

Part E

Foundation knowledge and skills for effective communication

11. Core concepts and skills

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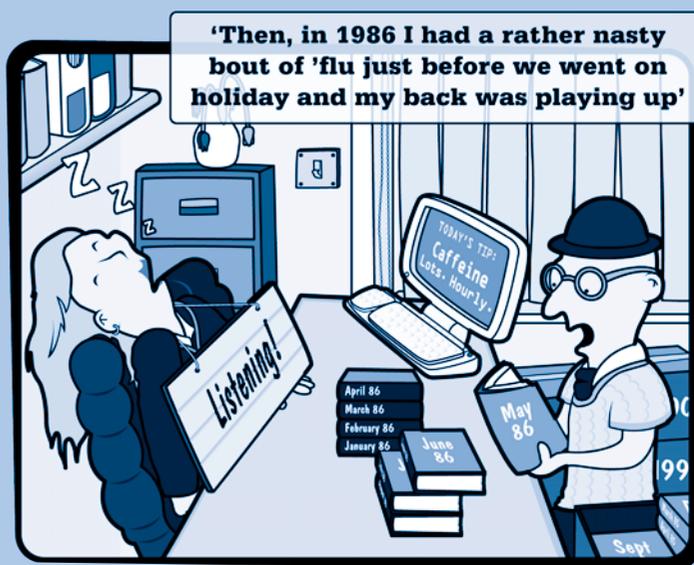
12. Special communication needs and processes

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The first chapter considers the direct practice application of all the background thinking and knowledge that has been reviewed so far. A small number of critical areas of knowledge and skill – caring, helping, empathy, listening and more – underlie all healthcare communications practice and these are examined in detail, illustrated with specific examples of interactions with patients.

The second chapter discusses broad issues that are relevant across healthcare relationships – the effects of becoming a patient, bedside manner and home visiting, sustaining long-term relationships, among others – which cut across all categories of patients and healthcare communications, and exert their own special demands.

For those who would like an introduction to a more methodical, structured approach to examining basic skills, Appendix 3 provides the core material from the remarkable work of Silverman, Kurtz and Draper, which will extend and enhance the reader's understanding of the issues that are dealt with more discursively in this book.



Ὁ βίος βραχύς, ἡ δὲ τέχνη μακρὴ, ὁ δὲ καιρὸς ὀξὺς, ἡ δὲ πείρα σφαιερὴ, ἡ δὲ κρίσις χαλεπή.

Ars longa, vita brevis, occasio praeceps, experimentum periculosum, iudicium difficile.

Acquisition of the unending art and craft of medicine is a task that is interrupted by death; life is short; opportunity fleeting; experiment (or experience) treacherous; judgement (or decisions) difficult.

Hippocrates

[Translation and interpretation rendered by the author with help from diverse sources.]

11 Core concepts and skills

A small number of areas of core knowledge and skills will equip HCPs to be effective, compassionate communicators who can understand their patients and the complexities of their lives more accurately and quickly than those who are less knowledgeable and skilled. The primary aspects of the core skills include empathetic attention to patients, active listening and the ability to elicit useful facts and information through sensitive questioning. HCPs need to care about their patients and show that they do, as well as helping them in ways that meet their felt needs. Explanation is a skill that requires careful thought; checking understanding at every stage is a critical process to ensure messages are fully understood.

Caring

Caring lies at the heart of all effective work and relationships with patients – and, like so many of the concepts and skills in this book, at the heart of humane and moral behaviour in any situation at all. The word and the concept sometimes seem to lack ‘muscle’, to be sentimental, and used so commonly as to have been weakened and devalued. It doesn’t help that the word is part of ‘healthcare’.

With its linguistic roots in ‘suffering’ (as in ‘the cares of the world’), *care* is a powerful concept in its meaning of concern, worry, caution about the welfare of a person or activity; commitment to nurture or development; dedication to the prevention or relief of suffering or danger; protection from harm – a safe place – and the provision of hope. Implicit in the notion are compassion, commitment, goodwill and, in its essential sense of kindness and generosity, charity. *Patient care*, in its widest sense, includes the physical environment and all kinds of other arrangements and the extent to which they appear to be provided by people who care and make patients feel cared for in the present and over time.

Box 11.1 ‘They don’t really care’

In the eyes of patients, there are few more damning conclusions about a hospital, clinic or an individual HCP. Whatever the truth, patients’ confidence and trust will be damaged if they feel they are not in the hands of people who *really* care about their jobs and their patients. Caring means making the object of care the number one priority, showing sustained seriousness, warmth and concern, the opposite of just ‘going through the motions’, which some behaviour can suggest. You have not only to care, but also to make it clear to your patients that you do. This requires all the skills we discuss in this book, along with the occasional explicit, genuine statement: ‘I do care about what happens to you, so I really hope we can find a solution together.’

Caring is a specific, intentional, active commitment to serve the welfare and nurturing of others: it may manifest itself in the shortest of encounters (perhaps a brief exchange in a community pharmacy, or in the waiting area of a hospital). It may be in a sustained relationship in which the patient is taken care of, looked after in one way or another over a longer period: examples include the best pharmaceutical care, or the relationship of a physician and team with a young patient with inflammatory bowel disease, or of a midwife with a mother

through her several deliveries, or of a community practitioner with a family over many years.

Kindness is the language which the deaf can hear and the blind can see.

Mark Twain

Care of patients has always been at the heart of nursing and it remains critical to the purpose and integrity of the vocation, but nurses cannot carry the entire burden of care for patients – cannot and should not – and their priority commitment should not be an excuse for others to care less, or delegate the burden of caring to them. Arrogant behaviour reveals that the HCP has missed the central point of what they are supposed to be doing: that is, *caring* for patients through the exercise of their talent and skill – being *careful* (full of *care*) in every aspect of their relationships and practice, with patients and colleagues alike. Caring originates in the mind and the heart, and is expressed through behaviour and communication. Those cared for feel they are in the safe, reliable and healing hands of dedicated professionals (see also Chapter 15).

Box 11.2 Bitter experience

A psychiatrist reports his experience of seeking help for his elderly mother.⁵¹

'The great man [*the consultant*] couldn't manage it. He had the cufflinks but not the questions. He had the style but not the substance. . . . It doesn't matter what you do because the "carers" do not care. It does not matter what you say, because they do not listen.'

It is a good thing for a physician to have prematurely grey hair and itching piles. The first makes him appear to know more than he does, and the second gives him an expression of concern which the patient interprets as being on his behalf.

