

Erin Welsh

Hi, I'm Erin Welsh. And this is This Podcast Will Kill You. You are listening to the latest episode in our special series we're calling the TPWKY Book Club. This isn't your typical book club where you spend about 10% of the time talking about the actual book selection and the other 90% eating tasty snacks and drinking tasty drinks and talking about a million other things which I absolutely love, by the way. Shout out to my real life book club. In the TPWKY Book Club, which I also adore, we're staying on topic, getting to hear directly from the authors themselves about what inspires them, how writing changed their outlook, what they most want people to take away from their book, and so much more. So far this season we've explored books on topics ranging across the fields of medicine, science, and history. And there is still so much more to come.

If you'd like to check out the full list of books we've covered so far and the ones later to come, check out our website [thispodcastwillkillyou.com](http://thispodcastwillkillyou.com) where under the EXTRAS tab you'll find a link to our [bookshop.org](http://bookshop.org) affiliate page. There we have several TPWKY book lists covering everything podcast related, including a Book Club list where you can see all of the books featured in these Book Club episodes. And one last thing before we get into the book of the week, that is to please rate, review, subscribe. It really helps us out so much and also share your thoughts with us. We always love to hear from you.

Think of the last time you spoke with a doctor about a concern that you had. How long did the doctor spend with you? Do you feel like they were present in the room or did they seem distracted, checking emails, typing up notes with half a mind on the conversation? Did you get all of your questions answered? Did the doctor give you time to ask questions? How did you feel at the end of the appointment? Did you feel listened to, understood, cared after, reassured? Or did you feel gaslit, condescended to, dismissed, unheard? Hopefully your experience falls into the first category of emotions. But I know that many, if not all of you, have at some point or another been made to feel the latter. Going to a doctor's appointment, whether for a routine checkup or a specific problem or concern, can be a very vulnerable experience. It's no exaggeration to say that you are putting your life and health into their hands. And when that trust is broken, the damage can be severe both in the short as well as the long term.

What is it about the physician-patient relationship and the way that medicine is practiced today that lends itself to this pattern of dismissal? That's exactly what Dr. Rageshri Dhairyawan explores in 'Unheard: The Medical Practice of Silencing'. Dr. Dhairyawan, who is a sexual health and HIV doctor with the NHS as well as a health equity researcher and science communicator, draws upon her own experience as both patient and physician to examine this nuanced topic from multiple perspectives. Through her research she demonstrates that this problem of silencing patients is not a matter of a few doctors acting negligent or being too exhausted to properly listen but rather a systemic issue in medicine where the foundations of patient dismissal are laid out during medical school training and perpetuated by the medical system. And as minoritized groups are disproportionately more likely to be silenced by their healthcare providers, they are also more likely to suffer the negative health consequences that being unheard carries with it. Compounding this are the knowledge gaps that tend to be wider for conditions primarily impacting minoritized groups, a reflection of research priorities that designate funding and resources to more prestigious diseases.

To say this matter is complex is an understatement in the extreme. Fortunately Dr. Dhairyawan's clear and compassionate approach in 'Unheard' expertly guides readers through the factors enabling the continued silencing of patients and crucially suggests how positive change can be made by individuals, during training, at an institutional level, and at a systemic level. I truly loved this book and this conversation for getting to the heart of this issue; for exploring not just why does it happen but also providing a road map for how it can get better. And I am so excited to share this conversation with you all. So let's get into it.

TPWKY

(transition theme)

Erin Welsh

Dr. Dhairyawan, I'd like to just first thank you so much for chatting with me today. Welcome to the This Podcast Will Kill You Book Club.

Rageshri Dhairyawan

Thank you so much for the invite. And I'm really, really excited to be here.

Erin Welsh

Your book 'Unheard: The Medical Practice of Silencing' was a truly compelling blend of infuriating and enlightening. And I suspect that it will resonate with many, many people. I also think it should probably be required reading for medical practitioners as a part of both initial and continued training. Can you describe your journey to writing this book and how your experience on both sides of the power dynamic as both physician and patient influenced the approach that you took?

Rageshri Dhairyawan

So I think it's been coming for a really long time and kind of this year is my 20th year of being a doctor, so probably all of my career it's been coming. And my work, my day work is I work in sexual health and HIV. So I work with some really kind of minoritized patients who are people who aren't heard generally in policy, who are often very poor, they have HIV, a stigmatizing disease. So part of that is my work with them I think. But what really instigated the book were my experiences as being a patient. So I was diagnosed with endometriosis when I was trying to get pregnant which was unsuccessful and kind of went on to have fertility treatment. And during one of those fertility cycles, I was on a lot of hormones and I developed really, really bad abdominal pain, like excruciating pain, the worst I'd ever had.

