Imagination and empathy in the consultation

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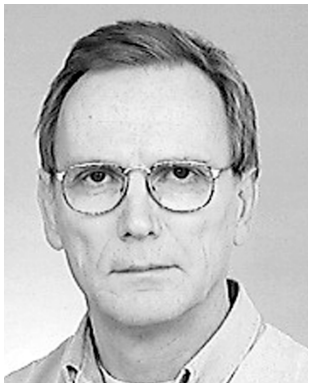

CREATIVE self-fulfilment is a basic human need. Imagination is the power of the mind to find meaning and coherence in the world, and to create new meaning where it is not immediately given.[1] Imagination makes me move beyond myself, in time and in space. It makes it possible for me to play with alternatives. Imagination is not magic, creating anything out of nothing. It is informed, based on the continuous learning process that life is. Even fantasy has its reference in reality.

What is the importance of imagination in general practice?

My non-scientific impression is that most GPs are much involved in their work. The spirit my colleagues mediate contradicts the supposition that they spend their working hours first and foremost reproducing evidence-based knowledge. They make a personal investment, they experience many efforts, but they get much in return. To me, such an experience would not be possible unless they challenged their imagination and creative potential. To understand general practice it is not enough to start from the patients' needs. The force that makes GPs go to their surgeries morning after morning, year after year, passing by the crowded waiting room, where everything may seem exactly as usual, cannot be purely altruistic. I think they feel the urge to see more, and to learn more, to feel the joy of maintaining the art of general practice. There is an aesthetic dimension in doing a good job, the sense of which is perhaps the most reliable personal assessment and the most endurable drive to keep going.

Imagination in general practice is about finding out the meaning in what patients experience and present and about making the doctor–patient relationship a creative alliance, where the possibilities outweigh the imperatives. It is the very nerve of competence. In this essay I will explore two ways it may act.

The choir of everydayness

The surgery hour is approaching. I pass by the crowded waiting room. I see the people, recognise almost all of them but, on the whole, what I see is a choir of everydayness, with the faces a little bit withdrawn. I hear someone coughing, the rustle of newspaper pages being turned, of shoes scraping the floor, of a mother trying to keep her child still, of low voices. And I hear the individual silences — together perhaps the most important pitch of the choir. They prepare and repeat their part in the encounter. Some of them hesitate, and some are very frightened. Their energy is silent.

It is exactly as usual, and yet I know that it will not be. It never is. I walk into my office, close the door, and sit down at my desk. Very soon I will be among them. One by one I will invite them into my office at a fairly quick rate. I will offer them a stage, my listening senses, and there it all starts.

In front of me, most of them will turn their silences into symptom presentations. *Fever, headache, fever and cough in a child, tiredness, bad throat, constipation, anxiety, weight loss, overweight, stomach pain, sleeplessness, diarrhoea, backache, long-term cold and now ear pain in a child, troubling knees, breathing problems, frequent urination, frequent and painful urination, loss of self esteem, chest pain, impairment of vision, impairment of hearing, fear of an unfamiliar body experience* … and so on.

It is exactly as usual, but still I know it is not, because survey is one thing and reality another. Once again, there is the moment of silence face to face, my attention and then invitation, perhaps just a nod, and then she says:

> *'I don't know where to begin. It is all like a mess. It is this pain in my back. Before it was more in my shoulders, but now it is down in the low back. I can stand it but it is pretty close to the point where I cannot. But what is worse is that my throat has been kind of sore since I visited you more than six months ago and you found out there was no infection then. And my tongue feels irritated; sometimes it is red, especially on the edges. It is not very nice to eat. Don't you think it is an infection after all? And I am so tired. After work I have almost no energy left, but then there is my family.'*

This patient is a woman aged about 40, from South America, who has lived in Sweden for quite a number of years. (This is case is inspired by an actual consultation, but

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the specific details have been changed.) She works in the kitchen of one of the schools in the community. She is rather shy in the encounter, talks in a low voice, and the spontaneous look of her face is thoughtful, perhaps with a trace of sadness.

The patient does not need much time to present her problems. The silence is broken. I listen. What do I perceive and hear and what decides the way in which I listen?

Listening is not just a passive transfer of information from patient to doctor. It is a task requiring imagination, to reach out for the meanings in what is said. It is through listening that a doctor allows the patient's private experience to become a communicated experience, which is their common product, and as such a matter for them both. In terms of clinical decisions the communicated experience, which in abbreviated and abstract form is put down in the medical record as the 'S' of the SOAP (Subjective, Objective, Assessment, Planning) formula, is usually the decisive one. But imagination may take diverse routes. It plays a part in more than one clinical method.

