The Power of Listening and the Patient's Voice: "Please Hear Me"

Carolyn L. Larkin

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Therapeutic Relationship
This means that the doctor (or practitioner) can imagine the inner experience of the patient and practices clinically sound medicine in a way that respects that inner experience. In other words, patient-centeredness is a mindset expressed in professional behavior; and consulting skills are the translation tool between the mindset and the behavior [1].

6.1 Introduction: Solutions to Help Build Trust with Patients

While growing research is focused on how to build a therapeutic practitioner-patient relationship, the current medical paradigm has a less-than-complete understanding of how to do so [1]. Ideally, practitioners should treat each patient as a client and as such provide their clients superior customer service. Superior customer service requires individualization of patient care, which should be the focus for all practitioners. It also demands a high level of engagement with the patient, one that can lead to mutual trust. However, a high level of engagement is only possible when the practitioner is trained in the best way to interact with the patient as an individual [2, 3]. In the end, the practitioner's goal should be to foster excellent relationships with patients to deliver superior, customized personalized patient healthcare [3].

Teaching behavioral competencies, also referred to as *soft skills* (see Table 6.1 for list of soft skills), has been an important part of leadership development in the corporate world for many years [1, 2]. The development of leadership soft skills and the teaching of soft skills competencies is a missing element in healthcare training and education [1]. Providing this model of education to all types of medical practitioners would improve patient interaction, communication, and engagement while increasing effectiveness in delivering personalized patient care in a time-efficient manner [2]. Exploring the importance of understanding and using soft skills within medical practice will be our starting point. To understand soft skills, practitioners need to learn how to use multiple assessments, including those that measure personal behaviors, team behaviors, emotional intelligence, resilience, and empathy.

This chapter is intended to demonstrate useful techniques for creating stronger trust relationships with patients that will become an integral part of patient therapy. A well-prepared practitioner who understands interpersonal skills and who communicates sensitively and effectively with patients of all personality types will improve their practitioner-patient relationships. We encourage practitioners to be involved in a holistic healing process encompassing mind-body-soul to deliver personalized patient care and to encourage families to become part of the healing process. We cannot continue to confine the healing process inside of disconnected silos. Everything related to the patient healing process should be part of the same system. We need to define and improve connectivity of the totality of the health system.

Table 6.1 Description of hard skills and soft skills competencies

Hard skills	Soft skills
A degree or certificate program	Communication skill
Technology experience	Interpersonal skill
Proficiency is a foreign language	Teamwork
Machine operation knowledge	Leadership
Coding ability	Problem solving

Trust impacts us 24/7, 365 days a year. It undergirds and affects the quality of every relationship, every communication, every work project, every business venture, every effort in which we are engaged. It changes the quality of every present moment and alters the trajectory and outcome of every future moment of our lives – both personally and professionally [4].

6.2 The Need for Improved Practitioner-Patient Communication: Practitioner Know Thyself!

Educating practitioners to understand their behavior styles and to help them to improve communication skills is a missing element of healthcare education curricula [2]. When practitioners understand their preferred work behaviors, medical teams can come together and adapt their behaviors to coworkers while meeting the needs of their patients [3]. This can help teams have a more cohesive, less stressful environment while interacting with all types of patients with all types of needs. If practitioners were to be taught new interpersonal skills or soft skills for effectively communicating with patients, the practice of medicine could significantly improve. Table 6.1 lists a set of useful soft skills, compared with more commonly understood hard skills that are usually acquired through education, training, and/or life experiences. In this chapter, we focus on communication and interpersonal skills.

The most effective use of behavioral soft skills occurs when practitioners understand how to adapt their own behavioral style to meet the needs of the patient.

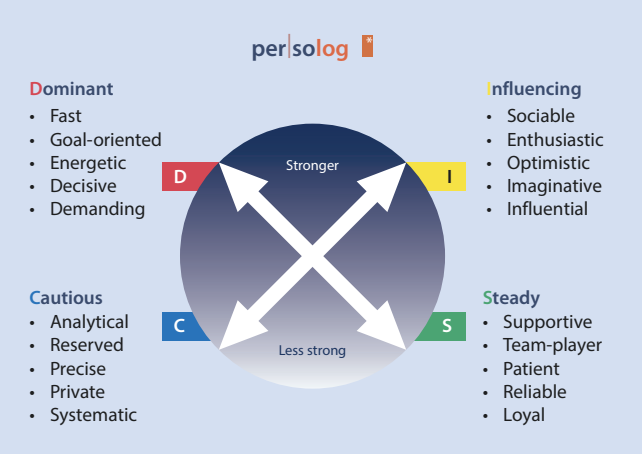

Fig. 6.1 Four behavioral styles originally described by William M. Marston in his book *Emotions of Normal People* [5] and illustrated by Persolog [6]. (Used with permission from Persolog.)

