Talking with patients.

The title of this book by Professor James Calnan, Emeritus Professor of Plastic Surgery at the Royal Postgraduate Medical School, Hammersmith is, in itself, thought- provoking. Talking **with -** and not **to -** patients is what we should really be doing, listening to what they say (or wish to say but are too scared to voice). The lessons taught by Professor Calnan will help us respect the rights of patients. They will also help avoid much unpleasant-ness and ill-will.

Unless there is a passionate conviction in the importance of talking with *that particular* patient, we cannot really aspire to the practice of good medicine. 'Eventually you must develop a conscience which says every time: "Have I said enough or too much, could I have spoken more kindly, listened more carefully?" ' He argues strongly for transcending 'the mediocrity that passes for communication today'.

Bedside manner

Much of what is termed excellent bedside manner consists of the way in which we put the patient at ease and facilitate a meaningful dialogue in which none of the patient's questions remains unanswered. The first requirement for this is an attitude of concern. 'You can't fake attitudes'. Subterfuge generates uneasiness, distrust and distaste. A sincere smile, a gentle touch and the question 'What can I do for you?' helps break the ice when you first face a patient. Such an attitude can only be based on respect for the patient as a person.

Tact, persuasion and participation will elicit the kind of cooperation never to be invoked by browbeating and the imposition of authority.

How can we improve matters?

The first step lies in recognising the fact that improvement is necessary. Patients find doctors impa-tient, always in a rush, unwilling to explain and, at times, abrupt to the point of rudeness. 'The patient is hungry for conversation and companionship, comfort and reassur-ance; he is lonely and his pride is hurt by illness; his mind and body are equally afflicted yet no one seems to care.. .'

The good talker

1. Is sensitive to his listener.
2. Strives to make the other respond.
3. Looks interested.
4. Always allows the other to speak when he wishes.
5. Follows the lead indicated by the other.
6. Is entertaining, has humour.
7. Uses language with feeling and sensitivity.
8. Discovers topics which interest the other.
9. Is a good listener.
10. Knows when to stop.

Courteous conversation at a time convenient to the patient and yourself will go a long way in reducing complaint. A warm, friendly attitude; sensitivity to his worries and aches; clear, simple sentences; truthful answers with acknowledgement of deficiencies in one's knowledge and expertise and leaving behind room for optimism - even if be merely the expectation of comfort over the remaining days - will reassure most patients.

Communication

We pass messages to another to inform, instruct and persuade. In dealing with patients we also hope to inspire confidence. Passing on too much information or only that of the unwelcome kind may prove counter-productive. At times it is best to parcel out information piece-meal with enough repetition to provide links, concentrating all the time on information required by the patient at that time.

It is up to us to ensure that the message has been received and understood.

It is best to provide details on the nature of illness, findings on investigation or at surgery, instructions on further drug therapy and follow-up examinations in writing. Convey facts and opinion separately.

The consultation

This is a serious occasion, the doctor trying to

elicit facts as a preliminary to physical examination of the patient and arriving at a diagnosis, plan of action. Remember that conversation is between unequal persons. The doctor is in good health, free from pain and sickness. The patient is troubled by illness and its consequent anxieties. The interview occurs at a time and place selected by the doctor, who also decides its duration.

Spoken speech and gesture

1. This is direct, effective and produces immediate response.
2. Use feedback all the time. Listen to the patient.
3. Speak slowly, clearly, in short sentences.
4. Start with the familiar. Proceed slowly to the unfamiliar and difficult.
5. Establish a logical chain of thought and avoid ambiguity.
6. Pauses, gestures, change in rhythm of voice will stimulate interest.
7. Humour, anecdotes, illustrations may make explanations more effective.
8. Do your best to dispel fear.
9. A smile, handshake or touch that comforts may do more than mere words.
10. Leave behind written details, especially when instructions are offered.

Above all else, listen to the patient. 'There are two great bars to communication: not taking enough time to talk to the other and not listening to what is being said.. . Be alert for the unexpected remark. Do not interrupt the patient's speech or appear anxious to cut in.'

At the end of the consultation, the patient should be left in a more pleasant frame of mind, having been provided information, assurance and advice. 'Life is difficult enough already and may so easily become unbearable without hope.. . When it comes to giving the patient his diagnosis, tact and a kindly humanity are paramount. '

Talking about diagnosis and prognosis

Most of us start with a presumptive diagnosis. After reaching a working diagnosis we plan a course of action regarding tests, procedures or therapy. The definitive diagnosis - an accurate label of the patient's illness - usually follows analysis of all the evidence and, often, the effect of treatment.

In most instances, the patient wishes to know what is wrong with him. More important, he needs to learn whether his illness is serious; details on the expenses he will need to incur; how long he will be away from work, home; whether he will be left with handicaps or restrictions placed on his way of life and how he can help in ensuring a rapid recovery.

Discuss the diagnosis as soon as vou are able to make one. This helps dispel anxiety.

It is best to provide truthful information in simple terms, remaining acutely conscious of what the patient does **not** want to know. When the situation is gloomy. try and find patches of brightness - absence of pain, comfort and care provided by a loving family.. . Calnan points out that often the patient is reluctant to discuss grim news with the spouse for fear of causing pain. Use all the skill and diplomacy you can muster to make them converse without fear. 'The rewards can be great all round.'

Many patients will respond with gratitude to questions such as 'Is there any other information you need?' or 'Is there anything else I can do for you?'

