3

Expectations in the Consulting Room

1. A 32-year-old woman came to her doctor for low back pain of one month's duration. Physical examination was within normal limits except for a small hard lump in her left breast. The physician suspected a malignant breast tumor and referred her to a surgeon, who admitted her to the hospital for breast biopsy. On admission, the patient was noted to be anxious and reticent. When the admitting intern asked why she came to the hospital, she said, "I don't know. I've had this back pain for a month or so—after straining it lifting a heavy suitcase. I guess you want to do surgery to straighten my back?" When the intern asked about the lump in her breast, she said, "Yes, my doctor told me about that. It doesn't hurt or anything, and I told him not to bother. He said it should be checked just to be sure, though. But my question is what are you going to do about my back pain?" The chart revealed the following note by the intern: "This 32-year-old white female was admitted to the hospital with the chief complaint of a lump in the breast."

2. A conversation at the bedside of a patient in a community hospital. Intern: "This is the 58-year-old gentleman with possible mitotic lesions of the liver." Attending: "Hello, Mr. X. How are you this morning?" Patient: "I am fine . . . er, much better, I think, Doc. I think I am getting a little less yellow now . . . maybe the X rays yesterday helped." Attending: "Fine, I think things are moving along O.K., Mr. X." Intern to Attending: "Mr. X had chest X rays yesterday for possible mets—negative." Attending to Intern: "Ought to repeat the LFT, lytes, and bilirubin and get a GI consult."

3. A 38-year-old woman visited her family doctor complaining of severe migraine headaches. She had had migraine for more than ten years, but

both the frequency and intensity had increased during the past three months. The intensity had increased to the point where she had nearly collapsed on several occasions. She made three visits to the doctor's office in three weeks, urgently asking him to "do something" about the headaches. Careful physical examination was within normal limits, and the headaches did not respond to the usual antimigraine regimen despite good results in the past. Finally, her doctor decided to ask her specific questions about any changes in her life during the past several months. Initially, she denied any major changes, but when questioned about personal habits, including sexual activity, she revealed that she had been involved in an extramarital affair for four months and that she felt intensely guilty and worried. Having shared her concerns about the affair, she was assured that the physician would help her to deal with her personal problems. The migraine headaches decreased in frequency and intensity.

A patient brings to the consultation with the physician both overt and covert expectations of the doctor. Conversely, the physician has expectations of the patient consonant with societal expectations about the *sick role* and automatically expects the patient to behave according to them (see Chapter 2). Especially important is the expectation that the patient will *cooperate* with the doctor to get well. Often there is an associated implicit idea that patients should and will be *candid* with physicians and that they will *volunteer* pertinent information. Because of this implicit expectation, some *doctors may fail to inquire* into personal situations and matters that may be relevant to help-seeking behavior. In vignette 3, if the doctor had *not* specifically asked about the patient's sexual life, a successful outcome would not have been likely.

Some of the patient's expectations in the consulting room manifest themselves only when they are not met, that is, when the patient is frustrated. An important conscious attitude shared by patient and doctor alike is that of *hope;* the patient's expectant hope that the doctor can help him and the doctor's hopeful expectation that he can do something for the patient (Freidson, 1970). *Relief from distress* usually holds top priority for the immediate help that the patient wishes and seeks to gain by consulting the physician. Implicit in this hope, of course, is the expectation that the doctor will be competent and that he will be interested.

In this chapter, we will discuss some of the expectations brought to the consulting room and examine how divergence or incongruity of such expectations between patient and doctor can interfere with optimal medical care. In the course of the discussion, expectations of the physician, that is, the "doctor role," will also be examined.

RELIEF FROM DISTRESS

As noted above, the immediate expectation of the patient is that the doctor will relieve his distress. This may, in fact, occur to a considerable degree simply by the experience of visiting the physician, even before the symptom or underlying disease has been changed. Freidson states that because of the mutual hope that the doctor can and will do something to help the patient, both patient and doctor are motivated to believe that something effective has occurred during the doctor–patient contact (Freidson, 1970). Consequently, according to Freidson, the patient may feel better and the physician may consider his ministrations to have been responsible (whether or not this was actually the case). But if, in follow-up contacts, the patient does not perceive that specific procedures to alleviate or remove the symptom are being instituted or planned, the distress may again increase.

