# Medical Opinion

# Communication skills for anesthesiologists

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**Purpose:** To provide a simple, practical guide to communication skills which might be useful to practising anesthesiologists.

**Source:** Selected citations from the literature on patient-physician communication, and the personal observations of the authors based on their reading and experiences.

**Principal findings:** Basic communication skills are introduced, and then their application to clinical anesthesiology described. The possible benefits resulting from the enhancement of clinical communication are outlined. Strategies for tackling four commonly-encountered situations - handling others' feelings, imparting information, explaining complex concepts simply and breaking bad news - are presented. By taking a skills-oriented approach, we hope that readers will be encouraged to view this area of their work as one that can be improved upon with continued observation and practice.

**Conclusion:** Communication skills can enhance medical practice and improve patient outcomes. We suggest that all anesthesiologists should give thought to their effectiveness in this area.

**Objectif :** Présenter un guide simple et pratique des qualités relationnelles utiles aux anesthésiologistes en exercice.

**Source :** Citations choisies dans des articles sur la communication patient-médecin et observations personnelles des auteurs basées sur leurs lectures et leurs expériences.

**Constatations principales :** Nous décrivons les qualités relationnelles fondamentales et leur application à l'anesthésiologie clinique. Nous indiquons les avantages possibles de l'amélioration de la communication clinique. Nous présentons des stratégies pour aborder quatre situations habituelles - tenir compte des sentiments d'autrui, transmettre des informations, expliquer simplement des concepts complexes et annoncer une mauvaise nouvelle. En choisissant une méthode axée sur des techniques, nous souhaitons que les lecteurs seront encouragés à considérer cet aspect de leur travail comme pouvant être amélioré par l'observation et la pratique.

**Conclusion :** Une bonne communication peut rehausser la pratique médicale et améliorer l'évolution du patient. Tous les anesthésiologistes devraient songer à leur compétence dans ce domaine.

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CLINICAL anesthesiology, like most areas of medical practice, involves more than the application of medical knowledge to patients. Each of us uses a wide range of other skills which may not have been taught at medical school but without which we cannot practise our craft. Foremost amongst these are communication skills. Gone are the days when newly-qualified but unpersonable doctors could be directed into anesthesiology on the grounds that this did not entail direct contact with patients; today we have extended our role to the delivery ward, intensive care unit and pain management clinic. Poor communication is implicated in complaints by patients and medical misadventures, and bedevils professional and personal relationships.[1] We need such skills for counseling patients preoperatively, for improving compliance with treatment and for breaking bad news. What follows may be unfamiliar to many anesthesiologists. However, when we started training in anesthesiology we learnt a repertoire of *skills* (airway management, invasive monitoring, pain relief) which we then combined into an *anesthetic technique* appropriate for an individual patient. Initially, we were aware of this process, but it soon became largely subconscious with practice. We have approached the subject of communication in the same way, by looking first at specific skills and then applying them to commonly-encountered situations.

## Benefits of improved physician-patient communication

### *Benefits to patients*

Many benefits can be expected from improved clinical communication. The literature on the patient benefits of improved communication has been carefully reviewed for a number of outcomes in a variety of healthcare settings.[2–4] Little of this work has been carried out within the domain of the anesthesiologist and hence there is scanty empirical work for us to draw on in the preparation of this article, though there are some notable exceptions.[5,6] However, over a range of other settings, outcomes as diverse as patient satisfaction[7] and functional limitation in patients with peptic ulcer[8] have been shown to be improved by enhanced physician-patient communication in randomised controlled trials.

### *Benefits to staff*

Communication difficulties are often cited as stressors by resident medical staff.[9] It might be expected that more senior clinicians would be helped by their greater experience; however, some are still troubled by feeling insufficiently trained in communication skills.[10] Thus, one would expect that greater facility with communication issues would make physicians and other staff more comfortable about this aspect of their work. The perception that we are more effective clinicians can only enhance our personal and professional self-esteem and work satisfaction, and the general improvement in the way we interact with other human beings should extend also to relationships with colleagues.

### *Benefits to health providing organisations*

If it is perceived that more effective care is being provided for patients, the reputation of the institution will be enhanced amongst patients, referring doctors and the community in general. One might also expect a decrease in litigation by patients.