So my husband took me to the emergency department. Initially I was seen, I was given really strong painkillers, and then I was admitted to the ward. And they were really worried that I had this thing called ovarian torsion which is when the ovary is so big from the hormonal stimulation that it twists on itself and you need urgent surgery. But a scan showed I didn't. But I was still in a lot of pain which they thought was due to kind of a flare up of the endometriosis from the hormones. And whilst on the ward I asked for more pain relief but I was refused it. Basically the medical team didn't seem to believe that I was in so much pain. They treated me like I was just trying to get morphine because I wanted it and it was a really shocking experience for me. At that point I'd been a doctor for quite a long time and was quite senior. And I just thought if this could happen to me, this experience of being disbelieved when asking for pain relief, what on earth happens to everybody else?

And in the end I needed my partner to advocate for me. I thought what if you can't speak English? What if you don't have a partner? I know how the healthcare system works. What if you don't know how it works? What happens to everyone else? So that was really what instigated it. And also the fact that at the time I didn't complain and I didn't complain afterwards either. I felt really ashamed and I felt silenced for quite a long time.

And it wasn't until kind of maybe six or seven years later that I started to do some writing and I ended up writing about this and really reflecting on why did I feel so silenced. And this really came together into the book. But also the fact I'm a patient but I'm a doctor patient, I'm not just any old patient. And I'm a doctor and I know very well that despite my best intentions, I don't always listen well. And much as I'd love to say that every single patient I've seen will say they had the best experience with me, that's probably not true. So I thought the book was a really good opportunity to look at why we don't listen and who doesn't get listened to.

Erin Welsh

In your book, you use the terms 'deliberately silenced' and 'preferably unheard' to describe those patients who are ignored by medical practitioners. Who are those individuals most likely to be? And what does being silenced or unheard look like? Because it can be a great many things. Sometimes maybe not as obvious as just like thinking about oh, someone is going 'I don't believe you'. Like that is not often how it comes out.

Rageshri Dhairyawan

I think when I started the book I thought it was just some people who go unheard. But during my research I actually found out that actually all patients go unheard. And I'm sure we'll talk more about why that is but obviously some patients go more unheard than others and these are often people from minoritized groups. So these are people who when they speak, they seem to be less credible when they speak so they're less likely to be seen as trustworthy and less likely to be believed. And these, as I said, are people who are from minoritized groups like people of color, women, people who are very old or very young, and people who are LGBTQ+. So they're just less trusted and therefore less listened to.

And I realize it's not just patients who go unheard in healthcare, it's also minoritized doctors, minoritized researchers, and this can happen at a global level as well. And that kind of thing about when you think about the patient-doctor kind of contact thing, people are dismissed, they're not believed, they can feel like they're being gaslit. So that phrase 'it's all in your head', they might feel like that. And they just may feel like they've been ignored. So they've gone at their most vulnerable with their concerns to their doctor and the doctor has kind of said okay but then they haven't acted on their concerns and perhaps they haven't reassured them or referred them or done a test. So I think there are different ways in which people can feel unheard. But I think that feeling of being gaslit is a really common one.

Erin Welsh

You also introduce the term 'epistemic injustice' as a framework to understand the ways people feel unheard in medicine. Can you take us through this term and the different types of epistemic injustice?

Rageshri Dhairyawan

This was a term which comes from philosophy. So the British philosopher Miranda Fricker coined it in 2007. And she basically defined this as being a wrong occurring to someone in their capacity as a knower. So basically as humans, we like to create knowledge and we like to be able to pass it on, it's part of what makes us human. And when we can't do this we experience an injustice and this is one injustice amongst many other injustices that people who are minoritized might face. And there are a couple of types of epistemic injustice. There's one called hermeneutical injustice and one called testimonial injustice. And I talk about both but I think I want to concentrate more on testimonial injustice here because I think it's something that people will identify with.

With testimonial injustice, it's basically when someone speaks, the listener is less likely to believe what they say or listen to them because they don't feel they're credible due to aspects of their social identity. So for example if you are a woman of color, you may not be seen as being credible so you're less likely to be listened to. So it's often minoritized people who experience this testimonial injustice and they experience what's called a credibility deficit. So they're not seen as being credible speakers by the listener. And actually it can happen in the other way as well. So you can experience an injustice if you are taken too seriously. So you can have a credibility excess. So quite commonly it's white men who speak on something actually they don't know that much about. I don't know if you've seen this anywhere.

Erin Welsh

No, never, I've never experienced that. (laughing)

Rageshri Dhairyawan

So they say something and people are like yes, they're probably right, so I'll believe them. So they actually also experience an injustice but perhaps one that doesn't cause them harm so much.

Erin Welsh

When a medical provider does not listen to or ignores their patient's concerns, that can impact both whether that person receives care at all as well as the quality of care received. What are some of the immediate and long term health impacts of being unheard?

