Communication Skills for Anaesthetists!

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INTRODUCTION

It is frequently thought that communicating effectively is something that one is born with – either you are good at it or not. We believe that communication is a skill that can be taught and improved upon. Although some anaesthetists have more intuitive skills than others it is relatively straightforward for those of us that are not “naturals” to learn communication skills that can be therapeutic for our patients. In order to learn these skills and utilize them effectively it is helpful to understand language structures that can elicit non-volitional subconscious patient responses that might be therapeutic such as anxiolysis. Patients when stressed are frequently unable to consciously comply or cooperate with instructions from medical or nursing staff even though they might want to. For example the distressed mother demanding “just put it in!” when requesting epidural analgesia but stating she can’t sit up or lie still.

Effective communication is increasingly recognized as not only important but an essential part of clinical anaesthetic practice. However an examination of standard anaesthesia texts fails to find even a single chapter on this topic. Perceptions and behaviours are frequently the result of subconscious responses to subtle non-verbal and other cues. Training in communication techniques can lead to an awareness and utilization of previously unrecognized skills that facilitates anaesthetist interactions with patients in a way that enhances and facilitates anesthetic care while at the same time allowing patients to feel more in control. The hypnosis and Neurolinguistic programming (NLP) literature is abundant with these concepts. We have been utilizing hypnosis skills in our day to day anaesthesia practice for nearly 10 years and have noticed dramatic changes in patient responses. Most medical training programs that teach communication skills are concerned with improving patients’ conscious understanding of procedures but are not specifically utilized to facilitate anxiolysis and provide reassurance in stressful situations of the peri-operative and childbirth environment. Indeed, this use of hypnosis and suggestion is having a renaissance of clinical interest and research. Advances in neuro-imaging have led to further understanding of the neuro-physiological changes that occur during hypnosis induced analgesia. The anterior cingulate gyrus has been demonstrated, by positron emission tomography, to be one of the sites in the brain affected by hypnotic modulation of pain. When patients are stressed they become overwhelmed by the external stimulation of the environment (incomprehensible technology and...
equipment) and as a protective mechanism they start to focus their attention internally. The reduced awareness of external stimuli is a protective mechanism and with it patients become highly receptive and responsive to suggestions. Suggestions are verbal or non-verbal communications that result in apparent spontaneous changes in perception or behaviour. These therapeutic communications are directed to the patient’s subconscious and patient responses are independent of any conscious effort or reasoning.

Anaesthesia and analgesia techniques are frequently approached by the patient with fear and trepidation. Fear that something will go wrong or fear that the procedure will be painful. The general medical model is one where the doctor is the active participant performing the procedure while the patient lies passively with little or no opportunity or expectation to assist or participate in his or her care. The sense by the patient of a “loss of control” and the perception that there is little that patients can do to assist with their care is usually accepted by both parties without question. There are however non pharmacological, communication techniques which can be taught or suggested to patients that can greatly assist them before, during, and after anaesthesia. Empowering the patient in ways that can enhance their sense of control rather than being the frightened “object” of the procedure can allow patients to become helpful participants that facilitate rather than obstruct the delivery of their care.

Being in “two minds” about something; Being “besides oneself”; “out of body” experiences; daydreaming; “tuning out”; are all everyday descriptions of altered states of conscious awareness that many patients find themselves in when presenting for anaesthesia and surgery. This hypnotic state increases the likelihood of patients responding subconsciously to communications which effectively function as suggestions that can lead to changes in patient perception and behaviour. This stressed state results in the patient entering, and maintaining, a spontaneous “trance” state with an internal focus of attention that results in increasing responsiveness to suggestion. It has been shown that well meaning communications by hospital staff can function as inadvertent negative suggestions that increase anxiety and pain. The anaesthetist however is in an ideal position to utilise suggestions in a therapeutic way that can elicit subconscious responses to facilitate anxiolysis, analgesia, an increased sense of control, and immobility during anaesthetic procedures such as intravenous cannulation or epidural catheter placement. As anaesthetists we are in the privileged position of treating patients who are highly responsive to our communications. At one extreme of this phenomenon patients hear everything that is said but fail to register the communications consciously. A not infrequent occurrence is the patient who apparently is listening to the anaesthetist’s instructions and explanation of a procedure and then having no recollection that they had been visited at all! All communications then become suggestions which result in subconscious responses and changes in perception, mood or behaviour.

