Host: Welcome to the Anesthesiology journal podcast, an audio interview of study authors and editorialists.

Dr. James P. Rathmell: Hello. I’m Jim Rathmell, Professor of Anesthesia at Harvard Medical School and Chair of the Department of Anesthesiology, Perioperative and Pain Medicine at Brigham and Women’s Hospital. I’m one of the Executive Editors for Anesthesiology and you’re listening to an Anesthesiology podcast that we’ve designed for physicians and scientists interested in the research that appears in the journal.

Today we’re going to talk to the lead author of an original research article that appears in the January 2020 issue. With me today is Dr. David Waisel. Dr. Waisel wears a number of different hats in the Department of Anesthesiology, Critical Care and Pain Medicine at Boston Children’s Hospital.

He’s Editor-in-Chief of the Journal of Anesthesia History, Program Director of the Pediatric Regional Anesthesiology Fellowship and Senior Associate in Perioperative Anesthesia as well as serving as an Associate Professor at Harvard Medical School.

Dr. Waisel is the first author on an article that appears in the January 2020 issue. That article is titled “Compassionate and Clinical Behavior of Residents in a Simulated Informed Consent Encounter.” Dr. Waisel, thank you for joining us.

Dr. David B. Waisel: Well, good afternoon, Jim, and thank you for having me and for discussing what I obviously feel is an important topic.

Dr. James P. Rathmell: Well, first, congratulations on the publication of your study. We don’t see enough of this sort of work that examines and analyzes physicians’ behaviors, particular subjective behaviors like showing compassion. What is compassionate behavior in clinicians anyway? Isn’t how each of us experience compassion very different?

Dr. David B. Waisel: So, I think you’re right to focus on the phrase “compassionate behavior.” How each of us feels compassion or experiences compassion may be different, but there’s remarkable uniformity in how patients in similar situations, such as a healthcare situation, define compassionate behavior in their clinicians.

Dr. James P. Rathmell: So, the compassionate clinician seeks to understand their patients’ needs and then tends to those needs properly and along the way figures out how the patient really wants to be involved in each aspect of their own care.

Now, of course, right away I’m thinking, can you really study that kind of behavior? Let’s see how you went about trying to figure this out. I know there’s no formal hypothesis in a study of this kind, but how did you get at how a clinician or anybody responds to a patient question or prompt? And what we found was that residents were not as skilled as we would like in terms of simple matters: responding to a complaint about postoperative nausea and vomiting, responding to a complaint of pain, responding to actions of pain, holding their stomach and so forth.

And what we really found was it was rare for a resident to even acknowledge “I see you’re in pain.” Oftentimes the resident would just go to their next step on what I think of as a predetermined checklist we all have of what we see when we see a patient.

So, the person holds their stomach and groans and they ask the person to open their mouth to do that assessment. Or they tend to reassurance by saying, “We will get you to the operating room as soon as possible” but don’t really say, “Tell me about your pain. Have you been treated for it?” And let me make an assessment about whether I can treat it or not.”

Dr. James P. Rathmell: Well, it’s no real surprise that there were significant differences among residents; we see it everyday in our own practices. Can you describe some of the actual behaviors you saw? Maybe some of the behaviors at the extremes.

Dr. David B. Waisel: The differences, while significant in terms of statistical sense, were all on the lower end which means that the opportunity for improvement is really all the way across the board. But what we saw was kind of what I described earlier: not responding to complaints of pain, not letting the patient finish their sentence, not answering the question asked and sort of just going through a checklist without really paying attention to the interaction.

And it’s really this interaction that we’re looking for in terms of compassionate behavior and not the completion of the checklist.

Dr. James P. Rathmell: What did you conclude from the study? And I’m going to throw another question in there: did you feel any of this behavior yourself or has your own clinical practice changed?

Dr. David B. Waisel: So, that is a very important question. One of the flaws of the study, that we didn’t have an opportunity to interview the residents afterwards to know what they were thinking or why they were thinking it. We also really don’t know a lot in the anesthesia setting of how well simulation represents real actions in terms of compassionate behavior.

That being said, what we did find was a lot of opportunities for improvement in interaction with the patient and it’s important to draw a distinction here between compassionate behavior and compassion. In no way do we think or are we suggesting that these residents were not compassionate. In fact, we know many of them and we know they are compassionate.
But what we are suggesting is that there’s a barrier sometimes to compassionate behavior and these barriers are widespread. There’s a problem in our training; we don’t highlight this, but we don’t have people teach this or trainees don’t get the feedback on this.

There is a difficulty with trainees knowing that this is a legitimate way of interacting with the patient, that not only is it okay, but it’s important and if they are uncomfortable with this kind of interaction, they need to develop these skills.

