REFLECTION

ABCDE in Clinical Encounters: Presentations of Self in Doctor-Patient Communication

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ABSTRACT

Professional discussions about communication in medical settings often ignore the various personal identities that doctors and patients bring to their clinical encounters. From my 26 years as a family physician, and informed by literature from other professional disciplines, I propose an alternate understanding: to think of doctors and patients as a collection of individual identities, each formed by a discrete presentation of self. I describe how at least 5 important presentations of self arise in clinical encounters, including those relating to meaning, community, agency, anxiety, and organism. I frame these presentations of self with the mnemonic ABCDE, briefly review key dimensions of each, and suggest how physicians can reflect on these dimensions in order to find equilibrium in their interactions with patients. Lastly, I submit that finding this balance can reduce relational challenges with patients and enhance the therapeutic effectiveness of doctor-patient communication.

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INTRODUCTION

Sometimes things go so incredibly smoothly. I feel a shared presence with my patients, listening deeply and attending to their concerns with tact and wisdom. Patients open up to me, and their histories of disease unfold as elegant narratives. In return, words flow from my mouth and seem to hit the target. Patients nod in agreement, educated by the turn of a phrase, enlightened by a suggestion born of some motivational insight on my part, and calmed by a slight gesture of inclusion—perhaps my nondominant hand placed lightly on a shoulder when auscultating a patient's heart with my stethoscope.

At other times it seems absolutely nothing can go right. I walk into the examination room and—kaboom!—find myself in a minefield of missed connections, misunderstandings, and miscommunication. An angry patient, frustrated by a lack of clinical improvement in symptoms that will likely never get better; the mother whose child has pushed her to her wit's end (a child whose condition has quite possibly been induced by the dysfunctional family system of which mother herself is an incendiary ingredient); a young man, dying before his time, filled with the burden of unfulfilled hopes; these are but some of the individuals who sit in the nondescript chairs of my clinic's exam rooms. They bear the role of unhappy patient, most often unwantedly, and their frustrations are reflected in the poor quality of interaction between us.

I bring my own shortcomings to the encounter as well. Spending just a few extra moments with a patient inevitably leads to delays for others, and time is a valuable commodity in our culture of medical practice, a statement of worth and respect that both patients and practitioners crave. The lack of time changes how I listen—I am sure of it—and my intent to find shared presence becomes less sincere as I struggle to catch up. Pre-

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occupations also creep into my consciousness, little bits of unresolved concerns left over from encounters with other patients or a known lapse in prior clinical judgment involving the current one. Then there is the exam room computer, an electronic siren that calls for my undivided concentration, and at its beckoning I am at risk of taking attention away from the person before me, my patient.

Presentations of Self

Add to all these joys and frustrations the complex nature of who is talking and who is listening on both sides of the stethoscope. We talk about relational ethics and professional communication between doctor and patient as if each were a single, solitary entity, even within the biopsychosocial model.[1] Although some have argued that cultural considerations should preferentially inform insights into physician-patient communication,[2] it seems equally valid to think of each party as a collection of individual identities expressed as discrete presentations of the self.[3] At any one time, with any one person, in any one situation, the self that others present to us (and that we present to others) may take on quite different appearances.

I believe that at least 5 important presentations of self appear in clinical encounters, those that emerge from my patients and corresponding ones that come from within me (Table 1). While there is no sequential relationship between these presentations and no hierarchy of importance, each corresponds to the first letter of a verb, from A to E, following the subject "I:"

• **A** is for I **am**. This represents the self of *meaning*. At a minimum, meaning implies grasping concepts like quantity and quality of life in the face of disease. Meaning may also connote making sense of illness and exploring its emotional and psychological effects on individuals and families. In examination rooms and hospital suites, meaning may be demonstrated simply by showing respect and offering hope; at the other end of the spectrum, it may be embedded in difficult efforts to share dignity when negotiating conflicts around decision making during life-threatening situations.

• **B** is for I **belong**. This represents the self in *community*. Patients may wonder where and with whom they belong, especially if they are not feeling well in the presence of a physician. Who is going to help? Who is with me on this journey? Especially when challenged by complex circumstances of medical, social, and structural origin, physicians may also wonder who is there to help and what backup resources are available.

