Contemporary Themes

Listening and talking to patients

IV: Some special problems

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In this last article I want to discuss some difficult problems of communication with patients, in particular with patients who have fatal illnesses.

Patients with special problems

FOREIGNERS

Communication with patients from another culture is difficult in many ways. When they know no English an interpreter is essential for verbal communication, but the doctor can use normal non-verbal methods of expressing interest and concern. It is particularly difficult to find out about psychosocial aspects of the problem. Unexpected misunderstandings can occur with patients from a foreign culture whose English is good: it is easy to assume that because they speak English they think as British people do and to overlook the confusion that may be taking place. Even when it is recognised, it is difficult to overcome without the help of someone who understands both sides.

DEAF PATIENTS

The first thing is to be sure that the patient has a hearing aid that is working. In some hospitals high-fidelity hearing aids are available. Those who have no aid may be helped by putting a stethoscope in their ears and speaking distinctly into the breast-piece. If you have to speak very loud avoid sounding angry. Be sure that the patient is watching you speak and that the light is arranged so that he can see your lips clearly; but avoid excessive mouthing.

PATIENTS WITH MENTAL HANDICAP

Remember that people who cannot talk freely may understand speech normally. The intense annoyance caused to aphasic patients by being addressed, as they often are, in baby language has been vividly described.¹ The handicapped are quick to note non-verbal indicators of lack of concern or respect. They should, like any other patients, be addressed and treated in terms appropriate to their age, using simple words and not

speaking too fast and without the over-familiarity that is often used. Longer pauses than usual should be left for answers to questions, which may be rephrased and asked again if the patient appears not to understand.

Reassurance

Reassurance is necessary in almost every consultation, for patients are usually anxious however calm they seem. Doctors often fail because they are seldom taught how to reassure patients, and few have given any conscious thought to how best to do this in the many situations in which it is needed. The art has been clearly and elegantly described by Kessel.² I will only discuss essentials in three common situations.

PATIENTS WHO THINK THEY ARE ILL

The first is when a patient has no serious illness but thinks that he is ill. It is never enough just to say that there is "nothing wrong." The patient has come because he feels ill or has symptoms, and these must be explained even if no more can be said than that the doctor is confident that they are of no serious concern. Encouraging the patient to come back if the symptoms persist "so that we can think again" may help. This is a common problem and one in which doctors may fail or even increase anxiety by not ensuring that the patient has accepted and is satisfied with their reassurance. Some morbidly anxious patients are difficult to reassure. It may help to give such patients their notes with the reports to read for themselves. Others may need to explore, perhaps with psychiatric help, the unconscious origins of their anxiety, which may be corrected.

PATIENTS WHO CAN BE CURED

The second common difficulty is when a patient has an organic illness that can be cured. Reassurance should then be easy but may be done so curtly that it is ineffectual, for many people believe that doctors never tell the truth about serious illness. It is necessary to ensure that the patient has understood and accepts the favourable prognosis and that he will do what must be done to recover. Reassurance should be firmly linked to the need to follow the prescribed treatment exactly.

PATIENTS WHO ARE GRAVELY ILL

It was only towards the end of my clinical career that I discovered, largely owing to Crammond's paper,³ how often I

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had failed to give my dying patients the loving care and psychological support that they needed. Many excellent, expert accounts are now available on the needs of dying patients and how the caring doctor can meet them.³⁻⁸ Here I can do no more than summarise the principles.