Rageshri Dhairyawan

So I think the most kind of immediate thing is that you don't get treated or diagnosed. So you're telling your doctor your symptoms and then nothing is done, so you may not be referred for tests. So you may have like a delayed diagnosis or you may have the wrong diagnosis, misdiagnosis. Or you may get the wrong treatment or no treatment at all. And I think in its extreme sense, it can be very dangerous, it can be very harmful. I think we see all the time in kind of patient safety reports. So for example, there's been a lot about maternal mortality both here in the UK and in the US. And a lot of the reports say that women and their relatives say that they are not listened to or believed when they're experiencing care. So kind of at its worst, it can even cause death.

In terms of kind of the more other long term things, I think if you are routinely not listened to by your healthcare provider, routinely not heard, it means that you're kind of less likely to go back to them. So you don't trust them, it increases mistrust. And you might think I actually don't want to tell them what's going on, so you may avoid healthcare or you may self censor. So if your doctor says what's happening with your treatment, how's it going for you? And you've told them time and time again that you're getting side effects, you might just give up and say oh no, they're fine. But in your own time, just stop taking the tablets, for example. So I think it can have a real effect of silencing, mistrust, and kind of healthcare avoidance.

Erin Welsh

Let's take a quick break here. And when we get back, there's still so much to discuss.

TPWKY

(transition theme)

Erin Welsh

Welcome back, everyone. I've been chatting with Dr. Rageshri Dhairyawan about her book 'Unheard: The Medical Practice of Silencing'. Let's get back into things. The dismissal of patients by healthcare providers is not something that happens spontaneously. As you point out, it is an explicit and implicit part of training, where the foundations are laid out for their hierarchical relationship between physician and patient. Can you talk about what that training is like and why it's viewed as an essential part of patient care?

Rageshri Dhairyawan

Yeah. So I talk quite a bit about medical school in one of the chapters because I think that's really where we start to develop this almost skepticism of the patient already coming from a thought that we don't believe patients right from the beginning. So one of the ways in which we talk about medicine particularly in the West is the biomedical approach. So this is where we think of the disease being separate to the patient. So it's not part of them as a whole, it's a separate thing and our job as doctors is essentially to find the diagnosis and then treat the patient. So we don't really think of a patient as a whole and it means that we don't necessarily provide holistic care. So it really teaches us to keep a distance from the patient. And it means that we're more likely to have boundaries. And I'm not saying boundaries are bad, boundaries are a good thing as well.

But sometimes when we have very rigid boundaries, we don't listen as well as we can do. And it means that we as the doctor, we hold the knowledge and the expertise. And it means that we can be very paternalistic because we think we know best, we know better than the patient themselves about their own bodies. And I think the other things about medical school is certainly as medical students you've come through so much to get to where you are, you've passed exams, you are some of the cleverest people at university, and you're taught together because you have long hours. So you kind of end up really being tight as a group. And I think that separation and that feeling of being special and separate to other students means that we can develop a sense of hubris or excessive pride. And again, that can make us seem kind of more unapproachable and less empathic. And I think the other thing about the biomedical approach that I was saying is if our job as doctors is to diagnose and fix, that's what we think our role is.

But we don't think about other ways in which we could treat patients. So for example, there is value in more holistic care and sometimes I don't think we think about that. So we are less likely to listen for example when someone is telling us something that we don't know how to fix. So if someone for example has an issue with chronic pain and we don't know what to do about it, then we find that uncomfortable because we can't fix them. And that makes us really question our role as doctors. So we might be more likely to shut them down and not listen to them. But I think if we were taught to find more value in listening as being therapeutic in itself, so being witness to somebody who is suffering, then I think we would see our role as being more healers rather than fixers and we would be better at listening in that way.

And there's a couple of other things at medical school which I think contribute to this not listening as well. We learn very early on to be very focused with our history taking. And that is a good thing because we need to find out what's going on with the patient. But sometimes it means we kind of strip away everything else that we don't think is important. And again, that makes us not as good listeners. I have this concept in the book of something called 'the ideal patient'. So someone has a heart attack, they present in a specific way, we kind of know what we expect them to say. But if they present in an atypical way or they respond in a way that we don't necessarily expect them to, that we haven't been taught to, then we're more likely to be skeptical of them and doubt them and not listen to them. So I think there's lots of things in medical school in the way that we're taught which really makes it less easy for us to learn to listen better.

Erin Welsh

Also in your book, you present these quotes from the 13th and 17th century discussing how or instructing physicians to doubt their patients and question their intentions. So it goes back literally like we're fighting hundreds of years of this. How is this tendency to doubt still reflected in the language used in medicine and enabled by the power dynamic of physician-patient relationships?

