

A GREAT interaction and the LAURS of communication in anesthesia

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Abstract : Although most anesthetist-patient interactions go well, by recognising that they occur at multiple levels of conscious awareness, clinicians can appreciate how they achieve this goal and teach what they do. The utilisation of communication structures that recognise the subconscious nature of many of our interactions can enhance patient safety and comfort. The GREAT (Greeting/Goals, Rapport utilising LAURS, Expectations/Evaluation, Answering questions/Addressing concerns, Tacit agreement/Thanks) language structure can be used to develop any anesthesia or pain related patient interaction. The LAURS (Listening, Acceptance, Utilisation, Reframing, Suggestion) approach will allow improved and rapid development of patient rapport.

Keywords : anesthesia ; pain ; communication skills.

Communication is being increasingly recognised as a vital component of clinical anesthesia patient care (1-4). It is the means of expressing, both to ourselves and to others, how we perceive and influence the world around us. It is a tool for exchanging information and meaning, but also allows us to connect with our patients in surprising ways that can be therapeutic. Without effective communication, our working lives would be greatly impoverished and patients exposed to additional risk. Recent evidence suggests that the words we use can not only inform, but also hurt or soothe. This makes effective communication in the context of anesthesia particularly relevant (5, 6).

THE CONSCIOUS-SUBCONSCIOUS CONCEPT

Although most anesthetist-patient interactions go well, few anesthetists recognise that they occur at multiple levels of conscious awareness. Clinicians, who do recognise the conscious subconscious concept, can more easily appreciate how they achieve optimal interactions with patients or colleagues and how to teach what they do. Intuitive communication skills are usually gained through many years of experience, rather than developing a structure of specific skills. Patient safety and

comfort are primary goals of every anesthetist. Less commonly, the importance of optimizing the patient's perception of control over what is happening to them and facilitating choice is usually overlooked. Most patients have both the ability and desire to assist and cooperate with their care wherever possible yet frequently, are so anxious and overwhelmed by the hospital setting, they are unable to do so consciously. In this mindset, patients tend to focus internally, dissociating from the external environment. They are effectively in a trance-like ('rabbit in headlights') hypnotic state and extremely vulnerable to suggestion - both positive and negative (Table 1). A suggestion is a verbal or non-verbal communication that has the potential to lead to a subconscious change in mood, perception or behaviour (6). An example of a negative (Nocebo communication) is handing a patient a vomit bowl when they don't feel nauseous (non-verbal cue) or asking a pain score when the patient does not have any pain (negative suggestion). Inadvertent negative suggestions are ubiquitous in hospitals worldwide and should be avoided wherever possible. Unfortunately, this can only happen with increased understanding of the nature of suggestion so that anesthetists become consciously aware of them. For example, an anti-emetic suggestion might include telling a patient that, "most people can look forward to eating and drinking after their anesthesia as soon as they feel like it". In line with the structured learning that goes into developing technical skills, learning communication skills can

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Table 1

Common inadvertent negative suggestions used during anaesthesia care and their corresponding positive suggestions

Inadvertent Negative Suggestion	Positive Suggestion
(After postoperative analgesia) Let us know if you still have pain ?	Let us know when you are feeling comfortable ?
This will hurt / This won't hurt	You will feel what you feel.
We can give you something for the itch (pruritus after spinal morphine).	The itch means that the spinal morphine is working really well and that you will be comfortable for longer.
If you feel sick and get nausea and vomiting it can be treated.	We can give you medication to help you feel like eating and drinking as soon as you feel like it.
The antacid tastes horrible so drink it quickly.	The sodium citrate neutralises acid in the stomach and allows you to have a safer anesthetic if a sleeping anesthetic is required.
This will sting ! (just before injection of local anesthetic)	This will numb the skin and allow us to finish the procedure more comfortably than otherwise.
The anesthetist is here to put you to sleep.	The anesthetist is here to look after you and keep you safe and comfortable throughout your operation.
There is nothing to worry about !	You can be reassured that everybody is focusing on your comfort and safety.

also be structured and is a lifelong process that must be continually developed.