Starting in the mid-1920s, personality researchers began to develop descriptions of human personality types as they relate to personal interactions. This work was brought into focus by William M. Marston in his seminal book *The Emotions of Normal People* [5]. After being refined through further research, the description of behavioral styles has settled on terms denoted by the acronym "DISC," standing for dominant, influencing, cautious, and steady [6]. The characteristics of each behavioral style are shown in Fig. 6.1 [5, 6].

> Using skills related with human behavior in the health field is an effective way to create a stronger therapeutic relationship between practitioners and patients.

There are specific and identifiable styles of communication between practitioners and patients that can be characterized using the DISC paradigm. What follows are examples of each style of either practitioner or patient behavior. These four styles are commonly seen in healthcare settings and offer some clues toward understanding behaviors of both the patient and the practitioner:

Dominant Behavior (D) This style of patient communication is interested in receiving bottom-line information from the practitioner. These patients prefer a brief conversation and limited social interaction. They are not interested in a lot of data – just enough to hear the news and what they will have to do with the news. They may test the practitioner by asking direct questions while evaluating if the practitioner knows what they are doing. They have a need to control their environment and have a tendency to act as the authority figure. When unable to take control, they can be aggressive and demanding.

Influential Behavior (I) This type of patient seeks more communication than in the dominant type above and may want hand-holding, reassurance, and their practitioner's understanding and acceptance of their emotional state. They want to hear information in simple words and will ask a lot of questions to help them understand the diagnosis. They may want to talk at length with the practitioner and may be emotional. They don't respond well when facing a practitioner who is all business. They prefer a practitioner they consider a friend.

Steady Behavior (S) Patients with this communication style will listen and take time to digest information. They limit conversation, are cooperative, and will want to know their prognosis. Their focus when listening to the practitioner will be mainly on how their health status will impact their family. They will want to protect and remove any risk to their loved ones and want to put things in order, should their health be in danger. They do not like conflict and are congenial and thoughtful.

Conscientious Behavior (C) Patients with this style of communication focus on accuracy of the diagnosis and will review all available data shared by the practitioner. They will conduct independent research to validate the data given by the practitioner. They want the diagnostic data numbers to be very clear. If they have access to a computer during a hospitalization, they may check the information they receive from the practitioner against online sources.

For an example of two different behavioral styles and their interactions, consider a practitioner who is a dominant A-type personality, or DISC-style type D, working with a patient who has a social-interactive style type I. The practitioner will be direct and conclude the conversation in a short amount of time. The patient's expectation of how the practitioner should communicate might include asking the patient questions such as, "How are you feeling today? Have you talked to your family about your situation? Do you have any questions about what I said?" Many of these questions from the practitioner will satisfy, reduce fear, and build trust and confidence with the patient. Some practitioners naturally connect with patients. For others, informal conversation is not easy. Soft skills education will help practitioners understand numerous communication styles.

> The objective of learning to understand behavioral styles for better patient care is to increase engagement between caregivers and patients, to further build stronger relationships.

6.3 Behavioral Competency Soft Skills Improve the Practitioner-Patient Experience

Time spent in the therapeutic encounter continues to be reduced. Today, a major opportunity in healthcare presents itself through teaching behavioral competency techniques that will mitigate the patient's frustration level when the

Table 6.2 The most important behavioral competencies (soft skills)

Competencies	Some critical behaviors practitioners need to strengthen
Leadership	Remaining calm and effective in high-pressure situations Taking initiative – doing what needs to be done without being asked to do so Demonstrating high standards of ethical conduct Dealing fairly with all people Showing sensitivity and compassion for people
Teamwork	Treating coworkers with courtesy and respect Supporting decisions made by the team Putting team goals before individual goals Helping coworkers when they are having difficulty Asking coworkers about their projects and priorities
Communication	Expressing thoughts, feelings in words Explaining the reasoning behind own opinions Listening to others without interrupting Communicating in a clear, logical, and organized manner Exhibiting an open mind when hearing people's opinions
Focus on patient	Placing a high priority on improving patient service Recognizing and rewarding people who deliver excellent patient service Encouraging employees to contact and listen to patients Identifying and understanding the patient needs and service expectations Appropriately communicating with patients to keep them informed on a regular basis
Interpersonal skills	Establishing effective relationships with coworkers Showing knowledge and respect for people's responsibilities throughout the organization Establishing trust with people at all levels Taking time to establish relationships with people at all levels Demonstrating an appreciation of the value a diversity of people in the workforce

practitioner does not have enough time to listen. See Table 6.2. Using interpersonal skills adapted to human behavior is an effective way to create stronger relationships between practitioners and patients [7, 8].

Behavioral competencies are identified in terms of both hard skills and soft skills. Soft skills are frequently used in the business realm, but currently less so in medicine. Soft skills are important competencies for practitioners to have, understand, and use when caring for patients. Improving behavioral competencies (listed in Table 6.2) will improve the practitioner-patient relationship.

