

Learning to 'see' in the clinician–patient relationship

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ABSTRACT

Medical education tends to praise or pay lip-service to the art of observation, while systematically teaching the science of technology. To the extent you were taught observation skills as clinicians, you may have learned how to listen and touch but not usually how to 'see' your patients and yourself. This paper considers how to see in the clinician–patient relationship, not merely in an optical sense but also to increase your perceptiveness. We suggest 10 strategies to enhance your ability to see.

KEYWORDS: Observation, perception, visual, clinician–patient relationship

The science of technology is subjugating the waning and difficult, but important, art of observation in family medicine, including diagnosis and consultation skills.¹ However, acquiring the skill of observation can require training in sense perception, which is perception through, or based on, a stimulation of the senses. Although each sense informs the others, vision is the dominant sense^{2,3} in seeking and providing information and facilitating and regulating social interaction.⁴

With a small but growing number of exceptions,^{5–9} medical curricula seldom include the visual encounter. Training in observation is also under-recognised as exemplified by the Calgary-Cambridge Observation Guide,¹⁰ which is a validated and widely used plan for assessing communication skills during visits. Therefore, although you are likely to have been taught how to listen and touch, you will probably not have been schooled in how to 'see' your patients and yourself. This paper suggests 10 practical strategies for enhancing your ability to see perceptively in the clinician–patient relationship.

Learning to see

1. **Protect your eyes.** It sounds obvious, but to see perceptively, begin by having your vision and eye health regularly tested and, if necessary, treated. Protect against eye fatigue and eye damage. For example, rest your eyes after their use for sustained, intense looking and attend to appropriate visual standards for occupational health, such as for task lighting and visual display unit settings. Coordinate with other health professionals to help prevent and manage visual disability in your patients.

2. **Seek to establish and maintain culturally-appropriate eye contact with your patients.**¹¹ in concert with other experience that you access through the senses. In general you will be conscious of the 'look' of the patient rather than of their eyes.¹² However, eye contact can allow you to access the inner selves of patients

in order to reveal, for example, their surprise (eyes widen), happiness (eyes glow), boredom or distraction (eyes glaze), or interest (eyes dilate). It can also help you engage with patients and evaluate your relationship with each other favourably.⁴ To minimise eye aversion by patients, use strategies such as rapport-building and praise.⁴

3. Be aware that the eyes of the patient also reveal your reflection.

Even if you do not see it, it is there in the meeting of the eyes. You can see yourself and you see the patient, by whom you are seen.^{13,14} This produces an ambiguity of perception, as a result of which the distinction between you and the patient blurs. In turn, you and they may begin to see each other through your eyes and theirs. Seeing and being seen reminds you that you and they co-produce care and we are all patients; this helps you care because 'only the wounded physician heals'.¹⁵ You and the patient can see how you can care for one another and yourselves.¹⁶

4. Look critically at your involvement in clinical care.

^{17,18} This reflexivity can further de-emphasise differences between you and your patients. Each of you shares the subjective experience of having a body, which influences your respective awareness of what it means to be a patient–healer. Your experience of your body reflects how you appear to yourself and your patients; for example, given your body size and shape; dress; body language; and work environment.¹⁹

