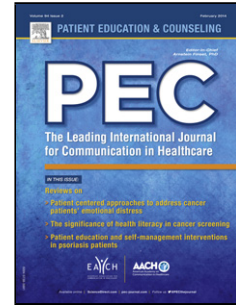


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# The possible impact of vulnerability on clinical communication: some reflections and a call for empirical studies

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## Highlights

- Vulnerability includes risks of compromised social bonds and may induce shame
- Unacknowledged shame is subtle and often not recognized
- Both clinicians and patients are vulnerable and this obstructs communication

**Abstract**

**Objective:** To direct attention to the concept of vulnerability, how it affects interactions in subtle ways and is difficult to detect in studies of clinical dialogues.

**Methods:** A reflection on three everyday examples of what seems like insignificant details in physician-patient interaction, enlightened by readings with an emphasis on unacknowledged shame, illness and social bonds, and the physician's role.

**Results:** Physicians are aware of patients' vulnerability as risk and susceptibility to harm under certain circumstances, but often miss the vulnerability related to perceived or anticipated loss of social bonds. The latter may elicit unacknowledged shame, which leads to subtle behavioral changes that are easy to overlook. Typical reactions are silence or lack of relevant response to questions. Physicians are rarely aware of their own vulnerability. Slight behavioral changes from a clinician may reduce or increase a patient's ability to partake actively in problem solving and decision-making.

**Conclusion:** When physicians or patients are touching upon unacknowledged shame as part of being vulnerable, subtle changes in the interaction may hamper efficient communication.

**Practice implications:** We need studies that add participants' unprompted and prompted reflections on encounter videos, with an emphasis on micro-events and their explanation and impact on the interaction.

**Keywords:** vulnerability; shame; physician-patient communication; physician-patient relations; medical ethics; medical philosophy; biopsychosocial; autonomy; self-determination theory; uncertainty; professional identity

“Le Moi, de pied en cap, jusqu’à la moelle des os, est vulnérabilité.»

“The I, from head to foot and to the bone marrow, is vulnerability.”

Emmanuel Lévinas (1908-1955) (1)

“No man is an Iland, intire of itselge;”

John Donne (1572-1631) (2)

## 1. Introduction

Vulnerability is derived from one of the first Latin words a medical student learns: *vulnus*, meaning wound, and means a potential to be harmed. Physicians learn that patients are vulnerable; they recognize the risks a wound poses, how frailty increases the risk of falling and becoming bed-ridden, how obesity may lead to cardiovascular disease. In biomedicine, vulnerability is understood as *risk*. In public health it usually connotes *susceptibility to harm* (sometimes referred to as social vulnerability) usually based on epidemiological observations, and is applied to groups. This understanding of vulnerability is, in the tradition of the natural sciences, something one can measure.

But vulnerability in philosophy (1) and bioethics (3-5) is also described as an inherent part of being human, an existential concept. It is a central word in the Barcelona Declaration on Policy Proposals to the European Commission on Basic Ethical Principles in Bioethics and Biolaw (5). The declaration states: “Vulnerability is the object of a moral principle requiring care for the vulnerable. The vulnerable are those whose autonomy or dignity or integrity are capable of being threatened.” Under certain circumstances, one’s autonomy (the capacity to make an informed, un-coerced decision), dignity (the right of a person to be valued and respected for their own sake), or integrity (the quality of being honest and having moral principles), can be in danger or lost. This applies to all humans as a quality, more or less consciously present. It can be presupposed, felt, described, but hardly measured.

In medicine, the threats of injuries, disease, and death are ubiquitous and recognized by most providers. The threat of not being perceived as worthy by others receives less attention, although even subtle signs of lack of respect may elicit a perception of threat to autonomy, dignity, and integrity (6). Experiencing or imagining not being worthy is associated with shame (7), may bring perception of own vulnerability up to the surface, and may lead to social isolation. Poor social relations are a much stronger risk factor for premature death than any known biomedical factors that we understand to be part of the mechanisms of disease (e.g. smoking, alcohol, diet, pollution), and this pertains both to objectively measured social isolation and subjective loneliness (8). Despite this, medical practice tends to overlook the important social burdens of patients in everyday work (9,10).

In studies of human interaction, it is of interest to think about how vulnerability in this sense can be observed. I propose that one likely reason for lack of attention to vulnerability is that it is almost undetectable, that this is in the nature of what it means to be vulnerable, as exposing vulnerability may increase the likelihood of harm. In this paper, I will use a few examples and discuss how vulnerability and shame might play a part in the interaction. With this, I hope to inspire

communication researchers to dig deeper into these phenomena and to provide more knowledge about micro-events in clinical interactions, events that seem to obstruct, derail, or destroy efficient and helpful communication despite the best intentions of the participants.

