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SPECIAL ARTICLE

Communication skills for the anaesthetist

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Summary

Anaesthetists have traditionally focused on technological and pharmacological advances when considering the provision of anaesthetic care. Anaesthetists are expected to be able to communicate effectively with peers, patients, their families and others in the medical community; however, few details are provided regarding how this might be achieved. Recent evidence suggests that communication practices should include a consideration of conscious and subconscious processes and responses. This model has potential relevance when learning and teaching how to communicate effectively in the stressful environment of anaesthetic clinical practice, and includes: reflective listening; observing; acceptance; utilisation; and suggestion. Understanding these processes could allow the development of a learnable framework for effective communication when the usual strategies are not working. This concept could also be used to facilitate communicating with surgeons and other colleagues, with potential benefits to patients.

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Anaesthetists have traditionally focused on advances in technology and pharmacology when considering how they can improve the care they provide to patients. The specialty of anaesthesia clearly encompasses technical fluency; however, beyond competencies such as cannulation or tracheal intubation are unwritten and unvoiced strategies for managing the patient and recognising the limits of safe practice. True mastery involves communicating, anticipating and minimising discomfort, and knowing when to change strategies or techniques [1]. Patients have placed a value on communication and the provision of information regarding their care that is frequently underappreciated by anaesthetists [2]. Until relatively recently, it was a common belief that communication skills were natural talents that could not be taught – one was either endowed with them or not [3]. Anaesthetists tend to practice in a way that adheres closely to the traditional medical model whereby the doctor provides the care while the patient passively accepts it. Less commonly appreciated is that anaesthetists are in the fortunate position of having abundant opportunities to enhance the clinical care they provide through the way they communicate [4]. Good communication is said to improve health outcomes or patient satisfaction and reduce error, misunderstandings, distress and negligence claims [5]. The importance of learning communication skills has been well recognised in the context of the pre-anaesthetic visit [6], general practice [7] and more recently, a range of hospital specialties such as neurology [8], orthopaedics [9], general surgery [10], intensive care [11] and palliative care [12]. Anaesthetic training bodies in the USA [13], Australasia [14] and Europe [15] expect anaesthetists to be able to communicate effectively with peers, patients, their families and others in the medical community. However, few details are provided regarding how exactly this might be achieved, and the necessary communication skills being advocated are currently being taught and practised in a very limited way [16]. To date, there have been only a few reports providing some information that anaesthetists might use as a means of improving the way they communicate in clinical practice [17–19].

Anaesthetists in many ways are already expert communicators in the majority of situations in which they find themselves. They take a focused history and perform a targeted examination, frequently in extraordinarily stressful situations. They perform invasive procedures during which they communicate in ways that aim to facilitate relaxation and comfort. Anaesthetists also communicate to a wide variety of other colleagues – surgeons,

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nurses, midwives, administrators, intensivists, and radiologists to name but a few. As with technical skills, learning communication is a lifelong, ongoing process that can always be improved upon in clinical practice, teaching and research.

In the last decade, enormous strides have been made in our understanding of the neurobiology of communication [20], consciousness and subconscious processes [21–23]. Indeed, it is interesting that anaesthetists currently have enough research information to guide their clinical practice in this regard, yet frequently communicate in ways that current research suggests are suboptimal [24–26].

Some anaesthetists may have heard that learning effective communication skills in anaesthetic practice involves teaching anaesthetists how to 'make eye contact', 'sympathise', or 'try to imagine how the patient is feeling'. These communication skills may be of limited value to anaesthetists as a large proportion of their work (which is procedural) requires them to communicate without the opportunity for making eye contact, which may or may not be appropriate for some patients. With regards to 'trying to imagine how the patient is feeling' as a communication strategy, this may be unhelpful in the context of anaesthetic practice where patients are frequently distressed and in pain. Although some commentators suggest that trying to imagine how the patient feels improves empathy, we suggest that if anaesthetists try and imagine 'feeling' the pain and distress of their patients, this is unlikely to improve their communication any more than asking a physician to try and imagine experiencing hypertension, before effectively treating it. In many circumstances it is impossible for the anaesthetist to know or appreciate exactly what the patient is going through, and it may be more helpful to acknowledge this as a means of increasing rapport. There is a growing body of evidence that warning patients of a perceptual experience using language with negative emotional content, such as 'this is going to sting' or sympathising in a way that refers to negative experiences, may be unhelpful [25, 26]. It may be more helpful to explain why one is performing the procedure such as 'this will numb the skin and allow us to keep you as comfortable as possible'. Patients neither want nor need sympathy and would rather that doctors care, have expertise, and respect their autonomy [18]. This can be further enhanced by addressing the patient's concerns or reactions [3] and using reflective listening [17].

