchard, 2013, para. 6-7).

Eventually, someone believed the security guard and Brian was brought into the resuscitation room but it was obviously far too late: the autopsy revealed Brian had died of an easily treatable bladder infection from the blocked catheter two to seven hours before he was finally taken out of the waiting room (Lett, 2012). In total, he had been in the waiting room alive, then dead, for 34 hours (Lett, 2012 para 1 - 5).

Are you surprised to learn that Brian was Indigenous? I am guessing that's not surprising to most of my readers. And now that you know he was Indigenous, you are

likely not surprised to learn that hospital staff admitted they had ignored Brian because they had assumed he was either intoxicated or just a homeless and there to get out of the cold (Geary, 2017, para. 6)

You might not know the details of how bad the situation is, but you are likely not surprised that Indigenous people are underdiagnosed and undertreated by the Canadian health care system (Camillo, 2023; McCallum & Boyer, 2018;). And so are women (Camillo), and obese people (Gupta et al, 2020), and mentally and physically disabled people (Downer & Rotenberg, 2023; Du Mont & Forte T, 2016), and many, many other minority groups in Canada (Wahoush, 2009; Reitmanova & Gustafson, 2008; Asanin & Wilson, 2008; Pollock et al, 2012). Doctors are members of our society, so it is not surprising that they reflect the biases of that society.

Of course, justice demands that we change the system so that we all get the same level of care; but, systemic change takes a long, long time and there are people who need help now. When I woke up with chest pain and paralyzed extremities, I didn't have time for a government report to find that women's heart conditions are ignored. And the obese person who is, right now, having their acute illness – whether it's concussion, a broken bone, or a virus - ignored as their doctor drones on about calorie-counting, doesn't have time for med schools to implement anti-bias training.

Is there a way that patients can help themselves **now** so they are not ignored to death like Brian Sinclair was? As a woman living with multiple debilitating chronic conditions, I desperately wanted to learn how to talk so that doctors would listen. I started by writing to some medical organizations to see if they had any suggestions. Most referred me to lists like this one from the American National Institute on Aging titled "How to prepare for your doctor's appointment".

"Make a list and prioritize your concerns…

Take information with you to the doctor…

Consider bringing a family member or friend to the doctor's visit…

Keep your doctor up to date…

Be sure you can see and hear as well as possible…

Request an interpreter if you need one."

(*National Institute on Aging,* n.d.)

Some of this advice is undeniable common sense: you won't be able to get a proper diagnosis and treatment if you can't speak the same language or hear what doctors are saying. But what about the other strategies such as making a list, bringing information, keeping your doctor up to date, etc? Does any of that really matter?

I asked these medical organizations if there was any research to back up their suggestions on how to get the most from your doctors' appointments. None were able to provide any studies showing their suggestions worked. So, I spent some of my own time searching. I was unable to find any peer-reviewed studies showing that, for example, writing down a list of symptoms or bringing in information, makes the diagnostic process any faster. I believe that there is a reason why none of this helps: I found numerous studies, across decades, mostly from the USA, showing that doctors simply do not allow patients to speak at appointments (ex. Glauser, 2018, Ha et al., 2010; Phillips et al., 2019). Given that patients only have on average 11 seconds to speak before the doctor interrupts us (Phillips et al), it probably doesn't matter if I bring my journal of concerning symptoms or the narrative from the ultrasound tech to my appointment with the cardiologist. Doctors simply don't make time to review all this information. In just 11

seconds, I probably wouldn't even be able to tell the doctor that I have brought them. **The rhetorical strategies suggested by medical associations**, like making a list of concerns, taking information on your condition, and keeping your doctor up to date, **just don't fit the reality of the rhetorical situation**.

Telling a Good Story

Dr. Lisa Sanders, the inspiration for TVs "Dr. House", has noted that physicians, like all humans, love stories (Gonzalez, 2009). It makes sense, then, that Dr. Sanders' main recommendation to patients is that they learn to tell a good story (Fitzpatrick, 2009).

