



One example is worth a million words

Robert Buckman, MD, PhD

Teaching by example has been the foundation of clinical medicine from the very beginning. The principle of learning by watching the activities of experienced preceptors or mentors is how medicine got its start. But the problem with this principle is that, today, not every student will have equal access to good clinical examples from which to learn.

A hospital or clinical unit might not have the right type of clinical case or the right type of clinical teacher to demonstrate every topic and issue. This is where the latest advances in technology can help. The current expansion of accessible (and inexpensive) technology is widening the range of clinical teaching in medicine. In addition to traditional methods of teaching, such as lectures, textbooks, and bedside instruction, we can use newer technologies, such as CD-ROMs and videos, as supplementary teaching aids.

This can be frightening, but medical teaching has always changed with the times and has always incorporated new techniques. An apprenticeship was the main way students learned the details of medical practice in the earliest days. The Egyptians (about 5000 years ago, so I am told) and then the Greeks, including Hippocrates (some 30 centuries later) started recording some of the most important observations, which did not replace clinical teaching, but augmented it. Despite those early textbooks, medical students still required a master to show them what it was all about.

That fundamental principle has not changed, and I hope it never will. We cannot—and must not—learn medicine entirely from textbooks. We will always need bedside teaching in exactly the same way every profession, trade, and art has perpetuated its craft: hands-on teaching and apprenticeship. One thing, however, has changed. We now have the advanced technology to expand the realm of bedside teaching and to widen the range of examples. That is going to alter and improve immeasurably the scope of clinical teaching.

Seeing is believing

I began to see (albeit dimly) the power of the words we use in clinical practice when I was a medical student. I read a report of a symposium on dying

patients in the *British Medical Journal* in late 1972. Unusually, one of the speakers was a very well-known actress. Her husband had died recently, and she spoke about the dreadful moment when the resident said to her: “Nothing can be done.” I am sure that the resident had meant to say (or might even have actually said) “Nothing can be done to prevent your husband’s death.” I am sure he wanted to imply: “So this isn’t our fault, and we’re going to do our best to make your husband comfortable.” But what the actress heard and what she understood was: “We aren’t going to do anything.”

Instead of a simple acknowledgment of the sad facts of the medical situation, the resident had inadvertently closed the door to any form of supportive care. The actress talked about that incident with a great deal of insight, and it was obvious that the resident’s words unintentionally carried many unfortunate and unintended implications and attitudes. I, along with all the readers of that article, was basically told “don’t do it this way. This is an example of how *not* to do it.”

A few years later, I observed a superb example of how *to* do it. This particular clinical interview changed my understanding of potential outcomes of a doctor-patient interaction. I was working as the equivalent of a first-year resident in an oncology unit in Britain in 1975. A man in his early 30s was admitted with his third episode of paraplegia. He had a paraspinal sarcoma, which had been resected about 4 years previously. After surgery it had recurred, and he had been treated with radiotherapy. It had recurred for the second time, and he had had chemotherapy. Now the tumour was progressing again. He was absolutely desperate and in tears, which were a mixture of fear, anger against the tumour, disappointment, and hopelessness. My boss, Eve Wiltshaw, gently sat down on the edge of his bed. She put her hand on his forearm and after a pause said “Poor Mr Simpson.” He cried, and she stayed there.

I had never seen an interaction like that before. I did not know doctors (in that bygone era) were actually *allowed* to sit on a patient’s bed, were *allowed* to touch a patient’s arm, were *allowed* to start an interview in any way other than with a clin-

ical history, or were *allowed* to acknowledge a patient's emotions (which, in this case, were so obvious that *not* to acknowledge them would have been extremely insensitive). Without sounding too grandiose about that moment, I think it earns the title of epiphany, a point I have made gratefully several times to Eve Wiltshaw since then.

Even more important, it was an example of what can be done. In the field of communication skills, dozens of research studies, books, papers, and editorials tell us what to do. But fewer articles tell us how to communicate effectively in everyday, real-life clinical practice.

Over the years, a few published articles have outlined actual examples of dialogue from clinicians and researchers, such as that of Premi,¹ Maguire and Faulkner,^{2,3} Maynard,⁴ Quill and Townsend,⁵ and, more recently, my colleague Walter Baile.⁶ Every time there is an example of the words that people use, whether it is a "how not to do it" example or a "how to do it" one, readers can see the difference between what we say and what we mean to say.

Introducing CD-ROM

When videorecording became inexpensive and available in the late 1970s and early 1980s, more of the mysteries of clinical communication became accessible and intelligible and, perhaps, less mysterious. Peter Maguire and others started videotaping unrehearsed interviews with simulated patients, and for the first time viewers could see realistic ways of handling clinical situations and think about how they would react.

The advent of relatively inexpensive CD-ROM reproduction has taken all this a step further. The beauty of using a CD-ROM in your computer is that you can access any video scenario you want instantly (instead of rewinding or fast-forwarding) and you can have notes, comments, and references displayed concurrently above and below the video screen. A written running commentary (which you can also turn off if you wish) on the interview is provided while it is in progress.⁷

We are only beginning to see the potential of CD-ROM technology in medical teaching, but its greatest effect will be in this previously shrouded and mysterious area of communication skills—an area that has suffered most because high-quality examples are not readily accessible. What I gained from watching Eve Wiltshaw is now available to everyone. In her book about dying, Elizabeth Kubler-Ross constructed a tangible and accessible model of a process that was previously

taboo and almost mystical; the same process is now occurring in communication skills. We now have additional teaching aids that help us show our students the building blocks out of which the doctor-patient interaction is constructed. Apprenticeship (as the saying goes) is coming to a video screen near you. Examples are worth a million words and occupy a lot less space on your shelf, too. ♦

Dr Buckman practises internal medicine at Toronto-Sunnybrook Regional Cancer Centre and is an Associate Professor at the University of Toronto in Ontario.

Correspondence to: Dr Robert Buckman, Toronto-Sunnybrook Regional Cancer Centre, 2075 Bayview Ave, Toronto, ON M4N3M5

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