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5. **Attempt to see your patients without preconceptions**²⁰ so that you become aware of, and open to, new perspectives and possibilities. This is not to devalue your contextual knowledge of the patient, but rather to keep an open mind. Otherwise, you can risk selectively seeing and believing what you expect to see. For example, you risk reaching a diagnosis too early or falsely assuming what your patients want or that they see things your way.²¹ Clinicians tend to look for confirming evidence rather than contradicting evidence; yet looking for disconfirming evidence has been demonstrated to yield more accurate diagnoses more efficiently.²²
6. **Indeed, to achieve an open mind, look closely at your patients in context.** Look beyond the space they occupy (the positive space) in order to notice, also, the space between or around them (the negative space). What is not present adds depth, perspective and clues on the real meaning of the whole 'picture', and includes the physical distances separating you from your patients at face-to-face encounters.^{23,24} Similarly, attempts to uncover what you have yet to notice in order to be astonished. For example, observe the relationships that *break down*, since these make visible what is otherwise invisible in properly functioning relationships.¹⁷
7. **Be attentive also to the 'little things', such as subtle signs,**⁶ and to the detail in order to help detect, recognise and discriminate between the different stimuli that you see. However, be alert to the dangers of becoming too close to patients because this can mask your recognition of gradual clinical changes, such as the insidious onset of classical hypothyroidism, or produce countertransference.
8. **Improve your ability to see by learning to draw, produce and analyse photographs,**^{25,26} **and to understand fine art,**^{27,28} **including the depiction of medicine in paintings and drawings.**²⁹ You can learn to see artwork in settings such as a classroom⁵ or art museums.^{6,7} Strategies such as 'photovoice' (in which people take and interpret photographs) can also enhance your capacity to reflect critically on the meaning and significance of your work environment.
9. **Seek to identify perceptive people and study their approach to seeing.** Speak with them about how they use their vision and visibility in order to experience the visible world.³⁰ This approach to learning fits apprenticeship and mentorship models of education (which can offer expert, individual intuition through direct demonstration) as well as other approaches such as peer review groups.³¹
10. **Take as much time as your work and personal life allow in order to see and learn to see.** Seeing requires effort, patience and concentration. It is also a practical activity, best learned and mastered in the doing. Seeing improves with practice because, as Tielhard de Chardin reputedly observed, 'the more one looks, the more one sees. And the more one sees, the better one knows where to look.' With practice and by analysing how others see, you can learn how and when to make a 'spot diagnosis', literally through a glance to gather all the information you need to make a snap judgment, while avoiding traps associated with inexperience.³²

Conclusion

Medical education today emphasises the science of technology over the art of observation. Perceiving a need to (re)learn visual observation in this age of evidence-based medicine, this paper has suggested 10 strategies for seeing. Empirical research is needed to assess the effectiveness of interventions to help clinicians learn and adopt these strategies in their relationships with patients. Experimental study designs are usually considered the gold standard when such evaluations are made on the basis of individual studies. Dolev et al.⁶ therefore conducted a randomised trial to demonstrate the use of systematic visual training to enhance the process of seeing by medical students. Also useful, however, are qualitative research methods, as have been used to elucidate the felt impact of educational programmes in the art of observation.⁹ Because sight alone can mislead,³ observation best functions with the other senses, including verbal communication and the use of medical technologies.

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COMPETING INTERESTS

None declared.

Clinically important drug–drug interactions and how to manage them

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This article is designed to be read in conjunction with the A3 table of drug interactions provided as an insert in this issue of the *Journal of Primary Health Care* and also available on the journal website.

Background

The more medicines a person requires, the increased risk of a drug–drug interaction. Unfortunately it is not possible to simply stop potentially offending medicines, but the medicines interactions need to be managed as safely as possible.

There are two types of medicine interactions—pharmacodynamic and pharmacokinetic. Pharmacokinetic interactions are relatively straightforward and are relatively predictable if the actions of the medicine are known. These involve the additive effect of similar medicines, or a cancelling effect, for example:

- Increasing risk of hypotension with:
 - Two antihypertensives

- An antihypertensive + tricyclic anti-depressants
- An antihypertensive + isosorbide mononitrate
- Increasing renal impairment with:
 - ACE inhibitor, diuretic and NSAID.

Pharmacodynamic interactions are more complex and usually involve interference with absorption, e.g. tetracycline and food, calcium or metabolism by enzymes such as the cytochrome P450 enzymes, p-glycoprotein and other less common enzyme systems.

Twenty years ago we talked of 'liver enzymes' and competition through protein binding. This has become more sophisticated now, with many types of enzymes, but the main ones are a large

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