When the disease is very interesting

Let us first assume that my attention primarily is about symptoms of defined disease. This means that I extract, from the symptom presentation, those accounts that directly link to possible disease — in this particular case, back pain, long-term sore throat and irritated tongue, and tiredness. This may be done in an open, inductive fashion, where pieces of information are gathered and then found to establish a pattern of a tentative diagnosis.[2] It may also be that I very quickly form an idea and from it select the information that is relevant for that hypothesis.[3] Both strategies, which are unlikely to work completely independently, imply a high degree of editing in the symptom presentation. This editing is not just a product of learnt facts and experience; it is also a work of imagination. The ideal example of such diagnostic imagination within the disease categories is the old-fashioned internist, who would mould seemingly diverse clinical facts and come up with a rare, but relevant, diagnosis. The imaginative dealing with clinical facts is one dimension of diagnosis and it is in consonance with the 'detective style' of problem solving, an aspect of our job that is enjoyed, it seems to me, by many of us. It is attractive and it works in symbiosis with biomedical reflex thinking, grounded from early on in the medical training.

In our South American patient, her throat and tongue are slightly irritated; nothing else is evident. She moves normally with no obvious local tenderness in her back and with no signs of sciatica. Still within the biomedical frame of reference, I check that the patient does not smoke, inform her about my findings, and order a few tests. After a few days I have the results, which show slight anaemia and clear sideropenia. Here is a possible cause of her sore throat and tongue. The cause of her lack of iron should be easy to work out — this lack is probably adding to her fatigue; however, there seem to be other causal factors in her social situation.

The biomedical frame of reference — with a glimpse of the patient's agenda, but without too much involvement — would probably not fail in this case. Many of the quicker consultations tend to follow this routine, which may look straightforward. Still, I find it doubtful whether a very selective attention, right from the very start of the consultation, would in fact be straightforward. There is a split introduced, which has to be overcome in every case; the plain medical assessment and treatment is not exactly what the patient wants and needs. It is not to the patient that I offer my imagination, but the malfunction of her body. I tend to observe the symptom presentation rather than share it, which may be interpreted by the patient as a lack of interest in her particular situation, causing her to withdraw, which in turn may make the consultation dysfunctional. The selective editing of the symptom presentation incurs also the risk of my listening becoming shallow, which paves the way for misunderstandings, sometimes even with diagnostic implications.

How strong the diagnostic, detective archetype is in general practice is not easy to estimate. It has to be up to our self-reflection. I would guess, though, that the possible disease still activates our immediate imagination more often than the patient does. As long as this is the case we still need the patient-centred clinical method. Otherwise, such a method would be a paradox in a profession aiming at supporting patients.

Empathy

There is the patient and there is the disease. We often say this, although it is not the case if we look at the real encounter — here, we have the patient and the doctor. The disease is woven into the patient's predicament and it is working in the doctor's imagination. There is no disease-specific wavelength of communication. To avoid the patient being referred to the background of the 'inner consultation', doctors need to attend fully to the patient from the moment of silence that opens the consultation. They must make the patient the target of their imagination. But in contrast to a disease, a person can never be laid out in a pattern of facts and causal relations. Here, the imagination has to be of another kind. It has to be about understanding. Who is the patient? What are the patient's experiences?

Nevertheless, it has to be said that understanding and causal explanation are not antagonistic. On the contrary, it is easier to understand the patient if we know the character of the disease and the ways in which it causes harm. But how the patient actually feels and relates to the disease can only be understood.

Interpersonal imagination is otherwise known as empathy. The concept appeared in its German original form — 'Einfühlung' — around the year 1800, along with the emergence of hermeneutics as the method for interpreting historical texts.[4] The prominent figure of the movement was Friedrich Schleiermacher. The aim of hermeneutics was to reach an understanding of the text that was faithful to its author's thinking, intentions, and context. A text speaks, and hermeneutics is, according to Scleiermacher, 'the art of hearing'. Hermeneutics has developed and is an important element in contemporary philosophy, but the basic idea that the understanding of a text comes through dialogue and not through analysis is still very much alive. Schleiermacher found two elements in understanding: a referential one (where understanding is based on common experience) and intuition. In the intuition element, understanding is not

solely reproductive. In the referential element, understanding always has a factual base.

In the present day, and in medicine, empathy has an emotional connotation. This was not implied in the original concept, which embraced the whole of the inner world of the speaking voice. The emotional emphasis has narrowed the recognised role of empathy in clinical practice. There is no obvious reason that a doctor should restrict his understanding to the patient's feelings about his or her disease. It is not possible to understand an emotion without having an idea about the experience that evokes that emotion. Perception, emotion, and cognition are integrated dimensions of any experience. If this were to be realised and brought into action in medicine, empathy would probably be regarded with more interest.