A. Benson Cannon

Helping

Some years ago, a social science writer dryly described a social work 'client' (as they were then known), as: 'a person who receives what the social

services call help and who lives with the consequences of that help'.⁵²

In the past, and even now in many places, we could characterise a patient as someone who, 'receives what the doctor/hospital/HCP calls treatment and who lives with the consequences of that treatment.'

There are two critical elements:

- One is the risk that help or treatment is defined in terms of the provider's frame of reference or available resources, and not in terms negotiated with the patient and matching their wishes and needs.
- Help or treatment always has consequences which may not truly be taken into account at the point of diagnosis and treatment, and may sometimes be serious and/or long term. Helpers or HCPs may not recognise these, nor feel or take any responsibility, nor plan for them.

This book is an argument against the imposition of any decision or action that does not take full account of the patient's needs and wishes, and that does not have their consent. The point about consequences also relates to a vital issue in this book: the patient as a whole person beyond the healthcare encounter. This forces our attention not only to the depth and breadth of a patient's existence in its complex context of the here and now, but also over time and into the future.

A physician is obligated to consider more than a diseased organ, more even than the whole man – he must view the man in his world.

Harvey Cushing

It is too easy to find a neat solution or to carry out a procedure which appears to deal with immediate needs (even with the patient's consent), without adequate consideration of what the implications are for the patient's safety, welfare and happiness to come, and how they are going to cope in the future. The dispensing of a drug without discussion of the possibility of adverse reactions and what to do about them is perhaps the simplest and commonest example. Discharge from hospital, operations for back pain, lifetime medication, or

the birth of a disabled child are other examples, where potentially serious problems or long-term consequences may be quite unclear to the patient and perhaps to the HCP as well.

Patient consent needs to be consent to consequences across their whole life, as far as they can be defined and anticipated. Moreover, HCPs have an obligation to see that the patient has the resources, or has access to the resources, to manage the consequences of any event or intervention. In other words, responsibility does not stop at the point of treatment, discharge or the conclusion of a consultation: effective helping and caring demand that the longer perspective is considered and reviewed as well – that risks and needs are assessed – even if an HCP is unable to provide much in the way of future direct, practical help.

If I knew for a certainty that a man was coming to my house with the conscious design of doing me good, I should run for my life.

Henry David Thoreau

Everything an HCP does might be described as help, and many ancillary services are non-medical help. We need to be clear what the aims of helping are, and to be sure the patient's needs, wishes, dignity and autonomy are at the heart of our intentions. Patients often have ideas about what needs to be done, what help they require. Although we may be broadening their horizons about what is possible, we constantly need to draw out of them what they think is best, what they believe they can do. To the patient's question, 'What should I do?' the best response is, 'What do you feel the choices you have available are, what do you think will be the best answer for you, and how can I help you achieve it?'

Caring for people expresses itself in the compassionate activity of helping them towards good decisions and supporting them in carrying them out; achieving reconciliation with life as it is and is likely to be; protecting their independence; and managing the consequences of the process.

Give a man a fish and he will eat for a day. Teach him to fish and he will eat for a lifetime.

*Confucious*⁵³

Empathy

Empathy is central to everything you will think and do in healthcare relationships and communications.^{54–56} It is a skill that can be practised and refined; it arises from a disposition of openness and humility in the face of complexity.

This much-misunderstood, sometimes derided, concept lies at the heart of effective relationships and communications of all kinds.

Empathy is the capacity, experienced even if only for a split second, of understanding what it is like to be someone else; an accurate and transforming insight.

Box 11.3

In its purest form, empathy is not:

- feeling what it would be like for you to be in someone else's shoes (*it is being them in their shoes*)
- feeling sympathy for the suffering of others (*an outsider's, third-party response*)
- imagining how you would feel if the same happened to you (*you are not them*)
- drawing parallels with your own life experience.

The act of empathy requires:

- attention to every aspect of another person's presentation of themselves and their thoughts and emotions
- head, heart and imagination that are temporarily emptied of noise, interpretation, commentary, memory, emotions, ideas and responses
- senses that are perfectly attuned to the reception of complex information from another human being's inner life
- the ability to respond accurately and usefully when appropriate, either spontaneously or on reflection, in ways that absolutely match the reality of the other person's own emotions and understanding of their own life, and which they recognise as the truth about themselves when you show it to them – in short, accurate insight.

Why is empathy so important? Empathy allows us to perceive and to respond accurately and effectively to the otherness of a human being, by seeing them as they are, as they see themselves. It is

transforming, because it takes us out of ourselves, if only for a fraction of a second, and allows us to see and feel as if we were not ourselves.

Could a greater miracle take place than for us to look through each other's eyes for an instant?

Henry David Thoreau

Although the definition above describes the nature of empathy (the out-of-self understanding), there is also the broader capacity for empathy. This is the ability and willingness always to try to understand what is behind the words, behaviour and motivation of others, to seek how the world looks and feels to them. What is behind the behaviour of this irritating and disruptive child? Why is this nurse so brisk and cold with patients? Why is this patient constantly failing to adhere to treatment? What does how they are behaving feel like for them?

Observe, record, tabulate, communicate. Use your five senses. Learn to see, learn to hear, learn to feel, learn to smell, and know that by practice alone you can become expert.

William Osler

A crude parallel may help: suppose you meet someone to whom you talk in your native language, not realising that they do not understand or speak it: it is obvious that communication will fail because you did not have one piece of vital information about the other person.

The language that someone speaks is a simple fact to discover and does not require empathy. But, if instead of language, you think about, say, their experience of, and feelings and opinions about disease or injury – then you need to grasp much more than facts and try to perceive and feel what life is like for them, in order that what you say will be in the unique language of their feelings and experience.

Unless we have an accurate understanding of another person, we cannot tailor our communications and plans to fit that individual's needs. To take the example of emotions about disease or injury: an HCP might be perplexed by the anxious

Box 11.4 'If I were you . . .'

This phrase is on Hugman's 'Do Not Use' list*, because it is usually the preface to advice that will entirely miss the point, and may seriously upset the recipient. 'But you're not me . . .' is the instant response, with the corollary that what you'd do is probably of little or no relevance at all to what I should do. 'If I were you' denies empathy and stands in the way of finding solutions that arise out of the reality of the patient's life. Even if the offered advice is sound, and based on true understanding of the patient's life, the form of words is alienating in its implication that decisions I would make in my life are the kind of decisions you should be making in yours.

