

The ambiguity of preparing and being prepared for a patient consultation

WIBECHE INGSKOG¹ AND WENCHE S. BJORBÆKMO²

(1) Centre for Rare Disorders, Oslo University Hospital, Norway (2) University of Oslo, Norway

Abstract

This paper presents findings from a study on the ways in which counsellors working at national centres for rare disorders in Norway experience preparing, and being prepared for, a face-to-face patient consultation. The research involved semi-structured interviews with five experienced counsellors from different health professional backgrounds working at two separate centres. These interviews were then analysed with reference to the theoretical insights of phenomenologists. The excerpts chosen for this paper shed particular light on the process of preparing for a face-to-face patient consultation. Our findings underline the significance of preparing and being prepared while also drawing attention to the multifaceted, complex and ambiguous nature of the processes involved. Preparing for face-to-face consultations with patients is revealed to require approaches that are thoughtful, flexible and empathic. To be prepared for something one does not yet know is about being open to the unexpected and the unpredictable.

Keywords: ambiguity; patient consultation; phenomenology; preparing; rare disorders; uncertainty

1. Introduction

In this paper, we examine how counsellors employed at national competence centres for rare disorders in Norway experience preparing and

being prepared for face-to-face consultations with patients.

Interdisciplinary medical competence centres for rare disorders were established in Norway in the early 1990s. Currently there are nine such centres, all within the ambit of the National Advisory Unit on Rare Disorders (NKSD) and mandated by the Ministry of Health. Their principal role is to provide coordinated support services to people with long-term needs. Along with this they offer supplementary information on disorder-related topics not readily provided by the standard health service, and counselling and seminars related to users' designated medical diagnoses.

Definitions of what constitutes a 'rare disease' (also known as an 'orphan disease') vary between countries: the European Union uses the term to indicate a disorder that affects no more than one person in 2000 within a nation (Maiella *et al.* 2013; Boycott *et al.* 2013), while Norway (helsenorge.no 2016) reserves the label for a disease that affects just one person in 10,000 or fewer (which for Norway means a maximum total of 500 people). Many people have a rare disorder of one kind or another – there are between 6000 and 8000 such 'rare diseases' according to the EU definition, and one estimate suggests that in Europe alone as many as 30 million people may be affected (Haffner *et al.* 2002; Dodge *et al.* 2011). Roughly 80% of rare conditions are genetic.

Uncertainty still clouds the specific nature of many rare disorders, and often the disease will be progressive (Garrino *et al.* 2015). Patients therefore require long-term health care and follow-up in order to manage their illness, so far as this is possible (Garrino *et al.* 2015). However, public health services often lack knowledge about rare disorders, and this adds to patients' experience of isolation as they attempt to deal with their situation (Huyard 2009; Maiella *et al.* 2013; Garrino *et al.* 2015). Healthcare professionals tend not to seek advice when their own knowledge is limited, and people with rare disorders often feel they need to be their own experts and information bearers (Grut and Kvam 2013; von der Lippe, Frich *et al.* 2017).

Counselling sessions at the rare disorder centres may involve a number of issues, from requests for medical information about a diagnosis to more personal, existential issues: fear of death, coping with pain and how to manage everyday life situations with a chronic disorder. The counsellors require not only expert knowledge of the disorder and its medical implications, but also understanding of a disorder's possible impact on a person's identity, values and self-esteem.

This paper uses insights from theorists of phenomenology such as Maurice Merleau-Ponty, Jenny Slatman, Françoise Dastur and Max von Manen to explore how counsellors experience preparing, and being prepared, for a face-to-face consultation with a patient. Such preparation was regarded as a vital aspect of health communication by the first author of the current paper.

We begin with a brief review of some of the existing literature on counselling, patient communication and rare disorders. We then describe the specific phenomenological perspectives that have informed our analysis, along with our method. Thereafter, we present excerpts from our empirical material and analysis, interwoven with phenomenological commentary designed to shed light on our responses to our research question. We then discuss our findings in some concluding remarks.

2. Brief literature review

Good communication is regarded as being at the heart of effective medical practice (de Haes and Bensing 2009), and health professionals have

been concerned about communication with patients within the medical encounter.