Rageshri Dhairyawan

So I was really shocked when I found how long it has been going on for actually, like I didn't realize it had gone on for so long. So yeah. I think it is ingrained in our profession and ingrained in our language. So for example, I think we use language which kind of puts the patient at a distance and has kind of innate skepticism in it. So for example, some of the medical language, we may use terms like 'the patient denied' or 'the patient claimed'. So that's kind of inherently skeptical of the patient. Or it might be derogatory language. So there's a term that we use here in the UK, I'm not sure if you guys use it in the US, but what we call a heartsink patient. So someone when we see them, we know oh gosh, this is going to be a difficult consultation.

And we can sometimes use language that is victim blaming and language that is paternalistic. So I work in HIV medicine where we really want patients to take their tablets every day, it's very important. But we talk about patient compliance and that sounds like a very paternalistic attitude to patients. It's not a very patient-focused language. So I think it really is inherent in it. And the other thing is there is a lot of use of dehumanizing language. So again, from my specialty of HIV you can see people saying things like 'the HIV patient'. But there's been a real shift to talking about people living with HIV, so being person-focused first.

Erin Welsh

If the problem of silencing patients begins during medical training and also like hundreds of years in the making, it is only exacerbated by the way modern medicine is practiced, where the emphasis tends to be on maximizing productivity. In what ways does the medical system hinder or even discourage physicians from adequately listening to their patients?

Rageshri Dhairyawan

So I think you're really right when you talk about that emphasis on productivity. So it's numbers of patients seen, number of tests done, number of diagnoses, number of treatments. We get paid on that. And really what isn't valued are those consultations where listening in itself is therapeutic. So we're not going to get paid for just listening to a patient who is having a hard time and at the end of the consultation leaves feeling better because they feel like someone has heard them. So that just isn't valued by our medical systems, you don't get money for that. And because there is an emphasis on productivity, it means that we are often short of time. So we're often too busy to listen well, we're looking at our watches, we're needing to go on to the next patient.

We work in environments that aren't very good for listening. So for example, we work with very clinical rooms. So it may not feel like a welcoming or comforting space or there may not be privacy where people feel that they can talk. And I think with the emphasis on being more productive, and I think particularly since the pandemic I think healthcare workers are increasingly tired, stressed, burnt out, and those are all conditions which mean that we listen not as well as we could do.

Erin Welsh

And I really loved, like I said, how you provided this perspective from the physicians as well. And so in these scenarios in your book, you describe someone who is seeking medical care and then you kind of give the perspectives from both the different healthcare providers associated with the patient and the patient themselves. What might be going through their head, what might they be feeling. And I think that these scenarios help to illustrate the nuance in these interactions where sometimes there might be doubt, sometimes disbelief, sometimes neglect, and sometimes simple just miscommunication or just like forgetfulness. But all of these things tend to end up with more or less the same result in terms of harm or in terms of lack of care. Do you feel that the distinction between an unwillingness to listen and not having the capacity to listen due to things like you mentioned, compassion fatigue; do you think making that distinction is important? Like is one more easily addressed than the other?

Rageshri Dhairyawan

I think that's a really good question and you're right, they all lead to the same thing. I think that most healthcare providers, most doctors do want to listen. I think we kind of go into the field because we're caring people, we want to make people feel better. So I think generally for most people there is a willingness to listen and often it is our training or the environments that we're working in which means that it's harder for us to do so. But I do think there is an unwillingness to listen sometimes. So as I said when we're uncomfortable hearing what the patient is saying because we don't know what to do or when things are uncertain. So again, we're not entirely sure what is the next step to take. I think that's when we shut patients down. So I think there is that unwillingness to listen. But again, I think that comes from how we're trained to be someone who is a fixer rather than someone who is a healer and can just listen. So I think whether it's unwillingness or not having the capacity to listen, I think both involve system change and they're both really important.

Erin Welsh

Let's take another quick break. We'll be back before you know it.

TPWKY

(transition theme)

Erin Welsh

Welcome back, everyone. I'm here chatting with Dr. Rageshri Dhairyawan about her book 'Unheard'. Let's jump back into some questions. Getting into some of those changes that we could make, I loved how in your book you had at the end of chapters here are ways that we can change things at different levels of organization, at an individual level, training, and so on. And I was wondering if you could speak to that a little bit more when it comes to medical training. How can we fix this from the ground up? Or how can individual providers sort of reassess their own listening skills or maybe where they could improve?

Rageshri Dhairyawan

So I think there's things for individuals to do and I think there's things for system change which starts from medical training and education all the way to kind of how institutions are run and kind of post qualification training. So I think as individuals, I think it's really important that we learn to reflect on our listening. And certainly since writing the book, that's something I've been doing a lot more of, thinking why was that consultation difficult? Like what happened in it that might have made it difficult for me to really listen to what the person was saying? Being aware obviously that we all hold bias and thinking about when that's most likely to come up. So we're more likely to rely on stereotypes and what I call heuristic, so mental, shortcuts when we're tired or stressed. So for example, you may not be so good at listening or you may be more biased when it's three o'clock in the morning, you're in the emergency department and it's really busy.