In no aspect of talking with patients are the doctor's own attitudes and philosophy so clearly a condition of success as in caring for patients with fatal illnesses. Doctors must themselves be free from the embarrassment so often caused by the taboo on death which pervades our society. If they are not they will be unable to talk to dying patients with equanimity and give them the confidence they need to handle all the fears, disappointments, and frustrations that they have to face. Embarrassment is hard to conceal and is a sure way to lose a patient's confidence. Religious conviction is not essential: "We may have different ideas about the meaning of life and death but can all try to help a patient to attain some kind of harmony with what he sees as truth and rightness."⁴

What to tell them—When a fatal condition has been diagnosed the first problem is what the patient should be told. A few doctors advocate a frank and firm statement of the truth, but most prefer a policy of concealment. Both of these actions can cause distress. One difficulty in telling the truth is that prognosis is seldom accurately known at the time of diagnosis. We all know of patients who have been told that they have only a few months to live but who, after a period of unnecessary distress, survive for years. We should never assault a patient with what we think is a grave prognosis till he is ready to handle it. It is always possible to temporise, giving grounds for hope, and allowing the patient to become adjusted as the prognosis becomes clearer.

A sensible 50-year-old woman was abruptly told by her surgeon that he thought frankness was best and that the lump in her breast was a "malignant" tumour which had spread to the glands. After her breast had been removed she would have to have radiation treatment. She suffered 10 days of dread at the thought of this malignancy, only partly assuaged by some pamphlets from the Mastectomy Association. At operation a small, marginally malignant growth was found with a clear axilla. She was transformed by the optimism she could now enjoy, which she need never have lost but for her surgeon's practice of telling patients the least rather than the most optimistic version of a diagnosis which is known to be seriously liable to observer error.

Concealment on the other hand implies deception and when the patient finds out that he has been deceived (as almost invariably happens) he will lose confidence in whatever else his doctor says. A common policy is to tell the family, particularly the spouse, but not the patient. This may lead to tension and unhappiness as the patient begins to sense that his family, whom he had always trusted, are deceiving him and leaving him to suffer his fears alone.

The best policy at the time of diagnosis is to tell both patient and family the most optimistic version possible of the perceived facts, admitting that the illness may be serious but encouraging confidence that treatment will succeed. The whole clinical team, including the general practitioner, must agree on this policy. One patient with lung cancer, who I thought had less than one chance in a hundred to survive six months, was desperately worried for his GP had told him he had cancer. I assured him that he could live the five years he needed to enjoy his retirement. Five years later he told me that when I had left my office to arrange for his operation he had told my secretary that he did not believe what I had said. She said "If that is what Professor Fletcher said, you should believe him." It was her reassurance, not mine, that gave him hope.

If the patient believes or suspects that he has cancer he should be told of the many forms of cancer that are now successfully treated. He should fully understand what the plan of treatment is to be, and what it will mean to him. This must be done without hurry and the patient encouraged to ask questions to be answered in this optimistic way. If there are compelling practical or financial reasons for the patient to know that his life may be

shortened he should be encouraged to make appropriate arrangements while being reassured that they may prove to be unnecessary.

Sharing the burden—As the illness progresses, even if favourably, the patient may become demoralised by unexpressed fear. The question is not what the patient should be told at each stage in the illness, but what he needs and is ready to be told at any time. He should be given easy openings to voice his fears: "Are you worrying that you are not doing as well as you had hoped?" or something of that kind, and be given time to unburden himself. Every member of the clinical team can help the patient to talk and give time to listen to him. Most patients are more eager that we should know what they think than that we should tell them what we think.

The patient's fears, resentment, or depression need to be identified as they appear and shared so that his burden is lightened. The patient and family should be kept in step and separated as little as possible so that they can support each other and discover how best to share the limited time available to them.⁷ This may allow estranged families to be united so that the last months of the patient's life may be enriched by renewed intimacy and peace.

Showing that you care—What at all costs must be avoided is neglect of dying patients, as so often happens when doctors pass by the bed with no more than an embarrassed nod. The deepest reassurance is given when a patient is told that whatever he may go through his doctor will stand by him with all the skill at his disposal. Kessel² points out: "That is a great deal, but that is what the medical contract demands. The patient will not be abandoned. A doctor may offer no less."