The physician's expectations generally focus on a related but somewhat differently timed process: relieving the patient's distress by *treating the underlying disease.* This means that the doctor's inclination is first to identify and then to treat the underlying disease, with relief following naturally. Here, then, is the potential for a covert difference in priorities between the patient (relief from distress) and the doctor (treatment of underlying disease). Such a situation is particularly well illustrated when the physician diagnoses a serious medical condition unrelated to the immediate (coincidental benign) distress that brought the patient to him and then understandably subordinates the treatment of the immediately distressing, but minor, condition to the treatment of the serious one (vignette 1).

Depending on the nature of the symptom and the level of sophistication, most patients, of course, also expect treatment of the underlying cause. This may hold first priority for some patients, particularly those coming because of "limit of anxiety," but it most often takes second place to more immediate relief of discomfort. Covert differences in expectations can, of course, lead to difficulties in the doctor–patient relationship and interfere with the treatment process. Clearly, problems of this nature can be prevented or corrected by effective and open *communication,* and it is the doctor's responsibility to be alert to this phenomenon and to take the initiative in dealing with it.

Physicians expect their patients to cooperate with recommended diagnostic and treatment regimens, and patients do, indeed, expect to render such cooperation and compliance with the doctor's instructions. This

cooperation, however, is *conditional* on their understanding that such cooperation will eventually result in relief from distress.

Physicians expect (and require) that patients will provide them with information concerning past history, history of present illness, and other aspects of their illness to aid in the diagnosis and assessment of the illness, but patients do not know the relevant details and kinds of information that are needed. Yet some patients have an *implicit expectation* that the doctor will *divine* the source of their distress and do not expect to give detailed specific descriptions and history. Furthermore, body sensations are difficult to describe in words, even when the sensations are not threatening. Such communication problems can only be ameliorated by the physician's skill and patience in taking a medical history. This is an art that the good physician works an entire lifetime to perfect. Patients expect the physician to *communicate* diagnostic findings and therapeutic plans as well as to manifest an *interest* in providing relief. Communicating about diagnosis and treatment may be difficult and often requires considerable thought and planning. It can be misleading to assume that it is sufficient to convey only as much as the patient appears to be interested in and capable of understanding. Patients' interest in information, and their capacity for understanding, tend to be underestimated by physicians (Pratt *et al.*, 1957), and the amount of information received from the physician seems to influence the patient's readiness to comply with the physician's orders—the less information furnished by the doctor relative to the amount provided by the patient, the less compliance the patient is likely to show (Davis, 1968).

The physician may overestimate the strength of the patient's blind trust or the extent of his understanding. Overestimating the patient's trust leads to the unwarranted assumption that the patient will understand that every procedure and advice the doctor gives is aimed at relief from distress in the long run. The physician may then fail to make connections for the patient and express the intent to eventually relieve his distress. Overestimating the patient's level of understanding and sophistication leads to an assumption that the explanations are unnecessary, again resulting in neglect of full communication.

Many studies indicate that there is a higher level of dissatisfaction on the part of patients about the amount of information physicians provide than about any other aspect of medical care (Cartwright, 1964; Duff and Hollingshead, 1968; Waitzkin and Stoeckle, 1972). In addition to the factors discussed above, Waitzkin and Stoeckle (1972) postulate that the feeling of power arising from keeping the patient uncertain and uninformed may (unwittingly) motivate some physicians to withhold information.

The problems of frustrated expectations generally arise from problems in communication. In essence, both patient and doctor have the same and/or mutually syntonic central expectations, but the physician's intentions are often *implicit* and need to be made *explicit*. Treating the underlying illness first will lead to relief of symptoms; there is no inherent conflict, and, in fact, one follows the other. The patient, however, does not understand how an immediately distressful and seemingly irrelevant procedure like a breast biopsy (vignette 1) might eventually help relieve the felt distress of low back pain *unless* the physician explains *explicitly* that (1) the lump in the breast may be unrelated to the back pain but needs to be evaluated before it becomes a problem; (2) although unlikely, the back pain may be related to the lump in the breast (metastatic cancer), in which case, both need to be treated; and (3) in any case, the doctor *will* treat the back pain with medications. Physicians do attend exclusively to relief of symptoms when it is necessary, that is, when prompt treatment of the underlying cause is not possible.