*The more authoritative Joint Commission's 'Do Not Use' list is on p. 185.

or negative reaction of a patient to a treatment plan or proposals for an operation – they are reluctant, uncooperative, don't turn up for appointments, postpone decisions: what is going on?

There are three options:

- Struggle to deal with the difficult behaviour as it is presented, arguing the case for the treatment, persuading, cajoling and so on, which may or may not have any positive effect.
- Ask direct questions which may or may not be answered (the patient may not know what is driving their own responses).
- Listen and watch with empathy; suspend judgement; pick up and interpret hints; try to feel what underlies the patient's superficial presentation; gain insight into the buried problem and deal with that, which then releases the patient to collaborate.

Asking direct questions may not produce anything – especially if very strong or repressed feelings are attached to the problem in the patient's mind, or the patient doesn't know the answer anyway.

With a patient who is resistant to treatment, for example, the empathetic HCP might have a moment of insight, and say: 'I have the feeling that you're frightened by this and I don't really understand why. Can you tell me?'

If the HCP has got it right, and 'frightened' is the exact emotion that the patient is feeling, then a powerful connection is made, because the HCP has

shown that they are in touch with the patient’s emotions, which may not have been remembered or be clear even for the patient.

Such an accurate insight can lead to a moment of release and/or insight for the patient, and they can then explore what’s holding them back. For example:

‘Yes. You’re right. It’s all flooding back. I hadn’t realised I’d buried the feelings and that they were still so strong. I don’t like to think about it, but both my parents died in hospital and mother, especially, had a terrible time. She had an operation and was at home afterwards, in real pain for months, and I had to look after her while I was working. It was the worst time of my life and I was on the edge of collapse. The mention of an operation just brings back all those bad times and overwhelms me.’ (See Table 11.1 for a continuation of this dialogue.)

Now the difficulty is out in the open, and the HCP can begin to deal with it directly, rather than trying to manage only its symptoms – the lack of willingness to consider the possible operation. Certainly the HCP should express concern for the past suffering of the patient, but it is not the HCP’s job to provide some kind of psychotherapy for the problems and their enduring effects. What needs to be done is to take account of the past problems and factor them into the negotiations for the present situation.

Table 11.1 is a compact version of how an HCP might respond empathetically to what has been learnt about this patient, distilled from what would be a much longer interaction.

It is obvious that treating this patient simply as difficult, without understanding why they were being difficult, probably won’t solve the problem,

Table 11.1 A compact version of how an HCP might respond empathetically to what has been learnt about this patient, distilled from what would be a much longer interaction

‘I’m really sorry to hear about that.’	A genuine expression of concern.
‘It must have been a terrible time for you and the family.’	Showing empathy and understanding and recognition of the patient’s suffering. Using the same adjective (terrible) that the patient used.
‘Operations can seem frightening, especially when you’ve got memories like that.’	Acceptance of the patient’s perspective and the validity of the reasons for it.
‘Though it may be hard for you to accept this, I do think your situation is different.’	Transition: making a separation from the bad experiences of the past; focusing on the new situation. Here feelings are being respected and managed while a bridge to firmer, less emotional ground is built.
‘You’re young, healthy and strong and there are usually very few complications with this procedure.’	Providing reasons that the current situation is different; focusing on positives and the low risk; leading the patient away from fear.
‘I’d like you to meet the surgeon, hear what she has to say and then make up your mind.’	Transition: practical proposal for cautious, exploratory next step; reassurance that the patient remains in control; drawing thoughts about the operation away from fantasy to reality – the person who would do the job.
‘In the end it’s entirely up to you.’	Confirmation that the patient is in charge.
‘What you need to balance is the very small risk of the operation against the probability that the condition [maybe a knee injury] will get worse in the future, and may be quite painful.’	Input of professional judgement: frank exposition of the issues – risks and benefits – on which the patient has to decide.
‘Can we take that first step before you finally make up your mind?’	Seeking permission to move things cautiously forward; restating the patient’s freedom to choose.

and may result in a damaged relationship and a lost opportunity. This applies to hundreds of different circumstances, where, for various reasons something is:

- interfering with the honesty of a patient's communication
- preventing a patient from managing their disease or adhering to therapy
- damaging the effectiveness of relationships with HCPs
- provoking difficult or uncooperative behaviour
- distorting a patient's perception of other people, plans or suggestions, therapeutic options and so on.

Many of the experiences and emotions that may influence patients' behaviour are discussed in Chapter 9. You don't need an explicit, verified list of the details of a patient's inner life, nor to provide feedback on your impressions to the patient, but you need to be picking up the clues, asking yourself questions, and making choices. There may be occasions when an HCP might acknowledge, with

a gentle touch, the patient's predicament, as a way of throwing a lifeline to the heart of the problem. This would not be to put pressure on the patient to open up or discuss the issue (although that might happen), but rather to show the extent to which the HCP perceives and values the whole person and has empathy for their trouble.

When we acknowledge a child's feelings, we do him a great service. We put him in touch with his inner reality. And once he's clear about that reality, he gathers the strength to begin to cope.

Adele Faber

In the examples in Box 11.5, each item represents an insight into a patient's difficulties and the HCP's decision about the practical consequences. Each item is followed by a form of words that an HCP might use to demonstrate accurate understanding of the patient's pain and to provide caring support – without necessarily intending to open up the entire issue for exploration. Opening the doors to communication, however, is very often what

Box 11.5 Demonstrating empathy

The items illustrate, first, the insight and its practical consequences; second, what an HCP might say if it seemed helpful to share the insight. In these cases, the insights are gained from empathy, not from information provided directly by the patient.

This patient doesn't trust men and me as a male doctor; I'd better offer the alternative of a female colleague.

- 'I think you've had a rather hard time with the men in your life, so perhaps you'd feel more comfortable with a woman doctor?'

This patient is actually a depressed and disappointed husband, but he'll never admit it, so I'll have to factor that into the decision.

- 'I'm sorry things haven't worked out as you hoped at home, but can we think of some practical ways to manage your diet?'

There's a real risk of this patient doing something desperate: I'll have to limit the prescription and ask him to come back in five days.

- 'I'm very concerned about your welfare during this horrible period of your life. Do you need any help? Or can I give you medicine for five days and feel confident of seeing you again next Tuesday?'

This patient is terrified of disease, doctors, hospitals, I need to take this slowly and carefully.

- 'I'm sorry that coming here makes you feel so distressed. Today I don't want to do anything but talk with you and introduce you to the senior nurse. If you feel better after that, you can come back tomorrow and we can go from there.'