So I think individual reflection is important but I think listening should be taught at university right from medical school. So how we can be better listeners and also really taking that emphasis away from thinking all patients present in a certain way. Patients may not present in a way that we necessarily expect them to and not using that as kind of excuse not to believe them or to feel that we're skeptical of them. Understanding that people present diversely, people are diverse. I think there's also something there around being taught about the value of listening and that listening in itself can be therapeutic. So really taking us away from that kind of fixer model of being doctors to being healers again. And I think also really important in medical school is learning more about the social determinants of health. So understanding why people don't present as we expect them to, why they don't behave as we expect them to, and understanding more about the history of medicine. So understanding about bias, the history of medical experimentation, etc.

And then when we get into kind of clinical practice, I think there needs to be room for more reflection in the workforce generally. So I've talked about how there should be planned reflection time, so having team supervision. So in clinical practice, often if something bad happens then the team might reflect. But building that into kind of everyday practice. So teams together can talk about their experiences about what went well and what didn't, I think would be really good for everyone and would help prevent some of that compassion fatigue and burnout. And I guess the other things are about making better listening environments. So making those private spaces more available, making sure that we have regular breaks so that we can then feel rejuvenated again, more likely to listen. And thinking what does productivity mean? Maybe it does mean just listening as being a therapeutic tool.

Erin Welsh

Getting a bit more into what that reflection looks like, you discuss in your book how you as a physician sometimes don't always listen as well as you could. Can you talk about what those moments are like? Is it something that you realize at the time where you're not being a good listener or does it just feel like you said, like this consultation didn't feel great or something was not right about it? Or was it in retrospect that you're seeing this? Or is it a combination of both?

Rageshri Dhairyawan

I think it's a combination of both. So sometimes when you're, for example, in a busy clinic and you're rushing and you're on the computer trying to order tests while also listen to the patient, you're trying to make notes. Or someone pops in to tell you something or an email pops up on your computer, you know that you are distracted and you know that you're perhaps not listening or focusing as well as you can be. And obviously doctors are human, you may have not had a good night's sleep before, you might be tired and know that you're not at your best or something's happening in your personal life. So I think you can be aware of that at the time but sometimes you're not so aware. So it may be kind of towards the end of the consultation when you're just like oh that didn't feel right, as you said, or that was an uncomfortable consultation, I don't feel like the patient got what they wanted and I got what I wanted from the consultation.

But I think sometimes you don't even realize and I think that can happen to any doctor. But it is sometimes you think you've done your best but the patient doesn't agree with you. So I think trying to recognize when you know you're not listening, trying to reflect on those consultations which are uncomfortable, but then also kind of learning from patient feedback as well. And I think feedback is really important from colleagues and patients throughout our career to make sure we understand how well we are communicating and listening.

Erin Welsh

Patients who are unheard by their providers are often or sometimes told that they should better advocate for themselves, which as you point out is a form of victim blaming because it shifts the responsibility for the silencing of patients to the patients themselves and it enables the medical community to just keep things as they are or it doesn't really drive any sort of change. But until the medical institution takes meaningful steps to ensure better listening, what are some of the ways that people can increase the chances that they will be heard or listened to by their healthcare providers?

Rageshri Dhairyawan

Yeah, this is exactly why I wrote the book because I wanted the healthcare system to change. But absolutely, I mean it's not going to change quickly. And I think it's really important that everyone has the agency to try and get what they need from the healthcare service. So I do provide some tips. So if you are going in for a consultation with a doctor, I think it's really important to be prepared. If you're prepared, perhaps if you know a little bit about your condition or you know what questions you want to ask. So for example, I always love it when my patients write a list. So they come in with their list already thought about and then we sit and go through each point, like I think that's great. You feel like you've asked everything that you want to but importantly it makes a doctor feel that you care about what's going on. It makes you seem more credible. So I definitely recommend planning for your consultation.

You can always write things down while you're there as well. And I think if you're writing things down that you don't understand, then ask the doctor what it means. I think sometimes with this innate power imbalance between doctors and patients, it can feel scary to ask things. So I always say if you want to, you should take someone with you like a friend or a relative who can advocate for you. And if you do, again prepare them, so they know what you want answers to. So if you don't get a chance to ask the question yourself, then they can ask it for you and they can stick up for you as well. I think if you can, if you would find it helpful to see the same doctor, then ask, I think seeing someone who knows you and you've already had a good consultation with would be really helpful. So continuity of care I think is important and you can ask for it often. And if it doesn't go well, I think it's really important to know your rights, to kind of know who's in charge of your care, where you can complain to, and that you can get a second opinion and that you can ask for it. I think that's really important.



