The virtues of irrelevance

Why our opening comments are so important

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“Interesting belt—where did you get that?”

“I see you are from Youngstown. The key question is, are you a Steelers fan or a Browns fan?”

These are not the usual opening questions we teach for the medical interview. The answers are not included in the chief complaint, history of present illness, past history, social history, family history, review of systems, medications or allergies. There is no hat or belt section in the physical exam. Differential diagnoses on sports, clothing or food preferences are not a highly valued component of clinical reasoning. But often these opening comments and questions are the most important. They can be our tickets and our guides, ways to establish the connections that allow us to actually care for the person in front of us.

We believe that these “irrelevant” opening comments and questions serve four key purposes. First, they convey that we see the patient as a unique individual. Given the speed of medical practice, it is not surprising that patients worry that their individual concerns will not be heard. Second, these questions reveal that we have had shared experiences, that despite our training and attire we are not so different from the patient. Third, they communicate that we are observant and attending to details, which patients find comforting. And finally, they indicate that we are open to a conversation with the patient.

There are additional benefits. Seemingly irrelevant comments convey a message similar to the act of sitting down: “I have time for you.” When patients meet with their physicians, they are often anxious, and these opening conversations give them a chance to “warm up” while speaking about topics that are comfortable and easy to discuss. Opening with casual banter also conveys that we are probably not the bearers of terrible news, and it may thus help to allay the patient’s worst fears.

Sometimes it helps to try to inject a little light humor. “I see you’ve been sampling our cuisine. Do you have any comments or special requests for the hospital chef?” A quick shared laugh can be a balm during difficult times.

Experienced clinicians recognize that these comments are often an essential warm-up for the conversation and shared decision-making that follow. When patients are in the presence of observant, authentic, connected clinicians, they are more likely to share their observations, fears and questions. They are also more likely to move past the distrust that so often accompanies the perception of clinicians’ “otherness” and collaborate in addressing next steps that are scary, unknown or unknowable.

We have all had the frustrating experience of trying to help patients who prefer the advice of neighbors, aunts or hairdressers to our recommendations: they connect with those people, share a space with them. We believe that clinicians can also share this space, and it often doesn’t take much to get there. Just noticing may be enough. Share a laugh, admire a family-reunion T-shirt or an elegant walking stick, and you can become a kind of neighbor.

For many years, physicians regularly visited patients’ actual neighborhoods. In the 1930s, four out of 10 physician-patient contacts were house calls. Because physicians were embedded in the community and visited patients’ homes, conversations naturally included shared experiences and nonmedical observa-
tions. It may be impossible to recreate the intimacy of a house call in a brief outpatient or inpatient visit, but it is possible to take a few opening moments to reach beyond the immediate medical agenda and connect with the patient first.

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Numbers of home visits and durations of office conversations and hospital stays have been shrinking over the past half-century, and the nature of our interpersonal relationships inside and outside of medicine has changed as well. Patients often at least partially vanish into their electronic health record—becoming the “iPatient,” as described by Abraham Verghese. Speed dating has entered our vocabulary and our social landscape, focusing on the first few minutes of meeting a stranger. Cognitive neuroscientists teach us that we make judgments exceptionally quickly—and yet often accurately. Studies of “thin slices,” as these rapid assessments were described by Ambady and Rosenthal, reveal that “a great deal of information is communicated even in fleeting glimpses of expressive behavior.”

In a similar fashion, our patients are judging us from our first moments of interaction. They are deciding whether we are trustworthy, capable and interested. How we handle those first moments is critically important. Perhaps counterintuitively, we are arguing that it is often more important to be human than to be medical in those first moments, that our commitment to connecting is an important prerequisite for exchanging medical information.

Making this connection is natural for some clinicians, less so for others. It is hard to translate into checkboxes or manuals. There are no questions or comments that will always work. In the end, “working” depends on reading the signs, gauging the distance, accounting for professional boundaries, and genuinely, even a little vulnerably, showing your hand, acknowledging shared humanity: “I am interested in you, I could be where you are, we are not so different after all.” This behavior can be modeled and encouraged, and we believe it can be learned—or rather, relearned.

Most students come to medical school with reasonable social skills. Among friends, they usually know how to start a conversation in a humorous, interested or insightful way. The idea that we would need to teach this skill is a little absurd. But unfortunately, medical education actively stunts conversational skills, at least temporarily, loading students with lists of questions and pages of checkboxes that can eclipse authentic relating. Even displays of “empathy” are often scripted. Teaching the “irrelevant” comment or question is really just a matter of endorsing and modeling what students already know from their social development and extracurricular lives.

We would argue that this nod to irrelevance is more than a nice touch or an effective communication strategy. It is a necessary part of our personal and professional lives, which have been increasingly threatened by the pressure for ubiquitous relevance. Everything is supposed to count, or be counted. Purposeless moments—moments for deep breaths, surprises and insights into ourselves and others—are an endangered species. It is time for us to recognize, validate and support these genuine connections between doctors and patients.

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REFERENCES