## Tools of the trade: communication skills

### ESTABLISHING RAPPORT

As doctors we are used to gaining the confidence of strangers quickly. Yet, some of us are without doubt more skillful than others. The state of *rapport* occurs when one person appreciates that another's world may be different but tries to understand the other world. *Sympathy* is the capacity for sharing the feelings of others, but still suggests that we apply our own world-view to the other's circumstances. *Empathy* goes further; it implies entering the other's world, not just appreciating that it is different.[11] The art of establishing rapport incorporates many of the following specific skills.

By using *non-verbal signals* we convey our attitudes and values to the patient even before a word is spoken. We can show that we are receptive by making and maintaining eye contact, and by positioning ourselves appropriately in the room. To remain standing while the patient is seated is off-putting; a better way is to sit beside the patient, at their eye level or at an angle to them rather than straight opposite, which may be too confrontational.[12] As well as the words we speak, we have other ways of making ourselves understood; in fact, non-verbal communication is extremely powerful. Argyle has found that, where verbal and non-verbal messages concerning interpersonal attitudes are contradictory, observers tend to 'believe' the non-verbal one.[13] Tone and volume of voice, intonation, emphasis, facial expression and gestures all convey meaning; in fact, it has been estimated that such non-verbal elements carry most of our meaning, with only 7% of what we communicate contained in the actual words we speak.[14] Physical closeness and touch also have a part to play. Adopting some aspects of the patient's body language - for instance, frowning when they frown- is known as *mirroring* and also helps to establish rapport.

*Listening* is not simply keeping quiet while you wait for a chance to express the next thing you have to say.

Most people are readier to talk than listen and being in a position of power and responsibility tends to accentuate this. Yet, often, even when the conversation will end with our giving advice or offering information, we can do this most effectively if we understand the patient's background, beliefs and concerns. Developing an attentive frame of mind may require a little practice; it is easier to look inwards, on your own thoughts and feelings, or on speculating about what the other person is saying. Try to focus attention outwards.

*Encouraging* the patient to speak may be necessary.[15] If they are talking freely, you may need to do little more than maintain eye contact, and use the simple prompts of nodding and occasional interjection. If they need to be drawn out - and people don't always know what the problem is until they try to put their thoughts and feelings into words - then other techniques are appropriate. Questions (see below), checking that you have understood ('Have I got this right?') and repeating the patient's last phrase or a particularly puzzling word, may all be useful. Summarising what has been said so far is valuable, as may be using the patient's own words. Intentional silence may help to create a feeling of 'space' and encouragement to speak.

### Asking questions

Even when people are talking freely, questions may still be needed to guide and prompt them. However, the type of question will often predetermine the response you get and it is important to be aware of this.[16] *Closed questions* allow only one answer ('How old are you?') or a limited range of possibilities ('How did you get here today?'). This may be unobjectionable for everyday purposes. Indeed, such questions are usually easy to answer and are often used to put someone at their ease, for example at the start of a selection interview. However, if your aim is to identify how others are feeling, or persuade them to volunteer information, *open questions* are more fruitful. ('How do you feel about...?') Respondents are free to reply in their own words and answer in any way they like. The closed question 'Are you satisfied with your care in hospital?' is likely to yield less information than a more open version 'What did you think of your care in hospital?' though both enquire about the same experience.

*Leading questions* (You don't suffer from heartburn, do you?') tend to lead to a particular answer. This is all the more likely if the patients are eager to please their anesthesiologist by giving what they think is the expected answer, whether true or not. Another common mode of questioning, especially amongst busy doctors, is the *sequence* ('Do you have a cough? Sputum? Shortness of breath?') When the patient answers, which question are they answering? All of them, or merely the last in the sequence? Professional interviewers sometimes make use of sequences of questions, for instance moving from open to closed, to guide and explore more effectively.

### Understanding a different model of the world

One of the quickest ways to render a therapeutic conversation useless is to make the patient feel they are being judged, criticised or ridiculed. Patients come from a variety of backgrounds and cultures and differ widely in education and experience of life. Their beliefs and understanding cannot be dismissed simply because they happen to differ from those of their doctor. Acceptance of the patient's viewpoint is an important element in creating rapport[17] but some have argued that the professional detachment which physicians acquire during their training tends to leave them less able to empathise with their patients.[11] Perceptions of quality of life are one example relevant to our intensive care population. It is important to accept what people say as representing how they see the world, even if it comes across as threatening, bizarre or apparently stupid. You may need to challenge them, but this should be reserved until later. In the early stages of the conversation, the patient deserves to be listened to without hindrance.