It is generally thought that patients have to consciously believe in what is said to get results. Interestingly our anecdotal experience is that skeptical patients frequently are very responsive to suggestion. Anaesthetists have commented to us that the effort involved is too time consuming for routine use! However we have numerous examples in our day to day clinical practice that suggests that patients will frequently respond within seconds or minutes to suggestions that can elicit profound anxiolysis, analgesia and even anaesthesia. Communicating with highly stressed patients is commonly believed to be ineffective as they are not able to concentrate on what is said. In fact because attention becomes focused internally as patients become increasingly stressed the opposite is true. The more stressed the patient the more likely is a suggestion to be realized as a subconscious response. Although patients often appear to not be listening, they are usually hearing (at some level of conscious awareness) everything that is being said to them. Effective communication utilizing the language structures of NLP (Neurolinguistic programming), and suggestion whether patients are formally in or out of hypnosis has an excellent safety profile.

THE THREE REALITIES

How we perceive the world reflects all our previous experiences and interactions, how we talk to patients and what we expect from our interactions with them.

The first reality is our own. It is shaped by all of our life experiences, education and environmental stimuli within our immediate time frame. We assume that people will agree with
our view of the world because for us it is reality despite abundant evidence that other peoples’ reality view can be very different to our own world view. Despite this we frequently insist that patients’ experiences should be modulated to our own reality view rather than in a way that is most therapeutic for their treatment and symptoms. (See below)

The second reality in the clinical setting is that of the patient nurse or any other person we have contact with. As a society we are born to accept suggestions and mimic behaviour deemed appropriate.

The third reality is the real world independent of our own or our patients’ experience and perception. The third reality is what we don’t pay attention to and is outside the realms of our current belief system and sensory perception and therefore is not scanned into conscious awareness. An example is the near ubiquitous expectation of pain during labour despite the fact that some women (albeit a small minority experience no pain at all!). Similarly when discussing the topic of hypnosis most clinicians respond with a glazed look and the subject is dismissed as nonsense despite over 200 published articles in mainstream medical journals suggesting its effectiveness.

Why is an understanding of different realities important when we communicate with patients? Frequently we use words and gestures that suggest to patients our own experiences and perceptions. What is commonly not appreciated is that words with negative emotional content communicated to patients prior to procedures have been shown to increase patient anxiety and pain. If we expect patients to voice pain when we do a procedure such as venepuncture or regional block, the anaesthetist’s expectation of the patient’s perception of a sensation is likely to become a self fulfilling prophecy, making the patient’s experience of pain more likely. Fortunately the reverse is also true and words suggesting comfort or a neutral experience are likely to also to become self fulfilling. A typical suggestion given during an injection of local anaesthetic prior to placement of a large gauge intravenous cannula might be “this is going to sting”. An alternative suggestion might be: “This is going to numb the skin so that we can place the drip more comfortably for you”. A recent pilot RCT has shown that warning patients of a sting before intravenous cannulation may be unhelpful. This doesn’t mean we shouldn’t inform patients before venepuncture why the procedure is being done and when it is about to occur.

The “Dos” and “Don’ts” of subconscious communications that are likely to elicit a therapeutic non volitional subconscious response.

Some things to consider?

Seemingly innocent, casual comments can function as powerful suggestions. Careless use of words can have powerful effects especially from persons of authority when they have negative connotations. On the other hand, words with positive connotations can have beneficial effects and can be used therapeutically to the patient’s benefit. Factors that may explain why such communications can lead to improved patient outcomes include: appreciating skills by patients that the stressful environment of hospital enhances; utilization of patient behaviour and fears, patient motivation to experience procedures with a sense of autonomy and control. A genuine difficulty is that not all patients are receptive to such communications. However the majority of patients will respond to a greater or lesser extent. This is such a benign intervention that the dramatic effects seen in some patients make the use of such techniques very worthwhile. Well recognised hypnotherapeutic principles can be readily applied to communications used by the anaesthetist before during and after anaesthetic procedures. Hypnosis based techniques that can be utilised are briefly outlined below:

• Positive suggestions: Therapeutic communications that elicit useful subconscious responses such as anxiolysis and analgesia. Eg “the local anaesthetic will numb the skin and allow the drip to be placed more comfortably for you”
• Negative suggestions: Communications that are given with the best of intentions but inadvertently produce unwanted symptoms or behaviours such as pain, anxiety, nausea and vomiting. Eg “This is going to hurt!” “there is nothing to worry about”
**Sabotage words:** “Try” – the failure word. For example: “Try to relax” suggests to the patient that they will fail to relax. “Not” which the subconscious frequently omits. For example: “We will give you medication so you will not feel sick.” This is a subconscious suggestion to “feel sick”

**The law of reversed effect:** Can use sabotage words therapeutically eg “Try not to relax!” can use the failure word “Try” and the “not” to improve relaxation. The conscious suggestion is try not implying failure to not relax which then allows the subconscious “relax” response to occur. The confusional element of this also facilitates the subconscious therapeutic response.

**Utilization and confusion:** Utilizes an aspect of patient behaviour for a therapeutic effect. For example a patient who says she’s anxious can be told that the more anxious people are the more relaxed they become as they stop trying to relax – also confusion

**Double binds:** are when patients are given two options that appear superficially to be a choice eg during a gas induction one can ask the patient to “breathe in deeply or blow the gas away”

**Dissociation:** For example when placing an IV cannula using the words “the arm” rather than “your arm” tends to dissociate it from the body making hypnotic “arm anaesthesia” more likely

**Embedded suggestions** are integrated within an apparently normal conversation. This effectively utilizes previous examples of positive suggestion and incorporating them into normal conversations with patients in a seamless way that does not draw conscious attention to them.

**Indirect suggestions** are communications that do not appear to be directed to the patient but are usually accepted subconsciously by the patient. For example: “Most people find as they breathe in they feel stronger and more in control and when they breathe out they find them, selves relaxing automatically without even thinking about it” This indirect form of suggestion is less threatening than a direct suggestion eg “as you breathe in **you** will feel stronger…”

**Metaphor.** The language of the subconscious is imagery and imagination. This can be utilised to encourage subconscious responses. For example telling a patient that learning to relax is like driving a car. At first one thinks about the accelerator and brakes and signaling yet pretty soon one just drives to the destination without fully appreciating all the complicated manoeuvres necessary to get us there.

**Primary sensory language:** Utilising patient’s language patterns eg visual, auditory, kinaesthetic, to increase rapport. Eg I see what you mean (visual); I hear what you say (auditory); that feels right (kinaesthetic)

*Inadvertent negative suggestions* sometimes used in anaesthetic practice have been described by Bejenke previously. Some examples of possible alternatives that facilitate useful therapeutic subconscious patient responses, to some common communications are given below: Examples of unintended negative suggestions (UNS) and possible alternatives (PA) are given below:

**UNS:** “The anaesthetist is there to put you to sleep!”

**Explanation:** “Putting the patient to sleep” is a subconscious suggestion for death for some patients who may have experienced a favourite pet dog or hamster that has been “put to sleep”

**PA:** “The anaesthetist ensures your comfort and safety during surgery for when you wake up in recovery.”

**Explanation:** This statement reassures the patient that their comfort and safety is important and that they will wake up at the end, and not before the end of the procedure.

In paediatric anaesthetic practice it is not infrequent that a nurse or doctor innocently says to a parent as soon as their child has been induced to anaesthesia

**UNS:** “Would you like to kiss your child goodbye”

**Explanation:** This statement again may be processed as a subconscious suggestion for death by some parents.

**PA:** “would you like to kiss your child? You will see him/her soon / as soon as he/she is comfortable enough to return to the ward”

Other examples of inadvertent negative suggestions and more useful alternative communications

**UNS:** “Let the nursing staff know when you have pain!” or “We will give you pain killers to help with your pain after surgery”