Using soft skills allows practitioners to consider how the patient is receiving a difficult diagnosis, for example, while simultaneously allowing the patient to understand what the medical expert is saying. If behavioral competency soft skills are not in place, the patient receiving the medical diagnosis may not be able to understand the important information the practitioner needs to deliver. Health practitioners frequently convey diagnoses to their patients using medical jargon or vocabulary that non-healthcare providers may be unfamiliar with, making it more difficult for patients to accept or process the information. If the medical practitioner does not consider how the patient is able to receive the information, then the patient can experience confusion, fear, worry, stress, and denial. The intent may be good on the part of the practitioner, but the message's impact on the patient will be ineffective.

In healthcare, practitioners would be more effective if additional educational curriculum included competencies focused on personalized patient communication.

There are definite challenges and barriers between practitioners, team members, and the patient; these challenges and barriers are, in part, communication barriers. Strengthening soft skills and enhancing communication reduces conflict and initiates cooperation and collaboration. It turns disagreement into discussion, which leads to creative solutions. Communication skills are sharpened to humanize the delivery of information to the patient and to help the patient understand the practitioner more clearly. Besides words and body language, better communication also includes allowing the patient to be heard. This reduces patient fear, resistance, and shame in the clinical setting [9–12].

The responsibility for effective communication rests with the practitioner. Focusing on meeting the needs of the patient through effective communication can help improve patient care, satisfaction, and outcomes. Enabling practitioners to learn and develop specific and critical behavioral competencies may significantly improve the level of engagement in patient interaction. In some ways, the healing process begins when patients feel they have a voice in the conversation and an audience for their story, one that listens, rather than directs, how the conversation should go.

The patient who believes their practitioner is listening to them will begin to trust and be more willing to reveal information. Information such as the possible root cause of their ailment, a trauma that could have initiated the beginning of the disease, emotional upheaval, stress they live with, fears, denial, and/or concern for their family's reaction will be shared fully. A psychologist is not necessary to uncover such background. A trained, patient-focused team can do it when it works in synergy. A term, *situational communication*, has been developed to describe this type of teamwork [12]. Please refer to the Case Study.

Case: Effective Communication to Build Strong and Trusting Patient Relationships: A Way to Personalized Patient Care

Optimal health depends on a robust practitioner–patient relationship. This relationship involves the critical need for patients and their families to have their often-unheard voices heard. Information shared in an open and safe environment contributes to the formula that will effectively change the current model of the practitioner–patient relationship. Paramount in this process is the need to examine the importance of storytelling as a means to build trust and the significance of identifying support communities when striving toward optimal health. These communities have been identified as tribes and are a rich resource and support for the patient and their families. As a new type of practitioner, it is critical to be armed with the communication resources to facilitate these trusting, healing connections.

Below is a shared story; with changes in details and variations in setting, thousands of people with similar life-altering experiences have told this type of life narrative. Important in this story is the focus on the conversation and allowing the storyteller to speak uninterrupted so as to value their experience [14, 15].

The storyteller was first exposed to a family member's serious health challenge when she was a young girl. She had a younger brother 10 years her junior who was ill from birth, and she felt compelled to help her mother care for him. He had been born with a congenital urinary disorder that was not diagnosed until he was a toddler and was eventually found to have an obstruction of the urethra, resulting in reflux with injury to the bladder and kidneys. The obstruction was surgically removed, but recurred quickly. As a result, he underwent many surgical procedures over the following years. The mother became his nurse, changing catheters, while the sister was designated as her "little helper," sterilizing the equipment and assisting in other ways. The family members were not specifically trained, but knew these interventions were necessary and critical to save the child. They did the best they could to understand the complex conversations and directions for interventions the practitioners shared, including information regarding prognosis, what treatments he required, and what to perform at home. The storyteller recalled her mother "doing everything she could possibly do to keep him alive," in addition to answering the questions about her brother's condition in a way the family could understand.

What the storyteller remembers vividly is the frustration her mother expressed in this situation, the isolation she experienced, and feelings of being incapable of providing accurate information to family and friends. She describes these feelings as "palpable." The storyteller discusses being involved throughout the remainder of her childhood until she was a young adult and no longer living at home, when she describes her support changing from direct involvement to moral support. She describes her mother providing 27 years of effective care for her brother until he died.

As the only girl in the family of four children, she had an early education in "caretaking," but believes this early education allowed her to acquire many competencies that proved to be extremely useful later in life. As the storyteller describes, "These skill sets were ingrained in me and allowed me to face one of the most challenging health crisis I never expected to deal with again. A crisis that changed my life in ways I never expected, never thought I could endure, nor survive."

