



## A Conversation About... Health in all its Complexity: Working with the Inexplicable

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**Host (00:01):**

Hi there. Welcome to Mental Health Professionals Network podcast series MHPN's aim is to promote and celebrate interdisciplinary collaborative mental health care.

**May Su (00:19):**

Welcome to the Mental Health Professionals Network Presents A Conversation About health in its complexity. My name is Dr May Su, and I'm joined by my co-host, Associate Professor Louise Stone. Our last episode we talked about health in its complexity with Professor Michael Kidd and we discussed about the concept about working with the undifferentiated and complex care within health systems. In this episode, we're going to be talking about working with the inexplicable, the rare, the unknown, the complex, the not learnt about or the different. In our third and final episode, we're going to be talking about working when it may stretch our moral code. For those of you who are joining us for the first time for this series, I'm just going to give a brief introduction about ourselves. I'm an academic GP with an interest in complexity, mental health, abuse and violence and neurodiversity. I'm also the chair of the Royal Australian College of General Practise Abuse and Violence and Families. And I have an educational role in mental health and I've just started a high degree of research, master of philosophy with a view to PhD, which has started off this conversation. Louise, would you mind sharing a little bit about yourself?

**Louise Stone (01:53):**

No worries. It's nice to be here. Hello everybody. My name's Louise Stone. I'm a GP in Canberra, but I've also worked in rural and remote settings in my life. I have a clinical research teaching and policy background actually in mental health and I ran GP training for about 10 years in Australia. I also have a few projects on the go at the moment, which are of interest, including my PhD was in medically unexplained symptoms. So nice and vague. I'm looking at young people as they travel around the health



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system and right at the other end I'm about to start a research project on talking to GP's, female GP's who are about to retire. In addition, I'm also trying to finish off a international book on sexual harassment in medicine. I think this probably talks to the next session where I've got 76 authors from 23 countries, so a little like herding cats may. So I'm very glad to be here talking about complexity. I feel like I'm up to my neck in it at the moment.

**May Su (02:53):**

Louise, I feel like it's a conversation you and I had a lot actually.

**Louise Stone (02:58):**

Yes, we have.

**May Su (02:59):**

Louise and I have many years of working together, which started off working in mental health, but the reality is it's actually all of health that's complex and a lot of what Louise and I both often speak about is that sometimes it's not always clear and not always obvious professionally and sometimes outside of just generally about health as well. Louise, the idea for this series podcast really came up from a concept that you've talked about over the years, which explores the epistemological variances for GP's between the safety working in the high ground of known parameters of knowledge and rigour versus moving out of the stable state of certainty into uncertainty and complex poorly demarcated issues. For those of you who are familiar with the term epistemological, because I remember when I started out and I still always have to keep looking up the definition, it means the theory of knowledge. So specifically how we come about to know things, the process of it and how it fits the purpose of knowledge acquisition and how then that fits with the application of that knowledge. It's really about how do we know in the first place and what do we do with that. Louise, you really introduced this whole concept to me. Would you mind sharing a little bit about, and this really speaks to work from your blog and of working in the swamp.

**Louise Stone (04:34):**

So I've been talking about the swamp ever since I did my PhD, but look, it's from a guy called Donald Schön who was actually an architect and he wrote this little book called Reflective Practise and he says that it doesn't matter what profession you're in, there's always this high hard ground overlooking a swamp and up on the high ground you have very well-defined problems that lend themselves well to technical solutions and to science-based types of research. But it's down in the swamp where everything is messy and confusing that other problems of greatest human concern. And I suspect that most of us are down in the swamp. It's where primary care lives and breathes and there's a few things about being in the swamp that I think are really important. The idea is not that it's an awful place to be, it's an ecosystem. There's a lot of us there.

**(05:26):**

This is where the community lives and it forms a very important function, but it's murky and it's sometimes hard to see where you're going. And for many people it's unfamiliar when they get stuck in the swamp with some rare disease in general practise, 6% at least of our patients have rare diseases, obviously not the same one. So it's quite common for us to get those patients, but also now that



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hospitals are sending patients home quicker and not admitting them very often because they're so stretched, we're getting more of the uncertainty, more of the trauma, more of the difficulties, more of the diagnosis. I can't remember the last patient I put into hospital that I actually got them in on the basis of any diagnostic uncertainty. We used to be able to admit people for a few days to get sorted out. That doesn't happen anymore. We're losing our general physicians who used to hold our hands and help us through this.