It’s interesting: we talk about how anesthesiologists’ jobs are to treat and prevent pain, but we don’t also recognize that emotional distress, anxiety about surgery, fear of complications is pain and that it’s our job to treat it.

In addition to those barriers, there are other well-described barriers across other domains where this research has been done: burnout, fatigue, production pressure is a big one. For anesthesiology, several other ones are a lack of a previous relationship with a patient.

Our workplace culture just does not support this kind of behavior and oftentimes in most preoperative areas the physical layout is not necessarily quiet, there’s not necessarily a place to sit, there’s not necessarily a place to engage in what we would call a good interaction.

Dr. James P. Rathmell: Well, lots of problems with modern medicine in our practices and lots of room for improvement. What did you conclude from this study?

Dr. David B. Waisel: We concluded that there are opportunities for improvement in several areas. One is in practicing compassionate behavior and we have to work on it in the areas we described. We also think we found some concerns about knowledge about interaction between informed consent and pain management and perhaps lack of realization that you can obtain informed consent after you’ve given appropriate pain management. And, in fact, the patient may be better off and may be able to engage in the informed consent process with greater clarity.

Finally, we did find a wide variation in the informed consent practices. Now, we can theorize, and it makes sense, that the informed consent practice will vary based on the patient’s interests and requests. For example, this patient was asking about postoperative nausea and vomiting, yet 15% of the residents did not talk about that.

But any variation beyond that strikes us as unusual and kind of hard to legitimize. One would think that for the most part the informed consent “stump speech” would be very consistent except as variation in terms of patient illness, patient desire; but we found a wide variation that is worth, at some point, looking at in the future.

Dr. James P. Rathmell: Well, the American Board of Anesthesiology conducts Objective Structured Clinical Examination, or OSCEs, as part of the initial board certification process now. How might your work help inform residents who are preparing for that examination? And I want to give a full disclaimer here: I’m one of the directors of the American Board of Anesthesiology, so I’m very interested in your answer.

Dr. David B. Waisel: Well, one of the things the ABA is responsible for is helping us be better anesthesiologists. And as we’ve seen from many, many patient surveys, patients want good communicators. So, what we hope is that this initial work describing what good behavior could look like and where we maybe are not as good as we could be will help residents realize the importance of this, realize what behavior is worth trying to emulate and hopefully implement other things to help the system barriers that I discussed earlier.

Dr. James P. Rathmell: Well, I think you’ve answered some of this, but I’m going to ask again so we get back to it. Can the same simulation paradigm be used to teach physicians to deliver more compassionate care? And can we really change these behaviors in a positive way that’s sustainable in those who aren’t displaying compassionate behavior?

Dr. David B. Waisel: So, underlying your question is one of the discussions that goes on the literature: whether you have to feel compassion to have compassionate behavior. And for the most part, we realize that you can get pretty far on just behavior if you just don’t have a large amount of compassion for the situation. Not because you’re a bad person but because you’re tired, because you’re hungry, because you’re taking care of a lot of stressful patients.

If it is compassionate behavior we’re looking for, numerous studies across medical students, nursing, physicians and social workers and psychologists really indicate that by filming video with the standardized patient, reviewing that video for opportunities for improvement, getting to practice those opportunities for improvement and reinforcing them over time can lead to an improvement in frequency and type of behaviors that patients feel is compassionate.

Dr. James P. Rathmell: So, what comes next for you and your research team?

Dr. David B. Waisel: Well, I think there are two areas that our next step is: one is no one’s really defined what in anesthesiology the specific behaviors. Now while we have general behaviors, we think that in the perioperative setting, which is different than any other setting especially if you’re obtaining informed consent in that setting, patients may have different preferences or may have more specific preferences that we can use to recommend for appropriate behavior.

The second study is to translate some of this which was in simulation to actually do it in real life and to see some real conversations and to be able to assess how much this behavior we found reflects real patient care.

Dr. James P. Rathmell: I look forward to seeing some of that future work. I hope today’s discussion will lead many of you listening to read this new article. It appears in the January 2020 issue of Anesthesiology. You can learn more about barriers in training and practice that work against providing exemplary compassionate care.

Dr. Jon Wanderer from Vanderbilt and I also created an infographic that appears in the same issue that’s titled “Informed Consent: Address Pain Before Passing Go” where we aim to explain the major findings of this study.

Dr. Waisel, thank you very much for joining me today and for the terrific explanation.

Dr. David B. Waisel: Thank you for having me.

Host: You’ve been listening to the Anesthesiology Journal podcast, the official peer-reviewed journal of the American Society of Anesthesiologists. Check anesthesiology.org for an archive of this podcast and other related content.

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