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Case Study

Effective Listening to the Patient affects the Outcome

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What does this paper contribute to the wider global clinical community?'

- Healthcare working in acute and chronic settings need to be open to new ways of delivering care to people which meet their relational needs, and take account of their biographies using narrative approaches to assessment and feedback.
- In order to commit to person-centred care, continuous assessment and feedback should be sought from older people in acute care settings.
- Essential mechanisms for effective listening and learning from patients in acute and chronic care, synthesized from this review, can contribute towards model development in implementing change in practice.

Introduction

Listening to patients is regarded as essential to the provision of individualized, person centred care that promotes dignity. Whilst dignity as a concept may elude precise definition, debate about achieving dignified care emphasizes the relevance of behaviors and the need for person-centred approaches to care delivery [1].

The act of listening extends beyond a communication skill. It requires presence, engagement and has therapeutic effect, through acknowledging the dignity and personhood of the person speaking [2].

However, although listening is valued as a comforting act in healthcare, there is a dearth of systematic research integrating it into support literature [3].

Listening is part of person-centred communication and integral to relational care, yet little is written about how to develop effectiveness in listening and responding to older patients in acute settings.

Emotional Competence [4].

Emotional competence refers to the ability to appropriately manage and express one's emotions. Emotionally competent professionals effectively deal with their emotions in interactions, without suppressing others or their emotions.

In emotionally competent environments, individuals display a mutual respect for patients and colleagues, an understanding of basic motivations, and a commitment to take responsibility, a desire to correct faulty situations, and the ability to assume full accountability for self-actions and take positive action to correct actions resulting in lack of accountability [5].

There are five key characteristics of emotional competence:[6].

Self-awareness involves knowing your emotions, reactions associated with emotional interactions, recognizing feelings as they occur, and discriminating between your feelings. Self-awareness in the health care work environment has four stages [7].

First is creating self-awareness of concepts and phenomena. This process involves health care professionals raise questions and possible answer questions using mutually respectful interactions and integrating caring behaviors towards each other and each patient. Second is developing a language that influences thinking.

Through both thoughts and dialogue, it is possible to abstract information about what one understands or does not understand. From what is expressed in language and non-verbal communication, it is hoped that one can understand and realize the power associated with behaviors expressed to patients, significant others, families, and coworkers.

Third is developing a preferred model of communication. This stage involves talking about one's feelings, assessing the impact of what one says or does in relationship to the reactions in others.

Insight makes it possible to support patients in expressing what kind of help is needed or what inner resources they possess. The final stage is reflection. Reflection requires health care professionals to reflect upon the type of care and interpersonal interactions provided.

Reflection can be very powerful and result in a better understanding of self, but it requires differentiating between feelings of guilt and strategies

to make future interactions more meaningful and positive. For example, it is important to find answers to questions such as, "Why did I snap at the patient and fail to be open-minded?" or "Why didn't I listen and integrate caring behaviors into my words and actions?" [8].

Mood management involves handling feelings so they are relevant to the current situation.

Self-motivation involves gathering your feelings and directing yourself toward a goal, despite self-doubt, inertia, and impulsiveness.

Self-motivated individuals display positive attitudes, high energy levels, enthusiasm, and overall positive role modeling behaviors.

Avery and Bashir, [9] suggested that self-motivation could be cultivated by therapeutic interpersonal interactions. For instance, a motivated peer or manager can assist staff with being inspired to have positive daily interactions, provide quality patient care, and develop staff efficiency and overall productivity.

Self-motivation is a process that can be nurtured and encouraged by interpersonal warmth, peer support, managerial support, and recognition. Respecting individual capabilities, actively listening, and cultivating new capabilities are instrumental in developing potential and increasing motivation.

Empathy is recognizing feelings in others and tuning into their verbal and nonverbal cues.

Emotional empathy allows the health care professional to respond professionally to colleagues or patients in an attempt to meet their needs. An integral part of responding professionally includes accurately synthesizing interpreted words into meaning interventions. According to many experts, emotional empathy is learned by experience and by modeling. Professionals describe this as knowing implicitly what to do with distressed colleagues or patients. The actions resulting from the emotional response or recognition of other's needs are often nonverbal, for example, a touch, a smile, or genuinely listening.