## 2. Examples from practice

I present three examples. The common denominator is behavior that *may* be rooted in fear of exposure. The content of the exposure differs.

### 2.1 *The inexperienced student with patient in the subacute ward*<sup>1</sup>

This male student was in his first clinical rotation, meeting patients in the subacute ward for the first time, accompanied by me. We approached a 75-year old woman who had consented to talk with students. She was lying almost flat in her bed, fully awake and mentally alert. I noted the initial turns of the talk:

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EXCERPT 1 – Student accompanied by professor in subacute ward, December 5 – S=student, P=patient

S: So why are you here?

P: Do you want me to take it all from the beginning?

S: (hesitant) Well, yes.

P: I had surgery for cancer. And so yesterday I got fever, and then I called them, and then I came here. Now I feel better so I think they will send me home.

S: So you had surgery for cancer? When?

P: October 25. (long sigh)(pause) In my stomach.

S: Yes. (pause) So, stomach surgery, then fever.

P: Yes. And then I got chemo several weeks after. I've had two. One last week.

S: So you associated fever with the chemo?

P: I don't know. I'm not familiar with all that.

S: The physician didn't tell you anything?

P: Yes. He said that the chemo would kill my immune system and that I would be more susceptible to infections, and that I should call them if I got a fever.

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We see that the woman, despite being well informed about why she should call the hospital if she developed a fever after a course of chemotherapy, initially claims that she does not know when the student asked: "So you associated fever with the chemo?" It is a closed question, so she could have responded yes or no, but she does not. One reason could be that she did not understand the question. Alternatively she could have understood it, but was reluctant to provide an explanation of the association. Either way, it is often uncomfortable to acknowledge that you do not understand if a question is posed in a way that presumes you do, and it is potentially uncomfortable to reply in a way that might be wrong because you could be exposed as inferior or dumb. If the student had not asked

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<sup>1</sup> The hospital has a <24h-stay ward for patients who need a quick evaluation to decide whether they need admission or may be discharged for outpatient follow-up.

a much better follow-up question, we would not have known how well the woman actually understood. The follow-up question does not presume an understanding on her part, because he asks if the treating physician had not told her. Then, she could describe with confidence precisely what the physician had said. I propose the underlying issue here could be vulnerability.

## *2.2 The woman without a family*

A young pregnant couple who I know well contacted me because the midwife who performed the mid-term routine ultrasound suspected the child might have clubfeet, and had referred them to a university hospital for a more thorough investigation. They asked me if I would accompany them as she had mentioned amniocentesis, and they did not understand why. The following excerpt occurred right after the obstetrician had confirmed that the child had clubfeet.

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EXCERPT 2 – Obstetrician’s first meeting with couple expecting a child with clubfeet – O=obstetrician, M=mother, F=father.

O: There is a tendency for clubfeet to run in families. Does this run in your family?

F: No.

M: No.

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I had lunch with this couple right after the visit, and the mother said spontaneously that she did not really know her family. She did not know who her father was, her mother died when she was two years old, and she was raised by someone she called grandmother until the age of ten, when the woman passed away. After that, an adult half-brother, as far as she knew, took care of her. The question to think about is why she did not tell the obstetrician this information.

In this excerpt the obstetrician provides a brief legitimization for asking a question about a possible family history of clubfeet. One could ask why he needs this information, if the answer does not have consequences for whatever choice there is to be made<sup>2</sup>. The question is closed, and he gets a clear “no” from the mother. Since he brought the question up, one might presume that the mother would think a correct answer is important. Still she does not tell that she actually does not know the answer. She might have thought that the information was of little importance even if the physician asked for it. Is it likely that she considered the risk of holding back information? She knows she is carrying a fetus with clubfeet. What if there were serious implications depending on a yes or no answer? Would she then expect a different type of question, or introduction, so that she would know how important it is to respond correctly? The way the obstetrician asked the question was very matter-of-factly, and there were no signs of importance. The mother may have perceived this. However, when a question is posed in a way that presumes you have an answer, such as in excerpt 1, it is difficult to reveal that you do not. The obstetrician’s question takes for granted that the parents know their families. I propose the mother did not at all consider the risk related to a wrong answer, but rather responded intuitively with a perception of being vulnerable, not wanting to expose that she did not know her family. I think this interpretation is supported by the fact that the father did not intervene. He knew that she did not know her family, but he did not bring it up during the consultation, which is reasonable. His wife had chosen not to tell, and he would have exposed her unfavorably by revealing that she had withheld information.

