As trainees in Internal Medicine you can look forward to a stimulating career in a most rewarding profession, one full of intellectual challenge and professional satisfaction.

Your entry into specialist vocational training represents the culmination of many years of learning – your brains have been filled with facts and stats, you have mastered a lexicon of acronyms, undertaken the mystery tour of anatomy, greater and lesser sacs, circle of Willis, and rolled your tongue around the guttural assonance of borborygmi and paced alliteration of abdominal aortic aneurysms. You have learnt to communicate in unintelligible medical babble – interpretation only possible by one of your own species:

Twas brillig and the slithy toves
Did gyre and gimble in the wabe;
All mimsy were the borogoves,
And the mome raths outgrabe.

And thus did Alice slay the Jabberwocky (Lewis Carroll).1

Your scholastic learning has been shaped by the logarithmic accumulation of scientific facts and the technologic advancements of the modern lecture theatre. It is characterised by a shift from paper to screen, enabled by PowerPoint and Prezi, allowing orderly and hierarchical packages of data to be digested for spewing out in the multi-choice theatre of the examination room – no room for narrative or essay. Your e-generation has been described as falling victim to the ‘rapid fire, short attention span provoking, over-stimulating, largely visual, information-spewing environment’ of modern university teaching.

How then, do you develop the cognitive attributes of reflection, the ability to detect nuance, or subtext or ambiguity, so necessary in the context of human communication and understanding? How can you move from fact to reasoning, from bullet points to discursion? What is wrong with bewilderment, which is related to amazement and awe? Can one learn about life if one learns in packages? Life is messy, fuzzy, unique, and to quote one academic, ‘to approach it one must disconnect, unplug and log off’. Why no less a scientist than Albert Einstein stated that ‘Imagination is more important than knowledge’.

I acknowledge the benefits of the technological advances to learning – but paint and words add colour and shade. Many medical schools now integrate scientific learning with lessons from the humanities and other non-scientific faculties – art, literature, philosophy, music. Such learning may allow release from the constraints of logic, experiment and fact – freeing the intellect to imagine, reflect and dream.

Literary accounts of illness can be powerful learning experiences, expressing the harsh reality of sickness from a patient’s or relative’s perspective:

Toby’s father takes pills in a narrow bottle with a red wrapper insect ridden with instructions and warnings. Toby takes pills too for his fits that happen now only sometimes and then it is his mother, faded, shrunk, stolid, vague, with the hardened arteries and swollen belly of salt, who will comfort him.

Janet Frame describing the uraemic fatigue of the weary Mrs Withers in Owls Do Cry.2

What great works have come from the hollow-eyed poets and artists consumed by tuberculous? To write, as the 25-year-old consumptive Keats did, in Ode to a Nightingale3:

To cease upon the midnight with no pain,
While thou art pouring forth thy soul abroad
In such an ecstasy

To understand life, is to understand that death is a necessary condition – and in the revealing of mortality, doctors often find their communication skills wanting.

Let us go then you and I
When the evening is spread out against the sky
Like a patient etherized on the table

TS Elliot4

Death, that gentle friend of the very frail and infirm – yet why is talking about it so difficult for doctors who confront it almost daily in clinical practice? Despite clear evidence of an enhanced patient and family experience, doctors find it challenging to engage in
end-of-life discussions. Mastery in the art of difficult conversations is an essential physician competency and one that will allow you to have respectful and empathetic conversations with those who are suffering. In particular, it is important to recognise the role of families, particularly when patients are vulnerable and unable to communicate effectively or advocate for themselves. The recent public inquiry into shortcomings in patient care at the Mid Staffordshire NHS Foundation Trust noted that a significant part of the Staffordshire story was the exclusion of relatives from effective participation in patient care.1 Robert Francis QC, and author of the report, stated: I heard many cases where families had information about their relatives, but they were not listened to during the diagnostic process ... Carers of patients should not be ignored, they often have a depth of knowledge of their loved one's condition that is far greater than what staff can obtain on a brief acquaintance.

These are not uniquely British sentiments. Beverly Johnson, CEO and President of the Institute of Patient and Family Centred Care, has written extensively about the core concepts of the patient and family-centred model of care: respect and dignity, information sharing, participation and collaboration.2 If it is found that there are omissions of care that may or may not have changed the clinical course, there is evidence that early disclosure of such is likely to result in a lower likelihood of complaint and litigation.3 Communication, which is the key to trust between patients/family and doctor, is identified as one of 10 professional domains for an RACP Fellow, and a competency you must master.4

Patients' stories are richly narrative – but we must take time to hear them, not import material from electronic data sets, or copy from the notes of others. How often do patients complain when they have not been listened to, and how often do we miss the clues that might inform the correct diagnosis, and hence management. The story is to be listened to, the face to be regarded, the hand to be held. My first medical history as a 4th year student took 2½ days – that is now the average length of stay of a patient in our hospital. Yes, the constraints of time and the pressures of irrelevant chores, distracting interruptions and rudely chiming bleepers will be challenging. But marvel in the richness of the human voice, the expression of the human face and the subtle strength and frail weaknesses of the human personality reflected therein:

Mr Slope is tall, and not ill-made. His face is nearly of the same colour as his hair, though perhaps a little redder ... His nose, however is his redeeming feature: it is pronounced, straight and well-formed; though I myself should have liked it better did it not possess a somewhat spongy, porous appearance; as though it had been cleverly formed out of a red-coloured cork.

In his description of the Bishop's chaplain in Barchester Towers, Trollope clearly demonstrates how careful and reflective observation can reveal much about a character.5 That same information cannot be obtained by simply copying the medical history from the last admission notes. As physicians, you are master diagnosticians, but you will miss important clues if you do not take the time to observe, listen and reflect. The art of reflection will serve you well; you will consider your mistakes and learn from them, but go further and take counsel from others, and have the courage to seek feedback from your patients. The RACP website provides tools for reflective learning and as a Fellow you can obtain CPD credits for demonstrated reflective practice.

As physician trainees, relish the opportunity for lifelong learning and learning about life – look to the arts to provide you with the dimensions of humanity, and with that you will develop a rich empathy with your patients and their families. And never stop being curious – ask, query, search and question, particularly of yourself:

MASTERY IN THE ART OF DIFFICULT CONVERSATIONS IS AN ESSENTIAL PHYSICIAN COMPETENCY AND ONE THAT WILL ALLOW YOU TO HAVE RESPECTFUL AND EMPATHETIC CONVERSATIONS WITH THOSE WHO ARE SUFFERING.

I keep six honest serving-men
They taught me all I knew
Their names are
What and why and when
And how and where and who.

Rudyard Kipling5

Dr Margaret Wilsher
Chief Medical Officer, Auckland District Health Board

References
5. www.midstaffspublicinquiry.com/report
6. www.ipfcc.org