### Developing self-awareness

Before you can help others, you need to be aware of yourself. For instance, how do you feel when you are asked to meet the relatives of a patient with severe acute respiratory distress syndrome to tell them that his kidneys are now also failing? Are you anxious in case they ask if he has been inadequately treated? Are you irritable because it's towards the end of a long shift and you are tiring? Are you despairing because you feel helpless? Whatever your own feelings, it is important not to let them interfere with the job in hand, although the doctor's anxieties can easily do so.[18] When you meet the relatives, it is likely that you will form a rapid assessment of their intelligence and social background and make some assumptions about their attitudes, preferences and values. Our minds are used to completing a mental picture when some of the parts are missing, but reaching conclusions about the people we meet based on inadequate evidence can be unhelpful. We need to deal in facts, not assumptions.

## Applying the skills: framework and specific tasks

Although we most commonly use the word 'interview' in relation to the process of selecting a candidate for a

job, this is only one of a number of applications. An interview has been defined as 'a conversation with a purpose'.[19] However, many doctors do not think of interviews as having a format. Medical students often ask permission to 'have a chat' with a patient before attempting to take a history and this informality may be in keeping with the unstructured dialogue which then follows. As Umberto Eco has observed: 'Chat is the everyday manner in which we are spoken by pre-existent language rather than our bending language to ends of comprehension and discovery'.[20] Focusing on the purpose of the interview will help direct it to a satisfactory conclusion, and remembering that even the simplest interview should have a *beginning*, a *middle* and an *end* provides the structure to build on.

### BEGINNING

The physical setting for the interview should be right. Important conversations cannot be successfully undertaken in unfavourable circumstances. This means that somewhere comfortable is required, where you will not be interrupted.[21] 'It is regrettable that patients are often afforded more privacy, thought and time during a meeting with a bank manager, accountant or veterinary surgeon than with a doctor'.[22] A plan of what you hope to achieve in the interview is essential, as is ridding your mind of other preoccupations and redundant feelings. At the beginning of the interview, introductions should be made and the purpose of the interview outlined. It may also be appropriate to indicate how long it is likely to take. This helps to establish rapport but before getting down to the task in hand, it is worth investing more time on this. One useful technique is to enquire what the person you are interviewing already knows.[23] This gives you some information and some words which you can mirror. It also provides a basis for the conversation and allows you to avoid contradicting what might have been said previously.

### MIDDLE - GETTING DOWN TO THE TASK IN HAND

#### *Dealing with feelings*

The fundamental strategy when dealing with feelings is to acknowledge them, whatever they are. Many doctors feel uncomfortable dealing with patients' feelings. Sometimes this is because of the way the doctor feels about the patient, or about what the patient is saying. In fact, one of the main reasons for trying to focus on the patient while listening to them is to help distinguish the patient's problems from the doctor's. Trying to avoid judging the patient will also help keep the doctor well-disposed towards the patient.

Anger is common and serves to illustrate the strategy. Patients or their relatives may feel aggrieved, but this is not always expressed immediately. When a problem is compounded by further upsets, an apparently minor trigger can lead to a major outburst. The first priority is to stay calm and not become angry in return.[22] It may be natural to be defensive, but the anger is seldom directed personally. Acknowledge the anger ('You are obviously feeling angry about this...') and then try to identify the contributing reasons - and there may be quite a number of these. Only when all the reasons have been elicited should you begin to seek to resolve any of them.

*Uncertainty* is another common experience. Patients and relatives misinterpret things; people read things into what to us are quite innocent remarks. They learn from each other, comparing notes about their treatment and drawing their own conclusions. If direct communication does not take place, signs such as how long the physician round spends at the end of a bed during a round, or the expressions on the faces of the staff, are endowed with unintended meaning. Ignorance may be blissful; uncertainty is not.

