when he said (in *Tom Jones*): "It is as possible for a man to know something without having been to school as it is for him to have been to school and know nothing."

Effects of organisational change

To be an intending student just now is bad enough, but to be a dean is worse. Uncertainty turned uncertain: never has the financial position of the Health Service and universities looked less secure; never has organisational change shaken the Health Service with more consequences for medical schools than in the past few years, and still it continues.

One relative freedom medical schools have continued to enjoy since they lost their boards of governors in 1974 has been the opportunity to plan joint posts at both junior and senior level between school and hospital to mutual advantage and by local negotiation. At senior level this has been possible because area health authorities with teaching responsibilities have technically held consultant contracts but in practice have passed them down to the local district administration.

Now, although the Secretary of State proposes that the new district health authorities should hold consultant contracts when the AHAs disappear, the British Medical Association favours the region as the appropriate authority. Remoteness would almost certainly be second best for medical schools in this respect, except perhaps when there was only one university medical school in a region, with close proximity and understanding between university and RHA. Decision-making is a long enough process already and it would be yet one more nail in a dean's coffin to make it longer.

The reasons against the DHA employing its consultants would seem to be partly a fear that national regional specialty planning might be hindered (although the RHA could still take initiatives on this front) but mostly a mistrust of parochial administrators. Fears of local administrators applying sanctions against their consultant employees are surely ill founded: if a consultant has the support of his colleagues he is at no risk, and, if he has not, then surely it is at local level that a review should begin. Distance would only be a disadvantage either way. The current constitution of appointments committees will be essentially unchanged whichever authority holds the contract of employment.

Politicians do not always get it wrong, and local administrators are generally amenable to reasoned argument if not a little local pressure from those they have to live with. Perhaps on this controversial issue a concession to the occasional wisdom of the one and a vote of confidence in the good faith of the other would not be out of place.

Reference

1 Bruce-Lockhart, L. The college, the candidate and the inadmissible evidence. *Times Higher Educational Supplement* 1980 September 5: 9.
2 Universities Central Council on Admissions. *UCCA Statistical Supplement to the Seventeenth Report 1978-79.* Cheltenham: UCCA, 1980: 14.
3 Association of Commonwealth Universities. *Compendium of University Entrance Requirements for First Degree Courses in the UK 1981-82.* London: ACU, 1980:124.

This is the second in a series of occasional articles from an undergraduate dean.

Contemporary Themes

Listening and talking to patients

III: The exposition

CHARLES FLETCHER

Exposition is a convenient word to describe the second part of a consultation, in which the doctor explains his conclusions and tells the patient what he needs to do or have done to him in the way of investigations, treatment, or changes in his way of life. It is much more complex than the interview: a check list of topics that may be dealt with is given in the table. Not surprisingly, many patients complain about not being told what they want to know. Indeed, this is the commonest complaint that patients make about their doctors.[1-5] The reasons for failure in this part of the consultation are also complex.

20 Drayton Gardens, London SW10 9SA

CHARLES FLETCHER, CBE, FRCP, emeritus professor of clinical epidemiology, University of London

Reasons for failure

LACK OF TIME

We so often feel, or appear to feel, rushed in our work. This feeling should be concealed, but, since there is often too little time in which to tell patients all they need to know by word of mouth, we have to use other methods as well.

DOCTOR'S ATTITUDE

Some doctors still think that it is bad for patients to know too much about their diagnosis and treatment. To them "good" patients are those who do what they are told without question; "troublesome" patients are those who demand information in a way that seems to undermine medical respect and confidence. If patients are considered as clients then it can be seen that they are usually much less able to participate in deciding what to do about their problems than are clients of any other professionals, such as architects or lawyers. Some patients do not want to

Check list of topics for exposition

Investigations
- What they will involve
- Results and their meaning

Diagnosis and cause of illness
- Is it catching?

