Basic communication and counselling skills in the training of doctors

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Curriculum vitae

Dr M V (Mossie) Silbert was born in 1930, schooled in Paarl and studied at UCT where he obtained the MB ChB in 1954. He did his internship at Greys Hospital and has been in general practice in Sea Point since 1959. From early on in his professional life he took an interest in the maintenance and improvement of standards of general practice; this is attested by his active membership of a long list of colleges and similar professional bodies. Dr Silbert's special interests are in geriatrics, emotional problems and the care of the dying patient - and has written extensively on this. He was awarded the Louis Leipoldt Gold Medal and in 1984 he was the recipient of the prestigious Hans Snyckers Award.

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Summary

An important area of the doctor's medical competence is his ability to communicate with his patients. This area is badly neglected in the training of students and the ripple effect of this in the whole spectrum of medical care is emphasized.

In a document published by the Royal College of General Practitioners in 1981, titled "What sort of doctor?"[1], it is stated that four areas of a doctor's competence should be evaluated or be under constant scrutiny. These comprise: the doctor's clinical skill; his ability to *communicate;* his accessibility; and his professional values. Ability to communicate is ranked the second most important area of competence, and yet it is universally recognised that poor or non-existent communication is rated by patients as one of the most important sources of dissatisfaction in their relationship with their doctors.

Medical literature abounds with surveys of such opinions held by patients. Ley[2] and Congalton[3] state that lack of information from medical staff and the use of medical jargon incomprehensible to the patient, are prominent items of dissatisfaction. Badly chosen words or inappropriate statements by doctors offend or disturb patients. The term "neurotic" for instance, is upsetting to patients because they interpret it as a judgemental assessment of their personality. "You have a 'damaged' heart" led a very anxious patient to make arrangements for early retirement - a retrogressive step, as he had suffered a mild heart attack from which he would make a complete recovery. In this latter instance, adequate explanation of the illness, adequate time given to *listen to the patient's feelings,* and what was really bothering him, were absent.

Although many doctors do in time, become natural and skilled interviewers and listeners, few of us overcome communication difficulties in those commonplace problems encountered in practice such as

breaking bad news, explaining illness, sudden death and family crises ranging from marital breakdown to terminal illness. It may be argued that counselling in these situations falls within the province of the social worker, psychiatrist or psychologist, but every doctor, in particular the GP, is inevitably in the front line of these crises. Members of other disciplines are intensively trained to cope with such crises; should the doctor also not possess knowledge of at least basic skills and

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principles of counselling and communication to cope with these situations?

It is not only GPs however, who need to concern themselves with communication or counselling. Should an ophthalmologist, for instance, not be able to counsel appropriately a patient with incipient blindness? A survey of 16500 doctors in Australia revealed that 43% of GPs and 23% of specialists had taken, or were considering taking, extra training in communication and counselling skills.

It appears therefore that it would be appropriate to expose all trainee doctors to communication skills during their undergraduate training. Students are keenly observant of how their tutors relate to, and communicate with patients. But it is not only by precept and example that students should be taught. The glossary of communication skills reflects the need for a didactic approach. Terms such as open and closed questions, non-directive

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skills, patient-centred style, non-verbal cues, empathy, may be rejected by organocists as so much jargon, but they comprise some of the basic principles in communication skills. Awareness of these enhances doctor communication and the quality of patient care.

Although the teaching of communication skills is being implemented at some of our medical schools by physicians interested in the topic and by psychiatrists, Nash[4] is concerned that doctor-patient communication is not adequately covered in the undergraduate medical curriculum. At the University of Cape Town, in a course on the teaching of human behaviour to third year students, emphasis is placed on aspects of communication viz. methods of communication, doctor-patient transactions, and social and cross-cultural aspects. This should be re-emphasized to the clinical year student, ie. once the student has become exposed to patient care when communication becomes more relevant. By far the majority of students have shown to be extremely receptive to instruction in communication, and to benefit from such training.

Video cassette recordings have been found in most teaching institutions to be a most suitable medium for exposing students to communication and counselling skills. Of interest is a programme being carried out at the Albert Einstein College of Medicine where preclinical students are exposed to a video recording with subsequent discussion of the patient's feelings about her illness, eg. carcinoma of the breast and mastectomy, while being taught the pathological and surgical aspects of the illness.

Communication problems are not confined only to

Poor communication has a ripple effect in the whole spectrum of medical care

the immediate doctor-patient relationship, however. There are ripple effects in the whole spectrum of medical care. Of special interest for instance, is a survey by Blackwell[5], that between 30% and 50% of patients do not comply with prescribed medicines, or actually forget or reject their doctor's advice because of poor communication. (It is estimated that in Britain £300 million is wasted in the National Health Service every year for this reason.)

Another survey by Leigh Walker et al[6], of pre-operative surgical patients, demonstrated that failure to communicate adequately with such patients preoperatively, often delays post-operative recovery. Providing surgical patients pre-operatively with opportunities to discuss their feelings and anxieties - many of these misplaced and irrational - reduces the need for post-operative analgesics, and hastens recovery.

In the sphere of diagnosis and interviewing, the singular importance of *listening* as a communication skill has been emphasised by numerous authorities. In this so-called "patient-centred" style of communication, the doctor adopts less of an inquisitorial or authoritarian attitude - "doctor-centred style", and listens to what the patient wants to say or is trying to say. Michael and Enid

Balint[7] have demonstrated the significance of tuning-in to the unspoken signals which patients use in the doctor-patient relationship and transactions, as a means of communication.

The Academy of General Practice/Primary Care recognises the problems which general practitioners are experiencing in doctor-patient communication and counselling, and provides facilities for improving our competence as general practitioners. Those of us engaged in general practice teaching in departments of family practice at our medical schools, should also be constantly aware of exposing students to this aspect of medical care. The privacy of the patient's home and of the consulting room provides an appropriate setting for us to expose students to communication with patients and their families. We should not fail to utilise this unique facility to its fullest.

We are caring for people and their families, and we must talk with them. Our profession is criticised for being caught up with the technological, the material, even the mercenary, and that the practice of medicine has subsequently become dehumanised. Skilful and sensitive communication humanises the practice of medicine by enhancing total care of the patient - care for his physical, psychological and social needs, and ultimately caring about him as a human being.

Ability to communicate is an important area of competence for a doctor

Listening as a communication skill ...

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