Therapeutic dialogue

John Launer

'You're a doctor. Can I ask you a medical question?' It isn't easy to refuse when someone asks, so I said yes and waited to hear what would follow. The questioner on this occasion was a Greek builder called Costas. We were standing in my back garden, where Costas and his team of eastern European labourers were doing some work. He said the question was a very simple one—at least in his view: 'What are the chances of dying after a stroke?' I took a deep breath and asked him to tell me more.

The story, as it turned out, wasn't related to Costas himself. It concerned one of his labourers, whose father was in hospital in Rumania and being kept on strict bed rest following a stroke. The doctors had told his family he would almost certainly die—a 99% chance of doing so. However, when I asked how severe the stroke was, Costas said the patient could apparently walk and talk normally. The only problem seemed to be partial vision in one eye. Cautiously, I explained to Costas that this didn't sound such a grave picture. In this country the doctors would get him out of bed and mobilise him quickly. They would regard his general outlook as pretty good. Costas beamed at me when I said this and he summoned his Rumanian worker over to join us. 'I told you so!' he said triumphantly. 'This doctor says your father will live! Your family must ignore the doctors and get him out of bed!' I squirmed at his version of what I had said, but I couldn't do much about it. I tried to have a conversation with the Rumanian man himself, but his English was poor. He understood enough to confirm the story Costas had told, but not enough for me to add any notes of caution to his boss's reassurance.

Later, I shared some concerns with Costas. Maybe we didn't know the full history, I explained. Perhaps there were other problems the doctors in Bucharest were worried about. Besides, I told Costas, traditions of treatment differ in other countries. So do medical outcomes. Costas would hear none of this. His own

mother had died of a stroke, he told me, and she did so in exactly the same circumstances. 'They made her stay in bed', he explained. 'They kept feeding her. Day in and day out. She got bigger and bigger. I begged the doctors to give her an enema to get it all out. They refused. Then she exploded. I could kill them!'

CHALLENGES OF INTERPRETATION

On a superficial level, this encounter was just about as suboptimal as any consultation can get. It was unplanned, in a fairly public setting. It involved problems of translation and a passionately biased middleman, not to mention a patient and doctors 2000 km away. Yet I want to suggest this conversation wasn't a particularly aberrant one. In some ways, you could say it was entirely typical of what goes on in encounters between doctors and patients. The only difference in this instance was that the challenges of interpretation were obvious rather than concealed.

The encounter reminded me of a wonderful book about medical ethics originally written in the 1980s by the Yale physician and law professor Jay Katz, and called *The Silent World of Doctor and Patient*.¹ Katz discusses the difficulties of communication in medicine and he writes as follows: 'Even in their most intimate relationships, human beings remain strangers to one another. One can only understand another to a limited extent. But the problem runs even deeper. One can only understand oneself to a limited extent. The latter impediment powerfully reinforces the former, making it even more difficult to know another. Physicians and patients are not exempt from this human tragedy. Its pervasive impact on all human encounters contradicts one of the most basic and revered professional dogmas: that doctors can be totally trusted because they act only 'in their patients' best interests'. This dogma only compounds the tragedy by assuming an identity of interests and brushing aside the need to clarify differences in expectations and objectives through conversation.'

According to Katz, *all* encounters between doctors and patients involve immense difficulties of mutual interpretation. These aren't just the consequences of overt differences of culture and language such as the ones in my

conversation with Costas. They are intrinsic to human psychology. As Katz says, we listen to each other selectively, if at all. We listen to ourselves selectively, if at all. When we interact, we forget both these facts. We are overtaken by the bland and totally wrong assumption that effective communication is easy. It isn't. It requires constant, focused effort.

OVERARCHING IDEA

The Silent World of Doctor and Patient sets out the predicament that all doctors and patients face, and it offers ethical principles for dealing with this. However, it doesn't give specific advice about the skills needed to bridge the gulf between doctors and patients. Fortunately, a great deal of work has been done on this since Katz wrote his book. In my view, the most helpful guidance falls under the heading of 'therapeutic dialogue'. Therapeutic dialogue isn't a particular school of thought or a method of training. It's an overarching idea held by a range of clinicians who share the view that good and ethical communication with patients is invariably hard work, but possible with the right skills.

One of the most eloquent proponents of the approach is the Italian psychiatrist Paolo Bertrando.² He describes how he uses a wide range of conversational techniques in his work with families and individuals so that he can enter and share their worlds. These techniques include questions that are 'essential but seem silly or too naïve, like children's questions'. He talks about applying 'amiable impertinence', venturing outside the limits of usual politeness while still remaining within the boundaries of professionalism. He describes how he tries to be transparent in explaining his thinking processes to patients, how he judges when to offer some self-disclosure and how he allows metaphor to emerge in his conversations. Bertrando's writing isn't a do-it-yourself guide to therapeutic dialogue. Instead he lays out the kind of territory that everyone who wants to communicate with patients at more than a superficial level needs to explore.

He gives a compelling account of how we create meaning during conversations with patients: 'I cannot fully choose any meaning, because my meanings—and, above all, the meaning my interlocutors give to what I am saying and doing—are shaped by the context we are embedded in. Of course, this is also true of the meanings I give to my interlocutor's words and actions. Treatment, in this view, is a continuous process of negotiation of

Correspondence to Dr John Launer, London Department of Postgraduate Medical Education, London Deanery, Stewart House, London WC1B 5DN, UK; jlauner@londondeanery.ac.uk

meanings, where it is impossible to reach an end point but, rather, any negotiation opens new contexts that create new meanings, and so on. Both therapists and clients are extremely active in this process, as indeed are other persons and institutions not directly involved in the therapeutic dialogue but involved in generating contexts: all those who contribute to the significant system that surrounds—and shapes, and participates in—the therapeutic dialogue.’ To put it

another way, there were more people present in my back garden conversation about strokes than Costas, the Rumanian labourer and me. We were part of a vast conversational drama played out by uncountable Greek, eastern European and British speakers, all struggling to make sense of each others’ stories, to the best of our ability.

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