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Early cancer — communication problems

A report of a conference held at the King's Fund Centre on 20 May 1986

by

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KING'S FUND CENTRE CONFERENCE

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The conference on 'Early Cancer - Communication Problems', organised by Mr Graham Cannon, Director of the King's Fund Centre, on Tuesday, May 20, was attended by eight members of the medical profession, 62 of the nursing profession, and six others (administrators, education officers, etc). In a short introduction, Professor J S Scott, speaking as Chairman of the Standing Inter-Collegiate Committee on Oncology, explained that as cancer crossed all boundaries in medicine, the Committee was particularly concerned with the serious problem of education in communication. Many aspects of the problem were important, but it had been decided to take early cancer as the topic for this conference.

In his introductory remarks, the Chairman, Professor David Metcalfe, Professor of General Practice at Manchester University, said that anyone who had cancer or was suspected to have cancer, needed information, comfort, and support. The objective of this conference was to equip delegates the better to meet those needs, because there was evidence of unmet needs in this field. Problems in meeting needs, and how needs can be met, would therefore be considered. He then played a recording made by a mastectomy patient, now dead, expressing her feelings on discovering that she had a lump in her breast. She was first told it was probably a benign cyst, but after operation for its removal, and being told the growth was malignant and her whole breast had been removed, she was very frightened. She wanted to know the full facts, but realised she was not ready to cope with the truth, so asked carefully prepared questions each time a doctor spoke to her, thus allowing herself as much truth as she could cope with at a time. After a week she asked the doctor for the full truth, and on being given some very technical answers she became panicky, and did not regain her composure for a couple of days; she then realised that in fact her prognosis was quite good, and she could carry on with a normal life. She thought that cancer was portrayed by the media as too ominous and frightening, and that it was surrounded by too much jargon, whereas after her doctor had explained to her what cancer was and how the cells behaved to the wrong pattern, she found it less frightening. She became angry when doctors did not give her frank answers, and also when they were too reassuring.

Early and suspected cancer

The first speaker, Mr J S Kirkham, Consultant Surgeon at St George's Hospital, London, began by defining three problems in communication: first, how to inform the patient adequately so that the patient could make sensible decisions and judgements; second, how to avoid unnecessary trauma to the patient; and third, how to avoid errors which would damage the prospects for what was likely to be a long-term relationship between patient and doctor. One also had to consider the patient's right to know the truth, which in his view was almost supreme though there were certain exceptions, such as a frail elderly patient who had not long to live and would not be able to cope with the truth. In such a case one could not abrogate the responsibility and wish it on to the patient. He recalled an elderly woman saying to him: 'I don't mind dying, so long as I don't have cancer.'

Mr Kirkham went on to say that the best time for getting things right was at the first consultation, when cancer was first suspected. This was usually some time after the patient himself suspected he might have cancer. If the doctor is not honest at the start, the doctor/patient relationship begins on the wrong footing. If one avoids mentioning cancer at this early stage, the patient starts worrying. If one uses the euphemistic term 'a growth', some patients will not understand what this means, while others who had read the excellent articles on cancer published in some women's magazines will be better informed, and become suspicious. So one always must judge how well informed each patient is, and avoid using euphemisms.

One course was to be honest, and say: 'This might be cancer'. Mr Kirkham advocated using the word, explaining that one did not know if the condition was malignant but that it might be. He went on to define worry as 'a rehearsal for dealing with a problem when it arises'. Patients told they might have cancer will worry about it, but if they knew what to expect their worry was useful and would help them to cope if the fear became reality. If the tumour turned out to be benign, the period of worry would help to establish a good relationship with the doctor, as the patient would appreciate the doctor's honesty.

Mr Kirkham told a salutory story of a patient with a history of mental illness who, after being told by an inexperienced radiologist that he probably had an early cancer (when in fact he had a post-surgical deformity), went home and committed suicide. He said his aim was to establish a relationship with honesty that could lead to trust, and this was only possible by being frank at the outset. The advantages were enormous: the patient understood from the start why he had to comply with certain unpleasant procedures. Timing was often a problem, but most patients were well-informed and would be helped by being told what was suspected before the diagnosis was confirmed.

