Conversations Inviting Change

EFFECTIVE DIALOGUE FOR HEALTH & SOCIAL CARE

Conversations Inviting Change - John Launer, 2008

Why don't doctors pursue lifelong learning in their communication skills just as they do with their scientific and technical skills? Good medical communicators have fewer complaints in their careers [1]. They cost their employers and insurers less in negligence claims. Doctors who communicate well are better at putting patients at their ease. They are more likely to be given the right information, to make the right diagnosis, and to recommend the most appropriate treatment (which patients are then more likely to take) [2]. They will be able to cope with the large proportion of cases where people want to discuss their lives as well as their bodies. There is in fact an inextricable link between good communication and simply being a good doctor. The lack of any requirement for working doctors to keep improving their communication skills, as have to do with their other skills, isn't just surprising. It's alarming.

At present, most training in communication skills takes place in undergraduate medical schools. This is paradoxical. It means that students are exposed to this training when they are seeing very few patients, and have no direct responsibility for any of them. They may acquire some basic skills to use in their later careers. However, it may be several years before they can try these out in the real world, where attempts at good communication have to compete with a tremendous number of other pressures. These pressures include heavy workload, the hierarchy of the medical team, and the need to make quick decisions. It is rather like learning to ride a powerful motorcycle along quiet village roads and then being asked to navigate at speed around Hyde Park Corner, without ever having a chance of further training, observation or assessment.

There are a few examples of specialities that encourage training in communications skills beyond medical qualification. Trainee GPs usually examine videotapes of some of their consultations with their trainers, but this stops as soon as they complete their training. Some established GPs – although only a tiny number in the United Kingdom – belong to Balint groups, where the emotional aspects of consultations are scrutinised [3]. Psychiatrists may spend time talking to each other in detail about their consultations. However, even in these contexts, the emphasis is often on general issues of doctor-patient communication, rather than on what exactly the doctor said, and what effect this had on the patient. The vast majority of doctors in most specialities never once sit down to consider systematically the words and phrases they use when conversing with patients, or the tone and manner in which they deliver them. I suspect that most patients would be astonished to discover this.

Doctors and their patients may in fact have far lower expectations regarding good communication than they should have. There is an interesting contrast here between medical doctors and psychological therapists or counsellors. Most people in these professions regard conversations as therapeutic in their own right. They approach each consultation with the assumption that the acts of talking and listening will bring about change as a matter of course. They give priority to the teaching and learning of communication skills not simply because it will lead to better treatment, but because it will *be* better treatment. Therapists learn precise micro-skills that make the conversational skills of many doctors seem crude by comparison. Their training enables them to pick up exact words, hesitations, nuances of tone, or gestures of hands and body, and to be able to follow these through with sensitive questions or, if appropriate, with silence.

There is clearly a difference between medicine and psychological therapy. However, there is absolutely no reason why medical consultations should not be therapeutic in the same way. There is also no reason why the psychological effects of a good consultation should not go alongside the effects brought about in other ways, such as a careful physical examination or the right pharmaceutical treatment. Indeed, one of the markers of an effective consultation may be the doctor's ability to bring about an improvement both as a result of the consultation and through the conduct of the consultation itself.

Because communication is a two-way process, some people prefer the term interactional skills', and this makes a lot of sense. Good interactional skills are necessary not just for the consultation. They are essential in a wide range of other situations, including conversations with colleagues and in teams. Doctors with good consulting skills are generally good at helping their colleagues and juniors as well, through attentive listening and thoughtful questioning. They are better at promoting open communication in their teams and networks. A culture of good conversations is likely to lead to better systemic function within the workplace generally, and hence to greater patient safety and quality of care.

I have been personally involved in running trainings in interactional skills for over a decade now, and have watched as the demand from working doctors has expanded hugely. When we started in the mid-1990s, we only taught a dozen or so GPs each year [4]. Now our workshops and courses are available to all GPs in London who are trainers or who carry out appraisals – well over a thousand in all [5]. Recently we have extended our teaching to hospital doctors as well, and are offering workshops to acute hospital trusts right across London. Our courses draw on the ideas and skills used by therapists, especially those who see families and children. We teach mainly through the medium of peer supervision [6]. We ask doctors to talk to each other about difficult cases they have seen. We teach them to listen with minute attentiveness and to pose questions in a way that is both supportive and challenging. The technical term for our approach is 'interventive interviewing' [7] but we prefer the friendlier term 'conversations inviting change'.

We base much of our training on narrative-based medicine, which teaches that everyone – doctors and patients alike – has a need to tell stories in order to make sense of their experience and the world around them [8]. Sometimes these stories can become 'stuck', but if we question people sensitively they will generally find a way of telling the story in a different way, and then see the problem in a different way too. Encouraging patients to develop a new and more hopeful story about themselves can be as much a part of healing as any physical treatment. This is especially true in cases of chronic illness and disability,[9] in 'grey area' conditions like chronic fatigue and fibromyalgia, and with somatisation [10]. It also holds true with doctors who may be feeling hopeless or inadequate with some of their cases.

All conversations, whether with patients or colleagues, can be therapeutic. Collectively, good conversations can transform a working culture from one that is technocratic, impersonal and potentially dangerous, to one that is both kinder and safer. We need to persuade doctors everywhere that the lifelong development of interactional skills is a core professional need.

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