Patients simply want to be heard

We don't always need to find a solution; we just need to hear the problem.

Like most physicians, I want to resolve my patients' clinical concerns. But this intent is often challenged when I'm seeing patients who have long-standing workers' compensation claims. These often are patients who, after prolonged and complicated treatment with multiple clinicians, still have difficulty returning to their normal activities at work and at home. How can I presume to reach a perfect solution in such complex cases?

In medical school, we were taught to be sympathetic listeners because (except in life-threatening situations when quick action is required) people want to be heard—sometimes more than they want to have their problems solved. This listening may well be the heart of the art of medicine.

In medicine, we apply the scientific principles of the human body to the complex social system that is human life. In that way, medicine is different than other hard sciences. We are not mechanics adjusting the nuts and bolts of a machine, but people caring for other people. The direct application of medical science is colored through the lens of human communication.

Patients sometimes complain that physicians are not listening to them; research has shown that physicians don't usually listen very long to patients before interrupting them during a clinic visit; some earlier studies found that time to be about 20 seconds or less—a 2019 study showed only 11 seconds of listening. That's disturbing—but most likely we are simply following our compulsion to "do something." It's also an unfortunate unintended consequence of fee-for-service models of clinical medicine, with physicians compelled to do more in less time, to meet documentation requirements of billing and coding and to maximize specialty expertise. Having a conversation may not seem to be the best use of time—ours or the patient's.

One way to address this might be to schedule more time for a patient who needs more space to communicate effectively. While it can be frustrating to sacrifice "doing something" immediately, determining which patients need time for listening and then scheduling it can advance the physician-patient relationship. In the cases where this makes sense, we can support listening by billing cases with time-based coding, rather than meeting clinically irrelevant documentation requirements. A 2016 JAMA Internal Medicine viewpoint described the success of time-based billing in primary care practice in Switzerland (Selby, 2016). Adapting that to the U.S. medical system might be challenging, but ultimately worthwhile.

I have had success with patients who have chronic work-related conditions by scheduling longer appointment times and acknowledging—to the patient and to myself—that treatment with me may not be any more successful than their prior evaluations. But I assure patients I will listen to their story, understand their goals and consider what has not worked for them in the past as we look to future options. Surprisingly, patients are satisfied, even when they do not reach their optimal outcome, in knowing they were heard and understood. MM