By the age of 27, the storyteller was the mother of four children, all born within six years. She describes herself as a child raising children. During that time and before the development of the rubella vaccine, a rubella epidemic swept the United States. Over that short period, there were 12.5 million cases of rubella. Around 20,000 children were affected with congenital rubella syndrome (CRS), which left more than 11,000 children deaf, 3,500 blind, and 1,800 with mental retardation. There were 2,100 neonatal deaths and more than 11,000 abortions, some spontaneous because of prenatal rubella infection and others performed surgically after women were informed of the serious risks of prenatal exposure. The storyteller states 1965 as the worst year of her life and goes on to describe:

- "My one son was two years old at the time he contracted the disease (rubella). Unbeknownst to me, I was 1 ½ months pregnant. During this time, primary doctors made house calls and the doctor came to my home to treat my son. A month later, again not knowing I was pregnant, I called my doctor to inform him that I wasn't feeling good. I had a fever and felt like I was getting the flu. He suggested I take some aspirin, a warm bath, and try to get some sleep. I did exactly that, however I noticed that I had small bumps on parts of my body, so I called once again to inform him and was told that I most likely contracted rubella. After the rash had cleared, I went into the office for a blood test. It was during that visit that I found out I was pregnant. Little did I know that this event would change my life dramatically. My baby girl was born with multiple medical problems; problems that I was not aware could happen because of the rubella infection."

- "At the time of her birth, she weighed in at 3 lbs. 11 oz. and was 21 inches in length." When she reached 8 pounds, she had her first open-heart surgery at Boston Children's Hospital. At that time, neonatal care was just emerging. It was not until 1965 that the first American (neonatal) intensive care unit (NICU) was opened in New Haven, Connecticut and in 1975 the American Board of Pediatrics established sub-board certification for neonatology."

- "I had an appointment with the heart specialist to review her prognosis and prepare for her surgery. With my baby in my arms, terrified and alone, the doctor entered the room and introduced himself."

- "The doctor was all business and spoke to me in terms I didn't understand. The questions I asked were uninformed, too vague for the doctor to understand, and I was not confident enough to continue to probe. I just listened… my anxiety was at an all-time high. After about 20 minutes of listening to the doctor's information, he stood up and said his intern would be meeting with me to give me some printed information regarding my child's surgery. The surgery was scheduled for the next day. The doctor left the room, while I sat crying, holding my baby in my arms, wishing my resilient mother were with me.

- "The next person to enter the room was the intern. He introduced himself and handed me instructions and directions for the next day. I didn't hear much of what he had to say, I was still in shock at the reality of what was happening. My heart was racing, tears were flowing; I felt like a baby trying to save my child. Then, the most frightening words I ever heard came from the intern. He said, 'I'm sorry there is nothing that we can offer you to help you with your child's additional health problem.' Already confused, I said, 'What additional health problem?" He answered, 'Your child is deaf. Didn't your pediatrician inform you about this?' My reaction was filled with rage and emotion, 'You have the wrong chart. My child is NOT deaf! What kind of hospital is this? My child has a heart problem… That's all. I need to speak to the doctor!'

» "The doctor came back into the room. He tried to explain that my daughter had both health challenges, while trying to reassure me that everything would be fine. At that point, it fell on *my* deaf ears. I went into total denial. I would not accept the fact that my daughter was deaf. Even though her heart surgery was successful, I lost trust and confidence with the doctor, the hospital, and the staff. I was filled with fear for my daughter's survival. I left the hospital and drove back home in a rainstorm, with my tears flowing faster than the windshield wipers could wipe the rain away. As soon as I got home from the meeting I tried to prove to myself that my daughter was not deaf. I spent most of the rest of the day slamming cabinet doors and hitting pots together intensely watching my daughter's reaction, trying to prove that she was not deaf. I was in shock, ultimately ignorant about raising a deaf child. I had zero exposure or experience with her health challenge. The worst nightmare had just begun, and I had no way out."

The storyteller goes on to describe that 50 years later, her daughter, now a grown woman with multiple prior invasive heart procedures behind her, was facing another open-heart surgery. Due to the difficult and complex surgery she was facing, most of the extended family members were present. When the surgeon spoke to the family before entering the operating room, he was asked by the storyteller to take good care of their "little girl." She reports he replied, "I'll do my best, but this will not be easy," words not welcomed or comforting. The presurgical ritual was all too familiar for this mother as she accompanied her daughter into the OR and translated through sign language what was being communicated. Words of reassurance were signed to the daughter and received with absolute trust in her mother. Everyone in the room was supportive and kind, and the storyteller reported feeling satisfied with how events were proceeding at this point.

