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When ″clinician″ does not rhyme with ″communication″

BY **JOHN MICHAEL, LANDONI GIOVANNI, ZANGRILLO ALBERTO**

It is sad to say that communication skills, whether needed by a clinician to give a prognosis to a terrified patient or required by a petrified speaker during a congress presentation, are very often lacking from the modern-day biomedical professional's armamentarium.

Communicating with patients

Gone are the days, fortunately, when clinicians were looked upon by patients, but also by themselves, as god-like figures that made diagnoses based on textbook analysis, and rarely wasted time listening to what patients had to say about symptoms and sensations, and how their illnesses were affecting their lives as a whole.

The modern clinician understands the importance of listening to the patient, and uses protocols such as the 'cone technique', (1) beginning the interview with open questions so that patients can use their own words to describe their problems, before moving on to closed questions for specifics, clarification and confirmation.

However, this is not always the case. Indeed, patience is not always shown with patients. The fact that listening to them can very often be the first step towards a positive diagnosis might, even nowadays, not even be taken into consideration. Patients are not made on factory production lines, and even though types of patients do exist, doctors have to remember that a patient is, after all, a person, and no two people are totally alike. (2) The renowned Canadian-born physician William Osler (1849-1919), one of the pillars upon which the Johns Hopkins Hospital was constructed in 1888, believed that the patient should be seen as both the starting point and the conclusion of the clinical procedure. 'It is much more

important to know what sort of patient has a disease than what sort of disease a patient has', is just one of Osler's famed maxims.

At the Gesundheit Institute in the USA, Hunter Patch Adams is said to take up to four hours to complete the initial interview with his patients in order to get to know all he can about them and, therefore, make a positive diagnosis and help solve their health problems. Although this holistic method would certainly be out of place at most regular hospital structures, due mainly to time and economic constraints, clinicians should always use an interactional model (doctor explains findings to patient, and patient is asked what he/she has understood), rather than a simple transmission model (doctor simply explains findings to patient), to guarantee patient comprehension, which will inevitably lead to greater compliance when treatment has been agreed upon.

Communicating with peers

Similar problems exist in the world of peer-to-peer communication; where total clarity is required should authors wish to publish their research papers, especially in journals with an impact-factor. Of course, the need to write papers in English, which is the official language of the international biomedical community, yet is spoken as a first language only by a small proportion of its members, can create innumerable difficulties that need, somehow, to be overcome. (3) Grammar, spelling, sentence length, keywords, and the use of abbreviations need to be kept well under control, otherwise you risk becoming a victim of the dreaded reviewer(s). (4)

Speakers at international biomedical conferences often fall into the trap of preparing too many slides, filled with too many data, for the allocated standard 10- or 20-minute session. Add to this the fact that these slides will inevitably have a blue background (gradient fills cause even more problems), and that the numerous words crammed onto each one of them will most probably be written either in white, or yellow, font, and the recipe for impending disaster is almost complete. Eye contact with audience members is rare, dynamism and enthusiasm are rarer, and positive use of the laser pointer (i.e. the pointer should be used sparingly, and should never be shaken around excessively so as to merely irritate the audience), when presenters actually remember they have one in their hands, is almost non-existent.

Virtually nobody even remotely considers numbering slides, which is, on the contrary, a very wise move, as it not only gives the audience the chance to make a direct reference during the question-and-answer session, but also helps the presenter with timing.

One more thing, 'thank you for your attention', although words that need to be said, should never be written in the final slide, as they might distract the audience, and unwittingly become the presentation's take-home message.

In conclusion

Peer-to-peer communication is of fundamental importance to the biomedical community, yet physicians need to remember that the patient should always be at the center of their professional universe. Patients have to live not only with an illness, but also with fear, uncertainty, pain, tears, sleepless nights, financial worries, and psychological dilemmas. The worry-list is endless. Bearing this in mind, clinicians need to hone their communication, as well as their diagnostic skills, and show empathy and understanding to those that hope to receive treatment that will help them get well again, or, when this is not possible, at least face death in a dignified manner.

William Osler was right when he said, 'the good physician treats the disease, while the great physician treats the patient who has the disease'. Just remembering this fact can help to improve a physician's communication skills, and make ″clinician″ rhyme with ″communication″ more often.

References

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Faculty of Medicine, Vita-Salute San Raffaele University, Milan, Italy
Landoni Giovanni, Zangrillo Alberto
Department of Anesthesia and Intensive Care, San Raffaele Scientific Institute, Milan, Italy
Corresponding author:
Landoni Giovanni
Department of Anesthesia and Intensive Care
San Raffaele Scientific Institute
Via Olgettina 60.
20132 Milan, Italy
Phone: +390226436154
Fax: +390226437178
E-mail: landoni.giovanni@hsr.it