Communication concepts of relevance to the practice of anaesthesia

The medical model to which many anaesthetists still cling is very much a paternalistic one. Although terms such as 'patient autonomy' and 'choice' are frequently used, achieving these laudable aims in clinical practice remains limited. Language affects our patients, our colleagues and our own perceptions. This has profound implications in the practice of anaesthesia [19]. When communicating with patients or colleagues (including surgeons), it is helpful to consider the communication as being of two main types: conscious and subconscious. As scientifically trained anaesthetists, we are heavily orientated towards conscious communication, which involves predominantly logic and reasoning. However, the vast majority of our interactions with patients – arguably the most important ones – are subconscious. This involves an individual's perception or view of the world that is often expressed in the form of metaphor, symbolism, and imagery [19]. Professionalism and the art of medicine are about practising and understanding these conscious/subconscious concepts.

Conscious communication

Conscious communication is purposeful, logical and currently the main form of communication recognised and taught in anaesthesia. It is always verbal and involves logic. In the practice of anaesthesia the explanation and provision of information in the process of consent is an example of conscious communication. In a clinical situation one might give instructions such as 'lie still' or 'lift up your arm' while positioning the patient before surgery or placing a blood pressure cuff. In the traditional framework we ask patients to obey consciously our instructions while performing procedures such as pre-oxygenation or intravenous access.

Subconscious communication

Subconscious communication is 'below the radar' and requires a shift in thinking to become aware of it and then utilise it therapeutically. It makes up many of the communications commonly encountered in anaesthetic practice and because it is subconscious, it is frequently unrecognised unless one is looking out for it. This form of communication involves verbal and non-verbal cues (known as suggestions) that elicit non volitional changes in perception or behaviour. When patients are extremely anxious they are sometimes unable to obey a conscious command such as 'lie still'. In this situation, the use of suggestion is frequently more effective. An example of suggestions using non-verbal cues would include the conveyance of an anaesthetist's own calmness, posture, vocal tone and confidence to patients while managing their distress or pain effectively. An example of an inadvertent negative subconscious cue would be handing a patient a sick-bowl in case they feel nauseated.

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Communication structures of relevance to the practice of anaesthesia

The conscious/subconscious concept helps us to understand what may or may not affect rapport with patients and thus facilitate all our other interactions during the provision of anaesthetic care. There are a range of strategies that anaesthetists can use to elicit useful changes in perception. In addition, they provide patients with a sense of control and increase the available choices open to them. Provision of control and choice increases rapport and assists in modifying patients' demands that might otherwise compromise their safety. Patients whom we perceive as being demanding frequently respond positively when they are given some control and choice over what is happening to them. Listening to patients' main concerns frequently reveals opportunities to provide them with control, without necessarily acquiescing to all their demands. Ways an anaesthetist might decrease rapport include calling the patient by the wrong name or more commonly, one they don't usually use. Appearing not to pay attention, saying something one doesn't believe is true, patronising and talking down, or sympathising with phrases such as 'there is nothing to worry about', 'try to relax' or 'I know exactly how you feel' are also unlikely to be helpful. Anaesthetists can increase rapport and cooperation by utilising a structural framework of communication that has been reported previously in the hypnosis literature [27, 28] but is little known amongst the anaesthetic community. This includes reflective listening and observing, acceptance of different realities, utilisation and suggestion.