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<sup>2</sup> Physicians tend to ask such questions, to strengthen or weaken hypotheses about etiology and diagnosis. But often such questions are of limited value in the selection of treatment, and of little help to the patients.

### 2.3 The young resident in neurology with a 50-year old woman with severe atypical migraine

This example is from a video collected in 2008 during a randomized controlled trial (11). The resident seemed to have read the patient's record thoroughly, and in the first half of the visit he was focused on the patient with good eye contact. During the first 20 minutes, most of the conversation had been about the patient's complex migraine and tension headache history and a possible overuse of drugs. Then the patient reminded the resident that she had had a stroke at the age of 17, something he must have missed in his preparations, because he obviously was surprised and started watching the computer and studying MRI scans. The patient emphasized that she recovered without reduced functioning from the stroke. Where the excerpt begins, the resident was looking at her.

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EXCERPT 3 – Resident with woman with severe tension headache, migraine and a previous stroke – D=resident, P=patient, excerpt beginning after nearly 26 minutes.

- P: You know, then I'd like to tell you something that I experience, and that is that I am getting poorer and poorer memory
- D: Mm, yes (turns towards computer and starts clicking)
- P: that I almost haven't dared, hehe, say, hehe, with the risk of not being taken seriously
- D: Mm (still watching computer)
- P: Eeh...this short term memory of mine (physician looks at her) becomes poorer and poorer, I say
- D: Mm
- P: Yes (pause) eeh (pause), yes, eehf, yes (physician watches computer again) I haven't dared tell before even, because, my husband too is...thinks it is conspicuous that I do not, that so much slips away from that short term memory of mine
- D: I think this looks fine, except the trace of your stroke from earlier, no signs of ischemia, that is, little blood or such things...
- P: So what I say, it, it doesn't show at least (points to computer)
- D: No
- P: No
- D: It doesn't
- P: I just think it is so early to start to become, hehe, eeh
- D: Yes (still watching computer)
- P: to start having poorer memory and concentration and such
- D: Mm
- P: (brief pause) but, of course, I know I had some of it from the stroke as well
- D: Mm
- P: (brief pause) but I think it seems to become worse
- D: Mm

P: or it **BECOMES** worse, because...

D: eeh (looks down, pauses two seconds)...I believe we'll do this, I think you should...you should at least not use sumatriptan when you get these aura symptoms

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This excerpt is a quite different example of what I interpret as vulnerability, because the patient so openly discloses it, but also because vulnerability may affect the physician. The patient's statement about the difficulty of bringing forward her symptom of memory loss in fear of not being taken seriously, with referral to her husband as witness to support her concern, is unusual. Maybe as a precursor to her later openly declared vulnerability, the patient takes the resident by surprise by introducing the important element of a prior stroke in her history. It is a good move. By reminding the resident about a fact within his domain, she creates interest.

I note that despite this, the resident, who had performed what one would expect from someone of his experience, did not respond adequately, neither emotionally nor in terms of content, even when the patient strongly emphasized that the symptom progresses. His solution is typical for physicians. By giving information that the scans are fine, he tries to provide reassurance. His next concern is whether the information bears on his treatment recommendations for migraine. He does not give an excuse for having overlooked stroke in her history, nor does he explain why he needs to focus on the scans while she is talking. He does not take a more detailed history to understand more, and his final orientation is towards further migraine treatment with no more talk about her memory loss or stroke. I propose that such lack of attention to her emotional expressions might be attributed to the resident's expectations of himself as a physician. It is his job to know how to interpret an MRI scan, he has already made one mistake (missing the stroke), and now he must set things straight again by thorough examination of scans, while not forgetting the main purpose of the visit. *This* is what he should do, *this* is what makes him a physician, *this* is what he should live up to, *this* builds his identity. Failing at doing so would make him vulnerable, exposed as not good enough for his job.

### 3. Shame and vulnerability

Shame is an emotion all humans recognize and is one of the self-conscious emotions (8). It is an emotion that is highly unpleasant, and therefore strongly influences behavior. Shame signals that you are exceeding the boundaries of acceptable behavior or standards in the group. It is the glue of societies, likely present long before religion or law, probably the strongest of all non-violent means humans can use to regulate behavior and prevent dissolution of a group. Shame keeps us together, at the cost of individuals. For evolution, shame has been considered a necessary, risk-reducing visible expression of subordination (12). Hence, shame is more likely to occur in asymmetric interactions where interactors are superior or inferior, for instance physicians and patients, or experienced physicians and residents.