Mr Kirkham then made the point that one must avoid the transference of guilt for failure to cure from doctor to patient. 'We don't do too well with breast cancer', he said. Many patients felt they should have consulted a doctor earlier, and then it would have been all right. The doctor should reassure the patient that the diagnosis was the result of the type of tumour, and not his or her delay in coming to consult him; it is important not to make a patient feel guilty.

One must also consider the ethical issue of the patient's right to know the truth, but doctors must not cause unnecessary distress and suffering to their patients; a balance must be struck. One had to gauge how much each patient could take at one time, and this could only be done by turning the conversation round and finding out what the patient had understood from what one had said. One must confirm what the patient understood before confirming the diagnosis. It was also important to give enough time to this interview.

Mr Kirkham explained that many patients, when nervous, became manipulative, so a junior doctor should not discover the diagnosis by reading the patient's notes. When a new patient arrived, all the team must come together and study the message to the patient. It would be ideal to have the ward sister there as well.

The ideal way of managing a woman with a suspected malignant lump in her breast, Mr Kirkham said, was first to tell the patient, then find out how much she understood, then correct any misapprehensions, and gauge when the patient has had enough. One should then explain the procedures that would be followed, and that there was no rush. There was a rush only when the need for treatment became urgent and the cancer well established; breast cancer was never urgent, as it changed little from week to week.

A patient with an irritable bowel was likely to be very nervous, Mr Kirkham continued. One should reassure him that in general terms he was well, but a barium enema would be necessary. This might worry him, but his worry would be useful if he were told there might be a tumour, because he would know from the start that the doctor had been honest with him.

Mr Kirkham concluded by saying that he would support honesty and truth, but the whole truth in bearable increments.

Communication problems in cervical pre-cancer

The second speaker was Dr Malcolm Anderson, Consultant Pathologist, who has been in charge of the cervical clinic at the Samaritan Hospital for Women, London, for the past 13 years. Although he was to speak about a specific site and phase of the disease, the communication problems involved with cervical pre-cancer were general to all women, because the condition was picked up by population screening and by smears taken from asymptomatic women at family planning, ante-natal and VD clinics, as well as by some GPs. It was important that before a smear test, the woman should be told what would be done and what it would mean.

The cervical smear was designed to recognise pre-malignant disease, Dr Anderson continued, a condition which was amenable to treatment, with virtually no risk of developing cancer; this condition was termed cervical intraepithelial neoplasia (CIN). There were several stages in the investigative procedure, and the communication needs were a little different at each stage. First, the smear was taken, and if it proved abnormal the patient must be informed. The next step was an examination by colposcopy, which was done as an outpatient procedure, taking only about 10 minutes. This examination would define the nature of the disease. After colposcopy, the patient might or might not be treated; treatment might be by cone biopsy, which would further refine the diagnosis, or by local destructive methods, such as the laser. The patient would then be followed up by further colposcopy and cervical cytology. At each of these stages the patient required specific information about her condition and its treatment, and counselling for lifelong follow-up.

The first stage in the communication process, Dr Anderson said, was to encourage the general female population to have smears taken. Women must not be over-reassured, nor must they be over-alarmed. Everyone - both the media and the medical profession - must give the right balance of information about the purpose of the smear: to recognise the pre-cancerous stage of the disease, when it could be easily treated, thus almost guaranteeing that cancer would not develop in the future. Information should be given in such a way as to make women sufficiently aware of the seriousness of the disease, but not too frightened of it to make them stick their heads in the sand.

At the stage when an abnormal smear was found it was probably most important for the patient to be given the correct information, Dr Anderson continued. Many patients he saw in the colposcopy clinic at the Samaritan Hospital needed prolonged counselling, because they had been given the wrong information at this stage. They wrongly believed that the smear test was a test for cancer and if the result were abnormal they must have cancer. A few GPs seemed to give their patients this impression, although the smear suggested CIN. Most women were given inadequate information by the doctor passing on the result of their test, so they assumed the worst - that they had cancer. Patients should at this stage be told that they almost certainly did not have cancer, but a pre-cancerous condition that was amenable to relatively simple treatment.

Unfortunately, at this stage there were two uncertainties: first, the smear test alone could not make a precise diagnosis, only a prediction which was usually correct but might be wrong; and second, the relationship between CIN and invasive cancer was, in numerical terms, uncertain. It was not known what proportion of women with CIN would, if left untreated, eventually develop invasive carcinoma of the cervix. Figures ranging from less than 1% through 30% up to 70% had been quoted. It was enough, therefore, at this stage to tell the patient that there was a risk of cancer ensuing if further investigations and treatment were not carried out. It was risky, however, to over-reassure the patient, with only the smear to go on, as a few women with positive smears suggesting CIN did, in fact, already have invasive carcinoma.