Reflective listening and observing

Learning how to use subconscious communication in clinical practice involves one skill above all others, namely to listen. As doctors, we are used to telling patients what we need them to do to allow us to do our job, rather than listening to them and responding to their needs. Listening to what patients or colleagues are saying involves more than hearing what one thinks has been said. Listening while observing is one of the most important aspects of communication. It is not just about being silent while the patient is talking. It consists of a series of observations: looking at the patient's demeanor and posture, while noting the voice's tone, pacing, volume and pitch as well as the words used. There are four questions to ask when listening reflectively. First, did you hear what was said? Second, did you understand what was meant? Third, does the patient know that he/she has been heard? Finally, does he/she know he/she has been understood? To determine the answer to these questions requires a 'checking in' process. For example:

Patient: '*I'm scared*'
Anaesthetist: '*What are you scared of?*'
Patient: '*I'm scared of the epidural being inserted*'
Anaesthetist: '*Are you scared of the epidural?*'
Patient: '*No, just moving while it's being inserted.*'
Anaesthetist: '*Is it OK to let me know if you feel you need to move, so that I can stop until you are ready to continue?*'
Patient: '*That's OK*'

Acceptance of different realities

Acceptance is sometimes a difficult concept for doctors to grasp. It is the concept of being open-minded and having a non-judgmental attitude to other people. This can be a hard philosophical issue, especially if the patient's beliefs run counter to those of the anaesthetist and seem illogical or even stupid. There is little point arguing with patients logically if they are stressed or distressed, as they will probably be unable to accept reason at that time. Accepting the patient's beliefs or emotions, no matter how strange they appear, allows the anaesthetist to gain rapport and then move on to a situation that is more therapeutic for the patient. For example, a patient with special needs asked to 'go home' in the middle of a Caesarean section under regional anaesthesia, becoming increasingly agitated when she was told by theatre staff 'No, you can't leave, because you are having a baby'. However, by listening and using the patient's own language, the anaesthetist was able to obtain rapid resolution, relaxation and cooperation when the patient was informed that 'Yes, you can go home' after the baby was born and as soon as it was safe for her to do so. Accepting the belief (at least temporarily), even if illogical, usually allows any associated emotion to dissipate. The anaesthetist is then in a position to engage with the patient in a more cooperative manner. Anger is usually a demand for recognition of emotions, and the patient may be indirectly expressing that they do not feel that they have been listened to. When appropriate, venting of the patient's emotions can be encouraged. The anaesthetist's emotions also need recognition as a subconscious response. Once recognised the anaesthetist can interrupt their own usual behavioural pattern and make a choice as to whether to continue with their current behaviour or not. This break in the normal pattern of one's own subconscious behaviour allows logical consideration as to whether some other more useful behavior or communication strategy could optimise patient care.

The patient's view of his/her situation is frequently very different to how the anaesthetist perceives it. For example, it may be difficult to understand the patient with nipple rings and a tongue stud, who says he is needle

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phobic. The patient in this frame of mind may describe a 22-G intravenous cannula as a 'knitting needle'. Saying to the patient that 'The tongue stud would have been more painful than this little needle' is a quick way to decrease rapport. However, by listening to what the patient says, we can reflect back his own language to let him know that we have heard and understood what he meant and, have accepted his perceptual world (at least initially) without necessarily agreeing with it. This allows the anaesthetist to increase rapport.

On a more subtle level, our perceptions are frequently communicated in the form of sensory perceptual language, usually of the three main senses: visual; kinaesthetic; and auditory. Visual language incorporates phrases such as 'I'm not *looking* forward to my surgery' or 'I *see* what you mean', kinaesthetic phrases include 'It doesn't *feel* right' or 'it's like a *weight* off my shoulders'and examples of auditory language are 'I *hear* what you say…' or 'That *sounds* clear to me.' Much less commonly, gustatory or olfactory language is utilised, such as 'It leaves a bad *taste* in my mouth' or 'It doesn't *smell* right.' Utilising the patient's perceptual world is likely to increase rapport and allow the anaesthetist to reframe negative perceptions and experiences. For example a patient might say that he/she is not looking forward to their anaesthetic and is worried about not waking up. Rather than respond with a platitude such as 'Of course you will wake up' or 'It's very unlikely that will happen', the anaesthetist can use this perceptual language and reframe it into something useful such as 'You may not be *looking* forward to the anaesthetic but you can *look forward* to waking up in recovery'.

