

Trust me, I'm a communicator

A medical degree, according to George Bernard Shaw, is no substitute for clairvoyance. We can never eliminate the insecurity of medical uncertainty, which is precisely why we need trust.¹ In the paternalistic model of consulting, doctors are accorded blind trust and in response take the emotional 'hit' for their patients' uncertainty. In the new model of shared decision making, professional trust has to be earned through honesty about the limits of medicine and the unpredictability of illness. But sharing uncertainty requires skilful communication to avoid the ultimate irony of truth undermining trust.

Absolute truth may be an egalitarian ideal but it may not be practical, or indeed desirable. As Mendel argues:

'Whilst hypocrisy is odious, it is absurd to go to the other extreme. Role-playing, with its inevitable less-than-complete truthfulness, is an integral part of the art of medicine'.²

Nearly half a century ago, Balint observed that the doctor's attention is a potent prescription,³ a view later echoed by Blau:

'The doctor who fails to have a placebo effect on his patients should become a pathologist or an anaesthetist ... In simple English, if the patient does not feel better for your consultation you are in the wrong game'.⁴

Although this is undoubtedly unfair to today's anaesthetists and pathologists, the concept of 'doctor as drug' is as relevant as ever. The challenge is whether, and how, we can retain our placebo effect while communicating risk and sharing decisions in the context of a time-pressured, blame culture. A GP recently sent me an anonymised letter from a neurosurgeon, with patient consent for publication:

'I offered this lady an L4/5 discectomy. I have told her that the risks include, but are not limited to, complications of anaesthesia, bleeding, infection, development of any neurological deficit,

for example weakness and numbness of the legs, problems with the bladder or bowels, CSF [cerebral spinal fluid] leak, no improvement in current signs and symptoms, worsening of present signs and symptoms, death, and other seen and unforeseen complications. She understands and wishes to proceed.' (T Craighill, personal communication, 2004).

Were the surgeon to provide 'a (numerical) estimate of the relative risks and benefits of the proposed treatment' that was 'sufficiently detailed to enable the patient to arrive at a balanced judgement, having had a chance to put their own value on the relative risks and benefits described',⁵ it is possible that the process of consent might take longer than the operation itself. The doctor's placebo pendulum might also swing into the negative. Yet the concept of consent is the basis of civil law and a new 'Godless' morality,⁶ and it has been proposed that explicit documented consent should be extended to 'non-invasive investigative procedures, injections and even aspects of the bedside examination'.⁷ As Tallis argues:

'The ideal of informed consent, seemingly the least contentious principle of medical practice, and one of the most closely studied aspects of doctor-patient communication, runs into trouble as soon as it has to be realised in the real mess of the real world'.⁷

By the end of this year, patients in England will be offered a choice of five providers at the point of referral,⁸ with GPs largely charged with navigating this maze of comparative risk and informed choice in the timeframe of a consultation. Clearly we need help, and quickly.

In this month's Journal, Edwards *et al*⁹ report on GPs' experiences of implementing shared decision making and risk communication training. The intent was promising, with doctors positive about involving patients, but the frequency of

applying the new skills was limited outside of the trial:

'Doctors were selective about when they felt greater patient involvement was appropriate and feasible, rather than seeking to apply the approaches to the majority of consultations.'

The free text comments of the doctors are very illuminating: 'A lot of patients said "I never knew why I was put on this and it's really nice to understand why I've been given this treatment"'. And some doctors reported that they used the risk communication packages to legitimise and justify decisions made, rather than as tools for sharing decision making.

These findings would doubtless appeal to John Skelton, who has for many years advocated a deeper approach to teaching and understanding communication, rather than focusing heavily on surface skills and competencies. Were it not for his evident wit and wisdom, some might be offended by his paper 'Everything you were afraid to ask about communication skills'.¹⁰ Like a boy pointing at a naked emperor, Skelton questions the wisdom of our absurdly reductionist view of human communication and the 'low threshold of challenge' that results.

I should declare that I learned the art and craft of teaching medical communication with Skelton's guidance at the University of Birmingham. I subsequently took up a lectureship in communication skills in Bristol but to this day I can't, with absolute certainty, name any of the 70 individual, evidence-based communication skills that comprise the Cambridge-Calgary observation guide.¹¹ Fortunately, I can guess most of them, which is precisely Skelton's point. Why do we articulate and research the obvious? As a student, I found it patronising in the extreme to be told I should greet a patient and establish eye contact. But I wanted to understand why doctors didn't always do it.

There are approaches to communication that are undoubtedly useful; connecting, listening, acknowledgement, summarising,

clarifying, agreeing, and safety-netting are the ones I most often use, but when I'm conscious of a consultation going wrong, the problem usually lies deeper. You only have to ask: 'Do I give patients who irritate me a worse deal?' to appreciate the importance of attitudes in human communication. But do attitudes determine skills, or can attitudes be forged by attention to skills? It's an ancient debate, neatly articulated by Skelton.

Innes completes the triad of communication papers with an application of chaos theory to complex consultations. It's a deep and thoughtful approach, which brings us neatly in where we started:

'For too long, the medical process has been presented as one based on predictability and certainty, a presentation supported by the myth of physician supremacy and the power of modern medicine ... The "necessary fallibility" that arises from the complexity of individuals and health has been largely ignored'.¹²

Innes believes that by viewing the consultation as a complex adaptive

system, 'it increases our understanding of uncertainty and unpredictability'.

The challenge is how to communicate this understanding. GPs are already very adept at 'hedging'. Many consultations can be reduced to the sentence, 'I'm not entirely sure what the diagnosis is, but I'm fairly certain it's nothing too serious', but as nurse practitioners filter out more straightforward problems, GP consultations are becoming increasingly difficult. In addition, we have to assimilate the twin political pressures of a very computer-driven, disease-based style of practice with offering patients myriad choices that they may not want. If communication research and teaching are going to be useful and relevant, we must move on from simplistic skills and get real about the complex politicised chaos facing frontline GPs and patients.

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Ensuring that research governance supports rather than stifles research

A research governance framework was introduced in 2001 and updated in 2003 to ensure 'high scientific, ethical and financial standards, transparent decision-making processes, clear allocation of responsibilities and robust monitoring arrangements for research taking place within the NHS'.^{1,2} The overall aim is to improve the quality of research and protect the public while minimising bureaucratic processes.³ However, the haphazard application of the laudable aims of the framework risks having the opposite effect and bringing multicentre research to its knees.

Anyone intending to conduct research in primary care must obtain permission from

the primary care trusts (PCTs) in which the research will take place. PCTs have a responsibility to maintain records of all research being conducted in their area and to ensure that it meets the defined standards. In particular, all research must have ethical approval, be peer reviewed and have a defined sponsor who takes ultimate responsibility for its quality.

Ensuring the quality of research is clearly vital. But a well-intentioned policy has been implemented in PCTs with little experience of hosting research, by staff who are inadequately prepared and may have other priorities, against a backdrop of complex legislation, with often chaotic results. Although researchers have

repeatedly complained about the difficulties of obtaining ethical approval,⁴ our recent experience suggests that this is now relatively straightforward compared with obtaining research management and governance (RM&G) approval.

In order to conduct a national postal survey of GPs, for example, it is necessary to seek approval individually from every PCT in England. RM&G contacts are often difficult to identify and there is a lack of consistency between PCTs regarding the documentation they require. The volume of paperwork, from the researchers' point of view, is almost overwhelming. For one recent project we needed to send 44 different documents to