

Five Questions That Every Patient Has but Never Asks

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In more than 20 years of practicing medicine, I had never received a request quite like this. A person wanted to sit down for 30 minutes in my office (not the examination room) to tell me her story. She said she thought I should get to know her and to see if we clicked. She not only wanted to discuss her medical history but also her professional and personal life, hobbies, likes, and dislikes.

Honestly, I was a bit intrigued as to how this would go. So we met and had a good conversation. It did feel a little weird for me initially, as if I was on a job interview, which I guess I was. But what I took away from this experience is that she was essentially asking 5 questions that almost all patients have but never actually ask.

1. Do You Care About Me?

Fundamentally, we all want to know that people care for us, and we certainly want to know this when we are not feeling well. It may be a different type of caring than we receive from a loved one, but we still want to know that our physician cares about us personally, as individuals. When many physicians spend the whole 8 minutes of a visit writing a document in the computer, it does not come across as very empathetic.

Consider this: when was the last time we made a house call? Most of us have probably never done so. We need to make more eye contact, calling patients by name, holding a hand, and actually listening to what they are saying. Let's not always be so rushed.

We need to telephone patients more often to check on them if they missed several appointments or if they had recent surgery. Yes, we should do the calling. It simply is not the same if office staff makes the call. Whenever I call a patient, they always initially seem so surprised that I would take time to speak with them outside of the office setting. It sends a subtle message that I care. I am not suggesting that we all need to start frequently calling patients, but we do need to do better job of conveying to patients that we care about them.

2. Are You the Best?

I bet many people Google me prior to and after a visit. But it is really hard to determine online if someone is the best in their field, and I have never had a patient directly ask me about my skills. Patients might wonder about it and ask other people, but no one has actually asked me. I remember that, as a medical student and resident, patients would sometimes me ask before a procedure, "Have you done this before?" But most of us do not get those questions once we start to look like more seasoned professionals.

Everyone hopes that their physician is the best, and more and more people want to see some measure of expertise, but there is no simple and easy method for pa-

tients to truly assess our skills. Board certification does not mean we are the best, nor do the city magazines proclaiming someone as one of the "100 Top Docs." Realistically, we all cannot be the best. We all can, however, strive for excellence and make sure we keep up our skills and stay current with the latest recommendations. It can be hard for physicians to acknowledge that they need refreshers in some areas of medicine. We must make it our goal to provide the best patient care. That requires us going to lectures, attending national meetings, and reading the latest research in our area of practice.

3. Can I Trust You?

Trust is fundamental to the physician-patient relationship. Patients do not automatically trust the physician, especially when the clinician might be of a different race/ethnicity or sex. We deal with some of the most personal issues in an individual's life, and we need patients to feel that they can confide in us. This is not the same trust as the priest confessional, but it is similar. They tell us things that no one else may know. For us to treat them the best that we can, they need to trust us to tell us if they are feeling sad, depressed, or lonely.

We need to learn if they have substance use disorders, and that is not easy for most people to confide. They need to tell us if they have been having numbness or weakness, especially if they work a physically demanding job. So, trust is fundamental, and it takes time and reliability to develop. If patients know we care about them and are going to do our best, it makes trust a little easier to develop.

4. Are You Treating Me Differently Than Others?

Patients need to know that we are not treating them differently because of their race/ethnicity, sex, sexual orientation, or socioeconomic status. Let's be honest: health care disparities still exist and in some places are getting worse. There are a myriad of health conditions where outcomes are worse in women and racial/ethnic minorities. If patients are poor, this shortens their life.¹ There are many reasons why this is the case, including some caused by the health care system, such as problems with access; however, social determinants of health play a key role. We do need to be conscious of how we treat patients and how we might be perceived as judging them.

There have been many instances over the years in which the medical profession has performed poorly in delivering care because of biases. For years, patients with alcohol use disorders would not even be considered for a liver transplant. I remember that, up until a short time ago, patients did not want to get tested for HIV despite risk factors, because they were afraid of the stigma

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associated with the disease and how they would be treated. I still hear the occasional dismissive remark about a patient with lung cancer: "Oh, he was a smoker."

So differential treatment happens, and we need to address it. No one likes to think they treat patients differently. Why is it that African American patients are more likely to have dementia but less likely to receive medications to help treat it or slow decline?² This also seems to be the case with patients who are racial/ethnic minorities and have Parkinson disease.³ Why are women less likely to receive medications for secondary prevention of heart disease and fewer referrals for cardiac rehabilitation?⁴ We need to examine the reasons for this difference in care and make sure we are not personally contributing to inequity.

5. Will the Medicine Make My Life Better?

Every now and then, patients will ask me, "Is this going to work?" But usually they just go along with what we prescribe as physicians. Most people want to be perceived as good patients and please

the physician, and for many patients that means just accepting what the clinician suggests (at least in the examination room). Then they do not actually do what we suggested or take the medicine as directed, because we did not adequately describe why we prescribed something. They do not experience benefit, and so they stop taking the regimen, or they have an adverse effect that concerns them, and they do not want to appear stupid if they ask about it. The problem here is that we do not truly talk *with* patients; instead we talk *at* them. Sometimes this is because of time constraints, and sometimes it is a paternalistic pattern of behavior involving underestimating the ability of patients to evaluate benefits vs risks. *Patient-centricity* is a new buzzword, and we need to recognize that patients are experts in their own disease and that we need to understand what is clinically important to them.

As physicians, we are used to being the ones asking the questions; indeed, that is how we trained to be physicians. But let's also try to address fundamental questions most patients have—even if they do not explicitly ask them.

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1. National Research Council (US) Panel on Understanding Divergent Trends in Longevity in High-Income Countries. *Explaining Divergent Levels*

of Longevity in High-Income Countries. Washington, DC: National Academies Press; 2011.

2. Murray MD, Hendrie HC, Lane KA, et al. Antihypertensive medication and dementia risk in older adult African Americans with hypertension: a prospective cohort study. *J Gen Intern Med*. 2018; 33(4):455-462. doi:[10.1007/s11606-017-4281-x](https://doi.org/10.1007/s11606-017-4281-x)

3. Dahodwala N, Xie M, Noll E, Siderowf A, Mandell DS. Treatment disparities in Parkinson's disease. *Ann Neurol*. 2009;66(2):142-145. doi:[10.1002/ana.21774](https://doi.org/10.1002/ana.21774)

4. Benjamin EJ, Blaha MJ, Chiuve SE, et al; American Heart Association Statistics Committee and Stroke Statistics Subcommittee. Heart Disease and Stroke Statistics-2017 Update—a report from the American Heart Association. *Circulation*. 2017; 135(10):e146-e603. doi:[10.1161/CIR.000000000000485](https://doi.org/10.1161/CIR.000000000000485)