Utilisation

This is probably the single most important concept in facilitating anaesthetic related communication. It involves utilising the presenting problem or patient's concern and reframing it into a solution. The reframe is a concept whereby a patient's concern that is generating a thought, perception or behavior that is unhelpful (for example, anxiety) is reframed in a way that generates a thought, perception or behavior that is helpful or therapeutic (for example, relaxation). Utilisation involves more than words, but also meaning and metaphor, or even an aspect of the patient's behaviour. For example, if during an inhalational induction a child says, or behaves in a way that indicates, that he/she doesn't like the smell, the anaesthetist can accept and utilise this reality by saying 'That's OK, it is a bit smelly; if you don't like it you can just blow it away!'. Similarly, if a patient is anxious that there will be 'too many people' in the operating room, the anaesthetist can utilise this concern by reframing the perception. A therapeutic communication can be given that 'Every staff member in the theatre has their own job to do, in order to ensure your comfort and safety'. When saying 'Every staff member… has their own job to do…' the patient's concern has been utilised in a way that implies that no matter how many people there are in theatre, it can't be 'too many' (The proviso is that everybody in theatre does have a job to do and that it is not full of observers without the patient's permission). Patients who are encountering their hospital experience for the first time may have no model on which to base their interpretation of events. They are looking for, and are keen to receive, guidance (in the form of suggestion) as to how to do this in a positive way.

Principles of suggestion

Suggestions are verbal or non-verbal communications that lead to subconscious, non-volitional responses in mood, perception or behaviour. Patients and people generally are in large part subconscious beings. This is the basis of the whole consumer society and the advertising industry in particular. It is also the 'raison d'etre' for poetry, art, and prose. At times, the ability of people to respond to communications in a subconscious way is termed suggestibility. Suggestibility increases when patients are highly anxious, distressed or when in pain. It also increases in pregnancy [29] and is higher in the paediatric population [30]. We tend to focus and associate with what is being suggested. This is highly relevant for example in the recovery room after surgery, when the patient is repeatedly asked what their pain scores are. This encourages an association with the damage process around pain, rather than the healing process of recovery.

Direct suggestions

These tend to take the form '*You* will find that……', '*You* will be able to……' or '*You* may be surprised that……'. For example, at induction of anaesthesia, the anaesthetist could suggest to the patient 'You can be surprised how quickly you recover as the wound heals'.

Indirect suggestions

These take the form 'Most/some people find that…….' or 'A patient I saw last week found that………'. The implication here is that the patient too will experience the same thing. For example, at induction of anaesthesia, the anaesthetist could suggest to the patient that 'Patients having this surgery frequently tell us that they are surprised how quickly they recover as the wound heals'.

Negative suggestions

Lang et al. [25] have shown that the ubiquitous use of language with negative emotional content is likely to increase patients' anxiety, pain and distress. These