This patient won't talk about her abuse as a child and the problems she's having with her own children, so I'll need to treat her disease and then offer her an introduction to the women's group.

- 'I feel you've had a very tough time in one way or another, right from the beginning. We need to deal with your ulcer, but afterwards, I'd really like to introduce you to a friend of mine who's been through a lot and might be able to help.'

Half the health problems of this patient arise from loneliness and self-neglect; what resources can I suggest he might try?

- 'Although it's hard to admit, I think you're suffering from the condition known as loneliness, and it really is affecting your health quite seriously. Do you think we could talk about that problem before we turn to medicine?'

This patient has a whole bundle of deep and unresolved conflicts which are making her life a misery and treatment impossible: how can I find help for her?

- 'I get the feeling that you're so worried and anxious the whole time, that it's impossible for you to think about anything except how unhappy you are. I'm sorry I can't help you much with that, but I do know someone who may be just the person you'd like to meet.'

empathetic concern will do. As well as being a healing process (a relief, an unburdening), it is also risky, especially in opening the flood-gates of misery when an HCP may not have the skill, time or resources to respond adequately. On the other hand, the surprise and trust prompted by the accurate empathy of others can lead to facing, relieving or resolving problems.

Illuminating effects

The discussion so far has focused on empathy as a motivator and means for discovering problems and addressing them. Its importance is also much wider than that.

Understanding the power of empathy and integrating it into the habits of one's life alters how one perceives and experiences every aspect of human beings: they are no longer, to the same extent, inexplicable creatures who automatically stimulate a predefined response in us, but endlessly complex and deeply different from us and from each other, requiring serious attention and study if we are to grasp anything of their real nature. Empathy dissolves barriers of ignorance.

Understanding of others does not imply acceptance or approval, but it does mean that judgements and behaviour can be based on sound evidence and on the reality of people as they are.

Box 11.6 'Mindless violence'

'Mindless', as it is commonly used to characterise perhaps shocking and incomprehensible acts, more accurately identifies the state of the critical faculties of the people commenting on such behaviour, than the state of mind of the perpetrators. No human behaviour is devoid of meaning, even if it is at the boundaries of or beyond our intelligence or empathy to grasp it.

These are profoundly important issues in healthcare, because we are responsible for the health and welfare of people of an almost unimaginable variety, every one of whom, so very different from us, requires us to see them clearly and accurately. If we see them vaguely and

inaccurately, or as stereotypes, we cannot know them or respect them, or provide the best care and solutions for them.

Box 11.7 Lightness of touch

In the midst of all this desperately serious stuff, we should mention the extraordinary importance of lightness of touch, of humour, of laughter, of affectionate irony – those aspects of communication that bring a smile to lips or a chuckle to the throat. There are many things we can laugh about or poke fun at (including ourselves) in ways that damage no one but rather uplift spirits and deepen relationships. There will be situations in which humour is utterly inappropriate but many more in which it will warm people's hearts and help in their healing.

In the next section, on listening, we describe how powerful and healing an experience it can be to be given the attention of listening. Empathy comes from, among other things, serious listening, but empathy in action goes much further because it moves from receiving information to showing that it has been received, and received accurately.

The professional must learn to be moved and touched emotionally, yet at the same time stand back objectively: I've seen a lot of damage done by tea and sympathy.

Anthony Storr

Most of us, and most patients, have aspects of our selves which we do not want other people (perhaps especially strangers) to know about, and we'll protect those areas very carefully, even as far as using direct deception. An empathetic individual (a doctor or nurse perhaps) will sometimes get a glimpse of one or more of these hidden areas or sets of feelings and must decide, very thoughtfully, whether or not to pursue or reveal the insight. Empathetic understanding handled carelessly can be very damaging.

Whether you reveal to patients what you know about them is a matter of careful judgement. But what you know about patients, gained from the exercise of empathy, will always enhance your relationships and your practice, whether the insight is shared or not.

Humor is the affectionate communication of insight.

Leo Rosten

Listening

Everybody varies in their capacity to listen effectively and in the amount of information they retain during and after listening. Effective listening requires full attention and concentration on the source of the sound. Few of us have the mental clarity and commitment to do this consistently. The problems are exacerbated in a world full of distractions. However, listening skills can be learnt and practised, to the enormous benefit of all participants. HCPs can improve their skills, while they remain alert to the extent that their patients' listening skills will be highly variable (from zero upwards). Showing your patients that you are listening to them is a further important skill.

I remind myself every morning: Nothing I say this day will teach me anything. So if I'm going to learn, I must do it by listening.

Larry King

Box 11.8 Effective listening

'Effective listening' is the ability to receive (hear), process (interpret) and perceive (grasp and understand) accurately a message in the exact terms the sender transmitted it through their words and paralinguistic attributes (the non-verbal aspects of the sound). The message will include both the intended, voluntary content, and the unintended or involuntary elements. (Most listening is also accompanied by observation, of course, as a part of the essential interpretive process.)

What customarily happens in almost all social and professional situations is that we listen with only part of our brains, the other parts being variously occupied with:

- reacting to what we are hearing and preparing our response
- distracting thoughts about the person speaking, or about work, shopping, family and so on.

The opposite of talking isn't listening. The opposite of talking is waiting.

Fran Lebowitz



Our minds are usually a ferment of emotions, issues and questions, likely to fly off at any moment to some other preoccupation. It is most obvious when we consciously realise we have been briefly totally distracted from listening, miss what has been said, and have to ask for a repetition. Most of the time we don't notice this state of incomplete attention and listening, because we hear enough to continue the conversation coherently, without gross misapprehensions, and to avoid appearing absent minded. However, one of the reasons that we can easily make mistakes (the time and place of an appointment, for example, or the dose or strength of a drug) is that we are actually paying much less attention to the communication than we thought we were or should have been. This is profoundly true for patients who may have many, immediate and serious internal preoccupations distracting them from listening attentively to their HCP.

Listening is a magnetic and strange thing, a creative force. The friends who listen to us are the ones we move toward. When we are listened to, it creates us, makes us unfold and expand.

Karl A. Menninger

The next time you are having a conversation, and are listening to someone, try to notice the number of things going on in parallel (or spiral, more likely) in your head while the other person is speaking (and this exercise has just added another distraction to reduce your attention!) What can be done to reduce the noise and the clutter?

Activate listening!