Managing relationships, the final characteristic, is handling interpersonal interactions, conflict resolution, and negotiations in a constructive manner. According to Larson [10], the perceptions of nurses, colleagues, and patients that impact how relationships are managed can vary in a number of respects.

For example, the extent to which collaboration and mutual decision making are valued, a shared definition of what constitutes adequate and appropriate interpersonal communication, the quality of interactions, and the understanding of respective areas of responsibility including patients outcomes can all vary.

To effectively manage relationships, every human to human interaction should aim at achieving positive outcomes. In order to achieve positive outcomes both active listening and emotionally competent behaviors must be exhibited.

Additionally, mutual respect for all must be displayed to avoid interpersonal conflict and ultimately negative outcomes. Lastly, managing relationships involves various skill sets of collaboration and cooperation, promoting a caring and compassionate environment, nurturing opportunities for collaboration and sharing, and displaying mutually respectful behaviors [11].

Collectively, characteristics of self-awareness, mood management, self-motivation, empathy, and managing relationships can assist health care providers in cultivating emotionally competent behaviors while instilling active listening techniques.

Other Factors

Effective listening, often referred to as active listening, is a crucial communication skill that involves fully concentrating on what is being said rather than just passively hearing the speaker's words. This skill requires conscious effort and practice, as its purpose is to understand the speaker's message deeply, including the intent and emotions behind it.

Key Components of Effective Listening

1. Concentration: Effective listening demands focus. Listeners must engage their attention fully, avoiding distractions and multitasking during conversations.
2. Understanding: The goal is to comprehend the speaker's message rather than merely hearing the words. This involves interpreting the meaning and context of what is being communicated.
3. Feedback: Providing feedback is essential to confirm understanding. This can be done through verbal acknowledgments, paraphrasing what the speaker has said, and asking clarifying questions.
4. Empathy: Effective listeners strive to understand the speaker's feelings and perspectives. This empathetic approach fosters a deeper connection and encourages open communication.

Levels of Listening

According to Stephen R. Covey, listening occurs at five different levels:

- Ignoring: No attention is paid to the speaker.
- Pretend Listening: The listener appears to be engaged but is not truly paying attention.
- Selective Listening: The listener focuses only on parts of the conversation that interest them.
- Attentive Listening: The listener actively pays attention and absorbs the information.
- Empathetic Listening: The listener seeks to understand the speaker's emotions and intent behind the message.

Techniques for Effective Listening

To enhance listening skills, consider the following techniques:

- Maintain Eye Contact: This shows the speaker that you are engaged and interested in what they are saying.
- Use Non-Verbal Cues: Nodding and appropriate facial expressions can indicate that you are listening attentively.
- Paraphrase: Restate what the speaker has said in your own words to confirm understanding.
- Ask Open-Ended Questions: This encourages the speaker to elaborate and share more information.

- Avoid Interrupting: Allow the speaker to finish their thoughts before responding, which demonstrates respect and patience.
- Reflect Emotions: Acknowledge the speaker's feelings by mirroring their emotional tone and responding appropriately.

Importance of Effective Listening

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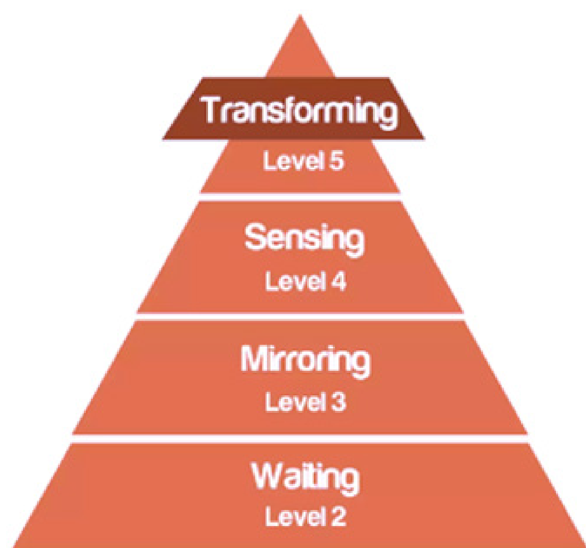

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Contextual Framework

Effective listening is vital in various contexts, including leadership and team dynamics. It fosters trust, reduces conflict, and enhances collaboration. Research indicates that effective listening can significantly impact leadership effectiveness, as it helps leaders understand their team members better and respond to their needs appropriately. In summary, effective listening is a multifaceted skill that requires practice and dedication. By employing techniques such as active engagement, empathetic understanding, and constructive feedback, individuals can improve their listening abilities and enhance their overall communication effectiveness.