And also I think another thing about being prepared is just before your appointment, letting them know if you have any special communication needs. So if you need an interpreter or something like that, then that's really helpful to the doctor as well. Other things, please bring any medications you're on, it's really helpful to know exactly what you're taking. If you're seeing other doctors and you have results and things, bring all of that with you, it's really nice for us to see it. And I do write in the book but sadly I think lots of studies show that doctors find patients more credible if they are, if they can be, if they can appear more well dressed. And I think that's a terrible thing but it does improve credibility.

And I talk in the book about my mother who is a retired family doctor. But she's also an older Indian woman and stereotypes about them is that they often complain about things that are all in their head. And she actually gets dressed up to go to her doctor appointments. And I don't think that should happen at all but there are lots of studies to show that people do it and it can help them come across as more credible. So I'm not really saying that as a tip but I think people should be aware of it. And obviously there's times when you can't be. So if it's an emergency, that's not going to happen. So I kind of give all these tips of the huge caveat that it is not down to the patients who have to kind of speak up to be heard, we should be listening more. But in an imperfect healthcare system, these are things that you can do.

Erin Welsh

And of course as you discuss, it's not just patients that face issues with being unheard. Can you talk about testimonial injustice and credibility deficit and how this affects minoritized doctors as well?

Rageshri Dhairyawan

Yeah. So we've talked about testimonial injustice with regards to patients. But yeah, minoritized doctors and researchers go unheard. So there is a good example of how it can happen. I write it in the book. So imagine you're in like a work meeting and you're having a discussion in a group and you say something and you think you've made this amazing point and you say it and you're kind of waiting for everyone to go 'yeah, that's a great point!' But no one says anything and the discussion kind of moves on. And then like a few minutes later, someone else makes exactly the same point as you and they get praised for it. And that's definitely happened to in meetings, it may have happened to you as well. So what you have experienced there is testimonial injustice and I think that can happen to anybody. But I think if it happens repeatedly to people, then you're just more likely to not speak up because you think no one's really listening to me. So why bother?

And what this can do in terms of career prospects for minoritized doctors means that they lose their self-confidence, they feel less likely to speak up because they won't be heard, that means they won't apply for promotions or posts on boards. And this can have a real impact in terms of their career progression and it can make them feel kind of excluded from the workforce. And I think it's really important that minoritized doctors get listened to. One, to have a diverse workforce, but it's good for patients as well. So yeah, I have a whole chapter about how minoritized doctors go unheard and the effect it can have on patients.

Erin Welsh

I know that you have a whole chapter on it but can you dive into that a little bit and give us some examples of how a more diverse medical workforce can improve patient health?

Rageshri Dhairyawan

So there's actually quite a lot of research to show this and that if you're listening, it may be something that you've experienced yourself. So it may be easier to talk to a doctor perhaps who looks like you or comes from a similar social background to you. You may feel kind of more comfortable with them. But in terms of research, there's lots to show that a more diverse workforce is better for diverse patients. So there is a study that I quote, for example, which is from the US in 2023 which showed that in counties with more Black primary care doctors, Black people had longer life expectancy and lower mortality rates. And that is absolutely huge, isn't it? To show that having more Black doctors means that Black patients do better. So there's lots of different research studies which show this. So it can have a real impact on patient care.

And if you think minoritized doctors who aren't heard, they're not able to stick up for their patients, so their patients then suffer. So it's really important that we keep the workforce diverse and also acknowledge that some patients also may not want doctors that look like them. And I think about this in sexual health a lot where perhaps some of our patients don't want to see someone who looks like they're from their community because they're worried about confidentiality. So if you've got a diverse workforce, you can give patient choice as well and I think patients have the experience of seeing lots of different doctors, some of who may suit them, some who may not.

Erin Welsh

As you kind of alluded to, research or knowledge gaps, especially when it comes to conditions that predominantly affect minoritized groups, take a long time to fill in. What are some of the factors contributing to these research gaps from funding to structural barriers? And how do these gaps impact care?

Rageshri Dhairyawan

A really good example of this is endometriosis, in that this is a condition which until quite recently we didn't know that much about despite affecting 1 in 10 cisgender women around around the world. So women have complained of symptoms of endometriosis for centuries but because doctors have been male, their symptoms are not being taken seriously. And because of that, the research hasn't been done, leaving us with this big research gap. Which means that we still don't know what causes endometriosis, what are the best ways to treat it, how we can help someone get pregnant if they have endometriosis. Even though there's been a lot of push to change this in recent years and I think that's probably because we have more female doctors and researchers. When we look at funding levels, we still see that funding, for example, for menstrual conditions is much lower compared to conditions that affect mostly men. So we still see these real kind of disparities in funding for patient groups who are less heard.