In our search for studies relevant to health communication, particularly research on counsellors' experiences of preparing and being prepared for face-to-face communications with patients with a rare disorder, we searched the Medline and PubMed databases. By entering the word 'counselling' we received roughly 100,000 hits. To narrow our search, we also used different combinations of the following words and phrases: 'counselling', 'counsellor communication', 'systematic reviews', 'experience', 'education', 'qualitative research', 'rare disorders', 'diseases' and 'orphan diseases'. Along with a considerable body of research on specific genetic disorders and their various aspects, this search revealed the existence of a large number of studies of counselling in healthcare contexts. However, we found that very few studies had investigated the lived experience of patients defined as having a rare disorder across the board (von der Lippe, Diesen and Feragen 2017) – this was despite the fact that the experience of living with a rare disease is vastly more complex than its medical features, raising the possibility that people living with a range of rare diagnoses may have similar experiences independent of their specific diagnosis (Cohen and Biesecker 2010). By the same token, it is likely that the experiences of counsellors working with such patients will have elements in common. We therefore began searching for studies with a specific focus on interaction and communication between counsellors and patients with different rare disorders.

We found a number of relevant studies. Sarangi and Clarke (2002), for example, undertook a detailed analysis of a single clinical encounter to examine how geneticist-experts handled various dimensions of uncertainty and expert knowledge when communicating with patients. The study showed how such specialists mobilised a range of discursive strategies (including contrast and 'hedging') and sought to maintain a 'nondirective' (i.e., neutral) stance. Another study, by Pestoff *et al.* (2016), found that genetic counsellors 'added value' in the clinical setting by acting as the 'spider-in-the-web' regarding case management, and that their more holistic and psychologically informed perspective made them more accessible to patients than medical geneticists. A more

prescriptive approach was provided by Hagen and Hummelvoll (2015), who developed a pilot program designed to provide counsellors at centres for rare disorders with training in communication via videoconferencing. Their study highlighted the importance of access to appropriate technical infrastructure, along with issues such as the potential loss of visual cues during videoconferencing sessions.

In general, the existing literature tends to focus on the training of physicians rather than other health professionals. For example, two studies found an improvement in physicians' communication skills following their participation in an intervention program (Griffin *et al.* 2004; Rao *et al.* 2007), while others revealed that training physicians to communicate better helped patients engage with treatment (Zolnieriek and DiMatteo 2009; Connor *et al.* 2012). Research conducted by Teutsch (2003) had an explicit focus on the components of effective physician–patient communication; these were identified as setting a good tone, interpreting communication cues accurately and active listening. Educational strategies for improving physicians' communication skills have also been explored (Maguire and Pitceathly 2002; Berkhof *et al.* 2011; Salmon and Young 2011; Fioretti and Smorti 2014; Deveugele 2015).

Other research includes preparation for a patient consultation within broader discussions of how health professionals communicate, focusing in particular on strategies for communicating difficult areas or bad news to patients (Atkinson 1995; Sarangi and Clarke 2002; Arnold and Egan 2004; Browning *et al.* 2007; Harrison and Walling 2010). In particular, Stone-Goldman (2013) argues that preparing for such an encounter starts with a health professional coming to terms with their own reactions. Conveying bad news is one of the most challenging forms of clinical communication. Research conducted by Harrison and Walling (2010) with physicians, students and other healthcare professionals reveals the stress experienced, and also the sense these players have of being underprepared for the task. All becomes even more challenging when the patient is a child.

Other studies have focused on patients' experiences of living with a rare disorder. In a systematic review of this literature, von der Lippe, Diesen and Feragen (2017) identified 21 studies covering three

main areas: living with a disorder, social aspects of living with a rare disorder and experiences of the healthcare system. On this last aspect, findings by Budysh *et al.* (2012) underline the importance of health professionals acknowledging the role of the patient as an interactive partner in their own treatment process, while Huyard (2009) argues that healthcare encounters would be considerably improved if health professionals more often fulfilled their moral obligations, especially regarding diagnosis disclosure and information. Grut and Kvam (2013) found that when accessing health and welfare services, people with a rare disorder often experience barriers related to the fact that their disorder is labelled 'rare' – and therefore beyond the knowledge of many professionals. Such experiences can occur irrespective of the specific disorder or medical service.