A more specific diagnosis could be made, Dr Anderson went on, by colposcopy and directed biopsies. With most cases it was possible to be certain about the diagnosis after colposcopy, and to reassure the patient wholeheartedly that she did not have cancer. Most patients with CIN could be treated as outpatients by various local destructive techniques. A few ould need to progress to a more formal biopsy under general anaesthetic, so that diagnosis and treatment were done by the same procedure. A very few would be found to have cancer at this stage, but the majority would have CIN.

Treatment for CIN was not the end of the story, for the patient with cervical abnormality would need prolonged follow-up, initially by colposcopy and cytology and eventually by smear alone, so there would have to be further discussions with the patient. The evidence suggested that a woman who had been successfully treated for CIN was at no greater risk of developing another abnormality than any other woman of her own age, but on the other hand a very few would even progress to cancer. This small risk must be explained to the patient, hitting the right balance between frightening her that the treatment hadn't worked, and over-reassuring her so that she did not present for long-term follow-up.

Dr Anderson concluded that communicating with patients with cervical pre-cancer was made difficult because, with only the smear to go by, it was not always altogether clear what stage the disease was at: some patients already had cancer. Once the diagnosisof CIN had been established by colposcopy, it was still not possible to say what the exact relationship of the CIN was to invasive carcinoma. These two uncertainties made it difficult to discuss the real nature of her disease with the patient.

If asked what caused the disease, and if it was linked with sexual promiscuity, Dr Anderson said he always answered: "I don't know what causes it. It may be a virus, or it may have been transmitted from your husband.' He left it there, because he did not want to make the patient feel guilty, although it was true that the disease was linked with early sex and multiple partners. At the same time there were many women with the condition who were not sexually promiscuous, and a lot of harm could be done by suggesting there was a link.

Established cancer - what to say and when

The third speaker, Mr W M Ross, President of the Royal College of Radiologists, said he was there as a practising radiotherapist in Newcastle, dealing with patients with cancer. Radiotherapy was often recognised as the 'cancer' department, and often treated late cancer, but it had a lot to offer to the patient with early cancer as well.

The term 'early cancer' meant one which was small and limited in size, confined to the tissue in which it arose, even though it might have been present for several years. Many early cancers were curable, though not all. There was a 95% cure rate for rodent ulcers, for example, while with early lung cancer if 5-10% were alive after one year, that was a good result. The first treatment was the one most likely to be effective: "You don't often get a second bite at the cherry', Mr Ross remarked.

Patients coming for radiotherapy would have seen other specialists who had referred them to radiotherapy for a second opinion or for confirmatory advice and possible treatment. The patient-doctor relationship was important; it was just as important to establish a relationship with cancer patients as with patients with any other disease. The best way was to find out what the patient thought and knew about the disease, what he or she had been told about it, and to take it on from there. Patients with mastectomy often did not realise they would have to come to the department for treatment for 4-5 weeks; they had usually been told they would have 'a little radiotherapy'. One had to confirm and amplify the previous information, or sometimes explain the facts which might be opposite to what the patient had understood. Further investigations might be necessary to establish how extensive the tumour was and whether it was still 'early', or had gone beyond that. It was very important to do this, instead of rushing into treatment.

Mr Ross said one should agree with the patient's concept of the diagnosis, and not hesitate to use the word 'cancer', though it could be modified as 'a form of cancer'. One should say there was a very good chance of curing it at that stage when that is true. With cancer of the lung one had to be guarded and say, 'We'll have to see how effective this treatment is going to be before we can tell you.' Then the doctor should explain what he intended to do and how, and also start to explain the side-effects. Patients coming for radiotherapy might have been told they would lose their hair and be sick every day, so one had to explain that there would only be hair loss on the area being treated, and that many patients could continue to work throughout the course of treatment.