Treatment
- Purpose—control or cure
- What is to be done and when
- Drugs: dose, frequency, side effects, for how long
- Operation: what will be done
  - how much it will hurt
  - possible complications
  - time in hospital
- Other treatment
- Modification of activities and for how long
  - Job / Diet
  - Smoking / Rest/exercise
  - Drinking / Sexual relations

Prognosis for health and survival

Remind patient to make notes of any questions to be asked at next visit

participate and prefer to have uncritical confidence in their doctors' wisdom and skill; but most of them, much better educated now than they used to be, want more information than they are usually given and even feel resentful about what they regard as doctors' superior attitudes and secretiveness. Cartwright[1] recorded remarks of unsatisfied patients about hospital doctors such as, "If only they treated you as if you could understand something. The doctors, especially, were very superior"; or "I didn't like to ask. You can't get through to them—they seem a bit above you"; and so on. The percentage of hospital patients who are dissatisfied with the information they have been given has been found to range from 11% to 65%.[1-5]

This apparent secretiveness of doctors may partly derive from our unconscious need to dominate patients to bolster our confidence in making important decisions, as we often have to, on evidence that is far from complete.[6 7] Professional secrecy is also derived from the old traditions of teaching hospitals, which used to cater solely for the sick, and mostly uneducated, poor. Perhaps this is also why some doctors stand by the bedside talking down to prone and undressed patients instead of sitting down to chat with them on the same level and why they discuss patients with other doctors or with students in their presence, referring to them in the third person—something they would never do on normal social occasions. Patients resent being treated in this way. A recent guide to medical services has a chapter on how patients should deal with doctors who try to dominate them.[8] It is sad that the authors should feel this is necessary.

PATIENTS' SUBMISSIVENESS AND FORGETFULNESS

Many patients have an almost obsequious respect for doctors, and this, combined with their anxiety about the outcome of their illness, inhibits asking questions in the consultation. This may also be why, even when given full information, they forget much of it. It has been shown that the more things patients are told the higher is the proportion of it that they forget.[9] Another reason is that most of them are so ill-informed about medical matters that much of what they are told makes little impression. They are like a visitor who asks the way in a strange town. He gets an account of left and right turns at shops, garages, or traffic lights which are quite clear to the resident but hopelessly confusing to the stranger, so he forgets it almost at once. Moreover, doctors tend to use medical jargon, which is incomprehensible to most patients. There are many other ways in which doctors may often accidentally mislead and confuse their patients.[7]

But even when clear explanations have been carefully given, some patients may remember nothing immediately afterwards. I suspect this is mostly due to a deep, unexpressed anxiety that inhibits listening and recall.

Improving the exposition

The first thing is to recognise that there is a real problem that needs careful attention and that we must investigate and develop better techniques. I often find that colleagues are largely unaware of the importance of the problem: they tend to regard it as inevitable and mostly the fault of patients.[10] This feeling is also shown by our attitude to the fact that a high proportion (perhaps half) of our patients fail to follow our advice.[11] We tend to blame this on them rather than considering how far we ourselves may be failing to be explicit and convincing. Patient satisfaction with communication is one factor in improving compliance.[12 13] Most patients nowadays are not satisfied unless they are told what is wrong with them in a friendly way and are encouraged to collaborate in their treatment so far as they can. When we fail to do this it is at least partly our fault if they do not follow our advice. Things are, of course, rather different in surgery: but well-informed patients tend to have less postoperative pain and to recover more quickly than those who have not been given so much information.[3]

Those who prefer not to know may be identified by a simple question such as, "Do you want to know what I am going to do?" A few will answer "No, just get on with getting me well," or words to that effect (and that's the end of it), but most will be grateful for information. In the case of disfiguring surgery, such as mastectomy, lack of a full discussion may lead to serious distress[14] which can be prevented by discussing beforehand the physical and psychological consequences of the operation.[15 16] (I shall discuss the special care needed with patients who have a potentially fatal disease in the next article.)

It is all very well being willing to give information, but it is not as simple as that. We have to know how to give it, so that our patients can both understand and remember what we say. The first essential is that we should always try to put ourselves in the position of the patient and to think what we would want to know if we were in his place. Some special techniques may help.