#### 3.1 *Shame in medicine*

The psychiatrist Aaron Lazare describes how patients may experience shame because they perceive diseases as defects or shortcomings, and how this leads to avoiding the physician, withholding information, complaining or suing (13). Shame is described as more frequent than anxiety, anger, grief, or fear in psychotherapy (14). Several diseases have been associated with shame: leprosy, venereal diseases, tuberculosis, cancer, infertility, epilepsy, severe burns, and congenital malformations to name just a few (15). Still, shame is largely ignored in medical practice outside psychiatry. This could be inherent in its nature: once shame is present, a preferred (but unhelpful) way to mitigate it is by silence: not exposing shame more than it has been already. According to Nathanson's "compass of shame," one who experiences shame will tend to react with withdrawal,



avoidance, attack towards others, or towards self (16). As clinicians consider themselves helpers, with good intentions, patient reactions in this vein might not be understood: “why would people withdraw or become angry when I am here to help?” Of note, such reactions may also occur in collaboration between physicians, if their competency seems to be questioned (17).

### 3.2 Subtle signs of shame

That shame reactions are visible as a risk-reducing strategy could imply that they are easy to observe, and recognized and acknowledged. However, man is a complex species with a wide repertoire of communicative actions, and some signals may have become subtle over the millennia of human existence. Helen B. Lewis has described two types of what she called *unacknowledged shame* (14): overt, undifferentiated shame and bypassed shame. The overt, undifferentiated shame is characterized by the person recognizing emotional pain (which can be accompanied by physiological correlates like flushing, increased pulse rate, sweating) without naming it as shame. Instead of naming the shame, the emotion is referred to with words like “uneasy”, “uncomfortable”, “weird”, “hurt”, or the situation is implicated; “it was a difficult moment for me”. Bypassed shame is not necessarily painful, but sensed as a deep, brief breath or an involuntary movement, often described as “neutral”, “hollow”, “numb” or “put out”. The person may or may not be aware of unacknowledged shame, usually s/he is not (15). Lewis’ interpretation is that the shame emotion is a potential, not allowed to develop further, but rather averted by use of quick mental, verbal, or behavioral means.

### 3.3 Shame and vulnerability

Vulnerability is in my view a broader concept than shame, as it includes the possible exposure to all kinds of harms, not just that of being shamed. When you are ill, or in the process of dying, or losing someone, it is likely that you become more aware of your vulnerability. That does not mean that you also feel ashamed, despite the documented relationship between disease and shame (15). On the other hand, feeling ashamed without awareness of your own vulnerability is highly unlikely. Shame is a marker: you are dependent on the evaluation of others.

Robert C. Smith lists 331 examples of emotions (18). At least 28 of them (table 1) can in my view be associated with unacknowledged shame. Becoming aware of one’s vulnerability may lead to anxiety or sadness as well. The reason I emphasize shame, is that it is much more likely to be concealed, is easier to forget when working in medicine (13), and highly likely to influence interaction.

## 4. Discussion and conclusion

I feel awkward and embarrassed to write this paper as if I am bringing something new to the field of communication. I am not. In 1986, Thomas J. Scheff connected the works of Helen B. Lewis and Erving Goffman, to suggest that shame is a ubiquitous presence in virtually all social interaction (19). If I dare write anyway, it is because this fact is usually ignored in the teaching of medical students. One type of action, active listening, has been promoted to improve physicians’ ability to pick up emotions, mainly anxiety, as this emotion is so obviously connected to symptoms and disease. But understanding of why physician-patient interactions are often so dysfunctional requires an inquiry into the reasons for why things are not said even when they are important. The physician’s perceived power and superiority, and the potential for unacknowledged shame that an inferior position represents, are clues here.

The physician’s role carries power, a positive power known to nearly all humans from early childhood, influencing how we feel when we meet one. A recently developed survey instrument to

measure patients' attachment to providers, found fear of rejection (and therefore cautious behavior), and feelings of being humiliated or shamed, as strong predictors of weak attachment (20). Surveys are indicators of what is important for patients, but we need detailed interaction studies to understand why patients are left with negative experiences (we must presume that this is not what physicians want to achieve). However, empirical research literature on the experiential consequences of turn-by-turn interactional patterns is scarce (21). Patients' deference for physicians, enhanced by the vulnerability related to illness, reduces the likelihood for physicians to receive critical feedback. This makes it hard for them to understand the need for improvement in interaction, and unless research can point exactly to what goes wrong, observation and feedback will not be sufficiently specific. For example, while we know that physicians carry presuppositions (10), only detailed analysis can uncover how this leads to questions that carry implicit expectations (21). For the obstetrician in excerpt 2, that the mother would not respond truthfully to his simple question was probably not in his mind.