(06:23):

And we also are getting a lot of the trauma because patients are going home quickly. And so the birth trauma and the surgical trauma and the ICU trauma all gets managed in primary care. So the swamp is getting more runoff if you like, from the high ground. We also have people in primary care who are doing what I call little gated communities where they're setting up little places where people can go for something incredibly specific where they can use very focused healthcare is one way of looking at it. But they might take for instance, only people who need contraception and that's all that they focus on. Now when you do that, you leave more uncertainty with everybody else and of course it's harder to navigate through. So I am finding that we have a lot more uncertainty. But I think the other thing to say is that science has been slightly, I think, misunderstood in that there's this language of evidence-based practise.

(07:24):

But of course if we look at something like depression, all the evidence is based on people with one disease who are literate and numerate and able to participate in trials and they bear no relationship to the sorts of patients that I look after who are homeless and struggling with literacy and probably have four or five different diseases and adding neurodiversity and sometimes some gender questioning. In a past history of trauma, they would never have got into the trials that produced the evidence. And so when we say something is evidence-based, we often take it out of context. And for me that's like trialling a scooter up there on the high ground and saying that it's evidence-based and co-designed and patient centred and it helps people get through the system. And then dropping it on my head and insisting I use it in the swamp where it obviously doesn't work.

(08:14):

So it's a difficult space to be when you are working with uncertainty because I think there's a lack of understanding a policy level, but also amongst consumers and carers that sometimes things can't be defined and can't be diagnosed and it is a mess and we've just got to plod through the swamp the best way we know how. And back to your question on epistemology, as we know, and Schön said this, he said there are some people who just know what to do. So Donald Bradman knew how to hit a ball, but he couldn't very well describe how he hit a ball. He just knew that your ball comes to you and you hit it. And there are some swap guides who know how to get through the swamp, but they probably can't describe what they do. It's actually quite rare that you get the educators in primary care who can deconstruct why they do what they do in all that mess and explain it in words of one syllable so that the younger doctors and social workers and psychologists can actually work out what's going on and certainly the patients can work it out because having a rare ill-defined condition is a very uncomfortable thing to have in our society where we like things all nicely boxed up.

(09:25):



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It was a very long discussion, but that's the basis of why it is that my hashtag is GP swamp warrior. I didn't think of that. Someone else gave it to me, but it's because I love that environment. It's where I've lived my professional life and I think the swamp is important and I think people matter in there and we need more people describing what it's like and more research where it belongs down here where we actually work.

**May Su (09:50):**

It's an interesting thing, Louise, because I know you and I have worked for many years together and mutually we both work in very similar areas of murky, undifferentiated swampiness and like you, I love working in this area. I don't think I'm ever going to give it up. And I think it's what drives me to do academia because trying to unpick and understand what it is that we are seeing, but also where it's not working out, advocate and look for changes, it's part of that whole cycle or coming together for that all to work as a whole. But one of the things that really struck me when I started out looking at this from a research point of view was I started to see things in different ideological lenses, which means that on one hand I can understand from a research paradigm point of view why it's easier to unpick one variable and so variable meaning the one thing that might influence the other thing. And even within trying to work that out, it might be that we don't necessarily know whether that one thing causes something or whether it's just associated with something. But from a research paradigm, you kind of need to take out all the messiness and the swamp to unpick it. But at the same token, it could be that as a researcher you're purest enough that one thing you're researching, you have this beautifully designed methodological study and you have this wonderful outcome that really speaks to what it is, but it's not relevant.

**Louise Stone (11:36):**

There's a researcher in America who said that 85% of his patients with depression wouldn't have got into any of the trials. And I think that there's nothing wrong with that. I did a master's of value-based healthcare with a team from Texas, and we were talking about value-based healthcare and the of that for those who've only heard the magic words, but dunno, what it means is that what we try and do is define a cohort. So it might be let's say all the people with type one diabetes, all the adults, and then we try and optimise a system for that cohort and that will save time and money and we measure the outcomes that matter to patients. It all sounds good. And if we did that well for ages, I was doing this master's and I was rolling my eyes and going, well that won't work in my environment because none of my patients are pure enough to fit your model.

