PERSPECTIVES

When Should Patient Intuition be Taken Seriously?

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As a style of information processing, intuition involves implicit perceptual and cognitive processes that can be quickly and automatically executed without conscious mental will, such that people know more than they can describe. Patient intuition can influence patient and clinician decision-making and behavior. However, physicians may not always see patient intuition as credible or important, and its management in the clinical setting is poorly understood. This paper takes a step toward suggesting conditions under which patient intuition should be taken seriously. These conditions relate to the credibility or accuracy of the intuitive beliefs held by the patient, and their significance to the patient. Credibility may be increased when the intuitions of patients (1) reflect their individualized knowledge, (2) can complement the common absence of scientific evidence in managing health problems, and (3) can quickly and effectively process key information in complex cognitive tasks. Even intuitions that lack credibility can be subjectively rational and meaningful to patients, and help to shape the decisions they and clinicians make.

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How patients make choices, and how clinicians respond to those choices, are important in understanding the health care behavior of these groups. A common influence on decision-making by patients and clinicians is their use of “intuition,” which refers most simply to instinctive or direct knowing. More specifically, intuition connotes a style of information processing that involves implicit, perceptual and cognitive processes which can be quickly and automatically executed without conscious mental will.^{1,2} As a result, people may know more than they can describe;³ their sense, for example, of if or when to seek medical care⁴ may not be consciously recognized nor easily be verbally articulated.⁵ In contrast, intuition is not present when knowledge is consciously recognized but individuals simply lack the ability to verbalize it.

The significance of intuition in health care is contested.⁶ In the West, the value of reasoned thinking has been extolled since the Enlightenment⁷ and strengthened by evidence that

intuition can be prone to producing biased or inaccurate judgments.^{8,9} However, evidence-based medicine also recognizes that clinical expertise, including intuition, is needed to integrate the clinical state and circumstances, research evidence, and patient preferences and actions.¹⁰ Moreover, discrimination between subtle stimuli and integrative processing are central to clinical skills such as ultrasonography¹¹ and are highly valued¹²⁻¹⁴ by the patient-centered clinical method, which uses patient experience to help guide clinical interactions and shared decision making. Nevertheless, physicians—unlike nurses¹⁵—have frequently been reluctant to publicly acknowledge using their own intuition in clinical decision-making,¹⁶ and they have been even quieter in acknowledging their need to take account of patient intuition in decision-making.

PATIENT INTUITION

Patient intuition around health problems has been little studied by the medical profession, in contrast to the growing literature, from health psychology, on patients' illness perceptions.¹⁷ This literature covers not only the basic perception of symptom-related feelings but also complex schemas (cognitive structures) that patients can create to decode those feelings and guide their decision-making. However, at this point we will confine our discussion to the potential for patient intuition to be a resource which clinicians may benefit from exploring.

Diagnostic errors are associated with both analytical and non-analytical reasoning.¹⁸ In this context, patient intuition can lead patients to make decisions not in their best interests.⁸ Under conditions of uncertainty, they may use heuristics (“rules of thumb”) and other simplifying cognitive frameworks, which are prone to cognitive biases that affect perceptions of risk.^{8,19} The probability that these biases will lead to intuitive errors in completing complex tasks is increased in patients, who may be anxious about, and vary in their clinical understanding of, health problems. Patients' experience of unrelated conditions, and their help-seeking through informal social networks,²⁰ can add elements of inaccuracy. Physician power over patients may further devalue patient intuition as “mysterious and unexplainable at best and as something inaccurate, hokey, or epiphenomenal at worst” (p.109).²¹

However, clinicians sometimes use and commend patient intuition,¹³ since its wholesale rejection in medical practice seems at best simplistic and at worst harmful to patient health. Although patient intuition is unavailable to introspection and can lead patients and clinicians astray, not taking it seriously can violate patient dignity and devalue potentially therapeutic information in clinical encounters. Therefore, since the use that clinicians make of patient intuition appears subtle and variable,

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a key issue to investigate appears to be *when*, rather than *whether*, they—and their patients—should take patient intuition seriously. Serious consideration entails acknowledging intuition as a legitimate and potentially useful form of knowledge in decision-making, which for example can generate hypotheses to test. So, after distinguishing between reasoning and intuition as basic forms of thinking or knowing, this paper will consider the issue of when clinicians should respect patient intuition in decision-making.

Reasoning and intuition can be considered on a single continuum (unitary perspective) or as constructs that form part of two systems of the style of thinking, (dual process view), which are distinct or possibly overlap.² The unitary perspective allows rational intuitions as self-evident beliefs. In contrast the dual process view recognizes (1) an intuitive and experiential system or style of thinking, which produces direct, tacit knowing without conscious reasoning,²² and (2) a conscious, slow, and effortful system of reasoned or analytic thinking. Brain imaging tools are generating neuroscientific evidence of neural correlates of each system.²³

In considering when to take patient intuition seriously, there appears a need to unbundle (1) the credibility (or accuracy) of the patient's intuitive beliefs as a means of potentially effective decision-making, from (2) the personal meaning and significance of these beliefs to the patient. These two domains are not rigidly coupled and we will examine each of them in turn.

CREDIBILITY

Three sets of related conditions appear, when present, to increase the credibility of patient intuition and its need for prudent management by patients and clinicians. The first set requires that, compared with the clinician, the patient holds data that can inform patient intuitions and may enhance decision-making. Whether patients are capable of expert intuition is arguable,²⁴ but they can, for example, produce complex schemas that reflect their awareness of patterned change in their bodies or the bodies of others, as when a mother strongly senses her child is unwell.