Some papers on the vulnerability of *clinicians*, focus on vulnerability as a strength. These papers are typically from general practice (22), or nursing (23). The clinicians in these qualitative studies have found that it is helpful in meeting with patients to recognize their own vulnerability and use it purposefully in the dialogue. Clinicians who work and live in small communities also experience that meeting their patients in non-clinical settings create a proximity between them that carries their clinical relationship further and usually strengthens it (24). Hospital specialties like oncology and cardiology, on the other hand, define physicians' work differently because death is ever-present. Here physician vulnerability becomes exposed as grief, which may induce embarrassment and shame (25), or loneliness and powerlessness as part of professional responsibility (26). In a qualitative study following an intervention to change the ward-round routines in a Swedish hospital to reduce medical errors, it was found that the attending physicians' ability to adjust to the new routines was better when they applied a "We-perspective" rather than an "I-perspective" on their work (27). The former perspective was characterized by a focus on teamwork, other providers' input was considered essential, and conversation with the patient was given priority compared to reading the record. The nucleus of the latter perspective was the physicians' perception of personal responsibility and being in control. Medical culture in the scientific era may have developed an unhealthy aim of eliminating uncertainty (28). If staying in control is the overarching paradigm of the working climate you are part of, loss of control means loss of confidence from peers and represents a major threat to your position and sometimes identity (17, 27, 29). It probably takes repeated unpleasant emotional experiences before many physicians are able to recognize and acknowledge their own vulnerability.

I have four reasons for emphasizing that unacknowledged shame and the behaviors it elicits are important reminders of underlying vulnerability. First, medical practice's neglect of social bonds, position in the hierarchy, and biography in the evaluation of symptoms and disease is a major reason for poor treatment outcomes (9,30,31). Second, exposure to unfortunate questions, as in excerpts 1 and 2, may remind patients of their limitations or create a feeling of being inferior. Third, overwhelming patients with information and expectations of making decisions, which are side effects of incompetent shared decision-making (32,33), may decrease trust and is likely to increase uncertainty and thereby awareness of vulnerability. Fourth, vulnerable physicians may inadvertently display signs of disrespect while protecting themselves, a possible mechanism in excerpt 3. I suggest that signs of disrespect are more likely to happen when physicians are challenged by not knowing how to handle a situation.

Ryan & Deci have proposed that all humans have three innate needs: a wish to be autonomous, a wish to be competent, and a wish to be related to others (29). Because patients often are in a weak

and vulnerable position, clinicians may inadvertently compromise these wishes and thereby introduce shame. For physicians, autonomy, competence, and relatedness come with the role, and recognition of being vulnerable appears first when an event reminds them that they cannot master it all. This can be heavily shame-inducing, and in the worst cases, lead to burnout or suicide (34).

### **5. Practice implications**

I suggest that further studies of clinical interactions should apply insights from micro-sociology and sociolinguistics to the highly skewed power differentials (35) in clinician-patient interactions to analyze details more thoroughly. Such studies may require theory-driven post-visit interviews with interlocutors, and/or audio/video reviews by them with unprompted and prompted comments on observations of their talks, in order to tap motives and reflections behind their own behavior. I think such studies will inform our endeavor to improve clinical communication.

Clinicians in general, and not just in psychiatry, need to recognize the inherent vulnerability of all people, including themselves, how it affects behavior and interactions, and how it can be mitigated but not removed. They need to understand that it is about perceiving the threats of diseases and death, but also the threat of being inferior and worthless. We need studies to help us recognize, discuss, and address vulnerability and shame more explicitly.

### **Conflict of interest**

I do not have any conflict of interest to declare.

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Table1. Examples of emotions that can be associated with shame. Extract from (18).

Abandoned

Alienated

Alone

Ashamed

Betrayed

Blamed

Condemned

Deceived

Degraded

Downtrodden

Dumb

Embarrassed

Forgotten

Ignored

Incompetent

Inferior

Isolated

Left out

Lonely

Neglected

Oppressed

Rejected

Unimportant

Unwanted

Useless

Vulnerable

Worthless