**(12:28):**

And it wasn't until one of the leads who were excellent said to me, but if we saved money on value-based healthcare, we could spend it on the mess. And if we did it that way, it would be great if we had the cheapest, fastest, most efficient way to deal with one issue like cataracts or fractures or cataracts. In India, there's a team in India who decided that it was ludicrous. They were spending so much money, they're now down to something like \$3 to do a cataract and they get as good an outcome as we do and we spend about \$500 to a thousand. Now if we could optimise cataracts, then we could then invest that money in some of the sorts of patients I'm sure everyone online deals with who have unstable housing



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and bad nutrition and live with a life of trauma and have a background of mental illness and all those other things that make that particular model of care not relevant to them.

(13:26):

And I don't mind as long as they keep their scooters on the high ground, if that makes the high ground cheaper, I don't have a problem. I do have a problem when we get things like currently we've got incentives, GPS will be incentivized to use evidence-based practise, I have a problem with that because it's not my evidence and it doesn't apply to my patients and I don't want to be forced into a position of using things that I know are not scientifically relevant. That doesn't mean I don't use science. Of course I do. And if I haven't got a choice and it's the best I've got, it works. Like for a pancreas for instance, it doesn't matter whether it's on the high ground or the swamp, it's still a pancreas chemotherapy. I hope someone's done a randomised control trial, but depression probably not going to be the same for my patients or for Aboriginal and Torres Strait Islander patients or for people with low literacy or for people with different cultural backgrounds.

(14:24):

And to say that CBT for instance is evidence-based because it's been applied in certain conditions in certain populations, it may or may not be for our patients. And I think that degree of complexity is not discussed enough. I think we need to think harder about what actually works. And the way I think about it is often in England they tried to do this to everything and they tried to make sure that everyone had their blood pressure optimised. And what happened was a whole lot of little old ladies fell over and broke their hips and that was bad. That was a bad outcome. I think trying to turn people into tiny little Lego blocks that were all sort of stacked on each other is not the way that health works. So that's my take on why I think it's important that we talk about how messy it is down there because it's often described in a way as though it's nice and straightforward, which it so isn't.

**May Su (15:30):**

You've touched on so many different things that I was reflecting on. One is about the whole issue about accessibility and equity of care, which as Michael also raised in our previous podcast, and it is that challenge where some of the research, in fact most of the research occurs in the more socioeconomically affluent countries, which also means that the interventions and the investigations may not necessarily be accessible to lots of other places in the world. I think sometimes that makes it really hard for the applicability of that research. There's another aspect that you talk about, which is actually just about the topic of depression. I've got a bug bear about the nomenclature of depression. It's a terrible situation where we have a diagnosis which is wholly descriptive to what is actually going on. It's all syndromic. And I think that's really characteristic of a lot of the diagnoses that we use in mental health. It's all very well and good as a clinician to go, right, I'm going to explore that further or we're going to work out then what is actually going on so we can pick a path in how we do for management, but then you put that in a research sphere and you've got a terribly poor description, which is incredibly heterogeneous that you are then trying to explain in a policy way.

**Louise Stone (17:04):**

It doesn't work. And I know everyone here is, I hope is nodding along, but the way I think about it is if we took everyone in the emergency department and gave them all Panadol, then on average they'd get





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better. But it doesn't mean it's great for everybody in the room. For some people it might cause all sorts of harms. And I feel the same way about depression because it isn't one thing. I think the history is really interesting and I hope you don't mind, but I happened to have read quite a bit about this and the story is that we really only got the first DSM because of the military. And the problem was that the soldiers with PTSD were coming back and some of them were getting a week in an asylum, particularly in America where at that time we had a lot of the psychodynamic psychiatrists coming over because they were refugees, they were Jewish.

