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. 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, have a message for today’s doctors?

I think he does: never underestimate the power of the emotions to disturb bodily functions.

Competing interests: None declared.

3 Kail AC. The medical mind of Shakespeare. Bingley: Williams & Wilkins, 1986.
18 Doi 10.1136/bmj.39062.728900.55

The night Bernard Shaw taught us a lesson

Michael O’Donnell

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?

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 least. Impossible, I was told, to adapt the five act play for a one-act performance. 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.”

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.”

That sort of self-confidence can be highly reassuring to patients, even those of some intelligence.

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 MRCPG 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 crassly obvious. He prefers to encourage his students to learn more about themselves.5 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.6

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.

Competing interests: None declared.

3 Skelton J.R. Everything you were afraid to ask about communication skills. Br J Gen Pract 2003;53:40-6.
5 doi 10.1136/bmj.39062.728900.55

Cultural studies

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. Presents for each patient were laid underneath. 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.

George Watts retired consultant surgeon, Birmingham