There were always questions to be asked and answered, Mr Ross continued: for instance, on causation. 'We very seldom know what causes a cancer in an individual patient, but the actual cause does not make any difference to the treatment or the outcome', he said. One must disabuse the patient of the idea that anything he had done had contributed to the cause. Another frequent question concerned contagion, or whether the disease could be passed on. One must reassure the patient that there was no question of his passing the disease on to the family or to colleagues. Then discuss his reactions to treatment, explaining what would happen in the future. Skin reactions were similar to sunburn, but like sunburn they would continue to increase for a while after treatment was finished, but would settle down in time. If a skin cancer were being treated, the lesion would not disappear immediately after treatment but might remain for up to a year, so the patient must return for lifelong follow-up.

Mr Ross said that at follow-up visits patients were screened for secondary cancers as well as to monitor the side-effects of treatment. Patients might return with some totally different complaint unconnected with the cancer (eg backache). In Newcastle, patients knew they could come back at any time without an appointment, and all patients will be seen in a week or 10 days.

Mr Ross ended by saying that it was 'in' to tell patients the truth - but what was the truth? He did not know what the response in an individual to the best course of treatment would be. With some forms of cancer, for instance, 95% of patients could be cured, but what about the remaining 5% where treatment failed? Doctors must therefore be prepared to qualify their statements. He said he did not find it difficult to leave the patient to make the decision about treatment by asking, 'What would you like me to do?; but found it impossible not to lead the patient, and many would say, 'Do what you think is best'. Pure informed consent did not exist, in his view.

Professor Metcalfe remarked that everyone should be cautious about using diminutives which deceived patients, such as 'a touch' of radiotherapy, or a 'little prick' for venepuncture; he would like to ban the word 'little'. He also remarked that there was no such thing as 'never' or 'always' in medicine.

The patient's view

Mrs June Adams, a part-time nurse, then described how she had had her first experience of cancer, when 18 years earlier at the age of 33, married with two children, she had had a malignant breast tumour removed. A year later a second primary tumour was found in the other breast. Since then she had undergone a hysterectomy and oophorectomy, and three years ago a pulmonary sarcoid was diagnosed. Having worked in a hospice for seven years, she said she strongly believed that the great majority of cancer patients should be told. It took great courage to ask if you had cancer, and you needed an honest answer from someone whom you could trust. As a student nurse she had felt frustrated and ashamed at having to deceive a patient who had asked her if he had cancer because the surgeon had said he must not be told. She was convinced that if everyone discussed cancer more openly, it would be more easily accepted.

The fact that it was still a problem whether to tell or not meant that many doctors and nurses were still unable to deal openly with cancer, Mrs Adams continued. The patient had a right to know, to make a will, put affairs in order, to right wrongs, make peace with his Maker, especially if time was short. She had asked her surgeon why he did not tell all his patients, and he had replied that not all could take it. She was sure they could.

After her first operation for breast cancer, Mrs Adams recalled, the ward sister had been kind and efficient, telling her she had had an extensive mastectomy and that all had gone well. That some ward sister herself had breast cancer, and told no one. Mrs Adams' husband had been with her when she came round from the anaesthetic, and told her she had cancer, and reassured her. She knew that at 33, with two small children, she could not die, as she could not bear the thought of leaving her family. She had five to six days to wait for the histology report, during which time she had bargained with God for more years of life . 'But it hits you when you wake up in the morning', she said. It was very important to laugh, and to listen, never to let people know how you felt, but always put on a good face. She could not discuss her illness with the nurses because they were always too busy, and she didn't want the other patients to hear the word 'cancer'. The histology report, when it eventually came, was all clear, and she was able to leave hospital on the ninth day; within three weeks of surgery she was swimming in the sea.

In conclusion, Mrs Adams reiterated her belief that patients should be told they had cancer, but with sympathy and understanding and in the presence of a close relative, and when the doctor had time to give to the interview. Also patients should be told in privacy, nut during a ward round. The doctor should discuss the prognosis and possible future treatment fully and clearly, never abandoning hope. Doctors should also discuss patients with the nursing staff. It was helpful to have a trained counsellor for patients, and there should be information about appliances and self-help agencies, as well as the opportunity to talk with other patients with the same operation. Her cancer, she ended, had been an enriching experience - 'but please would the medical profession improve communications with the patient'.

Nurses - their contribution and their problems

Miss Marilyn Marks, Senior Nurse in the Continuing Care Unit at the Royal Marsden Hospital, London and Sutton, began by quoting a speaker at the first International Cancer Nursing Conference (held in London in 1978), who in turn quoted a verse by Paul Simon:

'Fool, said I, you do not know,
Silence like a cancer grows.
Hear my words that I might teach you,
Take my arms that I might reach you,
But my words, like silent raindrops, fell,
And echoed in the well of silence.'