Scientifically trained anesthetists tend to be more at ease with conscious communication as this primarily involves logic and reasoning. For instance, when providing information or explaining anesthesia associated risks during the consent process. In a clinical setting, instructions given during the placement of a labour epidural catheter could be, "Please sit still while I am placing the epidural." Alternatively, one could communicate in a subconscious way by saying, "In a moment, knowing that the epidural will allow you to become comfortable, you will find that you can sit still." This type of communication requires a paradigm shift ; firstly, to become aware of it and then, to use it therapeutically. When injecting local anesthetic, an example of an inadvertent negative suggestion could be "This is going to sting" whereas a meaningful positive suggestion would be, "The local anesthetic will numb the skin to allow the 'drip' to be positioned as comfortably and safely as possible." An important part of the art of anesthesia is to understand how these conscious-subconscious concepts can be understood and put into practice. Anesthetists have many opportunities to use suggestions to elicit subconscious responses that benefit the patient and facilitate anesthetic procedures. Such benefits include: anxiolysis, more comfortable intravenous (IV) cannulation, an increased sense of patient control, and immobility when regional analgesia is being performed. These types of communication can be readily adopted by anesthetists in a variety of clinical situations. Many anesthetists already communicate well in most situations and facilitate their patients feeling relaxed

and comfortable without realising what language structures they are implementing to achieve this goal – especially in potentially stressful situations.

The **G.R.E.A.T** template is a simple mnemonic for any interaction and involves: **Greeting, Goals, Rapport (using the LAURS concept), Expectations, Evaluation, Examination, Acknowledging concerns, Tacit agreement, Thanks, Termination of the interaction** (7). This framework can be used effectively if the usual strategies of conscious communication fail. It can be modified to facilitate communication within the theatre team, resulting in benefits for patients.

G : Greeting, Goals

The interaction begins with the introduction of all those present and confirmation of its purpose. Greeting the patient and expressing the goal of the interaction are important first steps in the interaction. Introductions vary depending on context. Asking patients how they would like to be addressed shows respect and will increase rapport. For example, "My name is Dr., I will be looking after you during your operation, keeping you as safe and comfortable as possible for when you wake up in the recovery room." Is it Ok if I call you 'x.....' or "What do your friends call you? Is it OK if I call you.....?" In the case of children, it may be appropriate to ask their permission to talk to a parent. For example, "Would it be OK for me to talk to your mum now?" The goal of the interaction may not be immediately obvious and clarification is frequently necessary. The statement "I will be looking after you during your operation, keeping you as safe and comfortable as possible for when you wake up in the recovery room." implies

that the patient can wake up comfortably, that they will wake up at the end of the procedure and not before. Clarifying the goal of the interaction is particularly important to avoid misunderstandings as the interaction progresses. For example, in a situation where the goal is to provide analgesia, the anesthetist may be asked to provide a regional block or the patient may have reservations whether this might be the optimal choice. The patient's wishes, medical indications, and why the benefits outweigh the risks may need further explanation.

R : Rapport (using the LAURS concept)

Rapport is integral to the process of good communication. It helps develop trust, facilitates cooperation and information exchange, which in turn enhances patient safety. The principles described in the LAURS concept can be used as a practical means of establishing and maintaining rapport (see below). Critically important in the development of rapport is allowing patients a sense of control over what is happening during a procedural interaction that is potentially painful. For example, the anesthetist can say to the patient, "If anything I am doing is bothering you, please stay still and tell me to 'stop'. I will stop what I am doing and ensure that you are comfortable before we carry on with your permission when you are ready."

E : Evaluation, Examination, Explanation, Expectations

Depending on context, this part of the GREAT template may include: taking a history, performing an examination, and explaining management choices. It also includes a discussion of expectations, thereby reducing the tendency to make erroneous assumptions. It can be easy to overlook the need to address patients' concerns, especially if they are not expressed directly e.g. fear of pain, paralysis or even death ('will I wake up after the surgery?').

A : Answering questions, Acknowledging and Addressing concerns

Ensuring patients are heard and understood whilst letting them know their intended meaning has been heard and taken into account are essential components before terminating the interaction.

