How does an efficient and equitable health service also treat patients with humanity and take their concerns seriously? A response to Hannah Bradby

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As many of us on the receiving end of healthcare know to our cost, poor communication (or the absence of communication), whether in hospital, general practice or in the community, is detrimental. Hannah Bradby’s experience was clearly a distressing one. Like other patients’ anecdotal reports, and numerous studies (e.g. Wright et al., 2004; Mercer and Howie, 2006), it highlights the therapeutic value of communication. Hannah’s experience was also unfortunate. It is unusual for the surgeon who performs the operation not to see that patient again, and the registrar’s overworked condition does not excuse an apparent inability to communicate. But emergency surgery removes much of the scope for planning, discussion and getting to know the team. Perhaps the surgeon was caught in a series of urgent cases; or perhaps he disappeared to go on holiday. Might another surgeon, who understood and could explain the procedure, have taken his place? Could the registrar have returned when she was less busy?

Was Hannah given any explanation at all? Clinical guidelines (RCSE, 2008) state that ‘all surgeons must… listen to and respect the views of patients … insist that time is available for detailed explanation’, and ‘fully inform the patient…of progress during treatment’. Anecdotally, surgeons express reliance on patients’ narratives to guide surgery, and respect the patient’s need to be listened to throughout: as one surgeon reported (personal communication), ‘I imagine they are my own mother or father and how I would want them to be treated’. If Hannah had decided to register her complaint, it would have been taken seriously.

There is another side to the story. Not only do doctors need to remain responsive to individuals. They also need to spread themselves across the remit of their patients and the length of their working week. This is all the more challenging in a target driven culture and in the context of the European Working Time Directive (EWTD), introduced to limit doctors’ hours to 48 per week. This ruling is proving insufficient for junior surgeons to develop skills, and disruptive to continuity of care. Consultants are taking on more emergency work and patients may not see the same doctor twice (Oliver, 2009).

Contrary to the opinion expressed by Hannah Bradby, my experience indicates that medical students know the tensions between humanity and efficiency only too well. On clinical placement they deal with these on an everyday basis and discuss them with senior...
colleagues. Far from being insensitive to patients’ perspectives or developing immunity in order to survive, they centre their learning on what the patient has to say. The maturity of their outlook extends to redressing some of the miscommunications they encounter.

What does their training teach them? Reflective skills, critical appraisal, person-centred care, communication with colleagues, dealing with uncertainty, professionalism, empathy, self-care, and the everyday demands of the NHS. Their survival technique is one of balancing their own needs and professional boundaries alongside their capacity to care for patients. Their main concern may be ‘getting into the profession’; but what does that mean to them? They equate becoming a doctor with being safe and being competent (not with medical dominance or narrative denial). As medical students themselves said:

‘Placement-based medical teaching gives me the opportunity to see good practice by good clinicians who have enormous respect for patients and inspire more consideration than any simulated session. As for the rarer instances when you witness a bad patient-doctor relationship, the consensus among medical students is that this works as a deterrent very effectively. Nobody wants to be the cocky ‘so-and-so’ whom the nurses hate and who makes the patients feel small.’

‘I hope myself and my colleagues will be much different doctors from those qualifying a generation ago. It was enlightening to read her experience, and if I were a patient I can really understand where she is coming from. That surgeon shared a part of her that she will never know herself, and she never even got to know who he was until years later, let alone talk with him. But in the ‘real world’, her expectations may be unrealistic, even though they shouldn't be.’

‘In the final years of medicine when the ‘exigencies of medical training and the frustrations of NHS work’ kick in, we are more keen to hear the patient's story. It makes us re-realise why we came into the profession, to regenerate the altruism we all once felt. The more we have interacted with the patient and the more we care, the better able we are to pin that learning in place.’

‘We have all had 20+ years of practice at being human, and far less at developing the biomedical skills needed to make accurate diagnoses. But our placements still reinforce the important. For example even orthopaedic surgeons, often stereotyped as scalpel-happy and completely uncaring, ask the patient to what extent their problem is affecting their life and for their own views and these are definitely considered in determining if/when to intervene surgically.’

To answer the question, then, we need more than sociology; we also need a doctor’s understanding and application of sociology in practice. We need to understand how medicine blends social with biomedical sciences. We need an integrated approach, with debate to bring different disciplines and perspectives together. We could make greater use of medical students’ experiences to inform how we employ sociology and situate it within the undergraduate curriculum. On clinical placement, students see organisations in action, experience tensions between efficiency and humanity, play out learning acquired through lectures and simulated scenarios, and live through a doctor’s day and all it entails.

Within sociology, we need to explore a number of dimensions, including: effects of policy directives; clinicians’ everyday experiences; patients’ views concerning how, and whether, their needs can be met.

The question of how to remain patient-centred may appear harder to answer in hospital than, perhaps, in community psychiatry or general practice. But it is gaining increasing recognition in all areas of medicine, at undergraduate, foundation and continuing professional development levels. One solution, currently being proposed and explored across different clinical settings, is to equate efficiency with listening to patients’ concerns, e.g. by marrying process and content in history-taking and physical examination (Silverman et al., 2003).
Maintaining a careful and respectful communication approach requires a composite understanding that extends beyond single disciplines: one engendered through sociology, psychology, arts and humanities, ethics and linguistics, along with medicine.

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References


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