Cancer was too often surrounded by a well of silence, she said, and in their attempts to overcome this problem, there was a risk of nurses reacting subjectively to their patients. She illustrated this point by describing her own reactions of righteous indignation about a teratoma patient, very ill and with a poor prognosis, who at the end of the course of treatment got up and went home.

Nursing had today advanced into many spheres, she continued, in eduction and research, and in developing the role of the clinical nurse specialist, become expert practitioners, but what really mattered was patient care. Nurses were becoming more and more accountable for their actions, taking much more responsibility, working alongside doctors, planning and giving nursing care, using the methodical approach of the nursing process, but were they meeting the patient's need for information? Nurses were always being asked questions by patients and their relatives, but their uniform gave them status, and acted as a barrier, and too often they professed to be busy because that was easier than having to talk to patients. A uniform seemed to exemplify 'busyness'; when one did not wear uniform patients did not think one could be busy. But the role of the nurse was to provide explanations, to act as an information resource, and to give consistent support.

Relatives had probably got information about the disease from the popular press, radio or TV, or from 'know-all' neighbours. They were in a strange environment, suffering from separation and guilt, afraid of being a nuisance. Nurses should be available to them, and talk to them when they were at the bedside. They should reiterate the information given to reinforce understanding, as there was so often a difference between what was actually said, and what was heard. Communication skills were very important. It was helpful to have experienced a procedure, such as radiotherapy, in order to explain it clearly to a patient. Nurses needed greater knowledge so that they could be accurate in the information they gave. The Royal Marsden Hospital had produced a series of patient education booklets giving detailed information about methods of treatment, to confirm what patients were told by word of mouth. Nurses should have details of services and support groups for specific conditions (eg mastectomy or colostomy patients) at their fingertips. Miss Marks then mentioned stress reduction techniques, which she thought might be helpful. But the nurse's role was to give a positive response, and to help people to help themselves. She drew attention to the problem of 'burn-out' that nurses have, through working in a highly technical and emotive environment, which made them more vulnerable and involved with patients. The nurse had to be totally committed to a patient whose life was limited, and this extended role of the nurse could cause conflict with both social workers and doctors. She also had to cope with the fluctuating moods of a cancer patient, who one day accepted the facts of his disease and the next denied them. She might risk criticism from the 'establishment', as in the case of the clinical nurse specialist called to a patient who had panicked on being told that there was a slight chance she had cancer; the clinical nurse specialist calmed her and explained her condition to her, but was called before the medical committee for giving this information before the histology report was available. This was a warning not to work in isolation, but with other members of the team. There should be consistency in the information given to the patient by all members of the team at all times.

Knowledge was power, Miss Marks ended, and sharing knowledge would strengthen relationships between the patient and the care-givers. One should never forget that the patient was the head of the team.

At the end of the morning session, the chairman, Professor Metcalfe, summed up with 10 key words. (1) Teamwork: The professions must work together because patients expect different things from different people. (2) Time must be made. (3) Guilt must be avoided both in the professions and in patients. (4) Uniform could be a barrier or a hiding place. (5) Permission, which the patient had to negotiate to die. (6) Recording what had been said was important, because the patient's perception level could fluctuate. (7) Freedom to respond was needed, as not being free to respond had a deleterious effect. (8) Support systems were needed for care-givers, who also suffer in stressful situations.

(9) Experiential learning was helpful in explaining procedures from personal experience; one should empathise rather than sympathise. (10) Touching was an important communication skill. No one had mentioned how important physical contact was, how comforting a cuddle could be.

Ensuring communication occurs and knowing what has been communicated

The first speaker after the lunch break was Professor J S Scott, Professor of Obstetrics and Gynaecology at Leeds University, who began by saying that it was often difficult, when faced with a patient, to find out what she had been told, and in what terms, about her cancer. Patients' records could be voluminous and untidy, and difficult to follow. He said he saw approximately 30 patients individually at each 2½-hour clinic, allowing five minutes per patient. The great majority needed colposcopy or some similar investigation. He did not have time for a discussion with every patient with suspected cancer; it was dealt with fairly promptly.