Although the surgery was technically a success, the storyteller reported waiting for hours not knowing if there were complications or even if her daughter had survived. Nothing from the surgeon. Finally, the family was notified that the surgery was over, led to a conference room, and anxiously waited for the surgeon to enter. When he did arrive, the storyteller reported he looked at them, did not say a word, sat down on a chair, and reviewed his paperwork. They waited until he finally said, "Oh, the surgery went well." Aside from the communication skills lacking on the part of the surgeon, the family burst into tears of relief. With each medical procedure the patient endured, she insisted the storyteller be by her side not only to interpret by signing but also to interpret the nuances of what was being communicated – or poorly communicated.

By telling her story, this storyteller was able to impart the nuanced richness of her life and life experiences and better able to project whom she is based on these experiences. If not allowed the space to tell her story, an important element of care would be lost. The practice of medicine has improved and will continue to improve, and medical practitioners are dedicated to providing best-known solutions for their patients. Patients cannot expect medical practitioners to excel in patient care when medical curriculum does not include what is currently unknown to them. Unknown curriculum subjects such as storytelling and practitioner-know-thyself training accompanied by important applicable self-assessments should be mandated in medical curriculum in order for practitioners to have the tools to be successful while providing personalized patient care.

Trust needs to be established between the medical practitioner, the patient, and the family members. Trust is inherent when communication is valued. Just as this storyteller describes, examples of poor communication can isolate patients and family members. When they are not heard, healing is not facilitated. As highlighted by this story, ineffective communication practices existed throughout the medical establishment; unfortunately, they still exist. Education to teach practitioners to hear the stories is paramount. As a new breed of practitioners, we need more focus on listening with our hearts, using better ways to acknowledge the patient's voice, and finding solutions to capture the stories, in order to realistically achieve personalized patient care.

Situational communication is a clear, concise, and focused communication strategy that maximizes the ability of a minimum amount of time to achieve successful results and effective relationships [12]. Although it may be used in personal settings, situational communication is mostly reserved for business and professional interactions, especially those that are challenging, where the points of view, interests, or preferred solutions of the communicators are different or in conflict. Leaders must be capable of planning for and executing situational communication in order to be both successful and effective. These interactions differ greatly from our mostly effortless run-of-the-mill interpersonal interactions. Situational communication represents purposeful, thoughtful engagement. In the case of situational communication, there is a planned payoff. These types of interactions are more formal, structured, and well-planned, requiring significant energy and focus [13].

In most businesses, the organization strives to help its human talent develop necessary competencies in order to be successful. In the healthcare industry, practitioners would benefit by employing the same approach. This is accomplished by adding educational curriculum that includes behavioral competencies focused on personalized patient communication with a desired effect of improved patient outcomes. Developing soft skills competencies that focus on communication skills needed by the practitioners will improve the patient's experience and make the job of the practitioner less frustrating and more rewarding.

Experts in situational communication know how to engage in robust and fruitful conversations that are tailored to the individual patient. As previously noted (Table 6.2), There are other soft skills practitioners should develop that impact the practitioner-patient relationship in addition to communication skills. All of these important skills promote a stronger trusting therapeutic relationship and improve the biological function of the human body through mind-body interactions.

Behavioral competencies should be required as part of medical curricula across all medical professions, and integrative and functional practitioners have been leading the way. When the interaction is personalized, patients can express themselves in ways that lead practitioners to understand the patient's status in a clear and concise manner. Behavioral competencies and communication skills are mandatory in any industry; however, behavioral competencies and situational communication skills will enhance the development of the therapeutic relationships that leads to successful patient outcomes.

6.4 Leading the Interdisciplinary Medical Team

There are unique competencies that all members of the medical team bring to their specific roles. One important role is leadership. Many practitioners have not been schooled in leadership competencies. However, leadership competencies are highly relevant when it comes to patient care. Members of the entire medical team (such as dieticians, physical therapists, psychologists, health coaches, pharmacists, nurses, doctors), referred to as an interdisciplinary team, need to function together in relating to a patient. The interdisciplinary team has shared leadership responsibilities, starting with understanding the principles of behavioral competency soft skills in relationship to patients.

Research states that the parts of the roles practitioners are highly competent to fill are usually roles that are personally motivating for them [13]. Excellent leaders understand that some of their roles are not self-motivating and frequently ask for feedback from the interdisciplinary team in order to gauge their own effectiveness. They seek out feedback on their leadership style. They also self-evaluate their level of effectiveness. Ineffectiveness demands leadership changes. Without the willingness to change, everything becomes static [13]. Competencies associated with corporate business are transferable throughout many industries and can be adapted to healthcare to improve patient care. Improving patient care is the ultimate outcome healthcare should strive to accomplish.