Good listening has at least one feature common to meditation practice (and empathy): calming and emptying the mind: that is the secret. The moment a patient starts talking to you, you must instantly calm and empty your mind; make it a receptive instrument for listening, by sweeping, as it were, the noise and clutter out of the way, and concentrating, focusing exclusively on what the patient is saying. It is a trick or a tactic that you can learn to execute whenever you recognise that listening is important, in any situation. The internal command is: 'Listening. Switch on.' It becomes easier as you practise, although it may never become entirely foolproof or automatic.

The same tactic of switching on mentally attentive calmness applies to effective visual observation too.

Mass communication, radio, and especially television, have attempted, not without success, to annihilate every possibility of solitude and reflection.

Eugenio Montale

Author's note: Since the Nobel Laureate died in 1981, we should perhaps take the liberty of adding mobile phones, personal sound systems, the internet and computer games as further threats to solitude and reflection.

At the same time as you are focused on listening, what you are hearing has to be stored and retained in a temporary mental 'holding bay', which can release its content when input has ended, and allow you to review it and to respond accurately and intelligently. It is hazardous to form reactions or reach conclusions before the input has ended, because those may become barriers to hearing

what follows, or may prejudice better conclusions you would make later on the basis of further evidence. (It can be particularly unhelpful to interrupt a patient's story simply because you have a point you want to make – see below for more on this.) You may need to store some temporary assessments or conclusions if they seem strong, but only in such a way that they do not interfere with hearing what is still to come, and to their being modifiable in the light of later information.

To perform effectively at this level, you also have to be aware of the limits of your attention span, as well as the occasional need to clarify your understanding of what you are hearing. The amount of input any one of us can store in the temporary holding bay will vary greatly, and there is no point at all going beyond its limits and finding you've lost the first half of the patient's communication. As you come to the limit (which you'll come to recognise and which may grow as your listening skills improve) you need to ask the patient to pause, so you can review what has been said and react to it and record it (perhaps in your notes).

Equally if your attentive listening reveals something the patient has said which you do not understand, or is contradictory to something that has gone before, then you need either to store the query for later or to ask them to pause and help you understand what they mean. It is important that such interruptions should not disturb the flow and direction of the patient's story; that they should be made in such a way that they support continuity, not divert the narrative. Repeating the last words or the gist of what the patient said before the interruption is a powerful way of achieving this.

You can't fake listening. It shows.

Raquel Welch

Some exchanges may be quite short, of course, but accurate interpretation of short messages still requires intense concentration: in a rapid exchange there is considerable risk of misinterpretation on either side, and of heading off down a blind alley.

Insensitive interruptions of any kind from any source (mobile phones especially) can be very damaging to attentive listening and, for the speaker, the confidence that what they have to say is important.

Helping patients to listen effectively

Although an HCP's own listening skills must be honed to a fine degree, knowledge of the extent to which a patient is listening is a further vital dimension of this topic. There's more on this in the section 'Checking understanding and seeking feedback', later in this chapter, but there are a few issues that need discussion here.

Most patients will not be familiar with effective listening practice, and will not necessarily pay careful attention to the individual words or phrases or sentences that an HCP utters. They may not be familiar with processing serious, dense messages at all; they may pick up only a general impression of what is being said or the feelings expressed; they may overreact to certain words or phrases and lose the general sense or context; they may miss vital details.

There are many benefits to this process of listening. The first is that good listeners are created as people feel listened to. Listening is a reciprocal process – we become more attentive to others if they have attended to us.

Margaret J. Wheatley

An HCP needs to be closely monitoring the extent to which a patient is listening, and is able to make sense of what is being said. Should a patient be distracted (in a busy pharmacy, for example), or have withdrawn into introspection, or seem to be reading the package or a poster while the HCP is talking, or the patient may be fiddling with their mobile phone, or attending to a demanding child – whatever dilutes attention, then the HCP has to pause, try to remedy the cause of the distraction, ask for feedback about the information already conveyed and find diplomatic ways of demanding the attention necessary: 'I really need you to understand this. It won't take long. Can we go through it again together?'

Effective listening can take place only when a patient is communicating, of course, and the skills of questioning and active listening are those that will increase the chances of your having something to listen to, and something that is relevant and important to the patient and you.

Listening to people keeps them entertained.

Mason Cooley

Questioning

A patient consultation is not a simple encounter between a patient with information they want to give and an HCP who wants to hear it. A patient may not know that they have information that is important for the HCP to know, or they may have information that they are keen to shield from the HCP. Initially, the HCP will get to know only what the patient chooses to tell them, and all kinds of vital information may remain hidden unless it is expertly sought and discovered, overcoming many kinds of possible barriers.⁵⁷

Questions are a burden to others; answers are a prison for oneself.

Patrick McGoohan

Questioning is an intrusion into another human being's life. Conventions in many societies place some degree of obligation on someone asked a question to answer it or appear to be answering it. Questioning, then, can be seen as (and may be), at one end of the spectrum, an intrusive, aggressive act, an assertion of power, whereas at the other, it can be a demonstration of gentle and affectionate concern. We may be only seeking information, but the meaning of that seemingly non-threatening intention may prompt very different reactions from different people. (Teenagers commonly react very negatively to 'simple' questions about what they're up to, and may resist personal revelations very strongly, for example.)

[In personal relationships] . . . beware the man who does nothing but ask you questions about yourself and offers

no information about himself. Not only is he keeping you at bay, he is probably not listening to your answers.
Merrill Markoe

Questioning skills are very important, but not at the expense of listening, of course.

Box 11.9 Illuminating research

Hargie⁵⁸ vividly describes a common state of affairs:

West (1983) revealed that of 773 questions featured in the 21 doctor–patient consultations sampled, only 68 (9%) were initiated by patients. Indeed, in a study cited by Sanchez (2001), doctors incredibly managed to ask, on average, one question per 4.6 seconds during consultations lasting little more than 2 minutes each. Patients may even be interrupted in order for a question to be asked. In one investigation, patients got little more than 18 seconds into a description of their symptoms before the physician butted in (Epstein *et al.*, 1993). Summing up this state of affairs, Street (2001, p. 543) noted: ‘Research consistently shows that physicians tend to talk more, ask more questions, give more directives, make more recommendations, and interrupt more than do patients.’

The research findings are open to several interpretations (not all of them entirely bad), but none of them can banish the image of the patient as a pretty passive recipient of interrogation and instruction. Although we know nothing about the seriousness of those patients’ symptoms, and have no evidence about levels of patient satisfaction or outcome success, the picture is stark enough: these patients were not partners in their healthcare.