*Anxiety* is perhaps the commonest feeling that anesthesiologists encounter. Preoperatively, patients commonly have one or more of a number of specific fears related to anesthesia.[24] The most frequent are waking up when they should be asleep (unintentional awareness) or staying 'asleep' when they should be awake (death). Other fears identified include postoperative pain, nausea and vomiting, painful or distressing procedures (masks and needles) and giving away secrets or showing oneself up when disinhibited by anesthetic drugs. Underlying many of these is the perception of loss of control which is frightening for many people. Although it is an inevitable part of general anesthesia, we can go some way to restoring psychological equilibrium by involving the patient in decisions and discussing anesthetic options. Choosing techniques such as patient-controlled sedation or analgesia may also help. The major benefit of preoperative information may be its effect on the patients' perceived control over their hospital experience.[25] This can be powerful and far-reaching; Anderson[6] found that cardiac surgical patients whose preoperative preparation consisted of an information-plus-coping package reported less emotional distress, made better recovery and were less likely to suffer postoperative hypertension than those who received only 'routine' information. Other strategies, such as relaxation techniques, may reinforce these benefits but are not widely used.[5]

Some of the patients' worries may be quite surprising. For instance, one study found that 45% of patients admitted to concerns about the qualifications of the anesthesiologists, but only when asked direct-

ly.[25] It is clear, then, that patients have different concerns, and it is important to be able to recognise this and elicit the concerns individually. 'Double-guessing' the patient's anxieties and attempting to reassure patients on matters that had not previously troubled them may lead them to lose confidence in the anesthesiologist, if not become even more anxious! It is important to realise too, that patients differ in their coping styles. Some reduce stress by seeking information, and some by avoiding it. Whilst current trends suggest that all patients should be as fully informed as possible, this may not reduce their anxiety levels preoperatively, and the amount of information as well as its comprehensibility will need to be matched to each patient's needs. Furthermore, medical reassurance may have only a short-lived effect, dependent on the patient's general anxiety about their health[26] and the preoperative visit may be better spent simply trying to establish a trusting relationship rather than dealing with individual fears.

*Imparting information*

A common complaint from patients is that they are not given enough information.[1] Few patients complain of being told more than they want to know. Those who do are often the ones who maintain denial to cope with anxiety. However, when information is given, it may be of the wrong sort, or come at the wrong time. There may be many reasons for this. A few decades ago it was simply unfashionable to keep hospital patients fully informed. Doctors and others may believe that patients simply do not wish to know, or that they will not be able to cope with difficult truths. Simple practical reasons may play a part, in that pressure of time may prevent clinicians dealing as fully as they might like with this aspect of patient care. If the interview entails your giving information, of whatever kind, ask the patient first what they already know and then if there are particular areas they wish to know more about. The patient should be given time to react and opportunities to ask questions,[22] for it can be difficult otherwise to ascertain what impact the news has had, or indeed how much has been understood.

*Explaining complex concepts simply*

Much of what anesthesiologists do is complex and sophisticated. Nevertheless, we should be able to make ourselves understood to those without specialist knowledge. With patients, our aim is to give appropriate information. One way to meet patients' different demands for information is to start by asking what they already know. This can be followed by a short summary of the main points and then more detail can be added as the patient wants. This way, it is easier to avoid becoming entangled in difficult explanations which the patient did not wish to hear in the first place! For instance, does the anatomical difference between a subarachnoid and an epidural injection really matter to a woman who is to have a Cesarean section? Why get bogged down in trying to explain the anatomy when she has already made the most important decision, namely to avoid general anesthesia?

Jargon is a major barrier to effective communication.[27] Doctors use many abbreviations and acronyms as well as terms from their specialist area of practice. Patients' understanding of some apparently unambiguous medical terms has been shown to differ considerably from that of doctors[28] and, thus, there is great scope for misinterpretation, even of words whose meaning seems very straightforward to us. Thus it is wise to check understanding from time to time during the interview ('I'm not sure if I've made myself clear. I'd like to know what you've understood so far'). If you ask the patient if they understand, they may give you words which you can use instead of medical jargon. Slang, euphemisms and local phraseology are also best avoided. Summarising what has been said is also useful.