> It's hard to listen to a story that's not told well. That's a terrible thing to say, but we all feel this. You know, when we're at the dinner table and Uncle Dave is telling a long, windy story, what you're really thinking is, "Where is this going? What is the bottom line?" That kind of impatience is not just limited to the dinner table; that's often how doctors feel. When you didn't have any other [diagnostic] tools except that story, you just buckled down and listened. But now that we have other [high-tech] tools, we feel like, "O.K., I'm out of here.
>
> (Sanders quoted in Fitzpatrick, 2009)

Instead of taking advice such as that given in "How to Prepare for Your Doctor's Appointment", which is not backed by evidence or the anecdotes of patients and doctors, I decided to see if there was any evidence that, as Dr. Sanders suggests, doctors, like all humans, would listen to a good story. If doctors zone out when patients drone on, as Dr.

Sanders suggests, **is there evidence that patients can use rhetorical devices to tell a story doctors will listen to?**

Logos, Ethos, and Pathos

When I teach undergraduate students how to get an audience to listen, I start with the familiar Aristotelian rhetorical triangle of logos (logic and information), ethos (character and credibility), and pathos (emotion). You need to present information logically (logos), but you also have to make your audience trust your character (ethos); and, of course, few audiences will keep listening unless the speaker appeals to their emotions (pathos).

The messaging that we get from medical institutions like "…take information with you to the doctor" (*National Institute on Aging*, n.d.) sounds like logos to me, so that's where I started. As I stated earlier, I couldn't find any evidence that bringing information such as previous test results, peer-reviewed studies, or even a time-line of symptoms, has any effect on outcomes.

Let's think back to the story of Brian Sinclair. He had a note from the drop-in medical clinic clearly stating his condition – what better piece of "information on [his] condition" could a doctor ask for than a note from another doctor clearly stating the patient's condition? But that didn't matter: we have no evidence that anyone even read that note (Geary, 2017). What good is the appeal to logos if no one reads your notes from other doctors and your doctor cuts you off after 11 seconds? We will need to figure out a different way to get doctors to listen.

So what about ethos? Does a patient's character impact how willing doctors are to listen to them? It is well-documented that college-educated patients have better medical outcomes than those with high school or less (ex. Raghupathi & Raghupathi, 2020). Obviously, this is bundled up in a big mess of socioeconomic factors: well-educated people generally have better nutrition, live in less polluted areas, have less stress over money, etc. I can't categorically state that well-educated people have better health outcomes *just* because of their ethos; however, I found studies documenting that, for example, “doctors are less likely to inform [perceived] poorly educated patients about the possibility of seeking a second opinion” (Benbassat, 2019). If you have the *ethos* of an educated person (you don’t have to actually *be* educated), doctors are more likely to inform you of your options. I don't think it is a far jump to also assume that doctors are more likely to *listen* to people who have an educated ethos.

So what should people do to establish an ‘educated ethos’? There are, of course, studies stating that things like wearing glasses will make you be perceived as more educated; but the effects are small (ex. Al Ryalat et al. 2022). So what can you do if you can’t establish an educated ethos yourself? Though they don't mention ethos directly, medical associations do often advise you to bring a friend or family member with you to appointments (ex. (*How to Prepare for a Doctor's Appointment | National Institute on Aging*, n.d.). This is the one and only piece of advice on the lists from medical associations which actually has evidence behind it. Studies have shown that family and friend involvement in care improves outcomes. (ex. Jazieh et al, 2019; Rosland et al, 2019). However, this doesn't prove that it is due to the other person's ethos alone. An interesting area for further research would be whether the perceived education level of the family and friends improved patient outcome. Personally, I have found I receive

much better care when my husband – with his glasses and general 'professorly' air – accompanies me to medical appointments. I suspect that if a white, middle-aged, able-bodied, male in a suit and glasses walked into the emergency room and confidently stated, "My friend Brian Sinclair needs immediate attention as his catheter is blocked", Brian would have received treatment that day.

The final side of Aristotle's rhetorical triangle is pathos (emotion). We can all guess that doctors, as humans, are more likely to help patients who appeal to their emotions; but, finding doctors willing to admit that they only listened to a patient because they tugged at their heart strings is not an easy task. I could not find any research on the topic. However, arousing sympathy is not the only way to appeal to a doctors' emotions: threats are also pathos. Reminding doctors of the repercussions of ignoring patients is a technique many patients recommend. One suggestion I often come across in chronic illness support groups has to do with requests being denied: if a doctor refuses a patient's request for a particular test, referral, or prescription, the patient can ask that the fact the request be denied by noted in their medical chart. Anecdotally, patients report that doctors often relent and fulfill the request out of fear that the patient may use the denial against them at a later date (such as in a malpractice suit) (ex. u/EvaRawr, 2020). However, despite anecdotal reports that such threats 'help' doctors listen, I could find no studies on the topic. I worry that the implications of such threats, even if they are just requests for doctors to follow proper procedure, might backfire on patients.