Inaccurate estimation of patients' desire to receive information is particularly problematic in dealing with patients of *lower socioeconomic status*. Cartwright (1964) reports that professional white-collar workers obtained most of their medical information by asking their physicians and nurses direct questions, while blue-collar workers received such information through a passive process not involving active asking and consequently tended to receive less information than the upper classes. He attributes this diffidence of the lower class concerning medical personnel to four factors: (1) their sense that doctors do not expect them to ask questions, (2) a problem of language that results from their unfamiliarity with the technical terms doctors use, (3) the awe with which they regard physicians, and (4) their social distance from physicians' higher social class. This reluctance to engage in active information-seeking behavior is often misinterpreted by the physician as a lack of interest. But it should be emphasized that *there is no general class difference in patients' desire for as much medical information as possible* presented in nontechnical language. "Good explanation" of illness is considered to be one of the most important qualities of a "good doctor" by a majority of hospitalized patients (Skipper and Leonard, 1965).

Differences in language skills and pattern of *linguistic use* may also contribute to the phenomenon of the lower-class patients receiving inadequate information from physicians. There are two basic linguistic codes differentially used by the middle and working classes (Bernstein, 1964). The *elaborated code* refers to the mode of speech in which the speaker selects from a wide range of syntactic alternatives, and it renders itself more easily to descriptions and reasoning based on the content of

the speech. The *restricted code,* on the other hand, has a reduced range of alternatives and syntactic options, and the vocabulary tends to be drawn from a narrow range. The restricted code tends to discourage verbal elaboration and discussion. The elaborated code also often involves "expression of intent," while nonverbal signals are usually used for this purpose in the restricted code. The elaborated code uses higher levels of abstractions than the restricted code. The elaborated code, then, is the linguistic style used by the middle class, while the lower class tends to use the restricted code.

Physicians, using an elaborated code, are likely to expect patients to express intent verbally, while lower-class patients, using a restricted code, are not accustomed to making such verbal requests. Thus, their expectations, expressed nonverbally, are likely to be frustrated.

The physician often concludes incorrectly on the basis of the restricted-code language used by lower-class patients, with its usage of a lower level of abstraction and a lack of verbal expression of intention, that the patient lacks the *competence* to understand his explanations and that the patient also lacks the desire to know about his disease processes and plans for its treatment (Waitzkin and Stoeckle, 1972).

Actually, this difference in language use between the classes is largely one of *performance* rather than of competence. Chomsky (1965) uses the term "performance" to refer to language use in concrete, specific situations, while "competence" is used to refer to the person's actual knowledge of language. Although a lower-class person is more accustomed to the restricted code in speaking, influenced by early experiences and current practice of his social station, he is nevertheless usually able to understand the elaborated code of the upper classes.

COMMUNICATION OF INFORMATION

Reference was made above to patients' desire to know about illness in nontechnical language. Even if a patient belongs to the middle class, with its elaborated code, he still has a class difference from the physician—doctors belong to a special closed class whose members habitually speak in a language comprehended only by its own members. Technical language or jargon serves several useful *functions.* One, among others, is setting the context of meaning (in this case, medical) and being specific. For example, carcinoma of the cervix refers to a particular form of cancer

arising from a specific area of the female genital organ, and it is clear that this term is used in a medical context.

When communicating with nonmedical persons (patient or family or both), however, the doctor may encounter problems in attempting to translate medical jargon into nontechnical language. One problem with such translations is the loss of *specificity.* In the example given above, translation of "carcinoma of the cervix" to "cancer of the womb" clearly loses the specificity concerning the type and the exact site of the lesion. This can give rise to confusion in the mind of the layperson, who may have heard the same term applied to such diverse conditions as endometrial carcinoma, fibroadenoma (considering that "tumor" is often used synonymously with cancer), ovarian tumor (some laypeople may confuse the womb and ovaries), and carcinoma of the vagina. Of course, there are marked differences in the course, treatment, and prognoses of these conditions.

Translation to nontechnical language is nonetheless desirable, since the use of jargon results in both noncommunication and misinterpretation. It is important to recognize that in translating medical jargon to lay terms, specificity is very often lost and that the person is likely to have his *own fantasies and ideas* about what the doctor is telling him. For information to be communicated accurately, therefore, it is essential that the physician attempt to be as specific as possible and that he *ask* the layperson what he *understood* from the explanation provided. This will provide an opportunity for prompt clarification of possible misunderstandings and misinterpretations.