*Breaking bad news.*

What constitutes 'bad news'? Clearly, telling relatives that a patient has died, or has only a small chance of surviving intensive care, is bad news. But there are also other, more minor, examples. Telling a patient that their operation has had to be canceled, or telling relatives that there is no intensive care bed available in the hospital, also need a similar approach. Patients may see things differently, however. When we expect that what we are about to say will be upsetting, we start with 'I'm sorry to have to tell you...' or 'I'm afraid...' Apart from the fact that this unwittingly lets slip our discomfort at performing the task, it may not even apply. Sometimes, an end to uncertainty can be welcome even if the information is disappointing. However, it is vital to use simple language and to avoid euphemisms, particularly for death.

Allowing emotions to be expressed is valuable; the aim is to acknowledge any distress, to explore concerns ('You seem upset. Can you bear to tell me just what's making you feel like that?) and to tackle each in turn. Our main challenge here is dealing with grief, and it is important not to be afraid of that grief. However, if people do not wish to discuss their feelings immediately, this should be respected. Delivering the news at a pace which the recipient can assimilate is also helpful.[29] When giving news that might seem

TABLE Outline interview format

| | |
|---|---|
| *Beginning* | |
| | Preparation: allow time, inform yourself and attend to privacy |
| | Know what you want to achieve during the interview |
| *Middle* | |
| | Establish rapport and respond to concerns: |
| | show empathy |
| | start with what is already known |
| | find out what patient wants to know |
| | give information and feedback and address specific concerns |
| *Ending* | |
| | Summarise |
| | Check that you have reached a satisfactory outcome |
| | Say good-bye |
| | Follow up |
| | Record/ hand over |

hopeless, it may be useful to stress what *can* be done,[30] for instance ensuring that someone who is dying is kept comfortable. An offer of follow-up or further help should always be made.

ENDING

Bringing the interview to an end is important. An 'unfinished ' feel can result if this is not achieved. This may result in the individual coming back later for some reason because they feel that there is something unresolved.[31] A useful technique is to summarise the interview so that both of you know what has happened. It is also important to check that the outcome of the interview - whatever it is- is acceptable to both parties.

Questions such as 'Do you understand what I have said?' and 'How do you feel now?' may be valuable. Finally it is important to say goodbye and, if appropriate, thank you. Once the interview is over, what has taken place should be conveyed to colleagues and, for clinical purposes, recorded in the patient records.

The elements of the 'therapeutic conversation' are summarised in the Table.

## Improvements

We can expect considerable benefit from improved communication skills. Our patients should suffer less anxiety, be more satisfied with their care, recover faster and maybe suffer less postoperative pain. We might benefit from our enhanced ability to detect emotional distress, suffer less stress ourselves and be more effective as clinicians. The organisations in which we work should run more efficiently and their reputation might be enhanced amongst local patients and professionals alike.

It is often assumed that successful communicators are born, not made. This is only partly true, and calling these attributes 'skills' serves to emphasise that they *can* be taught.[32,33,34] Techniques include using simulated patients, video and audio taping[22] although the most effective setting for this is in small groups with feedback from experts. However, we can start to improve simply by appreciating the specific skills involved and noticing when and how we use them. Measuring success, and hence gauging improvement, is not straightforward. There are no algorithms and protocols for effective communication, and no gold standard with reference ranges and confidence intervals. There is no right or wrong way to communicate; the only evidence of effectiveness is the result obtained. It is important, then, to be aware of one's own strengths (so they can be used to advantage) and weaknesses (so they can be worked on).

## Conclusion

We all talk to patients. It is tempting, and less damaging to our sense of professional pride, to think that, because we do it frequently, we must be doing it well. This is not necessarily true. It has been recognised in recent years that traditional medical education has concentrated on equanimity at the expense of empathy, measurement at the expense of understanding, and the pursuit of what is quantifiable rather than what is felt. The move from doctor- to patient-centred care is touching anesthesiology too, and we should embrace it, for the reasons we outlined at the outset of this article. We would encourage colleagues to look at their effectiveness in this area of practice. Should they feel that improvements are possible, then a simple start is to ask from informal feedback from those around us. Formal training is also now available. However, the essence of beginning to improve is to think about what is happening in the conversations we already have. We hope that this article has provided food for thought and a useful starting-point for future exploration and experiment.

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