

Communication

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BACKGROUND

Readers may know that we have in the past year suffered the terribly sad and untimely loss of the Journal's Editor-in-Chief of 10 years standing, Dr Anne Szarewski. It was therefore with a mixture of sadness and privilege that I took part in a recent Memorial Lecture Evening held in her honour. The organisers particularly wanted to reflect Anne's commitment to patient-professional dialogue, and asked me to speak on that topic.

Though poignant, the task was in some ways easy. As Anne's colleague over the years, I witnessed her consummate communication skills. I had also, as her former patient, been on the receiving end of those skills. Anne not only had mastery of the content that should be asked, answered and imparted during a consultation; she also had the magic ingredient of being totally at ease around that content. She was entirely comfortable talking to patients about sexual issues and entirely comfortable listening to their answers; as a result, her patients were, or became, entirely comfortable too.

Hence my memorial presentation focused on a single point with two interdependent aspects. The single point: 'comfort'. The two aspects: the comfort of the professional and the comfort of the patient. The source: the lessons I learned from Anne and from my own work with, and observation of, other similarly-gifted health professionals

WHY MIGHT HEALTH PROFESSIONALS NOT FEEL COMFORTABLE?

Let's start with cause. Why, at root, might a health professional feel ill-at-ease around sexual discussion? The prime possibility is, of course, concern for patients. Yes, we live in a world where sex talk is splashed across newspaper front pages, but that very fact may mean increased anxiety about raising personal topics for fear of client reaction. What if

the client feels embarrassed, offended, intruded on?

Contrariwise, it is entirely possible – and understandable – for discomfort to be down less to concern than to irritation. A long day of consultations – often in the context of a long career in sexual health – may result in vexation set aside at yet another client whose lack of knowledge or disorganised lifestyle means they are putting self and loved ones at risk. However much feelings are hidden, such frustration does not lend itself to comfortable interaction.

It may be our own sex lives that create discomfort. If we are – short- or long-term – lacking sexual fulfilment, it may be difficult to hear about someone else's sexual acrobatics. If our own love life is flourishing it may be difficult to witness someone else's sexual angst. We don't reveal to our clients as they do to us, but our minds make the links; ironically the more precious our own sexual experience, the more uneasy we may feel at others' intimate revelations.

WHY MIGHT PATIENTS NOT FEEL COMFORTABLE?

Let's ask the same causal question about patients. Why might they feel ill-at-ease with sexual discussion? Here there is a partial mirror image; patients may be concerned about the professionals' reaction. They may not want to shock or to offend; they may fear pity if their sex lives are unfulfilled, envy – or condemnation – if their sex lives are rampant. Their discomfort may not only arise from cultural or societal embarrassment at sexual talk, but also from personal defence of their previously unspoken secrets.

In addition, there may be awkwardness both caused by confusion and adding to that same bafflement. Patients may be puzzled by the formal terms used in a consultation, perplexed by the questions, thrown by the information or instructions, all of which cause unease. Add feelings of disempowerment from feeling physically not on home ground, as well as feeling



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emotionally subordinate to an authority figure, and discomfort levels may soar.

WHAT'S THE IMPACT?

Let's be clear about the effect such soaring levels of discomfort can have on the consultation. Uncomfortable patients may mishear, misunderstand, massage the reality, hold back the truth, challenge the diagnosis, ignore the advice, resist compliance and be wary of attending a sexual health consultation ever again. Meanwhile, uncomfortable professionals may also mishear, misunderstand, misinterpret, misjudge, then unwittingly and unwillingly mishandle the situation.

Of course the opposite scenario – professional and patient both at ease – results in the reverse. Anne Szarewski's unworried approach to sexual discussion, for example, produced an alliance with patients that both supported her medical treatment and was one of the cornerstones of her research work. Her subjects typically felt able to answer honestly and to comply fully. As an example of this, it was Anne's personal intervention in a smoking cessation study that was widely held to be the cause of nearly 30% of the subjects giving up or reducing their smoking consumption by 75%. Compare this with the 5% success rate of smoking clinics at that time and the current success rate, given pharmacological intervention, of about 15%.