Professor Scott said his style of communication was well established. Juniors who did not accept the style of their seniors could be selective, taking what they wanted from the range of styles to which they were exposed. The success of communication did not relate to the volume of words: indeed, the fewer words were used, the less opportunity there was for misapprehension.

There were two extreme methods of communication, he continued: the very brief 'We'll have you in and we'll have it out' approach, or the careful and detailed explanation with too many words. Case sheets had become pseudo-scientific documents spewed out by computers. Their function as an aide memoire had developed into a lengthy medico-legal document in which it was not possible to find what had actually been said to a patient about her condition. It was important to try to see patients quickly and have investigations done as soon as possible so that patients did not have to wait. Patients then had to be seen after therapy, and after five years, for follow-up.

Professor Scott remarked that he did not conduct 'grand rounds'. When he walked round a ward he would tell the ward sister if he saw anything wrong, but he did not stop at the end of that bed; he would see the patient later in the examination room in privacy, with the nurses present if necessary, for a serious examination and talk. In Leeds they had devised a system for knowing what had been communicated to the patient in the form of a 'communication sheet', printed on a strong emerald green paper so that it stood out from the other forms on the patient's records. When the diagnosis had been made, this communication sheet was placed in the front of the case notes, so that it could not be overlooked. It contained such questions as 'Has the patient been told the exact diagnosis?'; 'If not, what has the patient been told? If a relative has been told, which relative?' The use of this form had improved general awareness. A doctor coming new to the case was immediately in the picture, and if there were an emergency he could converse with the patient without causing unnecessary distress.

An unexpected effect had been the extent to which the regularity and quality of communication had improved, Professor Scott concluded. The system had helped to ensure that there was no failure of transmitting information at the very outset, as had occasionally occurred in the past.

Communication about children with cancer

The next speaker, Dr P H Morris-Jones, Reader in Child Health at Royal Manchester Children's Hospital, described the special problems involved in childhood cancers. One was dealing with a very different time-scale; children normally did much better than adults with cancer, but one had to come to terms with a sudden decline in the patient's condition. It was essential to communicate with the primary carers, but even the youngest child needed to be told something about his illness and treatment. Some parents did not want their children told the true diagnosis, but even children aged 3 or 4 could take it in; they needed to be told the truth and to know that you were being honest with them.

Dr Morris-Jones said she insisted either that parents told the child themselves, or allowed her to tell them in simple language. Children over the age of 5 understood about death, and there was no doubt that some kind friend would tell them they were going to die because they had heard their mother or father say so, so the child must be told he was not going to die. It was also important to tell parents and children that cancer was not contagious, as children were often ostracised and avoided by their friends because people believed cancer could be passed on by contagion.

Another distressing problem was dealing with a family who felt guilty at having failed their child. It was important to talk to the siblings and grandparents as well as to parents, of a child with cancer, so that they all understood the illness. Some grandparents were not supportive, believing they should be able to sit back and enjoy their grandchildren, and they could be very destructive of the family's attempts to return to normality. They also took a more negative approach to the outcome. Teenagers were the most difficult group of all, when they were at the age of just leaving the nest, but suddenly found themselves afflicted with a condition that affected their normal life, with their parents being over-protective. They often began to regress into childhood because of their anger and concern about the future. Suddenly a lot of people were running their life for them, at a time when they had been looking forward to running it themselves.

Group discussion was helpful, Dr Morris-Jones continued, and there was also a need to communicate with other disciplines, many of whom were ignorant about the curability of childhood cancers. It was not generally known that over 50% would survive to normal adult life, and it was important to see that they could cope with that life; they might have psychological handicaps as a result of the way they had been treated.

Is communication a teachable skill?

The last speaker, Ms Penny Morris, Teaching Research Fellow in Doctor/Patient Communication at Addenbrooke's Hospital, Cambridge, gave the answer to this question as an undoubted 'Yes', as her work was to research into the long-term effects of teaching communication skills to medical students. Teaching communication was not just 'tricks of the trade', but went much deeper and into the realms of what she called the 'touchy-feely stuff'. She quoted as an example, teaching history-taking to a small group of medical students in their first clinical year. Making a video was a useful method of instruction which provided good feedback to the group. Simulated patients were placed in a confrontation with a nurse or doctor, who discussed afterwards what he or she felt during the confrontation. In history-taking or assessment, it was too easy to feel that concern was a luxury.