(17:54):

And so America and Argentina for some odd reason, and England had a lot of the leads from the schools. And so you would go to this asylum and Joe might get a week's worth of therapy and Fred might get them a year and the military will say, well, we can't cost that. We can't do anything with it and you've got to do better. And there was one little school and I can't remember where it was, who were taking a more behavioural approach and they commission then to write DSM one, tell us how we can differentiate because we just can't work with this chaos. And over time, if you look at DSM one, it still has a lot of those psychodynamic principles in it. It's still got neurosis and psychosis and all of that. But over time, well we went from DSM three to DSM four, they tried to take all the theory out of it and unfortunately that takes out the quality of what we're actually talking about by looking at behaviours.

(18:51):

We've lost that qualitative theme. One study looked at GP's and said, how do you make a diagnosis of endogenous depression, which was still around? So that's for those who haven't come across that term, that's the term where we assume it's coming from the body rather than from circumstance. It's one of those more neurological end. The GP's all said they looked dead behind the eyes. They didn't say, oh, they've got three out of these five criteria. They said it is a qualitative thing, you feel it in the room and makes you feel heavy and they feel like there's just this weight in the room and everybody who works in mental health will know exactly what I mean. But now we've got this classification system that works on sort of behaviours. I mean if my patient has acute lupus, they would fit absolutely every criteria for depression and anxiety if we didn't put in that bit that says that they're actually depressed.

(19:54):

So I think that has impoverished our understanding of what is actually going on. And for my patients, what I say is it's more like I know nothing about art, but if I went into a gallery and I looked at a painting, I might say, oh, that looks like, I dunno, a renaissance painting or something. An art critic might go, oh, well it's a little bit of this and a little bit of that and a little bit of something else. And to me that's what diagnosis is. It's a point of view of a way of looking at something, looking at a person and saying, okay, I can see they've got a theme in there of depression, but there's also this theme coming in for neurodiversity or for trauma or for just having a really difficult life and living with poverty, those sorts of things. They're all ways of knowing.

(20:47):

They're all ways of seeing and they're all important. And to reduce that down to just the diagnostic label I think is just turning something very complicated into something that's very simple and probably too simple for many of us to get a handle on. Except I think in anxiety disorders where there really are people who just turn up with a phobia, it's lowly, you know what to do with that. You've got your



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evidence exactly what you're doing, but for most people it isn't brief and loss and life really on top of everything else, plus or minus something that perhaps the medication might help.

**May Su (21:27):**

Louise, I was kind of thinking as you were talking that I think this stems to a bit of a theme here about maybe not taking at face value, just the words a bit that maybe it's actually about understanding the reason behind that came about in the first place.

**Louise Stone (21:46):**

Yes, and patients need a story. They need a story to be getting on with. One of the things about being a GP is we're often before the patient admits they've got a psychological problem. So they're coming to us often, I mean not so much now because mental illness is discussed, but they used to come in with undifferentiated distress and we were the ones working it out weirdly enough. I find I'm often now the ones saying, actually I don't think it is depression. I think you've got something going on in the brain or something going on hormonally or something like that. But it used to be that we were picking that apart and trying to get a story together to be getting on with before the patient then was able to seek the help that they needed. And to do that, you have to meet the patient where their stories at.

**(22:32):**

You have to use their metaphors. When I was in Broken Hill, it was all about how to drive the car, but you haven't got any petrol in the tank. And that was the way of describing the metaphor and it is a metaphor about neurotransmitters and serotonin that worked with miners, they got hold of that, that made sense. They see their body as a mechanical thing and they could work with that. It wouldn't make no sense to somebody who was grieving or somebody who had had a lifetime of trauma. In fact, it would invalidate them terribly to be told, oh, it's just chemical imbalance. I mean it doesn't make sense. You've got to work with a person to get a narrative that they can use to seek the help. And that's not just about medication psychotherapy, it's about getting food on the table and a roof over your head and Centrelink payments and all the other things that our marvellous social workers and occupational therapists.