• **C** is for I **can**. This represents the self of *agency*. Agency is the belief, emergent from one's personal or professional constitution, that change is possible. How agency manifests itself may differ depending on cultural factors. In individualistic societies, people commonly see themselves as active agents; in collectivist societies, agency may take shape as part of communal undertakings or even a reliance on fate. Physicians are socialized to accept agency as part of their professional mission. Their challenge may lie in helping patients acknowledge how personal and collective responsibility can effect positive change.

• **D** is for I **dread**. This represents the *anxious* self. For patients and families, fear can range from discomfort to unremitting terror in the face of sickness. It is often unspoken, buried beneath a litany of complaints, or disguised as insistent and unrealizable demands. For physicians, fear may be linked to the prospect of a poor outcome or an upcoming appointment with a hateful patient.[4] For those early in professional training, anxiety is a feeling commonly associated with issues of competency and its attendant question, "Will I be exposed for what I don't know?"

• **E** is for I **exist**. This represents the *organismic* self. This is the terrain of physiology and the existential mechanistic fact that our bodies are functioning, to greater or lesser extent. It is the ground on which we as physicians spend much of our time, trying to figure out and manage biomedical diagnoses and treatments. It is the place that patients also may figuratively dwell, given that mind and body are not as far apart as medical science commonly suggests.[5]

I submit that by reflecting on these 5 presentations of self—ABCDE—physicians can become more conscious of the interpersonal dynamics that emerge during their encounters with patients and, by doing so, enhance the therapeutic potential of these encounters. Let us be honest, however. It is hard enough to

Table 1. Presentations of Self in Clinical Encounters

Self	Theme	Prototypical Patient Issues	Prototypical Physician Concerns
A. I **am.**	Meaning	What is most important in my life?	How do I find meaning in my work with this patient?
B. I **belong.**	Community	With whom can I bear my problems?	What resources do I have at my disposal?
C. I **can.**	Agency	Do I have the capacity to get better?	How can I positively influence this patient's health?
D. I **dread.**	Anxiety	I am worried–What about?	Will this patient improve or decline?
E. I **exist.**	Organism	What is wrong with my body?	What is the pathophysiology and treatment?

be aware of what presentation of self we project to others, let alone understand what presentation others offer us. Nonetheless, through conscious awareness, studied attention, and honest practice—combined with a willingness to accept that within the boundaries of our work lies a need to connect with patients on levels more intimate than those represented by diagnosis and treatment alone[6]—we can expand our sense of self-awareness and, at the same time, grow our understandings of those who come to us for medical care.

Alternate Considerations

Many in the conventional psychiatric community might argue that I am picking apart what are fluid, dynamic components of the self.[7] Health care professionals with leanings toward Buddhist psychology might note an under-representation of the "we," the "non-self," and the interrelatedness of all in the construction of reality.[8] Those with philosophical perspectives from relational ethics and social constructivism might suggest that any appreciation of self is a result of, rather than an antecedent to, shared presence.[9] To a certain extent and from a certain point of view, all these critiques make sense.

I, however, am not psychiatrist, psychologist, or theoretical philosopher. I am a family physician. It is my day-to-day work to find balance between science and art, biomedical practice and household living, home and hospital, young and old, and life and death (or at least how people understand and approach them through their perceptions, their reflections, and their actions). It is not my work to get caught up in the nuances of psychodynamic constructions, but to find time-efficient and clinically effective ways to help people find some balance in their own lives, whether it be through medication, motivation, meaningfulness, or some therapeutic mixture of these in doses appropriate for the place, time, person, and environment.

CONCLUSION

By reflecting on the mnemonic ABCDE in relationship to our patients' and our own presentations of self, we as family physicians can work to find the equilibrium between who's talking and who's listening. We can assess the concerns of others, simultaneously exploring our own concerns relative to them, and try to find a healing balance between them and us. By recognizing the self each patient presents and at the same time examining our own selves within, at least some of the relational and communicative challenges we face with patients can fade away. Attending to the presentations our patients and we bring to our encounters, we can enter with them into the special space of shared presence that is so vitally important to our work, to their well-being, and to the therapeutic goals of our time together.[10]

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