MEDICAL PRACTICE

Contemporary Themes

Listening and talking to patients**I: The problem**

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When in 1973 I was asked by the trustees of the Nuffield Provincial Hospitals Trust to write a Rock Carling monograph on communication in medicine¹ I meant to concentrate on my experiences in broadcasting on medical topics, but I asked a medical librarian to help me look up literature on my title and was astonished by the number of papers he found on poor communication between doctors and patients. I had not realised that communication could so often fail in clinical practice. I knew that there was some non-compliance with treatment but had not checked this in my own patients: they were nearly always politely grateful, so I assumed that they had understood what I had told them and were satisfied. I now realise how often I must have been wrong.

After my monograph had been published, the trust arranged some seminars on communication with patients in which new work on the necessary skills and on how they may be learnt were presented and discussed.² Since it seemed that the problem might in part be due to few doctors having had any formal training in communication, the trust invited me in 1977 to visit medical schools to discover what was being taught. The topic had received no mention in the two-volume report of the General Medical Council on *Basic Medical Education in the British Isles*,³ so it was not surprising to find that most teachers seemed to be (as I had been) confident in their own skills and assumed that students would learn to emulate them if only they had the necessary natural gifts.⁴ Only a few teachers, mostly in departments of general practice or psychiatry, knew of the existence of

and need for special teaching methods. In 1979 the trust set up a working party, which has now produced for medical teachers a short account of recent developments in teaching communication with patients.⁵

In these articles I hope first to show that communication failures are common and are clinically important. In the second article I shall discuss ways of acquiring the skills needed for the first part of a consultation—the interview. In the third I shall consider how the second part of the consultation, which I call the exposition, might be improved so that we may tell patients more effectively what they want to know and encourage them to follow our advice more closely. In the fourth I shall discuss some difficult problems of communication, in particular with patients who have fatal illnesses.

Interview

I must first show that failures of communication are common and that they matter. A recent audiotape study of over 2000 consultations in general practice⁶ showed that most tended to be “doctor-centred,” with the doctor concentrating on closed questions about the patient’s first complaint, often ignoring or brushing aside hints of other problems, so that an organic diagnosis was quickly reached and a prescription given. About one-quarter of the interviews were more “patient-centred,” with the doctor using open questions and listening to the patient’s own account of his symptoms, fears, and stresses. Open questions leave patients free to answer as they will—for example, “Tell me about your sleeping.” “Do you sleep badly?” is a closed question. Each doctor tended to be consistent in his interviewing style with little variation to suit different types of patients or problems. This long-term constancy of style has been confirmed in a videotape study of another group of general practitioners

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in which no correlation was found between scores for interviewing skill and length of experience in general practice.⁷

As students most doctors have been given only general guidance about how to interview, and their "history taking" tends to concentrate on questions to clarify particular initial complaints and to discover symptoms that have not been volunteered. This sort of instruction is still common and may be responsible for the finding in several studies that students' interviewing skills often deteriorate rather than improve during the clinical course.⁸⁻¹⁰ No comparable study has been made of consultants' interviewing skills. But it has been found that while physicians make a high proportion of correct diagnoses on taking the history¹¹ they may overlook important psychological components of physical disease which can be as important to the patient as the disease itself.¹²

An unskilled interview may lead to an incomplete or even wrong diagnosis. It may also leave patients feeling annoyed and frustrated. It is impossible to say how often this happens, but a recent patients' guide assumes that it is common.¹³ Few patients explicitly complain that their GPs hurry them or fail to listen to them, though rather more made this complaint when asked in 1977 than in 1964,¹⁴ perhaps owing to rising expectations. Patients who have never had what Byrne and Long⁶ would have regarded as a good interview may feel no grounds for complaint. In 1977 I went to see a man who trains reporters to interview for a large newspaper organisation. He told me that he had just registered with a new doctor and said, "The first time I went to see him he stood up as I came in, greeted me, shook my hand, and signalled me to sit alongside him. He had my records there and checked them with me: then he just asked, 'Well, what's the problem now?' and he listened to what I had to say. I have never had a doctor behave like that before." I asked how old he was: "Oh, quite a young chap, less than 30." He belonged to the generation of GPs who have had postgraduate training in interviewing. GP trainers have told me that registrars who go into general practice often have insufficient skill at interviewing.

Most doctors have been trained as students to be competent at taking a history of physical complaints. With this emphasis they often remain insensitive to, or uninterested in, associated psychological or social matters which may be related to the physical symptoms. They may thus be good at diagnosing organic illness, but tend to miss many simple opportunities of relieving anxiety, depression, or psychosocial causes or consequences of illness.

Exposition

The second part of the consultation—the exposition—in which the doctor explains his diagnosis and what is to be done about it is much more complex. In the consulting room there may be little time for all that has to be told. In hospital even more has to be explained—the strange environment, many investigations and changes of treatment which can alarm and confuse the patient. There is no doubt that the exposition often fails to convince or satisfy patients. We often meet patients who seem to have been told nothing about previous illnesses and give strangely distorted accounts of them.