We must constantly watch and strive to build up our patients' morale. A few simple words at the right moment can make all the difference to a frightened or depressed patient. It may not be necessary to do more than give confidence by small talk about anything of interest. Non-verbal communication can be even more important—a smile with a gentle clasp of the hand or even a hand placed reassuringly on the shoulder. We must try to get the amount of information right for each patient, particularly on what we can be optimistic about even if it is only the prospect of symptomatic relief.⁸

Much of the excellent recent literature on how to handle and help patients with grave illnesses⁵⁻⁹ is concerned with malignant diseases, for this is the commonest form of disease that usually has a steadily downward course. The principles are the same with patients who have progressively fatal disease of other kinds. For all such patients care, concern, and communication to suit their individual needs can change what is too often a miserable stretch of suffering and anxiety into a period of peaceful acceptance and reconciliation which gives strength to those who remain to face bereavement.

Conclusion

In these four articles I have tried to record the essence of what I have learnt in recent years about the importance of skilled communication between doctors and patients of all kinds. This can transform the formal or hurried exchanges of many consultations, which may leave patients beset by anxiety, disappointment, or even resentment, into encounters of mutual confidence and respect from which both patient and doctor emerge with satisfaction. The initiative inevitably rests with us "to read, learn, and inwardly digest" at least some of the ample but generally neglected publications on the subject⁹ so that we may discover for ourselves the value of what it has to teach.

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Lesson of the Week

Streptococcus pyogenes: a forgotten occupational hazard in the mortuary

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We report on an accidentally acquired, serious infection with *Streptococcus pyogenes* in a previously healthy mortuary technician.

Case report

A 25-year-old man presented at 3 am to an accident and emergency department complaining of a painful right index finger and of feeling increasingly unwell. The finger was oedematous, and there was extensive cellulitis up to the mid forearm. He was not clinically shocked, but was pyrexial (39.5°C). He had sustained a superficial nick in the skin of the right index finger while assisting at a necropsy examination of a 73-year-old woman who had died from septicaemia caused by *Str pyogenes* (β-haemolytic streptococcus of Lancefield's group A of M type 1, T type 1) 36 hours earlier. She had been treated with erythromycin. The injury was minor enough to be forgotten until clinical signs of infection developed. He had had no previous episodes of sepsis nor was there evidence of immunodeficiency, and the physical examination was otherwise normal.

He was treated with intravenous benzylpenicillin and flucloxacillin, and over the next 24 hours the cellulitis and the pyrexia subsided. The finger tip, however, became necrotic, requiring exploration and debridement. Culture of the tissue yielded a heavy growth of *Str pyogenes* M type 1, T type 1. Blood cultures taken on admission were sterile on subculture at seven days. Subsequently the patient's finger was amputated through the middle phalanx.

Discussion

Kolletschka, professor of medical jurisprudence at Vienna, died of streptococcal septicaemia in 1847. His finger had been pricked by a maladroit medical student during a necropsy on a victim of puerperal fever. This event led his close friend Semmelweis to recognise the mode of transmission of puerperal

Serious infection associated with "needle-stab" injuries may be caused by *Streptococcus pyogenes*.

fever.¹ Until the introduction of sulphonamides in 1936 this type of infection was not uncommon as a cause of death among medical personnel.² Outbreaks of infection with *Str pyogenes* associated with contaminated vaccine have shown that only a very small amount of infected material is needed to cause fatal infections.³ Although infections caused by *Str pyogenes* usually respond to treatment with penicillin, to which the bacteria are invariably sensitive in vitro, the speed with which they may progress to cause death should never be forgotten. Perhaps in recent times concern with the risk of acquiring serum hepatitis has led us to forget the bacterial infections that may follow "needle-stab" injuries.

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Correction

Non-surgical management of peripheral vascular disease: a review

In the article by Mr C A C Clyne (20 September, p 794) the headings of the first two columns of table I ("Proprietary name" and "Registered name") should be transposed.

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