This brief literature review suggests that the focus of much of the research on communication between patients and health professionals has been on improving skills. There has been little exploration of how professionals *experience* face-to-face counselling, or how they prepare for such consultations. There appears to be a need for research geared towards gaining a better understanding of professionals' experiences as they prepare, and are prepared, for such encounters. This paper is an attempt to address this lacuna.

3. Phenomenological theoretical perspectives

Our existence is a bodily existence; it is as body subjects that we act, live and communicate with each other. We communicate within specific situations and contexts as personal and also relational expressive bodily beings: 'What I communicate with [...] is [...] a speaking subject, with a certain style of being and with the "world" at which he directs his aim' (Merleau-Ponty 2002 [1945]: 213).

From this perspective, counsellors as well as patients are to be seen as communicative bodily beings with their own style of communicating in any actual situation. However, the quote from Merleau-Ponty implies that while our communication is always directed towards the situation we are involved in, it is also continually directed from our immediate perceptions within the situation itself.

It is this reciprocity between those who communicate and the situation that creates the specific communication there and then.

Merleau-Ponty (2002 [1945]: 228) further holds that we establish a relation to another person as soon as we use language. Language and communication become '*a manifestation, a revelation of intimate being and the psychic link which unites us to the world and our fellow men*' (italics in original). Elaborating on the connection between thought and speech, he points out that 'the orator does not think before speaking, nor even while speaking; his speech is his thought' (Merleau-Ponty 2002 [1945]: 209). It is the process of expression which 'brings the meaning into being or makes it effective.' This implies that thought is 'no "internal" thing and does not exist independently of the world and of words' (Merleau-Ponty 2002 [1945]: 213).

Slatman (2011 [2008]: 160) makes reference to Merleau-Ponty when arguing that thought as a form of expressing oneself is not pure, immanent or self-enclosed, but externalised and embodied. The oral space stands for the embodiment, the externalisation of the mind realised through speaking as well as through mimicry, gestures and other forms of expression (Slatman 2011 [2008]: 153). The meaning of a gesture or action (listening, for instance) is intermingled with the structure of the world, as suggested by the gesture the observer takes up on their own account (Merleau-Ponty 2002 [1945]: 216). One interprets language and gestures pre-reflectively, as if simply sensing what is seen and heard. As Merleau-Ponty (1968 [1964]: 155) explains it, 'meaning is not on the phrase like the butter on bread, like a second layer of "psychic reality" spread over the sound: it is the totality of what is said.'

What is said and understood in a communicative 'in-between' involving a professional and a patient is to be understood as a totality: of words said and not said; of questions asked and not asked; of gestures freely played out, as well as those which are suppressed. Like all human beings, counsellors and their patients are expressive, perceiving beings, always trying to understand and grasp the meaning of the situations they are involved in.

To be a speaking, thinking, expressive body subject is, for Merleau-Ponty (2002 [1945]: 171), to be 'tied to a certain world' in which 'our body is not primarily *in* space: it is of it'. He also draws

attention to another characteristic of our being: what he calls its 'temporal structure'. He holds that as living bodies we necessarily exist 'now' and can never become past: 'I am not in space and time, nor do I conceive space and time; I belong to them, my body combines with them and includes them' (Merleau-Ponty 2002 [1945]: 162).

As expressive, communicative bodies one not only inhabits time and space; one also belongs to them. In our research setting, communication during a consultation is established by what is said, how it is said and by whom, and what happens 'in-between' professional and patient. This is of relevance as we examine counsellors' experiences of preparing and being prepared for a communicative consultation.

4. Method

In order to explore counsellors' experiences of preparing and being prepared for a communicative consultation, we conducted interviews with five experienced counsellors working at two different competence centres for people with rare disorders. The counsellors had various professional backgrounds: physician, physiotherapist, educationalist and social worker. All had more than 20 years of practice in their profession, as well as long experience as counsellors (9–17 years).

Recruitment was done by each participant receiving a request to participate from their line manager. All five participants were provided with written information on the study and were asked to sign an informed consent form prior to interviews. They were told that they could withdraw from the study at any time.