How to get information across to the patient

BETTER VERBAL INFORMATION

Studies by Ley[3 9] have shown that patients' recall of what they have been told can be improved in various ways. They remember the first statement that doctors make better than later ones, regardless of the importance. They more easily remember things said in simple language and particularly with what psychologists call "explicit categorisation"—that is, telling the patient the sort of information you are *going* to give him before you actually give it: "First I'll tell you about your treatment, then about what is wrong with you. . . . Now, your treatment is . . . " and so on. (Note that treatment comes first, since this is usually the most important thing to be remembered.) Repetition also increases recall, as does specific rather than general advice: "You must walk briskly for at least two miles every day," rather than "You should take more exercise." Patients who are asked to repeat the more important parts of what they have been told remember it better.

It can be a salutary lesson when a doctor asks his patients to repeat what he has told them and finds what strange omissions and mistakes they may make. But, whatever is done, patients will still forget much of what they are told verbally, and other methods are often needed.

SUPPLEMENTING SPOKEN WITH WRITTEN OR RECORDED INFORMATION

"Better instructions are provided when purchasing a new camera or automobile than when the patient receives a life-saving antibiotic or cardiac drug."[17] Patients who are given written information about their prescriptions tend to be more

satisfied and to remember more and comply better, at least in the short term, than those who are only talked to.[18-20] A simple duplicated form may be used in the consulting room which is made out to suit each patient. For most patients it needs only to say "Your trouble is. . ." (diagnosis). Your treatment is. . ."—with a list of medications stating for each its name, purpose, and appearance (a sample of each pill can with advantage be stuck on the form with Sellotape). One senior doctor who had contributed to a report[19] of this method told me of his chagrin at finding after 40 years of practice that so many of his patients had neither understood not acted on his verbal instructions.

Written notes on possible side effects of drugs have surprisingly been found to increase the number reported to the doctor without increasing their incidence.[20 21] Perhaps in the future standard, simple printed pamphlets will be issued to all patients by pharmacists with prescriptions. A full acount of observed and potential benefits of such pamphlets has recently been published in the United States.[21] I hope that pilot trials will soon be carried out here. Meanwhile doctors could produce simple accounts of the drugs they most commonly prescribe, stating their actions and possible side effects, for their own patients. Many surgical patients appreciate a simple diagram of what has to be done to them.

Readable and helpful accounts of diseases are issued by many patients' associations and should be more widely used in appropriate clinics. Lists of patients' associations that supply leaflets are available.[22 23]

One orthopaedic surgeon makes audiotape recordings giving simple information about the nature of the operations he performs and of the postoperative care. Either on admission or after an outpatient consultation patients are provided with a tape recorder on which to listen to the tape. They are encouraged to ask questions about anything they have not understood. These tapes are much appreciated.[24]

AVOIDANCE OF JARGON

Talking about medicine in simple monosyllabic English is an art that few doctors seem to acquire, as I have often observed in television programmes that I have introduced. Doctors use phrases such as "dietary indiscretion" instead of "eating what doesn't agree with you," or even "diagnosis" instead of "what is wrong with you." Patients often have quite different ideas from those of their doctors on the meaning of medical terms.[25] A good way of checking the use of jargon is to make audiotape recordings of your own expositions to patients to check the number of technical words you use and to see how they may be explained in simple English.

ENCOURAGING PATIENTS' QUESTIONS

Most doctors ask their patients if they have any questions, but patients often forget these questions till after the consultation. They should be encouraged to write them down before they see the doctor. Inpatients especially should do this for they tend to forget their questions until after the consultant's rounds. One of Cartwright's patients[1] said, "You get hot and bothered when they are there and think afterwards, 'I wish I had asked them that'."

AVOIDING CONFLICTING INFORMATION

This is chiefly a problem in hospital where patients may ask various people about their illnesses. A policy of information should be agreed for each patient. One way of avoiding confusion is to have an "information sheet" in the case notes on which questions asked by the patients and answers given by members of the staff are recorded. I once tried this technique but it failed, probably because of insufficient preparation and persuasion of staff members. Sheets of this kind are a routine part of the case notes at St Christopher's Hospice, where they are regularly used and are a valuable means of assuring good communication.[26]

The exposition presents problems that need more research. Giving information is part of treatment, and its value should be assessed like any other aspect of therapy. This sort of study would nowadays be a fertile field for registrars and other junior staff, for it requires no elaborate apparatus.