**Explanation:** This statement is a subconscious suggestion for pain. It is being suggested that pain is inevitable and the only way to interpret the sensation
PA: “We will give you medication to keep you comfortable while the wound is healing and normal function returns.”
Explanation: This statement implies that the sensations after surgery can be interpreted as a signal that the operation is completed and as things start to heal the benefits of the surgery will soon be realised!
UNS: “There is nothing to worry about”
Explanation: This suggests there is something to worry about!
PA: “You are quite safe”
Explanation: Suggests safety
If the patient asks “Is this going to hurt?” It is just as inaccurate to say “No” as it is to say “Yes”
PA: “Some say it does but most are surprised it is more comfortable than they thought!”
Explanation: Indirect suggestion for comfort.
UNS: On giving Sodium citrate it is frequently suggested to the patient that “the anatacid tastes disgusting” or “salty” or “will make you feel sick!”
PA: A more useful communication could be “The antacid is given to settle the stomach and allow you to have a safer anaesthetic should general anaesthesia be required”
UNS: “We will give you something to minimize vomiting after your surgery”
Explanation: Suggestion for vomiting after surgery
PA: “We will give you something to allow you to eat and drink as soon as you feel like it after surgery”
Explanation: Suggestion for antiemesis
UNS: “Try not to move”
Explanation: Suggests failing not to move. This is an unintended suggestion for the patient to move (the law of reversed effect)
PA: “In a moment when you are ready you will find that you can lie / sit perfectly still”
Explanation: Suggests to the patient that she will be able to stay still.
How do you respond to the patient who says that following anaesthesia :“I always feel sick”
This statement is a generalization and on close questioning patients will frequently remember at least one occasion that they were not sick or at least not as sick, and this can be utilized to remember how that improved situation was experienced. The ignoring of positive anaesthetic experiences is an example of a deletion and the actual memory may be a distortion of what in fact actually happened even though the patient’s perception of that experience is very real.

POINTS TO CONSIDER WHEN MAKING A RESPONSE
1. You are no longer the same person now that you were then! And for that reason things can now be experienced in a very different way.
2. This is a different operation
3. The drugs being used these days are far more effective in allowing patients to eat and drink sooner than they might think.
4. You may also emphasize that with this particular anaesthetic and all the precautions being taken to make things more comfortable for the patient the most likely course of events is that most people (indirect suggestion implying that you will) find that they are able to eat and drink quite easily as soon as he/she feels like it.

Patient: “I’m not looking forward to my surgery”
Anaesthetist: “But you can look forward to waking up in recovery surprised how easy and straightforward everything went for you.” (Utilizing patient perceptual language facilitating rapport and making the elicitation of a subconscious response more likely)
“You can look forward to having the problem dealt with once and for all.” (Utilizing patient perceptual language). “You can look forward to the wound healing rapidly and getting back to your usual activities as soon as possible.” (Utilizing patient perceptual language)
Don’t
1. apologise before performing a procedure! This will facilitate expectancy by patients that something awful is about to happen and will increase the likelihood of anxiety and pain.
2. predict what the perception might be like by using words with negative emotional content (eg “sting”/”pain”/”vomit”, “panic” “worry”) before you perform the procedure.
3. mention pain or nausea /vomit unless the patient states it first and then reframe it with a phrase that is more useful. For example:
   Patient: “What about pain after surgery?”
   Anaesthetist: “Some people will experience pain but most find that the anaesthetic techniques and medications that we use these days allow patients to recover much more comfortably than previously”
   Explanation: This is an indirect suggestion that the patient can recover comfortably. In addition patients can be informed that they can have “as much medication as is required while healing occurs and normal activities return”

Do
1. offer useful information rather than statements containing negative suggestions eg “this will numb the skin”vs “this will sting”
2. take care when using the word “try” and “not” in combination. “Try” is a failure word and implies that the patient will fail to achieve what is being asked. The word “not” is not heard by the subconscious. For example the phrase, “please try not to move” during epidural catheter placement, is a subconscious suggestion for the patient to move! A phrase that would be more likely to facilitate the patient staying still would be “you will find in a moment that you will be able to stay still while we help you become comfortable as safely and expeditiously as possible”.
3. recognize that an individual’s perception of reality, rather than the reality itself, determines perception, mood and behaviours that underpin the basis of how we communicate.

Subconscious communications ie suggestions are an inevitable component of every anaesthetist-patient interaction. These have the potential to enhance or worsen patients’ experience. Our clinical experiences of utilizing this form of communication can result in a proportion of patients responding in ways that facilitates the provision of their anaesthetic care. Anaesthetists can adapt these well recognized hypnotherapeutic techniques[1, 10, 18-20] that have been developed over more than a century of use as an adjunctive therapeutic tool to their clinical practice. In addition these concepts can be incorporated as a basis for training not only anaesthetists in improving their communications with patients, but also other clinicians, nursing, midwifery and paramedical staff.

REFERENCES