of suicide after bereavement and here, again, Shakespeare has something to contribute, in the reported fates of Lady Macbeth and Lady Constance (table 1).

Shakespeare recorded fainting under strong emotion on 18 occasions. Nowadays called vasovagal syncope, this often causes myoclonic jerks, easily misdiagnosed as epilepsy.[16] Emotional fainting is quite common, and its mechanisms are familiar—vagal bradycardia and hypotension from peripheral vasodilatation. In Marston's *Antonio's Revenge*, the Duchess of Genoa swoons when she hears that, contrary to what she had just been told, her missing husband is dead (another case of contrary emotions in dangerously quick succession). In the same play, the heroine Mellida swoons at the (false) news of her beloved Antonio being drowned and fails to recover consciousness; this was the one actual death from emotion that I came across in the works by Shakespeare's contemporaries.

Shakespeare had no hesitation in going for dramatic effect by adding a death, a fit, or a faint to a play when this was absent from his source material, even with overtly historical plays such as *Julius Caesar* and *Antony and Cleopatra*. He may even have been more prone to include such "flags of feeling" in his work than other writers of his day, but this survey can do no more than hint at this.

Does Shakespeare, with his unique insights into the human condition,[17] have a message for today's doctors? I think he does: never underestimate the power of the emotions to disturb bodily functions.

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# The night Bernard Shaw taught us a lesson

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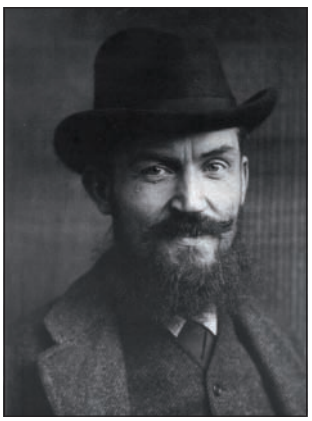
When the chairman of NICE phoned I assumed he'd called to confirm that I was no longer cost effective. Nothing so mundane. He announced that he and the editor of this journal were planning a reading of Bernard Shaw's *The Doctor's Dilemma* to celebrate the centenary of its first production. The performers would be medical persons of irrefutable distinction. Would I help?



Bernard Shaw, about the time he wrote the play

Seven weeks later, and dangerously close to the centenary date, my humble rural cottage was linked by conference call to two of the nation's medical powerhouses, the *BMJ* and NICE Supreme Command. Like the man in *Mission Impossible*, I was told that a theatre had been booked—well, a lecture theatre at the Royal College of Physicians—and my mission, if I was prepared to accept it, was to "adapt" the five act play for a not too arduous reading and to "direct" any members of the cast who could tear themselves away from busy lives for a moment or two of rehearsal.

I accepted the mission with delight. Before, and indeed during, the years I spent as a part time medical student I had appeared in—or, more often, stood in the prompt corner during—professional productions of half a dozen Shaw plays. I even starred in the *Dilemma* as the waiter who appears for 30 seconds at the end of act two and delivers the heart stopping line, "Yes, sir."

Listening from the wings to every scene, night after night, taught me that Shaw was a gifted maker of plays. I've little time for critics who dismiss him as a propagandist who used the theatre to broadcast social and political ideas. Of course the plays promulgate ideas but they are crafted so well and so wittily that they rarely fail to do what plays should do—engage the minds and emotions of an audience.

I decided to adapt the play as if for radio. We cut all theatrical "business" and the performers read their scripts from a row of lecterns. In rehearsal I didn't dwell on technique—or as doctors prefer "communication skills"—but encouraged the performers to do their stuff in their own way, intervening only to suggest a change of delivery to emphasise meaning or to inject variation into the long speeches, of which there were many—though not as many as there were before my "adaptation."

We had so little rehearsal I had doubts we'd get away with it. But doubt started to melt when we launched the first scene and I felt the audience respond. True they were a sympathetic bunch, and we

were helped by mischievous casting. The chairman of NICE played an andropausal physician who uses his power to ration treatment to murder the husband of a woman he wants to marry. The chairman of the BMA Council played a blustering surgeon who sees but one cause and one cure for every illness. Liam Donaldson metamorphosed into an impoverished general practitioner, and an MP, Evan Harris—albeit a Lib-Dem—played a man who had difficulty distinguishing between a loan and a donation.