RAISING PATIENTS' COMFORT LEVEL

So how can we help patients? I see three ways. First, by leveraging the content of what we say. Setting a clear 'why' framework at the start of the consultation; normalising the process with phrases such as "I always ask" or "All my patients find ..."; explaining the point of each question; adapting vocabulary to that of the patient; responding positively to every answer "Thank you ... that's useful". These verbal strategies and scripts – all well-documented and well-taught in books, manuals and courses – will reduce negative feeling.

Second, by leveraging the non-verbal channel to relax and reassure. Creating a sense of equality by sitting on equal-height chairs and at an angle rather than confrontationally opposite; matching or mirroring posture to signal empathy and understanding; keeping soft but steady eye contact; maintaining a positive voice tone; giving approval messages such as nods and smiles. These strategies too will create a higher comfort level.

THE THIRD WAY

But here's a thought. Could it be that the efficacy of all these direct and conscious strategies is actually determined by one single and more subconscious element, namely the health professional's own comfort level? Could it be that the principal thing we should be paying attention to in a sexual health consultation is our own state of mind?

For communication is always a system. What one side says or does will always affect the other. Less obviously and perhaps more importantly, what one side experiences emotionally will always affect the other. So what the professional feels will always affect what the patient feels, and therefore what the patient says and does, holds back from saying, resists doing.

Of course the words and the body language used when talking with patients have to be absolutely well-chosen and well-used. But if the professional's comfort level is low, those verbal scripts and non-verbal strategies will inevitably be undermined and so less effective; if the professional is at ease, everything they say and do becomes both more powerful and more helpful. Which is why the third – and arguably the most important – way of raising a patient's comfort level is for the professional to raise their own.

RAISING PROFESSIONALS' COMFORT LEVEL

The question, again, is how. The task perhaps begins outside the consultation room, well before any interaction, with desensitisation. Reading a few fully-illustrated sex manuals; perusing material aimed at a variety of sexual preferences; browsing the web for explicit blogs or forum discussions; talking to colleagues who are at ease with sexual discussion and can facilitate relaxed discussions of core topics. All of these activities help expand not only knowledge but also the comfort zone, helping us to let go of cultural judgements or hidden prejudices, broadening perspective as to what ordinary, happy, caring human beings might choose to do.

Within the consultation room there are further useful here-and-now techniques, once internal discomfort has been registered (**Box 1**). Try breathing deeply in and out to reduce stress; deliberately relaxing body posture; slowing down movements for added calm; taking pauses and gaps in conversation to regain self-possession, using positive and motivational inner self-talk; focusing deliberately on the patient to diminish over-awareness of our own unease.

Box 1 Some signals of lack of comfort: notice these in the patient but crucially also in oneself

- ▶ Internal signals: shift in breathing, rise in heart rate, sweating
- ▶ Body signals: hesitation, fidgeting, speediness, clumsiness
- ▶ Verbal signals: hesitation, stuttering, rise or drop in voice tone or volume, mispronunciation
- ▶ Mental signals: lack of understanding, becoming distracted, word confusion
- ▶ Social signals: lack of eye contact, frowning, turning away

THE VIRTUOUS CIRCLE

I would add one more possible strategy to all these practical hints. What may help to raise our own comfort level is to realise our own importance. What we do is vital in helping patients have more fulfilling sexual relationships and therefore more satisfying lives. Remembering that fact can let us far more effectively set aside the discomfort of sexual conversations because we hold clear the vital objective – dare we say, mission – and our crucial role.

I would argue that the more passionately we believe in ourselves and the value of what we are doing, the more comfortable we will be in doing it. Which was undoubtedly one factor that made Anne Szarewski so at ease and so effective in what she did.

To summarise then: the more comfortable the health professional feels around sexual matters, the more comfortable the patient feels. And the more comfortable the patient feels, the easier and more profitable is the working alliance. The result is a virtuous circle that not only enhances the individual sexual health consultation but ripples out to the entire professional relationship.

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