I talked about kind of testimonial injustice with regards to minoritized doctors but we see it in research as well. So minoritized researchers are more likely to study conditions that affect minoritized patients. And when they're not heard, they may not get jobs, they may not get promotions, grants, they may not get their research published or cited. All those things affect their career progression and mean that their research is less likely to be done, which means that the conditions that affect minoritized patient groups are less likely to be researched and studied. So we have that gap. And if you think of that on a really wider scale, if we think kind of when we look at global health, we know that Global North researchers are much more likely to be seen as credible researchers and they get all the grants and all the funding, leaving Global South researchers going unheard as well as the communities that they serve when it comes to research.

Erin Welsh

Yeah, I'm so glad that you brought up global health because I wanted to ask about sort of the imperialist and colonialist roots of global health and how those have left traces in the way that this field is practiced today or the topics and approaches that are prioritized in research. So I was wondering if you could just talk a little bit more about that.

Rageshri Dhairyawan

So I think there's been lots of discussion in global health recently about how its origins kind of come from disease control during colonial times and the approaches used then still exist to this day. So there is this kind of feeling of knowledge that comes from the Global North, so the countries that colonized other countries, is superior. So when it came to colonization, it wasn't just about taking land, it was also about erasing local knowledge and culture. And that included medicine. So Western medicine was part of colonialism, so replacing local health knowledge with Western medicine. And I think global health has continued to do this. So I think there is a critique at the moment saying that we do need to decolonize global health.

We need to value the local knowledge of researchers in the Global South and understand that they are just as credible as researchers in the Global North and if not more credible when it comes to conditions that affect their communities. So there needs to be more power sharing. So power needs to go from researchers in the Global North to the South. And one of the critiques of kind of the history of global health has been around how organizations in the Global North have kind of enacted policies on communities in the Global South that have been colonized without really collaborating with them and without understanding that perhaps there already is knowledge of how to treat some diseases. But that has been devalued and sometimes erased.

Erin Welsh

I pulled a quote in my notes from your book where you state that global health continues to see local people as being part of the problem, not the solution. And I feel like that was like yes, that is exactly what is always happening and really is I think a challenge, just like with medical training, just like anything where the change has to start from like the beginning. It's going to just take so much time and effort to correct and to fix things and to progress in a better way than we are currently doing.

Rageshri Dhairyawan

Yeah. And I think throughout the book, I think one of the main themes is it's about power and people who hold the power, be that doctors, be that researchers in the Global North are gonna have to give up some of that power. And that I think is going to be the issue. But we need to understand that it means that it's better for everyone overall if power sharing occurs.

Erin Welsh

Going back to the physician-patient relationship, I want to talk a bit about the problem of objectivity and the divide between symptoms and signs. How is evidence ranked in medicine and where does patient voice or experience fit in among those ranks?

Rageshri Dhairyawan

So I think we talk about the hierarchy of evidence quite early on in our medical careers because we're kind of taught how to read research papers and to understand them and critique them. So at the top of the hierarchy are things like meta analyses, systematic reviews, and then we see randomized control trials and then things like case control studies, cohort studies, and then lower down are things like case series and expert opinion and animal studies. And essentially what the hierarchy is doing is the ones at the top are those that are study designs which have less bias and are seen to be more objective. And essentially when it comes to research evidence, we value quantitative evidence much more highly. So we value numbers and statistics because we think they are more objective.

So obviously that kind of research has been really important and has improved patient care, so I'm not arguing against it. Evidence-based care is a really, really important thing which has improved patient care massively. But sometimes research questions aren't best answered by quantitative study design. So they're very good for asking how many or how much or is there a relationship between two things. But sometimes we need to understand how or why something happens. So other forms of evidence, like for example qualitative evidence may be useful but it's really not as valued as highly as quantitative evidence. And I think what's really interesting about the hierarchy of medicine is that there is no patient voice in any of that, it's all thinking really about numbers. And qualitative evidence isn't valued and that does include some patient voice. So I think it's really striking to me how we value evidence which doesn't come from patients because we see it as being too subjective. So I think that has again an impact on how well we listen to patients.

Erin Welsh

Maybe this is going a bit back to like the research gap discussion that we were having but I wanted to ask you about the table that you created for the most and least prestigious diseases. I found that really fascinating and truly eye opening. So could you just take me briefly through the characteristics of prestigious diseases and patients and not prestigious diseases and patients?

Rageshri Dhairyawan

Yeah. So this concept and this table came from research papers by Norwegian researchers. So yeah, I've just compiled it into a table to make it easier to read. But essentially it looks at how doctors look at diseases and value them and in turn value the patients who have those diseases. So things that might be more prestigious, for example, are conditions that have objective features. So easy to see clinical signs or symptoms or test results. So for example if you have HIV, you'll have a positive HIV antibody test. So that is easy to test for. Other things that make a disease seem more prestigious or valuable for example is if it's sudden or life threatening; if it affects patients who are young, for example; if the treatment is kind of active, a bit risky but means that you can cure somebody.