Back to experience — the symptom presentation

Turning back to the symptom presentation above, what does it really consist of? There is experience — in this case three symptom experiences: low back pain, sore throat and tongue, and tiredness. There is her experience of struggle, balancing the demands of her everyday life. There is also the impaired eating experience — not dramatic, but enough to take all the enjoyment out of eating meals.

Also mixed into the symptom presentation are her thoughts about causes and the request for treatment. Yet, still it is a whole; it is her life — and it is a mess. The presentation bears very clearly her personal, discrete imprint. If I had told her that it still was not an infection and nothing more, she would possibly have waited for another half year.

The core of the symptom presentation is her experience. Her life has taken a problematic turn in that her body, in certain ways, has detached itself from its background of normality, capability, security, and joy. When this happens, the role of her back of keeping her upright and, literally, bearing her burdens, and of her tongue and mouth in eating, stands out in new light. And, in addition, the lack of energy tends to make her body, in a general sense, a hindrance in her daily projects. Her body and her life are inseparable; why else see a doctor? The logic of her body experience is existential. Her tongue is talking, tasting, and also involved in chewing and swallowing; her throat is swallowing, breathing, and talking. Her back is standing and sitting, lifting, and turning away, as well as many other concrete and symbolic functions. Going through the whole body in this way we get the existential anatomy, which differs a great deal from — but is no less real — than the topographical anatomy we learnt as medical students.

The symptom presentation's role is twofold. First, the patient gives words and meaning to her experience and she invites me to use my interpretative imagination, to share her experience. There is no need to mistrust language in this regard. Language is in itself what is able to be communicated — even the language of 'private' experience.[5]

An observer — at least not on video — may not even perceive it. But whether I accept the patient's invitation to share her experience, or whether I choose to dismantle the possible disease piece by piece, is a choice between two very different realities. And it is a choice made in a millisecond.

Bodily empathy

Bodily empathy is the ability to grasp the lived experience of the body — the existential anatomy — of another person.[6] The prefix 'bodily' is not to suggest that the experience of the body may be extracted from the experience as a whole. Rather, it should be regarded as a matter of emphasis. In a certain moment, one may concentrate on the experience of one's own body, or on what is seen, heard, or smelled, or on the emotional tone of that same moment, or on the thoughts that tend to occupy the mind. Still, perception, emotion and thinking all are needed to form the moment in question. Consciousness is directed. What it is not directed to turns into background, which is not to say that it disappears. Perception is what comes to the fore in consciousness when emotion and cognition turn into background. Emotion stands out from perception and cognition, but is still totally dependent on them. Cognition is rooted in experience and its meaning in life has always its emotional aspect. In the listening position one may, in the same way, concentrate on different aspects of what is told, without losing hold of the background. The latter is what really makes the symptom presentation become an account of lived experience rather than the objective correlate of bodily derangement. It is the relation between words and emptiness that brings life into a text. In the clinical context this would mean that doctors, with a degree of interest and skill, listen to the accounts of body experience without ever falling into the illusion that the physical body of the patient speaks of its own, void of human emotion and reflection. For instance, doctors know that deep — but still often subtle — fear is one of the most salient expressions of severe disease. Once it is realised that a symptom presentation conveys a meaning of life, doctors may deepen their familiarity with the existential anatomy through their careers, since the patients' symptom experiences disclose the existential anatomy in a never-ending flow. Language establishes the common reality through which doctors can approach experiences, with which they formerly were not acquainted. Even if their understanding is far from exhaustive, they know more about the patient's predicament after the consultation than before and their open senses in the examination deepen the meanings of the words. The precondition here is, of course, that they want to know more, but once this is the case, imagination is the very way they relate to the patient. In the practical situation, doctors' familiarity with the existential anatomy is expressed in a richer and more sensitive web of connotations around the words that establish the symptom language. This implies an increase in self-knowledge, since the existential anatomy is universal. The base of this self-knowledge is that of corporeality as such, of being vulnerable and mortal. Doctors can never escape from those facts and therefore must integrate them. The further self-knowledge extends, the further imagination will lead the doctor in the direction of the patient. My glands, my openings, my death are my most private things, and yet they are my most general. This paradox is the bridge on which doctor and patient meet.

Biomedical expertise is the difference between doctor and patient, but the more that GPs exert their expertise in terms of bodily empathy, the more equal are the doctor and patient, and the more the patient feels to be seen.

Also, diagnosis is promoted by the accurate apprehension of the symptom presentation. There is no split between the task of relating to the patient and making a diagnosis. The split turns into the interchange between involvement and detachment that forms the 'attentive listening' described by Ian McWhinney.[7] From time to time doctors have to step back, look at what they learnt from the patient, make a judgement, and then act accordingly.

There is no method of adopting bodily empathy, but there is one rule: help the patient present the symptom in a way that is valid to the original experience. Only then will doctors have a chance to understand.

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