Some types of intuition, such as primitive instincts, appear naturally automated. However, others, such as interpersonal intuition, interact with the conscious process of reasoning and can become automated through learning and practice. The accuracy of these types of intuition may increase with patients' explicit (conscious) learning; their implicit (unconscious) learning through focused attention on their environment; the duration and repetition of their experience; and feedback from the environment.^{25,26} Sharing intuitive knowledge with the clinician can help the clinician make a differential diagnosis and manage concerns.

In considering the credibility of this knowledge, the lack of a relevant vocabulary is not as indicative of potential inaccuracy as is disordered, illogical or emotionally-loaded speech. However, such speech may still be accurate and some tacit knowledge cannot in principle be verbally articulated.⁵ For example, war veterans, refugees and people who survive natural disasters, domestic violence or sexual assault may struggle to verbalize their traumatic experience. This difficulty may exist not because their background is non-English speaking but rather because

their experience is mentally encoded in non-verbal imagery pathways.²⁷ Here, the inability to communicate in credible "medical" language is consistent with tacit and intuitive forms of knowledge. Whether "what is not said" is due to intuition²⁸—or to language barriers,²⁹ conscious choices⁵ or other factors operating independently of intuition—is a judgment that clinicians need to make on a case-by-case basis.³⁰

In addition, the credibility of patient intuition in decision-making may weaken under certain conditions. For example, patients may be hypervigilant; lack a history of making successful intuitive judgments; be oblivious to the limitations of intuition; develop schemas outside their domain of knowledge; or be cognitively or emotionally impaired. However, predictions tend to improve when analytic reasoning is coordinated with non-analytic reasoning, compared with each type alone.³¹ This coordination may reduce the risk of error associated with each type.¹⁸

Second, patient intuition may assume increased credibility when there are significant limitations to the expertise of clinicians as may occur in the absence of consistent scientific evidence.^{32–34} Medical evidence, even when available, is typically incomplete and provisional;³⁵ indeed "for most study designs and settings, it is more likely for a research claim to be false than true" (p.696).³⁶ Even when findings are internally valid, their translation to individualized patient care may be problematic.³⁷ Imperfections in clinical reasoning and in communication widen the space for patient intuition within and between clinical encounters.

Consider, for example, a middle-aged man who faces deciding whether to request, or accept, a prostate specific antigen test. There are no well accepted decision rules here for comparing and communicating the clinical benefits and risks and different solutions are plausible. The physician needs to carry out these tasks as well as possible, mindful that reasoned analysis may neglect key information (such as patient fear of the implications of a positive result) and suboptimally weight the importance of certain attributes. The task required of the patient, with or without the doctor, is judgmental rather than intellectual. However, consideration of patient intuition may be warranted to reflect the values of the patient, account for the disparate information available, and integrate it into a coherent judgment.

Third, certain sorts of tasks appear well suited to intuitive thinking. Such tasks may involve questions whose answers are self-evident. Alternatively the tasks may be complex, ill-defined, have high stakes and involve short time horizons. For example, consider a parent whose child's sleep is disturbed at night by wheezing in his or her chest. The parent has encountered these symptoms before, but this time feels especially apprehensive for no tangible reason she can clearly articulate.

Aware of the need to "think twice" before calling out a physician at night but mindful that serious harm could befall the child from not acting promptly, she is uncertain of how best to respond. However, she may appropriately use her intuition to seek medical care without delay and the physician will likely view this decision seriously.

SIGNIFICANCE

Even to the extent that reasoning is used by patients but is objectively mistaken, the intuitions themselves may be personally meaningful and significant. This situation can arise when a

“strong belief” characterizes patients’ intuition that illness threatens their health. From a felt sense of certainty, the significance of this health belief is its representation of how it is right, and hence subjectively rational, for them to act (cognitivist theory of action).³⁸ In this context, according to the Common Sense Model of illness cognition and self-regulation,³⁹ patient intuition can influence decision-making by patients,⁴⁰ including—when the intuition is stable⁴¹—decisions relating to how a treatment is self-managed. For example, a patient may sense a bodily need to change the timing of their anti-Parkinsonian medications in order to self-manage the symptoms of their Parkinson’s disease.⁴²

Illness beliefs, including intuitions, and the trajectory of the illness experience interact through psychophysiological relationships. Nerve cells receive sensory inputs that may undergo automatic preconscious evaluation. A general sense of the stimulus is fed back to perceptual centers, which generate a response⁴³ that can have a bodily expression.⁴⁴ The links between perception, negative affect, and parasympathetic inhibition of subcortical threat circuits now appear to influence physical and psychological illness or health.^{45,46} These relationships speak to the plausibility of experimental evidence that interventions that weaken illness perceptions can improve health states, for example quickening a return to work.⁴⁷ The clinician has reason therefore to explore and construct with patients the significance of their intuitions, whenever not doing so can compromise patient health; when little or nothing is lost by taking the intuitions seriously; and when it is important to demonstrate responsiveness to what is subjectively important to the patient, such as by providing reassurance or empathy.⁴⁰ Narrative medicine may facilitate this exploration through the clinician listening to, and witnessing, rather than judging, the complexity of patients’ stories in biographic and social context. This mode of response does not guarantee the credibility or significance of the patient report but it may help the clinician to develop a shared management plan.

CONCLUSION

Intuition, like analytical reasoning, is fallible. However, we suggest conditions under which clinicians and patients should take patient intuition seriously. We invite empirical investigation of these conditions, which relate to the credibility (or accuracy) of the intuition and its meaning and significance to the patient. More generally, research is needed on non-conscious and automatic processes of decision-making and on how patient intuition can complement rather than oppose reasoned thinking in jointly shaping patient and clinician judgments, decision-making and action. Such research may help to integrate the processes of intuition and reasoning used by patients and clinicians in decision-making, with a goal of improving the patient-clinician relationship and health outcomes.

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