In surveys of patients' complaints about doctors and medical services, lack of information is always a major feature. Between 20% and 60% of hospital patients have been found to express dissatisfaction with the information they have been given.¹⁵⁻²¹ Many say that they can't even get information if they ask for it. This complaint is sometimes made by patients who have actually been fully informed, and the frequency of the complaints may not greatly be reduced by special efforts to give information.²² Something must be wrong in the way it is given. Failures in the exposition not only lead to dissatisfied patients but are also a cause of poor compliance with doctors' recommendations for treatment and changes in habits.

Doctors whose sole or major concern is with their patients' physical wellbeing may well deny that they either wish or need

to improve their history-taking skills to encompass their patients' personal problems. But, unless they confine themselves to forms of treatment in which the patient himself has no part to play (which apart from straightforward surgery are rare), they need to learn better methods of exposition to ensure success.

Need for better communication

One practical consequence of poor communication and unfriendliness with patients is that a high proportion (57%) of all complaints against medical and nursing staff found by the health services commissioner in his most recent report to have some justification were due to "lack of information" or "wrong attitudes to patients or their relatives."²³

Nothing has so thoroughly convinced me of the need for doctors to become more skilled in communication with their patients than the response I get from laymen when I tell them of my recent concern with it. They show immediate interest and say such things as "You are on to something important there. It would be so helpful if doctors could learn to communicate better with us." This is usually followed by a sad story of some misunderstanding or unnecessary anxiety which they, their family, or friends have encountered owing to a lack of easy communication with a doctor. With professional colleagues I usually find that the response is polite but guarded. They seem, not surprisingly, to be as unaware of the publications on the subject¹⁻²⁴ as I was before I came to look into it. In the next three articles in this series I shall discuss why communication so often goes wrong and some ways by which it could be improved.

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Hospital Topics

Ethical problems in feeding patients with advanced dementia

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Summary and conclusions

Aged patients with dementia if not stricken by an acute disease sooner or later approach a terminal phase that is distinguished by a failure of spoon feeding. This condition induces great anxiety in the workers who care for these patients. The interaction between patient and care-worker during spoon-feeding failure is described by the psychological model of double-binding. Two serious consequences of double-binding are the distancing of the care-workers from the patient and scapegoating among the care-workers. It is essential that the pressure of double-bindings in the wards should be reduced.

Introduction

In the terminal phase of the care of elderly long-stay patients with dementia the patient becomes difficult to spoon-feed. The patient bites, spits, swallows the wrong way, and refuses to eat. Some years ago it was common in Sweden to feed such a patient with a nasogastric tube or by intravenous or subcutaneous infusion. Today there is a tendency to avoid both tube-feeding and infusion.¹ A patient who is tube-fed may be bed-ridden for years with contractures, bent like a fetus, with no mental contact with the care-workers. It is hard work to save the patient from decubital ulcers. Some geriatricians in Sweden will not accept patients being fed with gastric tubes from other departments. They believe that the care-workers who gave the patient a gastric tube should take responsibility for the patient to the end. A patient on infusion can be kept alive for only about four weeks. The veins are brittle in these patients. After a few weeks it is no longer possible to feed the patient intravenously. Then she—

most of these patients are women—has to be fed subcutaneously. Many care-workers believe that the infusions cause the patient only pain, and hence they also try to reduce the use of infusions.

The restrictive use of tube-feeding and infusions has, however, made spoon-feeding more distressing for the care-workers. In the past when care-workers had difficulties in feeding a patient with a spoon they were able to resort to tube-feeding or infusion. Now they have to decide whether to continue the spoon-feeding or let the patient die from lack of water and food. This is a difficult decision to take because of lack of knowledge. If the patient dies from water deficiency, has she suffered from thirst? When nurses turn a dehydrated patient they feel that the muscles of the patient are hurting. Consequently care-workers try to continue the spoon-feeding as long as possible.

We describe a psychological model of the interaction between demented patients with imminent spoon-feeding failure and their care-workers, the double-binding model developed by Bateson *et al* in the study of schizophrenia.² We also describe two consequences of double-binding: the use of defence mechanisms, leading to distancing,³ and scapegoating³ games.^{1 4}

Patients and methods

The study was done on four geriatric wards at Saint Lars Hospital housing 96 long-stay patients—mostly with senile, presenile, or multi-infarction dementia—and staffed by 92 care-workers. The term "care-worker" includes doctors, cleaners, sisters, nurses, and auxiliary nurses. The investigation was based on prolonged observation and repeated discussion with caring staff of many years' experience and centred on patients who had become unable to take spoon-feeding. Conclusions were drawn from analysis of tape-recorded, unstructured group discussions with staff from each ward. Most patients with feeding problems were women.

Results

When the patient is difficult to spoon-feed the care-workers may feel conflicting demands:

You must keep the patient alive—It is not easy to decide, "Now the patient takes too little food and drink; we will not, however, give the patient more food by tube or infusion; we accept the coming

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