Physicians sometimes use medical jargon deliberately when they are communicating with each other in the presence of the patient. This can be very risky. *If the patient is not provided with sufficient information, he will attempt to construct his own meaning out of whatever he heard.* Just imagine for yourself the fantastic notions the patient in vignette 2 might have developed from the wholly unfamiliar terms he heard the doctors using.

Another problem with translation of medical terms into lay terms is that the loss of medical context may result in the concomitant loss of "affective neutrality" (see below). This is obvious when one considers the nontechnical terms that denote such body organs as the uterus, vagina, and esophagus. With the popularization of medical terminology in nonmedical populations, however, this particular problem has largely abated. Nonetheless, some terms may still run into difficulties in translation (e.g., "mortality rate," "prognosis"). Medical context should be kept in translations as much as possible.

RECOGNIZING BARRIERS TO COMMUNICATION

Quill (1989) describes as possible indirect signs of the existence of a barrier in the doctor–patient communication the following: verbal–nonverbal mismatch, cognitive dissonance, unexpected resistance, physician discomfort, noncompliance, treatment not working, and exacerbation of chronic disease. Verbal–nonverbal mismatch refers to a discrepancy in what the patient says and what he does (e.g., avoiding eye contact, appearing anxious while saying "everything is OK"). Cognitive dissonance on the part of the physician, that is, what the patient is saying simply does not "add up," for example, a patient denies any feelings of distress in spite of recent death in the family, divorce, financial mishaps, and so forth.

Once a communication barrier has been recognized, it may be attenuated or resolved by considering the barrier itself as a clinical problem. This may be achieved through open discussion with the patient and negotiating with the patient a new or different approach that lessens the barrier preceded by empathic understanding of the barrier (e.g., patient's use of restricted code in language) and legitimation (acceptance by the physician that the patient's feelings or reactions are reasonable and appropriate).

EFFECT OF PRIMING FACTORS ON EXPECTATIONS

Previous experiences with illness, physicians, and hospitals also determine the patient's expectations in the consulting room. This is especially so if the present illness to be treated is in any way related to the previous experience—for example, same symptoms, same body organ, or same physician.

The physician's expectations are also influenced by his own previous experiences with the particular type of disease or symptoms and even with the personality type of the patient.

THE PHYSICIAN'S COVERT EXPECTATIONS

In addition to the shared expectations of the doctor and patient, some physicians have additional covert expectations of patients. For example,

some expect that the patient *should be suffering* to see a doctor and that the suffering must be *physical*. In such a case, if a patient visits the physician with a minor symptom from which little suffering is evident, he may be viewed with suspicion or even derision because of this expectation. When the expectation is that the suffering must be physical, there is a tendency not to consider the possibility that the presenting symptoms might be heterothetic, that is, problems of living presenting as a symptom. Such expectations on the physician's part, then, may result in *inadequate or delayed diagnosis* through the lack of vigilance and concern.

SOCIETY'S EXPECTATIONS OF THE PHYSICIAN—THE "DOCTOR ROLE"

Society has certain expectations of the conduct of physicians just as it does of ill persons. These will be referred to as the "doctor role" to complement the "sick role" of the patient.

Parsons (1951) elucidated the role of the physician together with the sick role in his book *The Social System*. According to Parsons, there are five essential aspects to the role of the physician. They are discussed below.

Technical Competence

The physician is expected to facilitate the patient's recovery from illness to the best of his ability. To meet this responsibility, he is expected to acquire and practice high technical competence in "medical science" and the techniques based on it.

Parsons points out that this can be a cause of frustration for the physician because of the inherent uncertainties in medicine and because scientific advances do not necessarily result in an increase in the physician's ability to facilitate recovery from illness.

In the context of "doing everything possible," the physician is *exempted from certain social prohibitions*. These include the need to invade the patient's *privacy* in handling and examining his body (physicians are allowed to look and feel and otherwise explore another person's body in ways barred even to a spouse or lover), to acquire confidential and personal information from the patient, and to subject the patient's body to discomfort and injury (such as surgical procedures).