There are several kinds of questions, some neutral in essence, to be chosen carefully for use at particular times, but damaging if carelessly used; others, essentially risky or manipulative, should be largely avoided.

The important thing is not to stop questioning.

Albert Einstein

Open and closed questions

- An open question is any enquiry that simply opens the door for someone to talk about something (the openness stops at the point of definition of the subject, of course, so even that has to be chosen with care, lest it should be off the point)
 - ‘How are you feeling today?’
 - ‘Please tell me about your symptoms’

- ‘What are your feelings about the treatment?’
- ‘How is the family reacting to the news?’
- ‘Is there anything else you wanted to mention?’
- ‘Are you worried about anything else?’

For clarity, here are the closed versions of the first four questions: assuming that these are the first questions asked, you’ll see that the patient’s freedom to answer strictly in their own terms is limited, and that a degree of assertiveness is required to answer more than ‘yes’ or ‘no’ or challenge the assumptions embedded in the questions:

- ‘Are you feeling better today?’
- ‘Are you getting on well with the new diet?’
- ‘Are you comfortable with the treatment?’
- ‘Is the family upset?’

None of these questions is bad per se, but if they are asked in a rapid sequence and before the patient has identified their feelings or their cause for concern in response to open questioning, there’s a risk that their real feelings will be inhibited by the limitations of the closed question; a patient could even get the impression that the questioning is a kind of empty routine and that serious answers are not expected. Such closed questions are fine for discovering more about the issues a patient has already had the freedom to identify as concerning them.

Closed questions will also be useful for diagnostic purposes, when an HCP needs factual information from the patient:

- ‘Is the pain worse?’
- ‘Is there blood in your urine?’
- ‘Do you drink at least a litre of water each day?’
- ‘Have you fainted before?’
- ‘Is there any history of heart disease in your family?’
- ‘Have you had unsafe sex?’

All of these will probably spawn further closed questions until the patient has no more information to contribute.

You mustn't always believe what I say. Questions tempt you to tell lies, particularly when there is no answer.

Pablo Picasso

The doctors who were asking one question every 4.6 seconds (Box 11.9) were almost certainly asking limited, rapid-fire questions:

- 'What's wrong?'
- 'How did it happen?'
- 'How long have you had it?'
- 'How bad is it?'
- 'Have you had it before?'
- 'Do you smoke or drink?'
- 'Are you allergic to penicillin?'
- 'Can you take this prescription to a pharmacy?'

All these questions may generate important facts, but, on their own, they may not provide useful information without further careful enquiry. An HCP who gets into a yes–no question–answer session may not learn enough about a patient, and the patient may not be encouraged to open up with new and useful information. Closed questions tend to generate more closed questions, which take the participants down a narrow and pre-specified track. A narrow and pre-specified track may be exactly where part of the consultation should be heading, but only by specific intention, not by accident or default.

Difficult as it is really to listen to someone in affliction, it is just as difficult for him to know that compassion is listening to him.

Simone Weil

Not every patient will be able to respond usefully to open questions, and may require help or prompting, but this should still be done in a spirit of open questioning:

HCP: 'How can I help you?' (*Just about as open as a question can be.*)

P: [baffled silence]

HCP: 'What made you come here today?' (*This confines the area of questioning to the cause of the visit, but leaves open all response possibilities within that field.*)

P: 'It's my chest.'

HCP: 'Tell me what's worrying you.' (*As open a question as possible.*)

P: 'I have this terrible pain.'

HCP: 'I'm sorry to hear that. Where is the pain?' (*Sympathetic response, followed by the first specific question of the diagnostic investigation.*)

You can see that the HCP's first three questions are open in their form but progressively narrow in scope in response to the patient's ability and needs. Although some patients would simply have declared their chest pain after the HCP's first question, this one needs gentle prompting towards the main point. A similar pattern may apply to any aspect of a consultation.

Leading or manipulative questions

If you have never beaten your wife, the lawyer's unscrupulous question, 'Have you stopped beating your wife?' cannot be answered by yes or no, and the fact that you have never beaten your wife can be declared only by rejecting the assumption in the question. This may seem obvious, but it is a good example of the category of questions that have unscrupulous motives and require some intelligence, assertiveness and mental agility to answer.

The form of a question can exert pressure for a particular kind of answer ('You don't really believe that, do you?') and many people will find it difficult to resist the pressure to give the answer that seems to be expected, or which seems to promise approval or avoid disapproval. This kind of question puts a person into a position where to express their genuine opinion they would have to make an assertive effort to challenge the questioner but may not have the strength or ability to do so.

The largest category of this type is known as leading questions. These are questions where the desired or expected answer is wrapped up in the question, and demonstrate bias and pressure on the part of the questioner:

- ‘You don’t drink a great deal of alcohol, do you?’
- ‘Do the children get at least two good meals a day?’
- ‘Have you been taking the tablets exactly as I said you should?’
- ‘You won’t mind if I examine your breast, will you?’
- ‘Can I take it that you’ve been having fewer headaches?’
- ‘I’m sure you’ll want to have the operation, won’t you?’

The open forms of these questions are as follows:

- ‘How much alcohol do you drink?’
- ‘How many meals a day do the children have?’
- ‘How have you been taking the tablets?’
- ‘I need to examine your breast. Are you comfortable with that?’
- ‘Have you been getting headaches more or less frequently than before?’
- ‘Do you feel you want to have the operation or not?’

Tone of voice is an additional variable in determining the meaning and impact of a question and on the patient’s freedom to answer openly.

Influencing memory and perception

There is a further remarkable effect from the way questions are formulated and the assumptions they embody: they can alter how reality is described or remembered.

We hear only those questions for which we are in a position to find answers.

Friedrich Nietzsche

The controversial issue of ‘recovered memory’ also relates closely to the methods through which information is sought: are memories reliably ‘recovered’ or can they be implanted by the nature of the investigation? (‘The headlight’ in the third example in Box 11.10 suggests that there was a headlight which the observer might have seen or missed, and therefore exerts pressure to claim recall of the headlight rather than admit missing it through stupidity or lack of attention.)

Box 11.10 Distortions

In Hargie’s summary of research on questioning⁵⁹ he reports on research that showed:

- People who were asked the height of a well-known sports figure estimated that he was taller or shorter by a wide margin, depending on whether they were in the group asked how ‘tall’ or how ‘short’ he was (the same differential applied to the remembered length of a movie (how ‘long’ or ‘short’ it was)).
- In responses to the questions, ‘Do you get headaches frequently, and if so, how often?’ and ‘Do you get headaches occasionally, and if so, how often?’ – the reported averages were 2.2 and 0.7 headaches per week for comparable groups of subjects.
- In reviewing a short film of a motor accident, the question, ‘Did you see the broken headlight’ produced fewer uncertain or ‘I don’t know’ answers than did the question, ‘Did you see a broken headlight?’