**(23:27):**

I'm going to put a shout out to occupational therapists in the room. I think you guys are awesome. I've watched some of my homeless patients who had never learned because they've gone from foster home to foster home, they've never learned how to cope with life. And I love the way OTs can teach them to cook and teach them to organise their life and my neurodiverse patients to try and get a schedule together so that they're not so overwhelmed with sensory overload. And all of us are adding pieces to the puzzle of that story and treating that whole story. It's terribly, terribly important that we open that up and to call that just a diagnostic name, I think it just trivialises a very complex experience from those people except for things like schizophrenia where it's much more like epilepsy. It's more like a neurological condition where that diagnosis tells you a lot and puts you down a path that's actually very helpful as does bipolar. But I find a lot of the other mental health diagnoses are part of the picture, but not all and not always helpful.

**May Su (24:37):**



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Look, I guess I'm thinking about this as you're talking and one of the things I was saying, I've started off doing a master's of philosophy and one of the things I did was I sat down and I was trying to understand what is philosophy and what does that mean and looked at the history of philosophy. But there was a quote from Bertrand Russell in his view on Western philosophy, which really just opened it up a little bit for me, which he talked about in studying a philosopher, the right attitudes are kind of hypothetical sympathy. So two things are to be remembered that a man whose opinions and theories are worth studying may be presumed to have some intelligence, but that no man is likely to have arrived at complete and final truth on any subject whatsoever. So when an intelligent man expresses a view, which seems to us obviously absurd, we should not attempt to prove that it's somewhat true, but we should try to understand how it ever came to seem true. And I wonder a little bit about this that I wonder about why our system likes to just simplify things into simple terms.

**Louise Stone (25:45):**

Well, it's behavioural economics is what it is. If all disease was like cataracts, we'd all be happy. I measure the person's vision, it's bad. I diagnosed a cataract, I've replaced the cataract using evidence-based techniques and look, they can see again and I can measure the difference. And trying to shove all of health into that model is the problem, isn't it? I have no problem with outcome measurements, but in primary care, when do you want me to measure the outcome? I see patients for years as the outcome after their six sessions of CBT, is it yearly? What does an outcome even mean when they're on this long journey of coping with whatever it is that they're coping with and including diseases that deteriorate, they may have goals that are utterly unreachable. And so this model of measure it, do something, measure it again, look, it's gotten better, is lovely for the economists and the statisticians and it's good in some fields. It's great for cataracts, it's great for fractures, it's great for diabetes in many ways, but I don't find it as helpful in mental health. For me, it's what I most want for my patients is that when they have spent time with me, they feel that they have a little more agency and a little more hope.

**May Su (27:07):**

I guess I'm just thinking about bringing the two together though in that I kind of respect you and I have acknowledged there is a simplicity, isn't there? It's a alluring to think about health broken down into really simple constructs. And I think even by the way that we use language, it's essentially what we try to do even in a formulation. We are describing a phenomenon that's complicated and complex and a person's personal story. And that's summarising it in language in some ways. It's just that I think you and I, Louise, I think I speak to hopefully both of us where I say I think we try to encapsulate that in a more complex nuanced way. But I also appreciate that as you're starting off sometimes on your journey working in health and working in mental health, the scaffolding process of how you learn about health sometimes means that you have pretty simple constructs to start off with.

**Louise Stone (28:06):**

Of course. And you have to and the patients have to, but we don't use drugs unless they've got a construct behind them. So if I'm starting an 18-year-old on an antidepressant, then I rely on all those studies over 40 years of randomised control trials to pick which one, and that's completely acceptable. But even more broadly than that, I was looking after a poor family that had lost a child and they were trying to manage the emotional needs of the other siblings. And often when you have a sibling of





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course, and the social workers will know more about this than I do, but the siblings obviously are very insecure and quite clingy. And I was talking about expanding that circle of security because that is a really helpful construct. And for that family, it was a beautiful match for what they needed with this is what's happening.

(29:01):

They'd never heard the term we're describing how you could expand that just a little bit now and then to try and give this little one confidence in the wake of this trauma, you pick and choose. And if you don't know, of course you start with the one that you know of. There's no problem. If nobody's had treatment, for instance in anxiety, CBT is absolutely the right way to start. And problem solving is always a good way to start structured problem solving. All those techniques have their place. I just think when they're given as the best way to do these things, I have a problem. I don't have a problem for them existing or being, I'm often criticised because I've been quite strong with mental health, not because I don't think it's helpful, it is, but because I don't think it is universally helpful. And I think that it has been funded very heavily.