This is the third in a series of articles on listening and talking to patients.

References

1 Cartwright A. *Human relations and hospital care.* London: Routledge and Kegan Paul, 1964: 73-115.

2 Congalton AA. Public evaluation of medical care. *Med J Aust* 1969;ii: 1165-8.

3 Ley P. Psychological studies of doctor-patient communication. In: Rachman S, ed. *Contributions to medical psychology.* Oxford: Pergamon Press, 1977: 9-42.

4 Parkin DM. Survey of the success of communication between hospital staff and patients. *Public Health* 1976;**90**:203-9.

5 Royal Commission on the Health Service. *Research report on patients' attitudes to the hospital service.* London: HMSO, 1979: 103-9.

6 Waitzkin H, Stoeckle JD. The communication of information about illness: clinical, sociological and methodological considerations. *Adv Psychosom Med* 1972;**8**:180-215.

7 Barnland DC. The mystification of meaning: doctor-patient encounters. *J Med Educ* 1976;**51**:716-25.

8 Stimson G, Stimson C. *Health rights handbook, a guide to medical care.* Harmondsworth: Penguin Books, 1980: 49-56.

9 Ley P. Memory for medical information. *Br J Soc Clin Psychol* 1979; **18**:245-55.

10 Stimson GV. Obeying doctors' orders: a view from the other side. *Soc Sci Med* 1974;**8**:97-104.

11 Sackett DL, Snow JC. The magnitude of compliance and non-compliance. In: Hayes RB, Taylor DW, Sackett DL, eds. *Compliance in health care.* Baltimore: Johns Hopkins University Press, 1979: 11-22.

12 Ley P. Improving clinical communication: effects of altering doctor-behaviour. In: Osborne D, Gruneberg MM, Elson JR, eds. *Research in psychology and medicine.* Vol 2. London: Academic Press, 1979: 221-9.

13 Korsch BM, Negrete VF: Doctor-patient communication. *Sci Am* 1972; **227**:66-74.

14 Maguire P. Psychological and social sequelae of mastectomy. In: Howells J, ed. *Modern perspectives in psychiatric aspects of surgery.* New York: Brunner-Mazel, 1976:390-421.

15 Mastectomy Association. *Living with the loss of a breast.* London: Health Education Council, 1979.

16 Robinson R, Swash I. *Mastectomy. A patient's guide to coping with breast surgery.* Wellingborough: Thorsons, 1978

17 Stewart RB, Cluff LE. A review of medication errors and compliance in ambulant patients. *Clin Pharmacol Ther* 1972;**13**:463-8.

18 Haynes RB. Strategies to improve compliance with referrals, appointments and prescribed medical regimes. In: Haynes RB, Taylor WB, Sackett DL, eds. *Compliance in health care.* Baltimore and London: Johns Hopkins University Press, 1979: 121-43.

19 Ellis DA, Hopkin JM, Leitch AG, Crofton J. Doctors' orders: controlled trial of supplementary written information for patients. *Br Med J* 1979; i:456.

20 Morris LA, Halperin J. Effect of written drug information on patient knowledge and compliance. *Am J Public Health* 1979;**69**:47-52.

21 Food and Drug Administration. Prescription drug products; patient-labelling requirements. *Federal Register* 1979 July 6.

22 Sayer K. *The King's Fund directory of organisations for patients and disabled people.* London: Pitman Medical Publications and King Edward's Hospital Fund for London, 1979.

23 Edsall B, Webb B, eds. *Health education index and guide to voluntary social welfare organisations.* London: Edsall, 1980.

24 Welford W. Closing the communication gap. *Nursing Times* 1975 Jan 16.

25 Boyle CM. Difference between patients' and doctors' interpretation of some medical terms. *Br Med J* 1970;ii:286-9.

26 West J. In-patient management of advanced malignant disease. In: Saunders CM, ed. *The management of terminal disease.* London: Edward Arnold, 1978:145.

(*Accepted 22 July 1980*)