Semi-structured interviews were conducted by the first author and took place at each counsellor's own place of work. Each interview lasted for approximately one hour. All five participants were perceived as eager to share their experiences of counselling and of preparing and being prepared for a consultation. The interviews were audio-recorded and transcribed (in slightly modified verbatim form) by the first author. Norwegian is the original language both for interviews and transcriptions. The first author then translated the excerpts from the interviews presented below into English. The generated data and transcripts in this

study are not publicly available because permission has not been sought from either the participants or the Norwegian social science data service, but might be made available from the corresponding author on request.

4.1. Analytical framework

A hermeneutic phenomenological approach involves reflexive awareness. It invites the researcher to bring forth a sense of wonder in order to explore and analyse moments and aspects of lived experience (Van Manen 2014). Additionally, phenomenological analysis consists of two methodical moves that complement each other: *bracketing* and *reduction* (Van Manen 2014).

Bracketing involves putting into brackets or ‘parenthesising’ our various assumptions and pre-understandings, since these may otherwise prevent our being open to perception of the ‘living meaning’ of the phenomenon in question (Van Manen 2014). In an attempt to gain awareness of our own pre-established interpretations, we engaged in iterative close discussion throughout the analysis. While conscious of our inability to put our understandings and assumptions totally aside, we sought to be as aware of them as possible, and to think in terms of them as resources.

Phenomenological reduction is about establishing a reflective attitude so as to address the uniqueness of the actual phenomenon, as it shows or gives itself in its singularity (Van Manen 2014: 228). This requires the researcher to turn towards and live the phenomenon in question; it relies on the researcher’s curiosity, openness and reflection. For us, reduction has involved a fascination with the moment, with the uniqueness of the various utterances made and stories told during the interviews.

We have striven to be transparent in our analytical interpretative reading, discussing and writing, so that our reflections and analytical points stand revealed to readers.

The choice of excerpts for this paper was undertaken in accordance with an understanding of phenomenology as the science of examples. Van Manen (2017: 814) describes the ‘phenomenological example’ as ‘something knowable or understandable that may not be directly sayable’. We sought to choose excerpts that shed particular light

on the singularity of the phenomenon of preparing and being prepared for a patient conversation. The selected excerpts aim to bring experience vividly into presence, enabling the reader to recognise the experiential possibilities involved in preparing and being prepared (Van Manen 2014: 241).

5. Experiences of preparing and of being prepared for a consultation

While all five participants in our study were asked about their experiences of preparing for a patient consultation, the excerpts that follow are drawn from interviews with just three of them: Ola, Lars and Kari (all names are pseudonyms). These specific interviews have been drawn upon because of the light they shed on the phenomenon in question.

5.1. Ola: *Preparing is to be prepared for what you still do not know*

Ola has been working closely with people with seven different rare disorders for 18 years. When asked how he prepares for a consultation, he leans forward and quickly responds, as shown in Extract 1.

Extract 1

Yes, I find it a bit difficult. I do not prepare. [short pause] But yes, but I do – I do prepare. [leans back, runs hands through his hair] Based on the information we have about the patient, I prepare by trying to understand his situation. He should not have to repeat everything. So I try to understand, but at the same time not be too rigid about it. I often find that a consultation or a meeting takes a different direction from what I anticipated. So I try not to be a slave to my own preparations. [smiles, expresses humour with his eyes] I’ve learned from experience that this is advisable.

Ola begins by saying he does not prepare, then quickly he corrects himself by acknowledging that he does. What is he telling us here?

Ola explains that, for him, preparing for a meeting and conversation with a patient is about trying to understand that person’s actual situation. You need to read the relevant medical journals, refresh your memory of previous meetings with the person you are going to see and maybe get information from colleagues who have also been in contact with him or her. The thing to avoid is

starting all over again every time the person comes to a consultation. Instead, you need to demonstrate your knowledge of what has gone before, to reassure the patient that you are up to speed with their situation, based on your own research as well as your knowledge of previous consultations. In this respect preparation is a caring act, a way of demonstrating your active concern.