T : Tacit agreement, Thanks and Termination

The successful termination of most clinical interactions usually involves a tacit rather than

explicit understanding that a medical relationship has been formed, that the anesthetist will provide optimal care of the patient, and that the patient accepts and understands this. In some countries, an agreement on a management plan or follow-up can be formalized verbally or by signing a consent form. Thanking those present concludes the interaction.

The LAURS of communication are a way of structuring the development of rapport as the interaction proceeds.

LAURS :

Listening

Listening is the most important skill when communicating in clinical practice. Doctors can become overly accustomed to instructing patients on what to do, rather than listening to and responding to their needs. Listening is not simply about keeping silent while the patient is talking. There are four key questions to ask oneself when listening reflectively: Did you hear what was said? Did you understand what was meant? Does the patient know he/she has been heard? Does the patient know he/she has been understood? Determining the answer to these questions requires a 'checking-in' process. For example, a patient vocalises apparent discomfort during intra-arterial line insertion.

Anesthetist : What's happening? Patient : I thought I felt something. Anesthetist : Are you OK for me to carry on? Patient : Yes,

Acceptance of Different Realities

Accepting a patient's behaviour even if it can seem disturbing may be helpful. There may be times when a patient's emotions can be accepted. For example, if a patient is crying one might say, "It's OK to cry as it's a great way for the body to relax and feel more comfortable"

Utilization

This is likely the single most important concept in facilitating anesthetic-related communication. It involves utilizing the presenting problem or the patient's concern and reframing it into a solution. Utilization may involve using a patient's words or behaviour. For example, if a patient speaks or behaves in a way that indicates that he/she cannot cooperate during the anesthetic procedure, the anesthetist can accept and utilize this by saying: "That's okay, if you can't stay still we will stop and

wait a few moments until you are more comfortable and ready for us to carry on.”

Reframing

If a patient in labour requesting an epidural is concerned about increasingly painful contractions, the anaesthetist can utilise this concern, by reframing the perception. “every contraction is a step towards you seeing and holding your baby for the very first time” and that “the stronger the contraction, the more effective it is and therefore the stronger you can feel”. This way, the patient’s concern has been utilised such that the contraction is perceived as a useful fulfilling experience rather than something to be feared.

Suggestion

Suggestibility refers to the ability of people to respond subconsciously to communications in a way that changes perceptions and behaviours (6). The response to suggestion increases when patients are highly anxious, distressed or in pain. Recent evidence suggests that there may be benefits when the latest research in placebo- and nocebo-type communications are integrated into clinical practice (8). Direct suggestions take the form of, “You will find that.....”, “You will be able to.....” or “You may be surprised that” For instance, after surgery, the anaesthetist may suggest to the patient, “You can allow yourself to recover more comfortably knowing that the wound is healing.” Indirect suggestions take the form of “most” or “some”. “Most patients find that.....” or “A patient I saw last week found that.....” These statements imply that the patient will have a similar experience. For example, an equivalent indirect positive suggestion to the previous situation might take the form, “Most people find that they can allow themselves to recover comfortably knowing that the wound is healing.” This indirectly implies that the patient, too, may feel more comfortable as healing occurs.

Negative suggestions are Nocebo-type communications and Positive suggestions are Placebo-type communications. A negative suggestion is usually given with the best of intentions but inadvertently produces a subconscious response in the form of unwanted symptoms or behaviours’ (e.g. “This is going to sting.”) The use of such inadvertent negative suggestions is apparently ubiquitous in hospitals in Australia, the USA and UK (9).

A positive suggestion elicits a positive therapeutic response (e.g. “Most people find it is more