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subconscious responses are a result of negative suggestions – verbal or non-verbal cues that lead to subconscious changes in perception, mood and behavior. The use of inadvertent negative suggestions in hospitals is apparently ubiquitous in Australia, the USA and the UK [24, 31]. Examples of inadvertent negative suggestions sometimes used by hospital staff, with possible alternative ways of communicating, are shown in Table 1. Some anaesthetists believe that they are being honest when preparing patients before a potentially painful procedure such as intravenous cannulation, or an injection of local anaesthetic, by warning them that it will hurt or sting. However, there are at least two reasons why such statements should be avoided. First, the sensation may not be unpleasant or hurt in a proportion of patients, and second, there is an increasing body of evidence showing that using language with negative emotional content can lead to an increase in the patient's analgesic requirements [6] and experience of pain or anxiety [25]. It appears that some communications, in the peri-operative setting, function as suggestions [6, 26]. This means that telling patients that a procedure 'will hurt' increases the likelihood that the perception referred to will be experienced as pain. Fortunately, the reverse is also true, and telling patients that there are ways to improve their comfort, such as coughing during cannulation or breathing exercises after abdominal surgery [6] can make things more comfortable for them. It is just as inaccurate to say something 'will hurt' as it is to say it 'will be comfortable' when there is a possibility that it will do neither. One is then left wondering what to say when the patient asks 'Will this hurt?'. If one responds 'no' or 'yes', the chances are that for some patients this will be less than truthful. If the anaesthetist responds by saying '*Some people* tell me it hurts while others are surprised it is more *comfortable* than they thought it would be' this is entirely consistent with honesty with the added benefit of giving an indirect positive suggestion. Negative words such as pain, vomit and panic should be avoided where possible unless the patient mentions them first. For example, if the patient asks 'Will I have much pain after my operation?' the anaesthetist can and should always respond honestly, and yet avoid the use of negative suggestions wherever possible. Thus a response might take the form 'Some people have pain, while others are surprised that the sensation of the wound healing is more comfortable than they had thought. In any event you can have as much medication as is safe for you, to recover as quickly and comfortably as possible'. Addressing the patient's concerns is always paramount and these need to be dealt with. Note the use of the indirect suggestion 'some people…'. This implies indirectly that the patient too may feel more comfortable than they expect. There sometimes is concern regarding the ethics of not telling patients

Table 1 Examples of communications encountered in anaesthetic practice that function as unintended negative suggestions, with possible alternatives and a possible explanation of psychological mechanisms.

Inadvertent negative suggestion	Explanation	Possible alternative	Explanation
'Would you like to kiss your child goodbye?'	Suggestion implying death	'Would you like to kiss your child? You'll see him/her as soon as he/she is ready to return to the ward'	Suggests that child will be returned safely after surgery
'The anaesthetist will put you to sleep'	Suggestion implying death (A favoured pet may have been 'put to sleep')	'The anaesthetist is here to ensure your safety and comfort throughout the procedure and when you wake up in recovery'	Suggests safety and comfort and that patient will wake up after the procedure and not before
'This will hurt!'	Suggestion to experience the sensation as pain	'You will feel what you feel'; 'You may or may not feel this'	Neutral suggestions
'This won't hurt'	(the subconscious doesn't hear 'not')	'Most people are surprised that it is more comfortable than they thought'	Positive suggestion
'Try not to worry!'	The use of 'try' suggests that the patient will fail to 'not worry' This is a suggestion 'to worry'	'As people find themselves focusing each time they breathe out, they begin to relax without thinking about it'	Physiological truism of FRC relating to chest wall relaxation. Linked indirect suggestion to relax
'This will sting a little'	Negative suggestion: the only way to experience this sensation is as a 'sting'	This will numb the skin and allow the procedure to be performed more comfortably'	Positive suggestion
'We will give you medicines to stop vomiting after your surgery'	Negative suggestion: 'vomiting after surgery' is being suggested	'We will give you medication to ensure that you can eat and drink as soon as you feel like it!'	Positive suggestion

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something will hurt when the anaesthetist thinks that it might do. However, the best available evidence suggests that patient's (and possibly the anaesthetist's) expectations in some part determines their experience [20, 24, 25, 32].

Positive suggestions

A positive suggestion is a communication that elicits a positive therapeutic response. For example: 'Most people find it is more comfortable than they thought' is an indirect positive suggestion to elicit the perception of comfort.

Linked suggestions

Suggestions may involve linking two perceptions or behaviours with one another. This means that when you do one thing (that is conscious), something else will happen (that is subconscious). For example, 'When you focus on your breathing (conscious), each time you breathe out you will find yourself relaxing automatically (subconscious)'. A direct suggestion can be quite confronting on occasion. However, patients are more likely to respond to them under extreme stress. Indirect suggestions are more permissive. For example; 'When *people* focus on breathing, each time they breathe out they find themselves relaxing automatically'. This indirectly implies that if the patient focuses on his/her breathing, then he/she will also relax.