How then to understand Ola's expressed ambivalence about whether or not he prepares? His use of phrases such as 'not be too rigid' and 'not to be a slave' in relation to his own preparation suggests that he detects dangers in the process of preparing and being prepared, things that may hinder an upcoming consultation. Preparing can make you a slave of your own preparation, he seems to suggest. There are dangers in believing that you can be 'fully prepared', for that could result in too rigid a communication or consultation. Preparation could also stop things opening up; it could be a barrier to letting things unfold in the meeting and conversation to come.

From his own experience, Ola is aware that a consultation can take a completely unexpected turn. His ambivalence about the value of preparing seems linked to the challenge of combining his previous knowledge of a patient with the need to remain open, to be ready for what he still does not know, for the unknown and the unexpected. Professional knowledge of specific rare diseases, he suggests, may not be what patients are seeking during consultations. Instead, the intersubjective interaction between professional and patient requires the professional to be sensitive to the patient's lived experiences and current concerns.

Our analysis suggests a possible conflict or contradiction between being prepared (in the sense of feeling 'fully prepared') and being open to what is yet to come. Ola's questions regarding the extent to which a consultation can be prepared for in advance seem to actualise the phenomenon of time: of past, present and future. Indeed, the phenomenon of preparing and being prepared seems to be closely related to the phenomenon of time.

Time, for Merleau-Ponty (2002 [1945]: 478), 'does not come from the past. It is not the past that pushes the present, nor the present that pushes the future, into being; the future is not prepared behind the observer, it is a brooding presence moving to meet him, like a storm on the horizon.'

This suggests that preparing for a future conversation takes place within limits; it is impossible to be 'fully prepared' for an event and conversation to come. Such an event can only be 'known' as a 'brooding presence moving to meet' us. Preparing for a future event or encounter can only be provisional, since so much remains unreleased. Preparing is about being prepared for something that moves towards and against you, like a 'storm on the horizon.' There is a need to welcome, or embrace, whatever is to come. In the context of a communicative consultation, this involves approaching the event with openness and with respect for what might be released. Françoise Dastur (2000: 179) argues that time in itself is what brings contingency, unpredictability, and also chance into the world.

5.2. *Lars: Preparing is being ready to listen and be surprised*

Lars has worked at the centre for 18 years. His special focus is on children and families. In Extract 2, he responds when asked how he prepares for a consultation.

Extract 2

Yes – hem. You get some experience of what is at stake after working for a while with the diagnoses. [voice rises] You must listen! This is perhaps the most important part: to be curious and able to listen. Sometimes you get surprised, but if you know how to start, that is most important. [sits back in chair with hands folded] In a way it's the patients who own the conversation, but you may also occasionally have an agenda. [nods] Yes, it can be about the child (if you're talking with parents) and you want to influence them in the 'right' direction, and you manage that, and you don't quite know how it's going, but you think they need to be given the information in order to make an informed choice. [makes eye-contact with interviewer] Then you do as best you can. Sometimes you succeed, sometimes you don't.

Looking over his long career, Lars considers the extensive knowledge he has gained, whether about medical diagnoses or about how life might be experienced by those living with them. For him, it is essential for professionals engaged in a consultation to be able to listen and be curious. Listening and curiosity are, he thinks, essential elements in a patient consultation. As a health professional preparing to meet a patient, you need not only to refresh your memory of the patient's story and

update your knowledge of their medical diagnosis but also prepare yourself to listen, to be curious and to be ready to be surprised.

While stating that 'in some ways' it is the patient who 'owns the conversation', Lars acknowledges that he might also have his own agenda – perhaps something he wishes to inform the patient about. His comments highlight two core aspects of counselling, and of preparing for it: on the one hand, having a message to convey; and on the other, adopting a sensitive, open-minded attitude in order to capture and grasp an individual's expressed needs and concerns.

Regarding preparation, Lars emphasises the importance of assuming a listening, interested attitude that encompasses the interests of everyone: the patient (in his case often a child), their family and other professionals. For Lars, all parties have something to bring to the conversation. Such a perspective suggests a desire to create a situation where all involved parties can contribute specific topics and experiences and raise their own questions. As Lars sees it, preparation is about getting ready to create a shared situation – while at the same time understanding that such a situation cannot be created in advance. As a health professional, you can never 'fully prepare'. When talking with a parent, a professional may have to make difficult judgment calls – for example, regarding the right time to discuss parent's expectations about their child's development, lack of development or retrogression. As Lars puts it, you have to do 'as best you can'.

