Those smug smart-arses standing at the lectern

Why are doctors so bad at talking to doctors? asks Jon Garvey

Very little research has been done on the interaction between organisers of postgraduate courses on interpersonal communication, who are usually emboli from the Royal College of General Practitioners, and the doctors who attend such courses. And yet in a recent study (Garvey, JC 1981, unpublished), which involved reading the correspondence and features pages of current medical journals, the author demonstrated that a large number of practitioners who had attended such courses had left feeling dissatisfied at the outcome of the interaction.

Various reasons were suggested for this. Of the sample tested (admittedly small) 14.3 per cent considered that the information imparted was "airy-fairy twaddle", 42.9 per cent that the organisers were "ivory tower academics" and the remainder that they were a lot of "smug smart-arses". How widespread such negative responses are is difficult to ascertain, but as over two thirds of GPs have made no effort to join the college, it is not unreasonable to take this figure as an approximation.

How is it that such a large proportion of doctors do not comply with suggestions made on the basis of the most up to date research? The answer, I think, lies at the doctor-organiser interface, as a result of the training given to academic general practitioners. Our teachers acquire, at the Royal College, a very good grounding in theoretical behavioural science, to the extent that the best of them could even make a fair showing in a social psychology degree course, and by way of intensive practical activities, such as Balint groups, they become well equipped to understand better the relationship between doctor and patient. However, as things stand at the moment, they are totally ill-prepared to meet and communicate in a real-time doctor—doctor confrontation.

Doctrinaire fashion

There are various reasons for this. The first is a woeful lack of training in verbal skills, such as the art of persuasion. Far too often theoretical constructs elicited from observational data are presented in a doctrinaire fashion which would not even be tolerated in the consulting room, and so can hardly be expected to convince experienced practitioners that they should modify their views and behaviour.

Perhaps more serious is the evident ineptness of many teachers in non-verbal communication, as the opinions expressed in our original study show. Academics who are, in reality, sensitive, altruistic and impartial allow themselves to give the impression of being opinionated, supercilious and cliquish individuals chasing an MBE.

At the back of this failure of communication is the outdated notion that knowledge is the monopoly of a small number of individuals or centres of excellence, such as colleges, to be handed out like a prescription to the uncritical and unquestioning masses. There is a tendency to blame the doctors' unwillingness to adapt for their hostility, but it is not the patient's fault if his doctor leaves him with a bad impression—it is the communicator's job to communicate. Until the present authoritarian view is replaced by the realisation that we are all equally participants in and contributors to the knowledge-gathering process, this dichotomy between "academic" and "traditional" is likely to continue, and little progress is likely to be made in the development of communicative skills, which are learned, not inborn.■

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