This is a fascinating area of research which we cannot pursue in any depth here. These are the things we must remember:

- Every aspect of the formulation of a question, and the attitude of the questioner may influence:
 - understanding of what the question means
 - willingness to answer the question
 - capacity to answer the question
 - adaptation of the answer to what the question appears to mean
 - adaptation of the answer to how the content of the question is interpreted (e.g. in relation to frequency, seriousness)
 - adaptation of the answer to gain the approval of the questioner, or not to challenge the questioner
 - accuracy or mutual comprehensibility of the answer.

Children, and those with learning difficulties are particularly vulnerable to the effects of leading questions, but everyone can be misled or manipulated by intended or unintended elements in the formulation of questions. In dealings with patients we have to make sure not only that we understand what they are saying to us but also that what they are saying is based on an accurate understanding of the purpose and terms of our enquiry, which itself

does not damage or interfere with the truth as they see it.

Multiple questions – a string of questions following each other – can be very problematic in terms of getting good responses and should be avoided almost always. Take questioning through a slow, step-by-step progression, dealing with one aspect of each topic at a time.

You can tell whether a man is clever by his answers. You can tell whether a man is wise by his questions.

Naguib Mahfouz

Active listening, prompting, probing

This section includes issues closely relating to everything that has gone before in this chapter. They are linked here, because they are all ways to ensure that, once a patient has started to communicate, they continue to do so and in ways that are relevant and to the point.

Active listening

This involves clear demonstration of the fact that you are listening, through some or several of the techniques in Box 11.11.⁶⁰

Box 11.11 Techniques of active listening

- maintaining visual contact (eye contact)
- head nodding
- furrowing the brow, narrowing of eyes or compressing the lips in concentration (not in scepticism or doubt)
- brief withdrawal of eye contact for absorption of information (a show of concentration such as indrawn breath, head tilted back)
- low-key, supportive or facilitating noises or phrases:
 - ‘Uh huh’
 - ‘Ah’
 - ‘Mmmm’
 - ‘I see’
 - ‘Really’ (as a quiet statement of acknowledgement, or an expression of surprise, or, if appropriate, incredulity)
 - Changing body posture to one of greater concentration (e.g. elbows on desk, hands linked in front of mouth)
 - Being silent and still, giving space for reflection and formulation of ideas and answers.

All these actions will have a helping effect on the patient’s fluency in telling a story. There is, however, one serious reservation about providing positive, encouraging feedback: should the respondent be more interested in giving you an answer that you approve of, than in providing the truth, then your active listening techniques may be seen as approval, rather than active listening, and so encourage the speaker to follow that line of thought even if it is not true. Your first nod of the head will confirm for the patient that you are listening and are happy with what you have heard, although what you have heard may have been a tiny experiment by the patient to see where you stood on the issue, an experiment that would have been abandoned in favour of another had you shown any degree of disapproval. People will often struggle to say what they think others want to hear, and will look for any clue being offered as to how they are doing, even unconsciously (remember the power of non-verbal behaviour and hidden motivation).

Active listening is important to demonstrate that you are paying attention, as long as your mind is calm and empty and you are really listening as well as giving the appearance of doing so.

What honour have we got left, when nobody is listening to us?

Abu Bakar Bashir

Prompting and probing

Prompting is the next stage beyond active listening, when the patient needs more active help to continue the story. In the discovery phase of enquiry, prompting should not take the patient off in a new direction but simply help them to complete what they have started.

These are examples of this kind of neutral prompt:

- ‘So, what happened next?’
- ‘When did your son get back from the hospital?’
- ‘What did your husband say when he found out?’

- ‘What happened after you were sick?’
- ‘Did the headache come back again then?’
- ‘This is important. Please carry on.’
- ‘Don’t be embarrassed. It’s fine.’

Some of these could also be probing questions, but may also simply be helpful nudges to keep the story going.

Every clarification breeds new questions.

Arthur Bloch

Probing a patient’s story really needs to come after the story has been told – because probing before the end may take the patient off somewhere new and make them forget the larger shape of what they wanted to say. (Remember the rapidity with which doctors interrupted patients in the study quoted in Box 11.9, ‘Illuminating research’.) Probing questions are used to clarify and extend information.

Box 11.12 Probing question types

Hargie⁶¹ lists the following kinds of probing questions, derived from an extensive review of research in the area:

- Clarification/informational probes (‘Can you just tell me that again please?’; ‘What exactly did you say happened after the accident?’)
- Justification or accountability probes (seeking reasons or causes: ‘Why was it you stopped taking the medicine?’; ‘What did you do when the bleeding started?’)
- Relevance probes (‘Please tell me how that relates to your stomach pain?’; ‘How does you son’s behaviour relate to your illness?’)
- Exemplification (giving specific examples: ‘Describe a recent occasion when you felt faint?’; ‘What are you doing when the pain in your back is at its worst?’)
- Extension (‘Tell me what happened next?’; ‘Did the pain get better or worse after that?’)
- Accuracy (‘Did you say five times a week?’; ‘Exactly how many tablets have you been taking each day?’)
- Restatement (repeating or rephrasing a question: ‘Can I just ask you that question again, to make sure we understand each other . . .?’; ‘Is this the question you want me to answer . . .?’)
- Echo (repeating a telling word or phrase: ‘You said like a hot knife in your brain?’; ‘You said you were “terrified” of needles – can you tell why you feel that way?’)
- Consensus (finding out if a view or fact is shared or agreed among more than one person: ‘Do you both feel the same about this?’; ‘Does you daughter agree with you?’)
- Non-verbal (raising eyebrows; tilting the head and frowning).

Good probing is vital to achieving good, comprehensive information. It is a process against which there is some cultural resistance in normal relationships because of our wish to avoid seeming intrusive or presumptuous: most people protect sensitive information about themselves and tend to behave in ways that support the protection of others’ privacy too.

HCPs must probe until they are satisfied that they have as full a picture as necessary and possible. For every HCP there will be a point when they feel that they are at a sensitive frontier – for themselves or for the patient. At that point the decision whether or not to pursue the issue needs to be made, and, in the event of going ahead, the tone and method need to be chosen to reflect both seriousness and delicacy. In doing so an HCP may have to express regret to the patient about the need to ask such personal or intrusive questions, explain the need for them, and help the patient to overcome such resistance as they may have to answering them.