Case Studies

Below are three case studies that are born from the principle outlined above.

Each represents the complexity of the syndromes involving more than one organ system with multiple interconnecting symptoms. The importance of listening and empathy are clarified as the relationship evolved and more was revealed in the therapeutic space of trust.

Case Study 1

Ilze

A 96 year old woman was referred to me having been brought to Indianapolis from South Carolina by her daughter because she was doing so poorly. She had been seen by multiple specialists for her spinal pain however they felt there was nothing more they could do for her.

When we met she was clearly in great discomfort and depressed about her medical condition with “nothing to live for” and even suicidal ideation. Her daughter provided me with voluminous records as well as imaging studies. A number of sequential MRI’s X-rays and CAT scans going back years showed age expected degenerative changes with no significant stenosis or cord pressure.

Examination revealed some peripheral neuropathic change with areflexia distal weakness and ataxia but little evidence for radiculopathy. There was hip and knee joint degenerative findings.

The electrodiagnostic studies showed typical distal denervation. Denervation was found in chronic lumbar roots with no acute changes.

We were dealing with severe chronic back and hip pain in a 90 year old consistent previous examiners.

On meeting her I noticed a hint of a German accent. So I said wilcommen

in German and her eyes just lit up. I asked her about her story. She got out of Germany after *Kristallnacht* since someone sponsored her in America with an affidavit.

Here was a real classy Viennese lady, very precise, very put together at 96, clearly with middle European values (no self-indulgence or pretension) which I needed to know. It was critical I intuited she has deep distrust American doctors and in addition she felt frustrated due to the run around, and was depressed about the pain to the point that her daughter had to relocate and move in to care for her, a professional woman who had to change her life and career because she was so desperate to take care of her mother.

In taking the history it was clear that this was not her first cycle of pain. She had shingles in the past, sciatica, lumbar disc disease and chronic joint arthritis, which was terribly painful and also in the same area of the low back radiating to the front and was really disabled by that.

Something had happened when she came to America alone as a 17 year old that was clear to me was traumatic and that when I said you don't have to talk about it I didn't push it that first visit but I saw her clearly didn't want to being reluctant and very private person.

On the second visit however, we were developing a rapport. I told her about my father in the *kindertranzport* and we just started talking about everything else but the pain. Listening to her intently how she lost her family and the deep psychic wounds. I spoke about my father …I talked about his guilt and silence while growing up, and as she listened and we were developing a rapport.

Now she volunteered that there was trauma when she came here as a young person. So when I am listening to this story about this person, I am considering her cultural and historical background as much as I am taking the history that this is not the first episode of severe pain.

My intuition is that you can have similar patients with the identical MRI proven herniated discs with the same clinical nerve pain however, depending on the cultural background, the socio-economic background, the religious and spiritual background, the outcomes of treatment will be different . Why? Because we have ignored the intangible effects of the pain on the human being which means the human experience of suffering and the human experience of anguish which differs in each person.

So I discussed with her the concept that the way she is experiencing her pain is as important as the pain itself, explaining there is physiological pain and then there is the emotional pain of how you experience that physical pain, and there is the human dimension of pain and suffering which includes the epigenetic history of her parents and their loss, her coming to this country and the trauma as a single girl alone.

She was smart enough to understand but said "I need help right now". So I prescribed short term opioids to relieve her pain and allow her to sleep. On the following visit her daughter "Oh my god she is actually sleeping through the night" but during the day every time she's bending down or standing up the pain is much worse and then I said so what I would like to do maybe is to consider a sacroiliac joint injection to which she agreed. The injection relieved much of the hip and SI joint pain to the point we tapered he opiates.

I believe that as much of pain was relieved because of the physician patient connection, the cultural and social ties and intangible spiritual connection. It is only when I was able to share my pain as a child of a survivor myself and open to her my own vulnerability did the interaction shift and the healing begin.

