Reflections of a PGY1 intern

Valuing effective communication

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It is commonly lamented that the modern medical graduate knows all about empathy and the patient-centred approach, but much less about “traditional” or “real” medicine. It was once cleverly quipped on the wards that today’s medical graduates may not be able to properly understand a patient’s pathology, but certainly will be able to truly empathise with how the patient feels.

Currently in the world of medicine we are aware that the ideal is for us to be patient-centred, giving perfectly clear explanations, allowing for informed decisions and patient autonomy. We are to be champions of the patient’s rights, which in NZ at least, have been clearly outlined out by the HDC since 1996.1 Paternalism is a dirty word and should be avoided whenever possible. Clear communication and effective encounters with patients and their problems is the goal.

Medical lectures now teach acronyms such as ‘SBAR’, ‘ISOBAR’, ‘EMPATHY’, and ‘SPIKES’. We are taught strategies, and mechanics to enter the weird and wonderful world of talking to a fellow human being. Trainees are offered opportunities to practice in role play how to communicate effectively with patients. Professional development opportunities can also offer similar experiences to the post graduate.

Many would rather have their teeth pulled than sit through this type of session, likening it to being taught to suck eggs. Can these strategies really help anyone who has not learned to communicate by the time they entered the medical profession? Is effective communication and empathy not just an innate skill that you either have, or have not? It has been said everyone at least concedes that the workforce could be improved if, when individuals are identified as having no-people skills whatsoever, we help by putting ‘SPIKES’ in their heads. Such cynicism from learners is common, and is reputed to be part of the problem.2

Despite learners’ scorn, it is not hard to see why there is such a focus on attempting to teach skills for improved doctor-patient interaction: poor communication is rife. Patient surveys consistently note doctor-patient communication as an area of concern.2

Even the very instructors who teach and model improved interaction techniques are not immune. I vividly recall an instructor earnestly informing an irate patient how much more validated they were going feel when the instructor sat down to listen to them. The awkward and difficult interaction that followed emphasised to me that whether or not the exercise of sitting down could have worked, simple tricks are more effective when the magician does not reveal their secret.
It is not uncommon to see a fourth-year medical student able to identify and help correct breakdown of effective communication between a team and their patients. They have after all, more recently than us, been made keenly aware to remain vigilant for these situations. I remember being in that situation myself and wondering how these doctors could not see the problems that seemed so glaringly obvious and easy to resolve to inexperienced me at the time.

Recently I spent a considerable amount of time with a family to discuss the unfortunately poor prognosis of their loved one. There had been a catastrophic infarct, picked up too late for thrombolysis, but there had been some initial recovery and some modest gains were made in the first few days. However, more recently there had been a turn for the worse when the patient developed intractable seizures overnight, and the prognosis had become very poor.

Initially I had thought my explanation was helpful. Then I began to realise how many emotional cues I had missed, and how little of what I was saying was being understood by anyone other than the other health workers present. My fourth-year self would have been ashamed of me. I had unwittingly regressed, and become exactly the poor communicator that I had set out to not become. Fortunately on this occasion there was an opportunity to notice the mistake and rectify it at the time. Sometimes similar moments come back to haunt me only after they have irretrievably passed.

There is great value in being able to stop and reflect, and afterwards to take action to change one's practice. (Incidentally, reflective practice is another of those oft-mentioned skills that are so obvious but often poorly executed.)

It is clearly documented that doctors' communication skills do decline with time. This is postulated to be related to the nature and stresses of our jobs. Also, particularly in the hospital setting, it is possible to be surrounded by medical discussion which may put us at risk of becoming more detached and less able to relate to our patients.

Sometimes I wonder if the truth behind stereotypes for different specialties exists not because they attract a particular type of person, but because the job moulds the individuals. Similarly the stereotype of an experienced doctor who communicates poorly may exist because the job can exert its own pressure to steer us that way if we are not careful.

Recapping the basics of communication is undeniably painful. However if you start to notice lapses in your ability to communicate, it is worthwhile taking the time to remind yourself how to suck those eggs, for your patients' sake. It turns out one can forget how…

References