6.5 The Powerful Art of Listening: Learning to Adapt Practitioner Behaviors to Meet the Needs of the Patient

The objective of learning to understand behavioral styles is to increase engagement between caregivers and patients, ultimately building stronger relationships. Effective communication occurs when both parties have a clear understanding of their own preferred communication style. To achieve that understanding, behavioral profiling tools can help and allow the practitioner and patient to become a cohesive team. Once practitioners are trained to understand their personal behavioral style, they can quickly assess the patient's basic style, enabling both parties to better work together. Understanding the behaviors of their patients allows practitioners to change their behaviors from expecting the patient to listen and understand them, to practitioners listening and understanding the patient. More importantly, behavior assessment tools can assist interdisciplinary medical teams to understand their own preferred work behavior, so they can also learn how to adapt their behaviors to meet the needs of the patients through stronger teamwork. Utilizing assessment tools like those described below can reduce stress for the interdisciplinary team when dealing with very ill patients and challenging situations.

All of the major psychometric assessment tools in worldwide use employ the basic behaviors established by Dr. John Geier, considered the leader in human assessment science [16]. A combination of psychometric behavioral assessments (Table 6.3) can provide important data needed to properly train and prepare medical teams. Practitioners and interdisciplinary teams gain insight into their behaviors and the effect on the patient, which allows the team to be of better service. Such assessments may include emotional intelligence, DISC profile, 360-degree assessments, and performance evaluations, if appropriate. Behavioral evaluation report results are directly available to each practitioner, which opens the door for the practitioner to share results with the team to facilitate improved cohesiveness. Patients may also be assessed, and this allows the practitioner to understand his/her own behavioral style, to recognize the patient's style, and how to adapt his/her communication behavior to best address issues with the patient [18]. If medical practitioners are educated in soft skills assessments, like the ones mentioned in Table 6.2, it would enable them to recognize how individual patients choose to hear information, resulting in improved communication between the practitioner and patient. The most effective use of behavioral soft skills occurs when practitioners understand how to adapt their own behavioral style to meet the needs of the patient as discussed.

Obtaining practitioner behavioral assessments for each member of the interdisciplinary medical team enables a team-building educational process. Tools, including training modules, can teach practitioner teams how to effectively improve their communication within their medical team while understanding and respecting everyone's behavioral style. Competencies within the team are strengthened and create more concise, positive outcomes in the management of the difficult patient. In addition, for complicated patients, the combined process of tools and training is not restricted to any particular disease or diagnosis. Any medical team can benefit from data-driven assessments. These, combined with educational methodologies, should be a necessary form of education for the entire health industry.

6.6 Telling the Patient's Story

For centuries, stories have been shared through the spoken word, interpersonal conversations, diaries, and the writing of history. Storytelling has the potential to reveal emotion and psychological trauma. People remember stories. They repeat them, often linking them to their own similar experiences. No matter what the story is, if it is told, millions of people in many different languages around the world will have gone through something similar. It is that sense of connection to community that says, "I've been there; I know what that is like." Sharing stories can be an experience of enlightenment as emphasized in the Case Study.

Table 6.3 Psychometric behavioral assessments commonly used worldwide

Assessments	What the tool evaluates	Description of tools
H R Tools, Inc. ► http://HRToolsINC.com	The following tools can be located on the ► HRToolsINC.com link	See the following tools
Emotional Intelligence	Ability to characterize emotions in oneself and in others, ability to use feelings constructively and to understand and analyze emotions and solve emotional problems, ability to take responsibility for one's emotions, attaining emotional growth and maturity	The person takes the assessment and identifies what are his/her strong skills and which are the ones he/she needs to develop. Then work with a coach or participate in a training program that teaches them how to develop each skill and work on that process
DISC Profile	The DISC profile describes human behavior on the basis of four behavioral styles, dominant (D), influencing (I), steady (S), and cautious (C), and aims at a better understanding of one's own needs and those of others	There are many different programs where participants take the assessment and then work in many different training programs (also in coaching works perfectly) like teamwork, leadership, communication, interpersonal skills, and many others. The model adapts well for all these methodologies because it is based on what is my behavioral style, how I can identify other styles, and how I can adapt to them [16]
360 Assessments	This methodology consists in receiving feedback from employee's managers, peers, and direct reports. The feedback is provided by them using an online tool that ensures the confidentiality of the feedback. The questionnaire of the feedback is based on competencies and behaviors that measure those competencies or soft skills	After the 360 assessment is completed, the person receives the feedback and a consultant or coach helps him to understand it and how to work in that, as well as how to create a development plan
E4 Method	The E4 method facilitates the connection through communication and identifying teaching materials	A teaching methodology tool for practitioners to develop a standard of patient communication principles. The E4 Method was developed by Butler and Keller [17] in 1999 and is a commonly used tool

In many ways, social media holds the potential to be a healing vehicle. It provides humans an environment wherein they can tell their stories. Postings can quickly go viral; as stories are shared, experiences connect us. In this era of advanced communication technology, we have the freedom to share information and stories that instantly reach every corner of the globe.

When a patient shares their story, it helps the caregiver to understand the patient's journey and health challenges through the lens of the past and enlightens the present state of health.