For Merleau-Ponty (1964 [1960]: 19), people are influenced by one another in every situation, activity or event they create together. He describes communication as taking place between two or more persons in such a way that each draws the other(s) 'by invisible threads like those who hold the marionettes – *making* the other speak, think, and become what he is but never would have been by himself'.

A communicative consultation between a counsellor and a patient is a shared space in which listening plays a key role, along with curiosity about what the other may contribute to the dialogue. As bodily beings, both counsellor and patient inhabit space and time, identified by Merleau-Ponty (2002 [1945]: 162) as aspects of our being: 'The space and time which I inhabit are always in their different

ways indeterminate horizons which contain other points of view. The synthesis of both time and space is a task that always has to be performed afresh.' In line with this, Depraz (2010: 224) questions the extent to which we can anticipate or foresee the content of a conversation. Is it not more likely, she asks, that we will always be surprised?

From Lars we learn that preparing for a truly communicative encounter involves readying ourselves to be open and capable of performing the consultation afresh. Preparing means getting ready to be surprised.

5.3. *Kari: Preparing is getting ready to be affected or touched*

Kari's office is decorated with different art posters from London and Paris, along with a big map of Norway. When invited to share her experiences of preparing and being prepared for a consultation, she has a clear starting point, as shown in Extract 3.

Extract 3

It's like a good foundation when we meet face to face. [looks round room before continuing]. The person usually waits in the lounge and I go out and meet them there. When we come in here, I try to establish an atmosphere. I know that people are nervous; you can just imagine how it would be yourself. [makes eye-contact with interviewer] So before raising central and important issues, I ask some questions about everyday things like 'How was your journey?' [points to map on the wall]

And the map on the wall, I use it quite deliberately: 'Yes, where do you come from?' We have patients from all over the country and I use this as a starter to make things ordinary. So that the patient can unwind, relax their shoulders, because the person in front of me is after all just an ordinary person, even if they're going to ask questions about difficult, non-ordinary things. [interviewer follows up] Difficult things? [deep breath before continuing] Many automatically believe that the most difficult conversation involves telling a person that she or he suffers from a syndrome or that they have a serious diagnosis. But a difficult conversation can actually involve questions such as 'What am I going to tell my boyfriend?', 'Can I go on holiday?' or 'How am I going to live my life?'

For Kari, being prepared is a good foundation for a consultation. Like Ola and Lars, she most likely prepares herself by acquiring the latest research knowledge about the patient's medical diagnosis and by reading their medical files. However, she also emphasises the importance of the opening

moment of a consultation. She makes a point of meeting each patient in the waiting room and walking with them to her office. By doing so, she *actively meets* the person. And by starting the conversation with small talk about 'ordinary things' (as 'ordinary people' do), she *meets the other as an ordinary human being*, not just as someone with a rare diagnosis. Her observation that 'you can only imagine yourself' the patient's apprehensiveness reveals her willingness and ability *to imagine herself in the other's place*.

Kari acknowledges that the core of such conversations often involves issues that are not easy to talk about: 'difficult things'. Such topics are difficult both for the patient and for Kari. While it is challenging to tell someone that they have a serious illness with serious consequences, perhaps even more difficult to cope with are questions such as 'What am I going to tell my boyfriend?'. Such existential questions, which address everyday life for someone with a serious diagnosis, are particularly 'difficult things' for Kari.

From Kari's perspective, preparing and being prepared for a consultation with a patient is about creating an atmosphere and establishing a relationship. Her aim is to create a situation where dialogue is possible. Their shoulders free of tension, the patient can relax and perhaps share a troubling concern or specific fear.

Through dialogue 'there is constituted between the other person and myself a common ground' (Merleau-Ponty 2002 [1945]: 413). Through the creation of such common ground, counsellor and patient may experience a dual being – a co-existence – in which their perspectives merge into one another in the context of a shared situation.