Repetition in a variety of forms is one of the most useful ways that people retain important information, both consciously and subconsciously. This learning response can be facilitated by using a variety of phrases that mean the same thing. For example, during pre-oxygenation before intravenous induction of anaesthesia, if the anaesthetist's suggestion for relaxation with breathing appears to be effective, this can then be reinforced by saying; 'That's good', 'Well done' or 'That's right', coinciding with the patient's exhalation.

Double binds

Double binds are statements of comparable alternatives that can facilitate a sense of control by allowing stressed patients the perception of choice when there isn't any. This is a technique most successfully used with children. For example, when leading a child in to theatre the anaesthetist can ask the child 'When you are lying still on the bed, would you like to hold mummy's left hand or her right hand?'. If the child chooses a hand, he/she has also told you that he/she will (probably) lie still on the bed! Another example of a double bind is to tell the child during an inhalational induction that he/she can choose whether to breathe the gas in or blow it away.

The law of reversed effect

Asking patients to do the opposite of what is required frequently allows them to respond subconsciously. For example, during an inhalational induction, the anaesthetist can ask an uncooperative child to 'Try not to blow the balloon up too hard as it might burst!' This usually leads to the child paradoxically blowing the bag up harder and quickens the induction. Stressed adults similarly can be asked to 'Try not to relax' as this frequently allows relaxation to occur (see below).

Failure words

'Try' is a failure word and should be used with caution. The word 'not' isn't heard by the subconscious. This means that when the anaesthetist asks the patient 'Try not to move' this is a subconscious suggestion for the patient to move. If the reader 'tries not to think of an ampoule of propofol', an image of a propofol ampoule usually appears in the mind and by the time it is crossed out, it is too late to avoid the thought. On the other hand, the two words 'try' and 'not' can be used therapeutically. For example, when the anxious patient is asked 'Try not to relax' the patient consciously will fail 'not to relax' but subconsciously the patient will relax as the 'not' isn't heard by the subconscious.

The goals of effective anaesthetist-patient communication

Communicating effectively in anaesthesia should function as the basis for improving rapport and patients' safety, comfort and a perceived sense of control. Over 40 years ago a landmark double-blind randomised controlled trial of anaesthetists' communications, utilising positive suggestions to improve rapport, showed a dramatic reduction in the use of postoperative analgesia and length of hospital stay [6]. This form of communication can assist patients before, during, and after procedures, empowering them to become helpful participants in their anaesthetic care [4].

Teaching communication skills

Anaesthetists usually learn their communication skills through modelling of peers, and then further develop these skills over several decades of clinical interactions. Although many anaesthetists demonstrate excellence in the way they intuitively communicate, it is not easy to appreciate how these 'intuitive' skills can be taught. The recognised language structures in the hypnosis [27] and neuro-linguistic programming (NLP) literature [33] can provide a relevant framework when teaching anaesthetists communication techniques in the stressful setting of

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hospital practice. This model could be utilised to implement change in the anaesthetist's attitude and behavior in order to accelerate the development of expertise [1]. As is often the case with elements of the 'unofficial syllabus' of professional education [34, 35], there remains little guidance in the anaesthesia literature regarding how communication skills could be developed and improved upon in clinical practice. Although the principles of communication can be taught in isolation, teaching communication skills separately from clinical skills may limit the coherence needed to ensure that satisfactory communication occurs [36]. Anaesthetists frequently communicate in ways that use repetitive, rigid, language structures that are deeply embedded in anesthetic practice and fall into specific patterns, with similar functions being shared across the anesthetic team [37].

The future of communication in anaesthetic practice

Communication is an integral part of almost every aspect of anaesthetic care. Although expert anaesthetists have always demonstrated competency in communication, it has not featured explicitly in anaesthetic training programs [38]. A learnable framework can be developed that will allow anaesthesia trainees of the future to communicate effectively when their usual strategies aren't working. These concepts can also be modified in a way that facilitates communicating with surgeons, theatre nurses and other colleagues, with potential benefits to patients. Communication is a core clinical skill in the practice of anaesthesia. It merits being an essential component of anaesthetic training programmes and an area for future research.

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