Ms Morris then showed, by a four-circle diagram, how four main areas connected with each other: clinical knowledge, elicitation, communication skills, and the whole relationship. The teaching was linked with practical tasks, and the emphasis was on the patient as a person. The video could be used to provide positive reinforcement. The patient had insight into his own feelings, and could pass this on to the students. After watching the video, the health worker would be asked what he thought he had done well, and what he thought he could have done better, and the group was then asked similar questions. Specific aspects of the interview were analysed, not generalities.

As another example, Ms Morris cited a woman with polyurea consulting her GP, who suspected diabetes. The student taking her history spotted that the patient was demonstrating 'postural echo' (ie lowered head, averted eyes, avoiding contact with the doctor) because she thought the diagnosis was bad news, as she was being married in six weeks. The student explained in detail how the condition could be managed with insulin, etc, enveloping the patient in sympathy and showing a caring attitude. There was positive feedback from the group watching the video but the student was apologetic for being side-tracked, although in fact her behaviour and conduct of the interview was good. 'Oh that, that's nothing special, I was just being myself', she had said. This reinforced the fact that the qualities which bring people into the caring professions should be preserved, not knocked out of them. Too often people lose self-confidence, respect for patients and empathy. Students had to be taught to use their own feelings in order to communicate successfully, to say to the patient for instance: 'That must be very difficult'. If good communication skills were learned, self-confidence would develop. The patient would feel most able to talk to the person he or she felt closest to - whoever it might be.

Multi-disciplinary groups

The delegates were then divided into four groups, each considering a different topic and reporting back briefly to the conference as follows.

Group A: Teaching communication - what do we do 'in house'?

The group thought there was a need for a teacher in communication in nursing and also for a pro forma on the lines of the communication sheet described by Professor Scott. Communication skills should be taught in all professions at pre- and post-qualification levels.

Group B: Policies for good communication and their administration

The group thought there should be more in-service training in communication in nursing, and that lay people were useful in leading groups. Teaching could start in a small way on wards, to prove that it worked, and then be demonstrated to other staff. However, tangible results would be required in order to justify expenditure on training in communication skills.

Group C: Inter-professional communication - how can it be improved?

The group thought there was a lack of communication between doctors and nurses; it was across the medical/nursing border that most difficulties existed. One nurse said she had 'prostituted herself' to get medical staff to go to meetings of this sort. Joint study sessions had been discussed, and in some units there was an increased involvement of nurses in clinical pathology conferences, which was to be encouraged as the nurses found it valuable. One good thing that had emerged from the NHS reorganisations was that communication between hospital and community nurses was much improved. So far as record-keeping was concerned, the GP's summary of treatment card was regarded as invaluable when it was well kept.

Group D: Colleague stress - diagnosis and treatment

The group considered that formal meetings were less successful than informal meetings. It should not be forgotten that senior staff also require support, as do ancillary staff such as ward clerks. The doctor/nurse relationship was poor, and needed improving. Individuals should be able to build on their negative aspects and make positive conclusions about themselves. The main stresses on staff were time, and the difficult patient, and relatives who were too inhibited to express their grief. The group agreed that doctors and nurses should support each other.