When the last line was spoken and the audience offered fulsome praise, we knew the source of our success was the genius of the man whose work we were celebrating. Listening once again from my perch in the prompt corner I sensed the empathy and understanding between audience and actors that dramatists can create . . . and which political and managerial wallahs demean with the label "good communication."

Liam Donaldson (Dr Blenkinsop), Fiona Adshead (Minnie Tinwell), Nicholas Godlee (Sir Patrick Cullen), Jim Johnson (Mr Cutler Walpole), and Michael Rawlins (Sir Colenso Ridgeon) at the reading of Shaw's *The Doctor's Dilemma*, on the 100th anniversary of its first production at the Royal Court Theatre, 20 November 1906

## Performance *v* roleplaying

They're not alone. Doctors like to communicate about "communication." During the past 10 years, the *BMJ* has published 406 articles or electronic contributions with this word in the title or abstract. Doctors also take great interest in non-communication. "Breakdown of communication" is one of the commonest excuses for failure or ineptitude.

Much of the medical teaching of this subject never gets beyond the Janet and John stage, concentrating on superficial and often banal "communication skills" rather than venturing on to the richer territory explored by dramatists. On the night of the *Dilemma*, a master craftsman taught us a lesson. Not for the first time I decided that doctors could learn much about their craft from the actors, writers, and directors I've worked with during the second phase of my career.

They have taught me to distinguish between performing, which is a creative activity, and the playing of roles, which is not. If you reduce the craft of communicating to the mechanics of role playing you ignore the limitations imposed by the individual quirks of doctors and their patients. You also imply that a doctor's personality makes a minor contribution to the ability to understand and be understood.

If, however, you acknowledge that communication is a creative performance you accept that a doctor's personality is sometimes the most powerful generator of empathy and understanding.

These qualities cannot be imposed from outside. Performance, as opposed to role playing, is an individual endeavour. Even the most versatile actors know there are limits to the range of parts they can play, imposed not just by their physical accoutrements but by their personality.

There are, of course, doctors so lucky in their genes that their persona needs no nurturing. Our audience was treated to Shaw's description of Sir Ralph Bloomfield Bonnington: "He radiates an enormous self-confidence, cheering, reassuring, healing by the fact that disease or anxiety are incompatible with his welcome presence. Even broken bones, it is said, have been known to unite at the sound of his voice."[1]

That sort of self confidence can be highly reassuring to patients, even those of some intelligence. Indeed it is commonly found in specialists in diseases of the rich. It may look like role playing but the skill with which the power of the personality is used to make the bombast believable defines it as a true performance. It also shows that a therapeutic relationship doesn't have to be a sympathetic one. There just needs to be an emotional link.

This never happens with the role playing favoured by doctors who pride themselves on their "bedside manner," by which they mean charm or sympathy switched on as a deliberate technique: the quick smile swiftly wiped on and even more swiftly wiped off, the show of interest that lives only in the lips and cheeks while the eyes remain dead. These tricks turn doctors into gameshow hosts and create as little sense of trust as a party political broadcast. As Samuel Johnson said, "Almost all absurdity of conduct arises from the imitation of those we cannot resemble."[2]

I've always been intrigued by the qualities possessed by doctors whom patients feel better for seeing, regardless of the treatment they prescribe; doctors whom patients sometimes call "good healers." This therapeutic relationship seems much like that which exists between performer and audience if only because it involves an ability to see the world as it appears in the eyes of others.

For every human action, I suggest, you can define two reasons: the good reason and the real reason. Like actors and writers, doctors who are "good healers" ferret out life's real reasons and, if they're lucky, establish contact with the person who lurks behind the social facade.

## Communication *v* empathy and understanding

The "communication skills" taught to many doctors are nothing more than a beginner's guide to role playing. Much is made of key communication skills, such as "establish eye contact at the beginning of the consultation and maintain it at reasonable intervals to show interest." Of course, eye contact matters. As does regularly checking that patients understand what's being said, asking open questions, and so on. But medical grown ups regard this as pretty obvious. They also know that the quality of eye contact—and how long it is held—varies with the age, sex, and cultural and social backgrounds of those engaged in conversation.

To accommodate this variance yet maintain the illusion of a measurable skill, the academic assessment of communication skills is peppered with equivocating adjectives such as "appropriate" and "reasonable." Appropriate crops up seven times in the schedule for the MRCGP video exam.[3] And reasonable eye contact, I suspect, is less easy to judge than unreasonable eye contact.