As stated by Hall and colleagues, medicine is an art whose magic and creative ability have long been recognized as residing in the interpersonal aspects of patient-practitioner relationships [19]. In the healing encounter, sharing stories between practitioners and patients is one of the most important parts of the healing process. When a patient shares a story, it helps the caregiver to understand the patient's journey and health challenges through the lens of the past and enlightens the present state of health. It is critical that the practitioner understand the patient's stories so the two can build a strong connection. Much of the psychological healing process depends on this relationship. With shared experiences through storytelling, synergy and mutual trust are created. The practitioner needs to understand the patient's feelings of fear, grief, or loss, and these feelings may be mitigated if received with the type of communication the patient needs. The practitioner and patient may then connect on another level where the patient feels understood, and, in those moments of connection, the practitioner is truly serving the patient in a partnership leading to the best outcome.

To facilitate the connection through communication, teaching materials are needed. The E4 Method developed by Butler and Keller [17] is a commonly used tool for practitioners to develop a standard of patient communication principles. The E4 Method includes the following 4 Es:

- *Engagement* – skills that support development of rapport with patients
- *Empathy* – skills that help clinicians reflect concern for the patient's condition
- *Education* – skills needed for discovering and developing the patient's understanding of his/her condition
- *Enlistment* – skills that help in motivating and changing behavior

As the craft of storytelling expands, education in the field of storytelling is emerging and accessible [17]. Medical practitioners need to be educated and trained through storytelling

curriculum, which teaches understanding of the process and the uncovering of hidden meanings. Materials like the E4 Method, developed through evidence-based research, are needed to build powerful relationships and would be a beneficial addition to the medical education curriculum.

As highlighted by the E4 Method, communication between the practitioner and patient is more effective when the practitioner allows the patient to construct a timeline of their story uninterrupted. A brief conversation with the patient is often not enough and may not be satisfactory for the patient in the moment. This storytelling process has power to reveal traumas and triggers and provides a window into the current state of the patient's physical and mental health. After the patient reveals significant psychological events and stressors by sharing life's timeline, the practitioner can pinpoint important information to help in the treatment of the patient's disease. The practitioner, indicating a degree of empathy for the situation, reflects the important events back to the patient.

As a cohesive partnership develops between the practitioner and the patient, family members can be enlisted as part of the team. This will serve to educate the patient and the family about the health condition in a safe and supportive environment. Enlisting the patient and family as a team will help with motivating changes that need to be made. The team will be in sync working together toward the accomplishment of the best possible outcome. It is time for medical practitioners to reap the rewards from the soft skill of listening…listening to the stories waiting to be told, shared, understood, and accepted.

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Barriers to implementing therapeutic storytelling include significant time constraints. The burden of the current healthcare paradigm with mandated abbreviated appointment times puts practitioners in a time-crunch that is not conducive to meeting the needs for personalized patient care. Practitioners expect patients to listen intently to what they have to say in this limited time, but the infrastructure of conventional care does not afford the practitioner similar time to listen to the patient. By the act of listening with intention to the patient's story and basing decisions on the shared conversation, some measure of relief of symptoms can be expected [20]. This can have the effect of reducing symptomatic complaints, shortening the length of the disease course, improving outcomes, and, in the long-term, reducing the burden of time with the patient.

Another solution to the problem of implementing and retaining the personalization in a therapeutic encounter is to depend on the contributions of the interdisciplinary healthcare team members. With common training of each team member in the art of storytelling and listening, the entire team can be called upon to effectively help when other members are unavailable. There can be building of trust, safety, and healing by wise use of team members' time.

Perceived barriers to training may also include the belief system that the practitioner is sacrificing time and energy when faced with coursework to develop communication skills. Training must emphasize the payoff of improved patient relationships, reduction in practitioner stress, improved effectiveness of time management, and healthier outcomes for patients and their caregivers. Training should be emphasized as a method to develop the skill to listen to and appreciate the patient's story which will pay dividends by providing the needed context to the patient's situation. Practitioners need to understand that this education would enable personalized patient care with effective interventions and enhancement of their skills.

We are overdue in providing the type of training necessary to change, improve, and close the gap between mediocre communication skills and high-performance communication skills. Connecting with the patient's story is critical. If practitioners are not trained in the necessary skills to connect with patients, those stories will never be heard. Training health practitioners to become proficient in storytelling and story listening is a viable potential solution to the current healthcare crisis.

6.7 Naturally Occurring Patient Tribes: The Power of Communities

Articles and methodologies are available that build on patient communities and patient support groups [21, 22]. Naturally occurring patient tribes are forming throughout the globe, and physicians, health practitioners, and health communities are not necessarily included in them. This model of patient support is becoming a powerful new way for patients to share their specific experiences and deepen their medical knowledge.