Universalism

Parsons characterized the doctor role as being "universalistic," as opposed to "particularistic," in two senses. First, this role is *open to anyone* who meets the performance criteria. This tends to reduce nepotism and to facilitate interdisciplinary communication and thus the furtherance of medical science. Second, the universalism of the role *protects the physician* from "assimilation to the nexus of personal relationships in which the patient is placed." This particular aspect also implies that the treatment the physician renders is universal; that is, he renders his professional services to *any patient,* not just to friends and relatives. This is clearly related to the functional specificity and affective neutrality described below.

Functional Specificity

"Specificity of competence" and "specificity of the scope of concern" are considered under this rubric. The former refers to the expectation that the physician will practice only the techniques and areas of medicine in which he is competent, and it also involves his right not to treat patients requiring skills he does not possess.

Through expectations concerning the specificity of the scope, the physician is expected to avail himself of the privileges, such as the exemption from the prohibitions concerning invasion of privacy, *only for the purpose of medical care.* This expectation tends to allay anxieties on the patient's part about being exploited by the physician.

Society supports the maintenance of the functional specificity of the physician by "segregation of the context of professional practice from other contexts." Thus, information gained in the context of medical practice is expected to be privileged and confidential, and situations suggestive of sexual or aggressive encounters in other contexts are perceived differently in the medical context, for example, having patients of the opposite sex undress in the same room or cutting a person's skin with a knife.

"The importance of functional specificity is to define the limits of the 'privileges' in the 'dangerous' area which the physician might claim," in situations where potential illegitimate involvements might develop.

Affective neutrality is considered to be the expected attitude of the physicians within these limits.

Affective Neutrality

This refers to the expectation that physicians will maintain *objectivity* in regard to their patients and will not become "emotionally involved."

Included in this are the expectations that the doctor will treat his patients equally, whether he likes them personally or not; that he will not become emotionally aroused in the course of his professional activity (such as erotic arousal); and that he will not reciprocate some patients' pull to become more "intimate" with them, such as becoming personal friends. Parsons sees a similarity between this and the affective neutrality essential in psychotherapy situations and infers that a functional significance of this aspect in medical practice might be that *there is a certain amount of "unconscious psychotherapy" in all medical practice.*

Affective neutrality does not mean that the physician should express no concern about his patient, but rather that this attitude is expected to be one of *professional* concern.

Collectivity Orientation

This refers to the service orientation of the physician to *subordinate his own personal gain to the welfare of the patient.* The collectivity orientation is considered to be the foundation of the "trust" that the patient is expected to have in his physician. Parsons states that this orientation is found in all cases of institutionalized authority. In the doctor–patient relationship, this authority is legitimized in a reciprocal relationship—the doctor has the "obligation faithfully to accept" the implications of the fact that he is the patient's doctor.

The significance of this orientation is in allowing the development of a trusting relationship between the doctor and the patient by reducing the threat of exploitation on the doctor's part.

In summary, then, society accords the physician certain *privileges* in helping the patient, accompanied by the expectation that he has high *technical competence,* that he will treat his patients scientifically, using *objective criteria* for diagnosis and treatment rather than personal feelings, that he will treat patients *only in the areas in which he has professional competence* and not spread his practice and areas of competence too thin, that he will maintain *objectivity* concerning patients by not becoming personally involved with them, and that he will always put the *welfare of the patient* before his own welfare in the practice of medicine.

SUMMARY

Physicians and patients have the mutual expectation that the doctor will *help* the patient. The patient's priority is usually *relief* from suffering

or distress. The physician's priority is generally the treatment of underlying *disease,* which is then expected to result in relief from distress. Neglect of the patient's main concern of relief from distress can result in a strained doctor–patient relationship.

In assuming the sick role, the patient expects to offer cooperation and compliance to the doctor, in return for some assurance that attempts will be made to relieve the distress. Effective doctor–patient *communication* and *information exchange* are necessary for optimal cooperation and compliance of the patient and effective treatment. Factors that can impede effective communication include differences in *social class* and *language style* (elaborated code vs. restricted code) and problems related to *medical jargon.*

Previous experiences with illness, doctors, and hospitals determine the patient's unique expectations in the consulting room. The physician's past experiences also influence his own expectations about a particular class of patients or illnesses. Many physicians have the covert expectation that distress should stem from physical causes, and patients with distress due to psychosocial events might, unfortunately, be viewed with negative bias.