Talking about treatment

Try and provide the following information to the patient's satisfaction:

1. What is the treatment for his illness?
2. If it involves surgical or other procedures, describe the procedure, using drawings if needed. Discuss pros and cons with some details on possible complications, morbidity, mortality.
3. Names of drugs, their indications, how each of them is to be taken and for how long.
4. How important is it to take the drugs'? What if he happens to miss a dose or two?
5. What are the side effects of the drugs and how will he recognise them? Which side effects should he specially look for? Which side effect should he bring to the notice of the doctor at once? Will alcohol interfere with his drug therapy?
6. Can he drive, swim, have sexual relations whilst on dr

Where possible categorise the drugs. Provide clear, simple, written instructions on dosage and administration.

Consent

Voluntary agreement to a course of action can never be valid till the patient has been provided full and frank information on it. Whilst the patient cannot be educated to understand his illness or the procedure as well as does his doctor, he can be assisted to make a rational decision.

Describe the problem as simply and accurately as possible, using evidence obtained by examination and investigation. Analyse the situation, explaining the need for further tests or other procedures and the line of treatment being advised. Discuss alternatives, pointing out the pros and cons and prescribe the best solution under the circumstances.

Except in an emergency. give the patient and his relatives enough time to arrive at a decision. Do not coerce.

Ensure that the patient is aware that

1. He can refuse the procedure or course of action.
2. Seek another opinion.
3. Make a choice on where he will undergo the procedure or treatment.
4. Leave your clinic or hospital at will.
5. Seek advice elsewhere without incurring your displeasure.

Talking with relatives

Introduce yourself to the relatives, ascertain the name/s of the principal relative/s and address them politely. The patient's diagnosis, prognosis and treatment must be discussed in detail with them in private after ensuring the patient's tacit approval. Relatives may, often, be able to tell you what the patient is afraid of voicing or reluctant to narrate. They may also be able to offer sound advice on dealing with social, personal or domestic problems faced by the patient. Confidential information about the patient should not be passed on to the relatives unless this is specifically requested by the patient. There is, however, no need to be secretive about the patient's well-being or progress.

The fatal illness

The traditional role of the doctor, from time immemorial, has been to cure sometimes, to relieve often, to comfort always

The time spent talking to dying patients must, of necessity, be longer but it is time well spent. If you have gained the patient's trust he will expect that you will not let him down towards the end. **'When treatment has failed to cure disease and the patient is going to die, the doctor and nurse feel they too have failed. They do not recognise that the patient now requires another form of treatment...'**

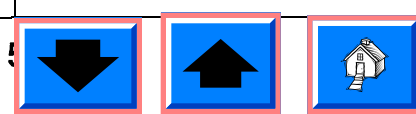
Looking after a dying person involves care. In the weeks before death, the doctor can ensure freedom from pain (physical, social and spiritual); as regular bodilv functions as possible; cleanliness and comfort; and the presence of his loved ones. At the moment of death, privacy, familiar surroundings, demonstrations of love by those near to him and, in many cases, spiritual warmth, are greatly valued. When Mother Teresa is asked the greatest misfortune of the dying, she replies: 'Loneliness. '

Complaints and criticism

The vast majority are trivial and born of misunderstanding. Sympathetically dealt with they may melt away.

Calnan found that most complaints stemmed from one or more of six causes:

- being given insufficient information;
- not being told about specific procedures or operations to be performed;
- untreated pain;
- noise;
- rough handling, lack of immediate attention when in need, being made to wait and being treated like a simpleton:
- not being told what is to happen next, and expected duration of stay in hospital...



Knowing that the patients' minds are idle when in hospital; vulnerable to anxiety, boredom and loneliness it is surprising that we are not subject to a barrage of complaints.

An ill individual will be snappy, show bad temper and overlook all that is being done for him. It is up to us to pay heed to aphorism four below, get to the root of the complaint quickly and deal with it to the patient's satisfaction.

Complaints: some aphorisms

1. To grumble is human.
2. Serious complaints can come from nice people.
3. All arguments have three sides: your, mine and the facts
4. All complaints have some foundation.
5. Grievances grow when neglected.
6. Grievances grow in size and importance irrespective of the data.
7. A grouse becomes an official complaint in time.
8. Grievances are prolonged in proportion to the number of people involved.
9. The majority of complaints are trivial but it is at times difficult to differentiate the trivial from the serious.
10. Prevention is better than facing plaintiffs in court.

Treat all complaints seriously and respectfully, however trivial they may seem to you. The are very important to the patient.

'Try to understand the patient's position, especially in hospital. He is bed-bound in a strange environment, not feeling too good, wholly dependent on those who serve him. his precious pills confiscated. He may be lonely, depressed and frightened. '

If you are in the wrong, say so at once, do all you can to rectify the situation and apologise for the error. Once you have investigated and dealt with the complaint, show your appreciation to the patient for his having drawn your attention to a deficiency in services.

Common faults in dealing with complaints:

1. Not listening to the complainant.
2. Not clarifying the complaint.
3. Getting bogged down in trivia.
4. Failing to show sympathy.
5. Neglecting to explain why and how.
6. Blaming others.
7. Apologising without rectifying the situation.
8. Doing nothing.
9. Absolute denial.
10 The cover-up job.

Reference

Calnan J: Talking with patients - a guide to good practice. William Heinemarn Medical Books, London. 1983. 15 1, pages and several cartoons.