(29:57):

I think there are other forms of funding that I think are important, but that doesn't mean to say it hasn't got a place it does. It's just I trust the professionals who are listing in, I trust you guys to make choices. And maybe it's because I work at a practise that's owned and run by psychologists and psychiatrists and I'm the only GP, but they've taught me so much about why you choose this technique or that technique or some other technique. And I think that's evidence informed, but it's not evidence based in a mechanical sort of way. It's not like you would treat a broken bone, you can put 'em up on a screen, you can go that fracture equals that plaster for that long. I don't think mental health works that simply in very many people.

**May Su** (30:41):

Yeah, I think that's coming back to a few of the concepts we talked about before. You and I have spoken about this, Louise is about using a hammer to hit every single nail. It's good to understand the specific frameworks and start off in a simplified scaffolded way, but it was what we were talking about in the previous podcast where it's also about being open and reflective and learning about when those ways don't fit and when we need to think about different frameworks or it does become that we are using the same strategies for every circumstance and we are not always open to when things aren't always clear cut. And that leaves us vulnerable to not actually addressing the needs of the person in front of us.

**Louise Stone** (31:32):

Yes, and I often see this, there's been a lot of debate about medical misogyny, but you start with the anxious little kid and then they turn into the histrionic adolescent and then they get written off as the anxious young mom. And then if you're my age, you're a neurotic middle aged woman and then you turn into a little old lady. It's awful. And I can't tell you the number of patients that have come to see me with put in quotes, anxiety that have turned out to have all sorts of other things. But I think you're right. And John Murtagh was great for anyone who's working in this generalist space, he had this great idea. He's a bit of our father of general practise in Australia when he wrote our textbook. But his idea was you



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go to the probability diagnosis first. What's the most likely then you go to serious disorders not to be missed.

(32:26):

And the discipline of that is really important because there are serious disorders not to be missed. It can look like absolute classic whatever. And it isn't. And the last one always said was what are the common masquerades? What are things that can look like anything? Which of course for us is always sarcoid, which you may not know about that condition, but could it look like anything? So there are always, for young doctors, that's what we would take them through. We would say, okay, this person's got a headache. And of course young doctors would jump to brain tumour because they always go for the rare thing. And you say, well, what's the most common thing? And it's tension headache or sinus infection or something like that. But what are the serious disorders not to be missed? And I think putting yourself through the discipline of making sure that you have covered off those serious things.

(33:24):

And that's often why it's so wonderful to share care with my psychiatrist and psychologists colleagues when I can because sometimes I really don't know. And the vibe of the thing is off. I've got one patient at the moment who has been told by everyone, she's got anxiety. All the neurologists say she's got anxiety, but the psychiatrist doesn't think so. And she's got a weird autoimmune inflammation in the brain. It's not a brain tumour, but it's organic. And I knew that because of the vibe of the thing. It wasn't anything scientific, it was just, I just knew it wasn't anxiety, it didn't feel like it, so we went hunting. So I just think when you're thinking evidence and you're thinking everything around trying to make things work, you do have to have that broader lens of what if it isn't? And I don't think mental illness is the default. I can't find anything else, therefore it must be anxiety is often the way, and the psychologists bless them, will often send it back saying, this doesn't feel like depression. Can you have a look at them? Which is marvellous usually obviously, right? Because they know. And that's where things start to sit. I think it's terribly important to keep an open minded and not get in the wrong groove and go down a track and refuse to move.

**May Su (34:39):**

Well, it brings us back to the title of the podcast, which is the rare, the unknown, the complex, the not learned about it, the different, you often talk about naming things. It's actually what makes practitioners really uncomfortable regardless of what profession you're in. It's that whole real uncertainty and disquiet about what if I'm missing something really important, but you're not really sure what you're missing.