It is the answers, not the questions, that are embarrassing.

Helen Suzman

Explanation

Diagnosis is not, of course, a communication skill, although it is dependent on expert communication in the gathering of fact and evidence to support it. But explanation of a diagnosis, or of a disease process, or of a treatment plan, and many other aspects of healthcare, all require great skill to explain effectively. They require the HCP to understand the topic clearly and fully, and to be very clear about the abilities and receptivity of the patient.

Many attempts to communicate are nullified by saying too much.

Robert Greenleaf

The purpose of explanation is to nurture understanding. In healthcare, its purpose may also be to lead to action or change of some kind, often

adherence to treatment or other kind of plan (exercise or diet, for example).

Box 11.13 Effective explanation

Effective explanation involves at least these steps:

- identification of the topic to be explained
- mastery of the facts of the topic, and the logical structure of the topic
- clarity as to why the topic has to be explained; what outcome is desired?
- clarity about what minimal, essential information has to be explained
- assessment of the patient's general knowledge, beliefs, linguistic ability and existing understanding of the topic (including health literacy)
- explanation of why the explanation is necessary and what it is hoped to achieve
- the choice of a starting point that connects accurately with the patient's abilities and needs – a bridge from the HCP's world of assumptions, concepts, jargon and professional expertise leading exactly to a point of knowledge or experience in the patient's world which they recognise and can respond to
- awareness that the basic terms (language) in which the explanation is being given may not be clear to the patient (enzymes, virus, embolism, stroke and so on)
- clear, logical, progressive presentation of information (structure) in chunks that match the patient's ability to absorb and process them (pace and volume of information)
- use of printed or visual material to demonstrate or clarify the topic or aspects of it
- checking understanding on the way
- seeking feedback about the content and the process
- inviting questions from the patient about the content
- providing supportive materials that repeat or summarise the explanation for later review
- ideally, assessment/evaluation of the effect of the explanation in terms of adherence, action or change over time.

Facts which at first seem improbable will, even on scant explanation, drop the cloak which has hidden them and stand forth in naked and simple beauty.

Galileo Galilei

Most of us will remember one teacher or lecturer whose abilities at explaining were exceptional. Some of their characteristics were:

- the ability to stimulate interest and engage their audience
- the ability to relate a complex topic to familiar or simple aspects of life and to demonstrate the importance of the topic
- the use of anecdotes, metaphors, parallels and questions about familiar, related topics
- the building of a progressive structure of understanding, moving from the simple to the complex
- the active involvement of the audience in building the structure and anticipating the next stages
- enthusiasm and humour.

Good explanation, like all aspects of effective communication, is never routine: it is tailored exactly to the needs and abilities of the particular individual and the task in hand. Sharing knowledge through explanation, about even the simplest of facts or procedures, is a powerful way to establish good relationships and to build trust and confidence in patients. It is also an important way in which to build patients' knowledge and confidence in medical matters (Table 11.2).⁶²

All HCPs, along with teachers, lecturers and almost every other professional providing service

Table 11.2 Health improvement processes and outcomes⁶²

HCP	Patient	Outcome
Friendly, attentive, creates partnership with patient, encourages, is supportive, explains clearly	Tells own story clearly, is encouraged to ask questions, decide on treatment with HCP, and takes responsibility for own health tasks	Increases probability of positive health outcomes
Cool, distant, non-attentive, interrupts patient, has quick-fire questions, gives several instructions, offers several pieces of advice	Passive, does not ask questions, unduly deferential, superficially agrees to comply	Decreases probability of positive health outcomes

to the public, need to have well-developed skills in explaining. Patients and customers, experiencing critical events in their lives, need to understand what is happening to them if they are to have any measure of control, to make informed decisions, and to be participants and not victims. Good explanation is also a vital element in the extent to which patients will feel satisfied with their health-care, with all the implications that has for adherence, optimism and general wellbeing (and, it has to be said, the avoidance of litigation).

Having the patience to explain is a sure sign of a great communicator.

Good luck needs no explanation.

Shirley Temple

Checking understanding and seeking feedback

This topic occurs repeatedly in this book, and cannot be emphasised enough as a critical element in effective communications of every kind: unless we have evidence from the audience about the receipt and effect of any communication, the process is incomplete; we can never be sure that the message has been received and understood as intended, nor that it has led to the action or change we hoped for.

Checking understanding needs to be carried out sensitively so that patients do not think their intelligence is being doubted. The checking can be presented, as indeed it really is, as a way of testing the effectiveness of the HCP's communication: 'I need to check that I've made this clear and haven't forgotten anything. Can you just tell me what you think I've said so I can be sure I haven't missed anything?'

The process applies to all communications of all kinds: if your recipient or audience hasn't given you feedback about your message, then you must ask for it. (For a discussion of user opinion and complaints, see Chapter 12.)

Box 11.14 Checking understanding

Done internally and silently or actively with the patient or audience it is achieved through these kinds of action and words:

- assessing the degree of understanding from levels of attention and non-verbal feedback, and from verbal responses
- asking if the message has been understood; 'Is that clear?'; 'Do you understand that?' This is the lowest and least satisfactory level of enquiry, because of a patient's possibly mistaken assumption that they have understood, or possible unwillingness to admit to not understanding, or because the patient wants to get home quickly
- asking for a repetition or rehearsal of the message:
 - 'OK. Please can you just tell me how you're going to take this medicine?'
 - 'Can you tell me in your own words what I've just explained?'
 - 'So what are the foods you must avoid while taking this?'
 - 'What do these test results show us?'
 - 'Can you tell me what has happened to your liver and what we need to do to help it recover?'
 - 'When are you coming back to see the surgeon? And where will you find her?'
 - 'I want to be sure you'll know what to do: can you just show me exactly how you'll use it?' (e.g. blood-sugar monitoring device).

Summary

These, then, are core skills of effective professional relationships with patients:

- caring and helping effectively
 - the exercise of empathy
 - active listening
 - accurate and purposeful questioning
 - explaining
 - checking understanding and seeking feedback.
- Deployed with the warmth and compassion that are characterised throughout this book, the improvement of these skills will refine and enhance practice, and lead to mature, effective partnership relationships with patients and other audiences.

There is frequently more to be learned from the unexpected questions of a child than the discourses of men, who talk in a road, according to the notions they have borrowed and the prejudices of their education.

John Locke

