Asking Hard Questions

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One reason that generalist physicians of all types are able to ask hard questions of our patients is that we have committed ourselves to being with them after the answers to those questions come out. Intimacy and reciprocity between doctor and patient were fundamental values that underlay the development of family medicine,[1] and almost every conversation between a patient and a doctor is best carried out in the environment of security and trust that comes with someone who knows us and accepts us for who we are.

One of my most vivid patient experiences was with a distinguished 70-year-old professor I had been taking care of for a decade, who suffered from a number of vexing somatic symptoms and whom, it seemed, I could never reassure enough. I got a call from the clinic one day saying that I needed to get there immediately; she was in a room and was hysterical and was willing to see only me. When I walked into the room, she sobbed that she could not keep it quiet any longer. I asked her what "it" was, and she told the long and painful experience of being sexually abused as a child and being too ashamed to ever talk about it with anyone. Why then, why me? Because I was her doctor and I was there when she needed me.

Medicine has come a long way toward opening up difficult conversations. Some of the earliest work on the prevalence of domestic violence in a general population and some of the barriers physicians found to asking about it was carried out in Wisconsin.[2] Wisconsin has led the way nationally in having end-of-life conversations,[3] even at the risk of being vilified as promoting death panels during the discussions that led to the enactment of the Affordable Care Act. Both of those issues are now codified as part of the basic training of all medical students in the United States and all doctors should be able to ask about them, but those conversations often still happen between generalists and their patients.

Research on career choice repeatedly points out that a relationship with patients is the central value that motivates students to choose careers as generalists and the one that keeps them there after they finish training. Those relationships are sources of enormous satisfaction but also of great challenges. Perhaps the newest one for many of us is the discussion of sex trafficking that often underlies the sexual abuse, drug use, and behavioral issues in adolescents and adults.

One of the oldest adages applied to ordering tests—and one often ignored—is that if one asks the question, one has to live with the answer. But the hardest questions are the ones we feel least likely to be comfortable with since we are not prepared to deal with the answers. My most frequent conversations with residents in family medicine over the past 40 years have always centered on why they were reluctant to ask patients about drug and alcohol use, domestic violence and sexual abuse, reasons for incarceration, dealing with anger, sexual behaviors, and all the other things that lie deep, often untouched, and threaten the health of our patients and, by inference, our communities. The rise of HIV helped make questions about sexual practices and intravenous drug use normal today. But that was not true in the early days of AIDS and was a source of discomfort and strife in the medical community.[4] Fortunately, we have gotten better.

However, the article by Rabbitt[5] on childhood sex trafficking in this issue of the *WMJ* raises an area of inquiry that presents some of those same challenges to physicians that the hard questions of the past did. Training clinicians to use their trusting relationships with patients to look more deeply into the story behind sexual abuse and risky behavior is more important than ever, not simply because the problem of sex trafficking is growing nationally and worldwide, but because Rabbitt points out a number of ways to help those clinicians deal with the answers. There is help, and there is hope for us and our patients.

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