Her daughter's analysis

Thank you again for all the help you have been giving my mother, she has improved so much under your care.

We were both blessed the day I called your office and you miraculously answered the phone!

My mother is a 96 year old woman who beginning in the late 80's early 90's she had multiple surgeries for chronic pain in her hips and legs:

She has had 4 surgeries following a hip replacement on her left leg.

The first year her hip popped out of place 3 times and it was put back in before a second operation. I believe it was because she was born knock-kneed and pigeon toed so could didn't use the prosthetic correctly. The surgeon at the Hospital for Special Surgery in New York put in a restraining ring, but that didn't hold it in place. I don't recall what 3rd and 4th surgeries were on that hip, but I do remember during physical therapy after the 4th surgery she was told never to lift the restrictions of bending only to 90 degrees and no more. It didn't come out after that.

Anterior surgery was performed for the right hip. The pain, recovery and healing was much faster than posterior surgery. In fact, after that she told everyone she knew to opt for the anterior method if the ever needed to have hip replacement surgery.

Either in the beginning of the left and right hip surgeries (or after - I can't recall) she had double knee replacements. She told the surgeon at the same hospital that she wanted to have them done at the simultaneously. From what I understand that isn't often done, but she said that she heard that knee surgery recovery was worse than hip surgery and she reasoned that if she did one, she might never have the second one done. I remember being with her the first time she rose and walked on the two new knees; it was terrifying and very painful. She soldiered through and managed to walk normally until she had to heave a redo on the left knee.

Beyond the hip and knee problems and being riddled with arthritis, she has suffered tremendously from sciatica pain. While still living in NY for about a 3 year period she tried everything to alleviate the pain. It was completely debilitating and would seem to attack her for no particular reason. She couldn't see a pattern. One day it was standing, the next walking, then sitting, then lying down. She tried so many different pain medications, guided injections, nothing even touched it. Then she saw a pain management doctor in Illinois who told her she needed surgery. She arranged for a laminectomy as soon as she got back to NY and that was an enormous help! For over 10 years that pain was held at bay!

She arrived in Indiana in June of 2021. Left the one home, the few friends still alive or living in the community, and life she knew for over 65 years. Shortly after her arrival the sciatica came back with a vengeance! She couldn't lie down which meant she couldn't sleep. Sitting was miserable. Walking was the only thing that gave her relief, but that was unsustainable especially at night. She would literally pace the floors and finally exhausted lay on her belly and cry herself to sleep.

Her primary doctor referred her to a sports medicine/pain management doctor where she had several injections which did not help at all. We purchased a lift chair which helped her to get some rest, but it did not get to the root of her problem or offer enough relief to have a quality life. She became depressed and asked for medication to help with that as well. It was a difficult adjustment on so many levels.

My mother is a survivor. She not only has been able to deal with physical pain, but she has also dealt with emotional and traumatic pain as a child. At

the age of 10 she was sent on the Kinder Transport train to a boarding school in England in order to get out of Austria. She didn't know if she would ever see her parents again. She learned to compartmentalize things early, but this pain was something all consuming.

The day before another injection was scheduled, I found Dr Ungar, a specialist who was willing to see her right away. I was impressed with the wholistic approach to her treatment at this clinic. Her doctor scheduled her for a guided injection but before that, the very first day she was given a back brace to stabilize her spine and confine her movements, a TENS Unit (was never given that before) and was told to schedule deep tissue massages two – three times per week in order to target surrounding supportive muscles.

She was also thankfully prescribed a pain medication that no one else was willing to give her. She was closely monitored with urine tests at every visit to be sure she was not overusing or taking unnecessary risks. We knew she could handle the stronger medicine from her experience with them in the past. Because of bleeding ulcers, she cannot take NSAIDs. Tylenol just wasn't helping the pain at all and it was an adding a risk to damaging her liver. A narcotic was what she sometimes needed and it really helped in the beginning.

The back brace wearing didn't last long. The Tens Unit did give her some relief; she allowed me to put it on her when she felt some pain beginning to brew. The massages, which she never indulged herself in before, would help at the time, but then she said they wore off quickly.

However I do believe that the consistency of going on a regular basis really did make a big difference! There have been times we weren't able to keep that up, but for the most part I still bring her to a massage therapist on a regular basis and it continues to help. She doesn't take much pain medication anymore. Only takes it if the pain is coming on a consistent basis.