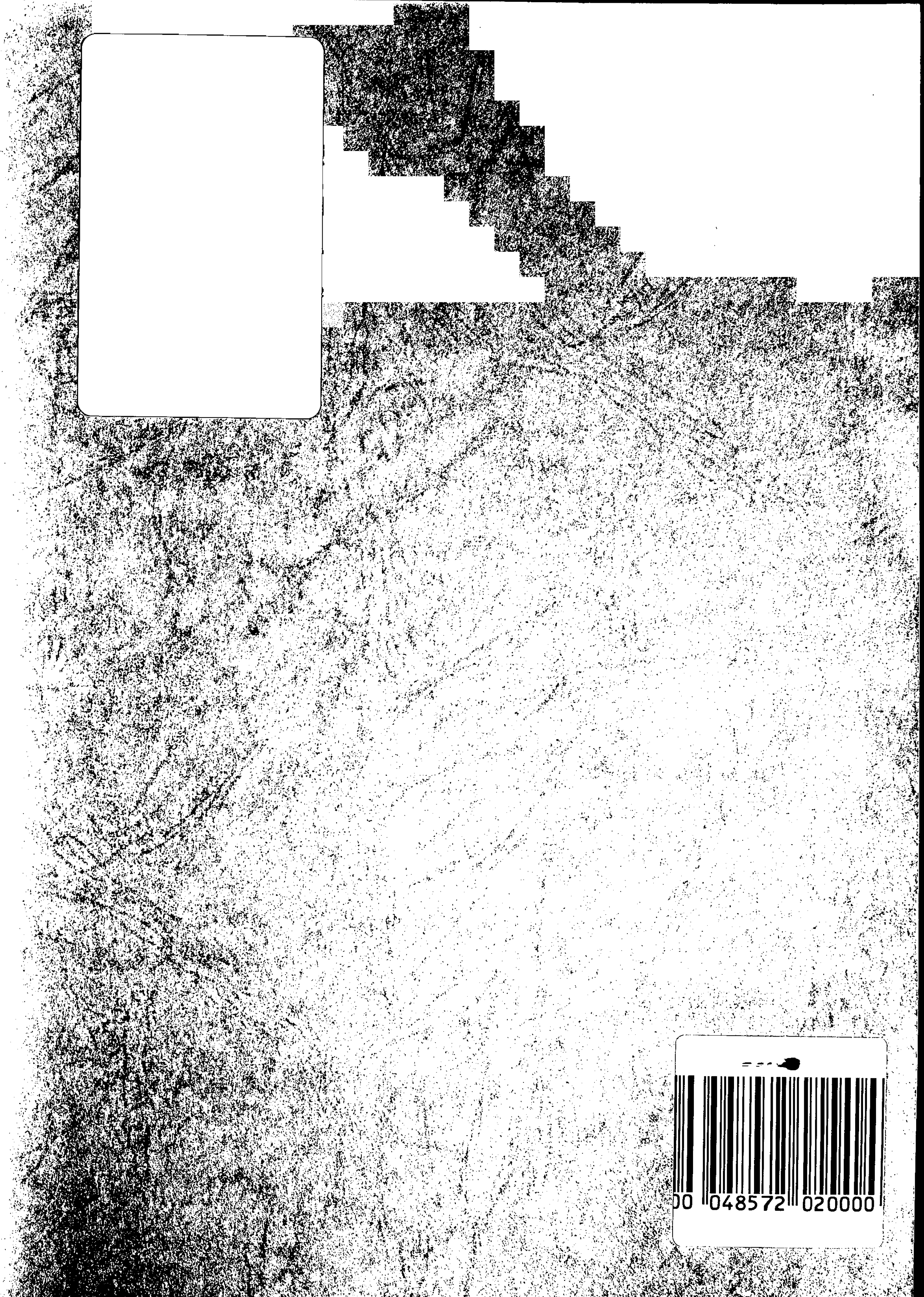
Chairman's summing up

In conclusion, Professor Metcalfe said there was a good deal of overlap between the four groups, which showed agreement about their concerns. He underlined the need to assesss the needs of people with whom one was going to communicate, saying that if you do not know the needs, you are not going to communicate well. There is a great demand for information from patients, carers, other departments, and specialties, 'rescue' organisations, but there could be no progress between teams if there was no trust.

As his second point he took the hierarchy barrier, saying that both medicine and nursing had been hierarchical since the days of Galen and Florence Nightingale. Hierarchy had provided barriers to communication; everything had to be negotiated, upwards or downwards, and there was unease about what was going on at other levels of the hierarchy. Communication crossed thresholds, and good learning involved taking chances, exposing oneself to patients, colleagues, and to oneself: learning about oneself was risky and difficult. There was no doubt that real communication meant commitment, and risk, and one had to be strong enough to take risks.

The health service was a 'culture of control', where the health professionals controlled patients, keeping them horizontal, non-autonomous, and undressed. One tended to use the time alibi to excuse this control. It was terribly easy to depersonalise patients, and to keep them dependent. 'But patients actually take care of us', he pointed out, "They are concerned for us and don't want to upset us, and relieve us of our responsibilities by not wanting to make things difficult for us'. Patients felt they must keep a stiff upper lip, they must die well, and not be difficult or yell their heads off when they were frightened or upset. Yet in many other sectors of society, one was encouraged to yell.

This conference had been working against the culture of control, Professor Metcalfe ended. All that had been said about improving communications could be seen as subversive - but the great thing about the King's Fund was that they liked to be subversive!



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