Some teachers reject this mechanistic approach. John Skelton, professor of clinical communication, chides those who waste precious time teaching the crashingly obvious. He prefers to encourage his students to learn more about themselves.[3] His approach mirrors that of drama teachers. They don't issue lists of key skills but urge their students to explore their motives and their attitudes in the belief that self knowledge will help them adapt theatrical skills to their own needs.

There are sound pragmatic reasons for medical teachers to follow their example. Doctors need more than imposed techniques if they are to treat illness rather than disease. The two are not synonymous. Diseases can be defined, their causes sought, organisms or mechanical defects identified. An illness is a unique event belonging to one person whose physical condition and emotional state determine the way the disease affects their life.

Even with diseases for which we have compelling data, clinicians have to weigh the generality of the evidence against the needs of the individual and seek to understand the feelings of regret, betrayal, fear, loneliness—indeed all the perplexing emotions—that can turn the same disease into a different illness in different people.[4]

If doctors are to treat illness as successfully as they treat disease they have to enhance their medical experience with some understanding of the world in which they and their patients struggle to survive. Their need, I suggest, is not "communication" but the empathy and understanding that, thanks to Shaw, we and our audience shared on that memorable evening. And we never knowingly deployed a key communication skill.

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## Christmases past in hospital

Christmas in hospital today is a rather sad affair. Most wards are closed, and those that stay open contain very sick patients. These poor unfortunates are unable to enjoy any festivities at all. A greatly reduced team tends to their needs. Their visiting relatives are all serious and sombre. But it was not always so.

Once all junior doctors and nurses lived in the hospital. This was their home. They were as isolated as nuns in a convent and monks in a monastery. Yet an almost family relationship existed among them. At no time was this more obvious than at Christmas.

Christmas celebrations began before the actual day. On the wards there was frantic activity preparing the decorations (which remained until 12th night). Ward sisters kept decorations from year to year, but each year strove to outdo its predecessors. Patients and nurses helped make new streamers.

Local shops took down their window displays on Christmas Eve in preparation for the Boxing Day sales. They gave the decorations to hospitals. A Christmas tree for every ward was brought up by the porters, and the hospital electrician decorated each with lights. Presents for each patient were laid underneath.

Several of the last outpatients before Christmas would be well known to staff. They would wait at the back of the queue until their turn came. They usually had mild chronic diseases, but their greatest disability was loneliness. We would go through a charade ending with, "I wonder whether it might be wise for you to come into hospital for a few days?" The patient's eyes would light up, they would nod vigorously, and admission would be arranged on Christmas Eve.

I particularly remember one who played the organ for the Christmas Day service. Every year she was admitted with severe difficulty in swallowing. Whether it was her organ playing or the hymns and prayers offered that morning in chapel, no miracle was more dramatic than the way her dysphagia recovered the moment I carved the turkey.

The real start of Christmas, however, was when the nurses, wearing their capes and carrying lanterns, toured the wards to sing carols. This ended in the hospital chapel, with a service attended by nurses and patients. The next morning the consultants came, often with their children. Each patient was usually given a further small gift. At the end of this round the consultant, the junior doctors, and the sister would retire to the sister's office for a glass of sherry, and to leave a present for the sister and the nurses.

Then the consultant would ceremonially carve the ward turkey. The junior doctors and nurses took the meals to the patients. And then they would take their own meal of what was left. The ward then braced itself for visitors in their best clothes, bearing gifts and accompanied by children with new toys. The consultants meanwhile would go to another ward to carve another turkey or several, before returning home for their own delayed family meal.

Perhaps the most touching part of the hospital Christmas were the events in the casualty department. Here children would appear in new boots that they had received from the charity of the local newspaper, which had an annual "boot fund." This was a reflection of the generosity of Charles Hyde, its owner, for our city. These boots were the only ones these children would receive until next Christmas. Each child was tended to gently by a doctor and a nurse: a little rubbing of a bruise and perhaps a bandage to get sympathy at home. And then to the tree. To their surprise there was always a parcel with their name on it—the only present that most of them would receive.

The children's relatives were given mince pies. No matter how many children or parents came there was always a present, and the supply of pies never faltered. I never knew how Sister Cunningham, who ran our casualty ward, did it: it was as though one was watching a miracle. While the children unwrapped and the parents munched, the nurses and doctors looked on. The young doctors received thirty shillings a week as their salary and the nurses less, but for them this was the spirit of Christmas—to give with no expectation of return. The recipients' joy is something that all who saw it will remember for ever. Perhaps with our modern wealth we have forgotten that spirit.

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