Demographic Homophily and Identification

After looking at the current research, I have to conclude that of the three sides of Aristotle's rhetorical triangle, it really seems like ethos is the one appeal that you can rely on to get doctors to listen: Doctors don't pay much attention to information, using emotions might backfire, but having the right character does seem to help. So instead of turning to more rhetorical advice from the ancients, I decided to reverse engineer the problem of how to talk so that doctors will listen: I thought about the times doctors had listened to me.

Of the host of complaints I have brought to dozens of doctors in the last thirty years, all but one of my many chronic conditions were diagnosed by female doctors. Doctors of my own gender listened to my complaints and followed through on my requests for testing, ultimately leading to diagnosis and treatments. I know that a lot of women prefer female doctors for this reason. Social scientists know that "demographic homophily", that is, "the degree to which pairs of interacting individuals are similar in terms of demographic attributes" (Rogers and Bhowmik, 1970) affects trust. In rhetorical theory, we can think of this as identification (Burke, 1969): people who identify with you due to shared demographics are more likely to be persuaded by you. Is it possible that female doctors listened to me because I was a female too? The answer I found In the medical research surprised me. I was correct that my female doctors listened to me more, but it had nothing to do with demographic homophily; rather, female doctors spend more time than male doctors listening to everyone, not just other women (Roter et al, 2002). It wasn't about the fact that female doctors identified with me as a woman, but rather, that females in general are socialized to listen for information (Trang, 2022), and female doctors seem to be no exception.

But I wasn't ready to give up on the notion of demographic homophily yet. The doctors who were able to listen and diagnose me were not just female, but also fairly young. Did it have to do with the fact that I was young at the time too? Again, I found that I was correct that young doctors happened to listen to me more, but it had nothing to do with demographic homophily; rather, doctors' communication skills decline the longer that they are out of med school. This decline of communication skills combined with other factors such as failure to keep up with medical advances, means that every decade a doctor has been out of med school is associated with a 4.5% increase in the mortality of their patients (Norcini et al. 2017)! Clearly, with regards to age, demographic homophily is not as important as the youth – or, more accurately, the amount of time which has passed since the doctor completed medical school. If you want a doctor who will listen to you, don't look for one your own age; rather, look for one fresh out of med school.

Finally, what about race? This seems to be the one category in which demographic homophily does matter. Though I couldn't find any studies on listening particularly, I did find several studies which noted that patients with doctors of their own ethnicity reported that they got better treatment than those of different ethnicity (ex. Takeshita, 2020; Tanne, 2002). I believe that the fact that they *reported* better treatment is an even stronger indicator of the doctor listening than patient outcomes. So, perhaps Burke was partially right: if you want your doctor to listen, look for a doctor the same ethnicity as you – just make sure they are also young and female.

Conclusion

University courses in communications and rhetoric teach students how to establish a professional ethos in a job interview, organize an argument for a term paper, and even make a speech at a wedding. Private courses promise to teach you how to pitch a movie to a producer, produce your own podcast, or even craft an online dating profile. Yet, I don't know of any classes which prepare people for what might be the most important rhetorical situations in our lives: encounters with medical professionals.

Billions of dollars a year are spent conducting studies to find out what arguments change voters minds. An even larger industry quantifies what it takes to persuade people to buy things. Though some money is spent trying to figure out how to get patients to listen to doctors, there has been very little research on how patients can get doctors to listen.

Unfortunately, I was unable to find any evidence showing that there is anything you can *say* to make doctors listen, but I did find that there are a few things you can *do* to improve your chances of having a doctor listen to you. Firstly, you can cultivate an educated ethos. Secondly, if you are in a position to choose your own doctor, choose a female doctor, of your own ethnicity, who recently completed medical school.

The terrifying truth is that learning to talk so that doctors will listen can make the difference between life and death. I hope that this exploration will help someone avoid being ignored to death as Brian Sinclair was.

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