comfortable than they might have thought”). This indirect positive suggestion (‘most people find.....’ implies that the patient will also experience the same) elicits the perception of comfort. Some anaesthetists think they are being honest when prior to a potentially painful procedure (e.g. IV cannulation or a local anesthetic injection), they prepare their patients by warning them that “it will hurt/sting”. Such statements should be avoided because the sensation may actually not hurt or be unpleasant for a proportion of patients, and there is evidence to show that using language with negative emotional content can increase the patient’s experience of pain or anxiety (10). This means that telling patients a procedure “will hurt” inadvertently encourages them to perceive that experience as pain. It may be more helpful to explain the purpose of the procedure, for instance, for local anesthetic infiltration, the suggestion could be, “This will numb the skin and allow us to keep you as comfortable as possible while we finish the procedure.” While there are ethical concerns about not telling patients something will hurt when the anaesthetist thinks that it might, evidence suggests that the expectations of patients (and maybe even the anaesthetist) partly determines their experience. Saying something “will hurt” is as inaccurate as saying it “will be comfortable” when there is a possibility of the converse being true. So, what can an anaesthetist say when a patient asks “Will this hurt?” A yes/no response runs the risk of being less than truthful for some patients. One possible response is to say, “Some people tell me it hurts while others are surprised it is more comfortable than they thought it might be”. This has the benefit of being both honest and providing an indirect positive suggestion that increases the likelihood of interpreting the sensation as “comfortable”. Linked suggestions involve linking a conscious action with something that is subconscious. For example : “When you focus on your breathing (conscious), each time you breathe out you will find yourself relaxing automatically (subconscious)”. While a direct suggestion like this can be quite confronting, patients are more likely to respond to such suggestions under extreme stress.

Indirect suggestions are usually more acceptable. For example: “When people focus on their breathing (conscious), each time they breathe out they find themselves relaxing automatically (subconscious).

Repetition in a variety of forms is one of the most useful ways to help patients retain important information both consciously and subconsciously. This learning response can be facilitated by using

a variety of phrases that mean the same thing. For example, if during preoxygenation a patient is responding to the suggestion to relax with breathing, this response can be reinforced by saying “That’s good”, “Well done”, “That’s right”, and coinciding that with the patient’s exhalation.

Double Binds are statements of comparable alternatives that can facilitate a sense of control by allowing stressed patients the perception of choice even when there is none. For example, the anesthetist might say, “When the oxygen mask is placed on your face would you like to feel comfortable and more in control breathing it in or blowing it away?” If an option is chosen, the patient has indirectly agreed to feel comfortable during oxygenation.

Failure Words

‘TRY’ is a failure word that should be used cautiously while the word, ‘NOT’ is not heard by the subconscious. This means that when the anesthetist asks the patient to “Try not to move” this is a subconscious suggestion for the patient to move. Similarly, being told “not to worry” invariably brings on anxiety as ‘worry’ is focused on and by the time it is crossed out, it is too late to avoid the thought.

The Law of Reverse Effect refers to a means of achieving a goal by asking patients to try to do the opposite of what is intended. For example, in a child complaining about the smell of the volatile agent during an inhalational induction can be asked to blow it away or if they prefer, “not to **blow hard**”. The subconscious doesn’t hear the word ‘not’ and the child hears “blow hard”. Even sabotage words can be used therapeutically. For example, the phrase “Try not to relax!” can be used to improve relaxation. The anxious patient is told to “Try not to relax and it will seem to happen on its own.” The patient will consciously fail to not relax but subconsciously the patient will relax as “not” is unheard by the subconscious.

Using Language Without Jargon

Patients need to understand the nature and risks of any proposed procedure before they give informed consent. Anesthetists need to communicate in a manner accessible to the patient such that she has an adequate understanding of anesthesia-related procedures such as inserting an arterial line.

A recent study found that approximately 50% of patients did not understand one or more terms used by the anesthetist during their consultation. Of the technical terms used more than once, reflux was the most poorly understood followed by aspiration, allergy, anaphylaxis, local anesthetic and sedation (11). Being aware of commonly misunderstood words may improve communication of information particularly if anesthetists appreciate that patients often do not fully comprehend the information they are given.

Research is increasingly being directed at developing protocols and techniques to hone communication skills and the way team interactions can be optimised. In an attempt to ‘technify’ the ‘non-technical’, communication techniques such as ‘GREAT’ and ‘LAURS’ may become part of an anesthetist’s technical armamentarium in the same way the rapid sequence induction (RSI) technique for emergency anesthesia or the failed intubation structured approach are currently enacted. It should be assumed that these skills can and should be taught and utilised alongside traditional technical skills.

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