**Louise Stone (35:01):**

And I mean, the average length of time it takes to diagnose lupus in women is 14 years. And one of the things I do worry about is often the narrative of my doctor didn't take me seriously or my doctor didn't believe me is that they didn't get a diagnosis. And sometimes we can't make one. And I think as clinicians, we need to get better at explaining that medicine has its limits and that we are on the edge of the knowledge and we are not sure yet. We don't know, but we keep having to put up a periscope and looking. We have to get better at explaining because patients believe that if House was in the room, he would've diagnosed it in five minutes. That's what they see on television. That's what they expect. That's



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what's often advertised is that nice simple model of see all the stuff in, you plug it into AI and out comes the diagnosis.

(35:56):

And it's really hard to sit with uncertainty and to say that nobody knows that we don't know. And often these patients have conditions that have really common things like fatigue or joint pain, and they look it up on the internet. And if we're unlucky, they get caught up in some online group that fleeces them for an awful lot of money for tests that aren't very useful. And we also have to be aware of just how vulnerable some of these patients are because it worries me a lot. It's a bit like cancer. There's a lot of charlatans out there who promise to check your serum rhubarb or something and take a lot of money from my very vulnerable patients, and that makes me quite angry. So I think it's really important that we keep an open mind and we're honest with our patients when we don't know, or in some cases when now our healthcare doesn't know they've got, and especially post covid, because we're seeing things we've never seen before in the brain that look mental and aren't. So I've seen weird things that I always thought was rare as, but they're turning up because covid does odd things in brains and it changes our epidemiology and things we thought were rare, aren't rare. Post covid makes it very hard.

**May Su (37:19):**

Actually, Louise, that's something that we haven't spoken about, but I think when you are working with what you are not quite sure about, patients will actually forgive you for being open to saying -

**Louise Stone (37:33):**

Oh, yes.

**May Su (37:34):**

And I think it's much more, we talked about authenticity in the last podcast, and it's about being authentic that sometimes we're on a learning journey together. And that's actually totally fine. And it also speaks to the fact that this is why we work in teams. We do peer support in all sorts of way, and that should also be in our clinical practise as well, that sometimes you're all a bit bewildered together and that's okay.

**Louise Stone (38:00):**

I will say though, I'm in a better position now. I'm old and grey and look experienced that I don't mind, and I've got my degrees behind my head in case I have people who call me just a GP. But the other thing is that now I could do that, but when I was 26, I couldn't have. And I will say if you're living with multiple layers of privilege, sometimes you cannot do that because the patients are being frankly discriminating against you for your age, perhaps for your gender, perhaps for your ethnic origin, whatever it is. And then you have to have some tricks up your sleeve. And I'll share the general practise one, which is two things. Firstly, you can always send patients for a urine test so you can look it up on Google and then go hunting down the papers if you're stuck. The other thing is patients never mind a second opinion. They actually don't mind feeling, I think this is complex and I think I want to do some reading and patients will accept that. But for those who are young in the profession, talk to you as supervisors and so on, because sometimes patients will be quite rude to our younger colleagues who don't appear to be confident. I



# Transcript



remember having quite a difficult consultation when I was in my twenties with an older male business owner who was very unhappy that I was unable to make a diagnosis.

**May Su (39:25):**

Louise, you're probably actually starting to slip into the topic of our next podcast, which is actually more about working in the moral dilemmas of-

**Louise Stone (39:36):**

Yeah -

**May Su (39:36):**

When people don't do things that we would expect them to do. But I'd just like to say thank you for sharing all of the robust and always wonderful discussion. Louise, I always enjoy talking to you, and I'm going to say thank you to you, our listeners as well for joining us on this episode of Mental Health Professionals Network Presents a podcast about health and its complexity. And you've been listening to me, Dr Ma Su and my co-host, Associate Professor Louise Stone. And we hope you've enjoyed this conversation as much as we have where we've discussed working with the rare, the unknown, the complex, the not learned about and the different. And if you want to learn more about us, your hosts, or if you want access to the resources to which we referred, go to this episode's landing page and follow the hyperlinks. Mental Health Professionals Network values your feedback, on the landing page you'll also find a link to a feedback survey. Please fill out the survey and let us know whether you found this episode helpful or provide comments and suggestions about how the Mental Health Professionals network might better meet your listening needs. And stay tuned for the next episode in this series, which will be released Wednesday fortnight. And in this the third and final episode, we'll explore what if working with the inexplicable challenges are moral code.

**Host (41:09):**

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