However, even if counsellor and patient share the same situation and dialogue, this should not be seen as a single project. As Merleau-Ponty underlines, the situation 'does not appear in the self-same light' to the two parties involved (Merleau-Ponty 2002 [1945]: 415). In a shared situation or dialogue, the participants do not adopt the other's perspective as their own: 'The phenomenological world is not a pure being, but the sense which is revealed where the paths of my various experiences intersect, and also where my own and other people's intersect and engage each other like gears' (Merleau-Ponty 2002 [1945]: xxii).

We are able to understand each other not because we become the other or possess their experiences, but because we are capable of adopting a 'certain hold upon the world'. This is made possible by our bodily being. As Merleau-Ponty (2002 [1945]: 412) observes: '[I]t is precisely my body which perceives the body of another, and discovers in that other body a miraculous prolongation of my own intentions, a familiar way of dealing with the world.'

As human beings performing our professions we have the ability to understand the other not only as an object (a patient with a rare disorder) but also as a living subject like ourselves. This is what Van Manen (2014: 269) describes as a pathic attitude. He uses the notions of *pathic* and *gnostic* to describe intersubjective practices in (for instance) healthcare and teaching. While the gnostic attitude 'holds that professional practice can be defined by rationalistic factors and gnostic knowledge' (Van Manen 2014: 268), pathic knowledge is more difficult to define and grasp. Derived from the Greek *pathos*, meaning 'sufferance', 'experience' or 'emotion', pathic refers to meaning that arouses experiential understanding. This implies a phenomenological sensibility to pathic expression, capable of presenting one person's presence to others.

In Kari's case, her way of preparing for a consultation, with its emphasis on creating a relaxed atmosphere in which it becomes possible to see the other as an ordinary human who happens to be caught up in extraordinary circumstances, reveals that, for her, preparation is also about adopting a pathic attitude. She prepares to see not just a patient but an individual, an ordinary human being like herself.

6. Concluding remarks

The analytical findings of this study suggest that, for health professionals, preparing for a consultation involves more than simply reading the latest research or reviewing a medical file. Health professionals need to be aware of the limitations of such gnostic knowledge. Given the temporal nature of our being, preparing for a conversation with a patient is about readying ourselves to create openness: a space to be shared and filled with content

in the here and now of the actual meeting. This demands curiosity and intense interest in what the other may bring to this 'in-between' space. In an important sense, preparing involves getting ready to be surprised, and nurturing an 'openness to unpredictability' (Dastur 2000: 186).

Preparing for the unpredictable involves preparing to create an atmosphere in which it becomes possible to speak from the heart and say unpredictable things. Our findings support the idea that health professionals need to strive for a pathic attitude, one that enables them to look beyond the patient's 'otherness' to recognise the ordinary person they are.

Our study also questions the possibility of being 'fully prepared' for a conversation-based consultation. Preparation instead emerges as an open-ended temporal process, often beset with complexity and ambiguity. It involves getting ready for something that is always relational and always made afresh. In a consultation, there are no finished products to be handed over. What matters is what the consultation itself creates.

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Conflict of Interest Declaration

The authors declare that there are no conflicts of interest.

Ethical approval

All procedures relating to research involving human participants were adhered to, in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards. The study was approved by the Norwegian social science data service (Personvernombudet).

Informed consent

The contributors received both verbal and written information about the nature of the study, and they were also informed that their anonymity would be preserved at every stage, including the presentation of findings. Informed consent was obtained from all participants included.

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Wibeche Ingskog, who died in March 2018, trained as a nurse before working as a counsellor at the Centre for Rare Disorders at Oslo University Hospital, Rikshospitalet. She received her Master's of Philosophy in Health Science from the Institute of Health and Society at the University of Oslo. Her research interests included patient communication, phenomenology and counselling within the field of health science and rare disorders.

Wenche Schröder Bjorbækmo is a researcher in the research program FYSIOPRIM (Physiotherapy in Primary Care) at the Department of Health Science, University of Oslo, and Professor at the Department of Physiotherapy, Oslo Metropolitan University. Her research interests include phenomenology, body and movement, function as ability/disability and physiotherapy theory and practice with a special focus on knowledge expressed, developed and shared in clinical practice. Address for correspondence: Faculty of Health Sciences, Department of Physiotherapy, Oslo Metropolitan University, Postbox 4, St Olavspl 0130 Oslo, Norway. E-mail: bjorbaek@oslomet.no