A naturally occurring tribe can be formed anywhere, anytime, and in any location. The beginning of a tribe often occurs when patients are gathered in clinical settings while waiting for treatment. In these situations, patient and caregiver tribes begin to form. What makes patient tribes different is the conversation shared between patients with shared medical challenges. Such conversations can be highly valuable for the patient and may even be more informative than a patient having a conversation with their health practitioner.

Naturally occurring patient tribes may be useful and effective for patients because individuals dealing with similar health challenges often find support in these informal connections. There may be an unspoken acceptance to engage in difficult conversations, yet facing the difficult conversation is necessary and consoling. There is a level of trust that the tribe environment creates. The trust is based on sharing information and like experiences, such as fears, doubts, and challenges with practitioners.

Patients may seek out guidance from each other, learn tips for managing their condition, and educate one another to understand the medical terminology associated with their diagnoses. People may not feel free to ask questions of their medical team, yet have no hesitancy in asking the patients or families of patients sitting nearby. There is power in this shared experience. The tribe members are on the same journey and perhaps have learned valuable things along the way. The tribe can help each other almost like a mentor helps a mentee understand specific situations and offers solutions that may be found to be extremely effective. There are many conversations about how relationships are built, how powerful they are, and how they naturally create tribes of like minds [14, 15]. This connection to the tribe is reinforced and strengthened as the relationship blossoms.

Tribes also connect and form in other ways. In today's world of technology, shared experiences go viral, and powerful connections are achieved on an unprecedented scale never before seen. Social media is an easy-to-access "share button" that connects to the world of human experiences. This global technological connectivity vehicle allows millions of people who do not know each other the ability to communicate, share stories, reveal information, and connect both intellectually and emotionally because of the thread of shared experiences.

> We want to encourage practitioners to be involved in a holistic healing process for personalized patient care and very importantly for families who should be part of the healing process.

This global phenomenon has informed many shared stories containing private information and diverse conversations in every language. This global engagement between people is powerful and has the ability to bond strangers together to become both a tribe of like minds and extended families. Evidence has emerged in recent years that reveals how powerful relationships are [21, 22]. The relationships you have and the tribe you spend time with and relate to are more powerful than even what you eat.

6.8 Conclusion

In conclusion, we cannot expect health practitioners to have skills that they have not been taught. Some health practitioners have a level of intuitive empathy and are able to fill the gap between formal education and understanding how to excel in patient communication, interaction, behavioral styles, and skills. However, all healthcare practitioners should be given the opportunity to be trained to understand the human dynamic and the diversity of each human experience. This training will be an asset to practitioners, patients, medical teams, and organizations that employ them. Communication skills are transferable and long-lasting. They may apply to other professional settings, as well as personal relationships.

When patients need information, the practitioner must give it in a clear and supportive manner. When patients need support, the practitioner must let them know they will be there for them [23]. In order to fulfill these needs and build a more effective practitioner-patient relationship, the practitioner can learn effective listening. When using effective listening, the practitioner maximizes valuable time over the long term. Effective listening allows the dialogue between practitioner and patient to be focused, informative, and positive.

In challenging settings where there may be time constraints or an undercurrent of psychological issues, the dialogue can evolve and become more productive when the practitioner attempts to understand the needs of the patient and puts the patient first. By being sensitive about word choice learned through training sessions, practitioners can make headway toward fruitful communication and let the patient know they understand where the patient is in the moment. It is important for many patients to hear and understand this. In addition, practitioners would do well to communicate with patients' families. Family members often deal with the shock of the illness of their family member and may put their feelings aside in order to cope and manage the medical situation. This situation can be acknowledged and validated. The practitioner needs to realize the family members have their own stories and can offer important insight into the history and status of the patient. Stories reveal important information indicative of their culture, family medical history, and genetic information. Families share stories. Stories have power.

The tendency to organically form support groups or tribes in medical office waiting rooms, social media, or other social venues is an important part of patient healing that healthcare teams could tap. If practitioners can develop ways to understand their patients' tribes and reinforce information shared, positive clinical outcomes will be fostered and enhance the practitioner's effectiveness and efficiency.

The time is overdue to identify and adjust the human factors that create barriers to build strong relationships. The differences in human behaviors are vast, unique, diverse, and can be complicated. However, as human beings we strive to be understood, respected, and included. It will take a concentrated effort to work to eliminate the barriers that separate us. The solution is to first understand our own behaviors and behavioral limitations, and work to improve them. "Knowing thyself" can be daunting and frightening. It will however be enlightening.

As practitioners, taking accountability for how we behave when we communicate to patients puts the onus of responsibility where it should be – on ourselves! Honing communication skills is worth the effort. These skills will improve our own lives, as well as the lives of others. When in the driver's seat, we hold the power to make or break relationships. The reward for taking responsibility and accountability for the effective way we communicate, listen, and respond to each other is a powerful reward for all of us humans. It will unite us in our effort to change and build a powerful and healing tribe of like minds.

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