And also I think really interestingly the researchers say here in terms of patients, if the patient is more likely to listen to the doctor and accept what they say, those diseases in which the patient is more likely to do that are more prestigious. So when they asked Norwegian doctors over 25 years to rank diseases by their prestige and kind of consistently over that time they found conditions like leukemia, heart attacks, and brain tumors to be the most prestigious diseases. So you can see those are ones with objective features that are life threatening and you need quite intensive treatment for it.

Whereas the diseases that are seen as less prestigious are those that are kind of the opposite. So there are fewer objective signs and symptoms, so you may have to rely for example more on patient testimony. There may be things in which there isn't an obvious cure or treatment. And there may be things in which the patient may have more to say, they may be more likely to contest what the doctor says. And consistently over the 25 years in this study, in this Norwegian study, fibromyalgia was found to be kind of the least prestigious disease. And I think we also see that with other conditions such as for example long COVID or ME/CFS. So these are again conditions which we can't just fix, which is not so easy to diagnose without patient testimony. So these are the conditions that doctors value less, find less prestigious. And I think that really affects the patients who have them.

Erin Welsh

I'm very curious to know sort of what reception or what sort of reactions that you have gotten from other physicians. Like do you think that most people in the medical field are receptive to the idea that medical practitioners aren't always good listeners and that they don't always provide adequate care? Or has there been any defensiveness or, I don't know, like just denial outright? Or is it mostly like yes, I understand and I can see that in myself?

Rageshri Dhairyawan

So I think actually people have been very receptive which has been really encouraging. And it's really interesting, I mean it does tend to be the people who have been patients themselves and have it been at kind of the end of being a patient and not not being listened to. And I think particularly for doctors, when that happens to you, it kind of makes you question everything. So people have been very receptive. And the other thing is all doctors at some point will probably be patients as they get older. So knowing that we will be on the other side ourselves at some point means that we will be more receptive to it.

And the other thing is there's so much evidence to show that patients say they go unheard, I don't think we can deny that data at all. So people have been really receptive and many of them have experienced it themselves as patients. But I think what is going to be interesting about the reaction to this book is the fact that I believe it is ingrained in our profession. I think many doctors will say yes, we're not very good at listening because we work in environments that make it very hard to listen. But I think it will be interesting to see what they think when I say I think it's actually ingrained in our profession right from the beginning.

Erin Welsh

You mentioned earlier in our discussion that working on this book has changed the way that you approach medicine. Can you describe a little bit about what you mean by that? How has your approach changed?

Rageshri Dhairyawan

So when I was writing kind of the book proposal and the first few chapters, I was very lucky because I had taken time away from clinical medicine. I took a year out after COVID, after the second COVID wave and did a master's full time. So I had a year out to study which was wonderful and I also had time to write the book proposal. So when I came back to clinical practice, I was still writing the book and I thought do you know what? I need to be better at listening, so I'm gonna try really hard. And after a few months I realized it's really, really hard; listening is really hard. But I think what has really changed is that I'm so much more reflective than I used to be. I also now don't feel as uncomfortable as I used to. Like I understand that if a patient wants to tell me about something which I can't actually help them with, it's okay for me just to listen because they come out of the consultation feeling better. So it's not a futile consultation, I am still doing something therapeutic. So I think it's really made me reflect on every consultation and it's really made me value just the benefits of just listening and how that can help patients.

TPWKY

(transition theme)

Erin Welsh

Dr. Dhairyawan, thank you so very much for taking the time to chat with me and for writing this incredible book that, I'll say it again, I really think should be required reading for anyone going into medicine and everyone already in medicine and anyone who has an interest in medicine. Basically everyone should go read this book. So go check out our website [thispodcastwillkillyou.com](http://thispodcastwillkillyou.com) where I'll post a link to where you can find 'Unheard: The Medical Practice of Silencing' as well as a link to Dr. Dhairyawan's author page.

And don't forget, you can check out our website for all sorts of other cool things, including but not limited to transcripts, quarantini and placebo recipes, show notes and references for all of our episodes, links to merch, our [bookshop.org](http://bookshop.org) affiliate account, our Goodreads list, a firsthand account form, and music by Bloodmobile. Speaking of which, thank you to Bloodmobile for providing the music for this episode and all of our episodes. Thank you to Lianna Squillace and Tom Breyfogle for our audio mixing. And thanks to you listeners, for listening. I hope you liked this episode and are loving being part of the TPWKY Book Club. A special thank you as always to our fantastic patrons. We appreciate your support so, so very much. Well until next time, keep washing those hands.