Doctors are expected, in general, to fulfill the doctor-role expectations: (1) technical competence; (2) universalism; (3) functional specificity; (4) affective neutrality; and (5) collectivity orientation.

IMPLICATIONS

For the Patient

When a person consults a doctor, he has certain expectations about what the doctor will do for him, how he should behave in becoming a patient, and how the doctor will behave as a professional. Some of the expectations are generally shared by most patients, while others are uniquely personal, based on "priming experiences." Some general expectations include *relief from distress, treatment of the underlying cause of the symptom producing the distress, cooperation,* and *compliance* with the physician who is *competent* and *interested* in helping the patient, and *communication* of information from the physician. The patient may feel that the doctor is uninterested in relieving his immediate distress or incompetent if he does not understand that the doctor's concern over the underlying disease is a necessary step in the ultimate relief from his distress. This danger arises especially if there is a problem in communication between the doctor and the patient.

For the Physician

The physician should be aware that the *first priority for the patient* in seeking medical help is relief from distress. The physician should effectively *communicate* to the patient his interest in relieving the distress and his *overall plans* in evaluating and managing the patient. He should recognize that the social class and language differences (related both to the social class and to medical jargon) can interfere with effective communication with the patient. After imparting information to a patient, the physician should specifically *ask the patient to explain, in his own words,* what he understands the information to mean. In general, patients are interested in *receiving more information than they actually request.* The physician should *ask specific questions* about the patient's experiences with illness, doctors, and health-care systems to understand the implication of individual "priming factors" for expectations. He should also understand the effect of his own past experiences on his expectations about patients and this particular patient. The physician should also be aware of the *doctor role,* which defines what is generally expected of physicians by the patients and by society.

Above all, the physician should recognize that the *expectations* and *hopes* of both the doctor and the patient are essentially the same, and he should form a *collaborative alliance* with the patient in planning evaluation and management.

For the Community and the Health-Care System

The health-care system should recognize that the "problem" patient is often a person whose adjustment to the sick role (expectations of health-care personnel) is difficult. Recognition of its own expectations of the patient and understanding the patient's personality traits that may make it difficult for him to meet these expectations can resolve an impasse (see Chapter 18). Medical education should emphasize relief of distress as well as treatment of underlying disease, to facilitate collaboration between physicians and patients. Hospitals and medical schools should devise methods of more effective *communication* with patients concerning medical matters such as diagnostic and treatment procedures. Health-policy planning should include considerations of the impact on the doctor role and the sick role and of the expectations on both sides and how they might change as a response to policy decisions (e.g., advertising by doctors). Attempts should be made to prevent an increase in the frustration levels of patients concerning their expectations that the physician will be interested in helping them as persons as well as in treating their disease.

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RECOMMENDED READING

Freidson E: *Profession of Medicine: A Study of the Sociology of Applied Knowledge.* New York, Dodd Mead & Co., 1970, chaps 10 (Illness as social deviance) and 11 (The professional construction of concepts of illness). Freidson is a sociologist who is a leading critic of Talcott Parsons. Although some of his writing is quite unsympathetic to the medical profession, there are very astute observations, such as that physicians are more likely to see illness than to diagnose normality, and this tendency may result in overuse of medical technologies (such as unnecessary surgery). Illness is seen as a social state, and a point is made that an idea about what is normal, desirable, and moral is essential to considering what an illness is.

Parsons T: *The Social System.* New York, The Free Press, 1951, chap X (Social structure and dynamic process: The case of modern medical practice), pp 428–479. A lucid discussion of the "doctor role" with elaboration on the five expectations. Discussion also of the sick role. A must reading.

Quill TE: Recognizing and adjusting to barriers in doctor-patient communication. *Ann Intern Med* 111:51–57, 1989. A comprehensive, useful discussion concerning how to recognize, define, and deal with barriers in doctor-patient communication.

Waitzkin H, Stoeckle JD: The communication of information about illness, in Lipowski ZJ (ed): *Advances in Psychosomatic Medicine.* Vol. 8: *Psychosocial Aspects of Physical Illness.* Basel, Karger, 1972, pp 180–215. A good discussion concerning the communication of information about illness to patients. A review article.