As a caregiver I saw the most improvement when several modalities were used together in approaching her condition. I wish she would be willing to address her diet; eat less inflammatory foods, and introduce more anti-inflammatory ones, but that might be asking too much of a 96 year old whose food choices are one of her only pleasures left in life.

I'm very grateful that she can get much needed sleep and get around safely with a walker now. I know what we could be dealing with at this point, and I can't ask for more than that.

If you mean her ability to tolerate pain from an emotional perspective I will think about how to put that in writing.

Compartmentalizing her emotions has been a life-learned skill. Do you find that to be true with people who lived through war experiences? The Holocaust in particular? Of course, she didn't suffer like those who were in the camps, so that played a huge role I think. She carried survivor guilt with her always. I think when the Holocaust deniers were speaking out so loudly she began to speak out as a witness to what happened and that opened a little bit of the box she stuffed it all into; she wrote her memoirs for her grandchildren, she signed up to work as a docent in a local Holocaust museum in Rockland County, NY. Those outward actions were good for society and her.

When we traveled back to Vienna together in 2008 by invitation of the Jewish Welcome Society, and she met many other survivors, oh my! That opened a huge box! Especially being back in her old neighborhood, walking the streets where it all happened. I'm so grateful to have experienced that with her. Exceptionally healing to hear Kol Nidre in the square where she saw Hitler exactly to the day 70 years earlier! We "happened" to be there on the anniversary of that day, A God thing to be sure! She didn't see it that way, BUT I Know it was!

Living here, in our home has softened her heart even more. I've seen my mother cry multiple times in the 3 years she's been with us, not just from pain, but from emotions which is something very new to me, She's more vulnerable, I think actually more herself. In the past 3 years, we've become more alike. She always wondered where I came from because we were so different. I wear my heart on my sleeve, she always kept it hidden, guarded… for example, she'd be very upset if she knew I was telling you any of this, not because of you, she doesn't want to be exposed in any way which is understandable, but sad.

Case 2
Case Study Veteran KW

K.W, a 39 year old Army veteran, African American, attractive and smart mother of 3 young children. W lived in homeless shelter in Lafayette.

W. had come back from serving in Iraq. She had subsequently struggled with chronic fibromyalgic pain, sleeplessness, night terrors, and a significant inability to maintain normal and sustainable relationships.

She was isolated, paranoid, on edge, aggressive, and incapable of caring for and then providing for her three young children.

Her mother took her children while W fell deeper into incapacitation. Depression and a combination of anti-depressant drugs and anti-psychotic drugs prescribed to her by the VA.

KW was then unable to continue to commit to her work schedule due to her suffering chronic fibromyalgic pain and soon was reduced to a lethargy she claims was as a result of the medicine she was taking and the lack of sleep.

KW had suffered a personal loss, the death of her cousin, that triggered her PTSD memories. Soon she could not function at work and was referred to us for a second opinion from the VA.

Treating this VET allowed me to share stories of abuse in my own regiment and develop a rapport. Death, loss family trauma and poverty marked an existential difference between the doctor's and patient's life experience.

Nevertheless it was vital for me to understand her economic woes and to what extent her poverty is affected by her inability to find resources in both time and medical expense to control her physiological pain as well as psychological trauma. Only by understanding these social and economic factors could I even attempt to unpack her pain and the multivalent influences and aggravations of her experience of her fibromyalgia.

Treatment plan included both the medical treatment of her physiological pain as well as finding her resources to manage her social and economic woes.

Writing to the VA board and supporting her (*the nexus letter*) increase in percentage disability plus my testifying on her behalf before the social security administrative law judge allowed her to receive a stipend, double what she presented at first to our clinic. These acts took time and effort but significantly lowered her pain threshold in the course of the next few months.

The role of the physician is well beyond the prescription of medicine or interventional pain strategies. It requires a listening to the extra-medical aspects surrounding her presenting complaints with a large heart.

It requires a sense of humility and compassion for more than just the presenting complaint and the desire to "fix" it.

Case History #3
The "Rebbetzin"

A 70 year old prominent clergy woman presented to me with a history of parkinsonism progressively getting worse, with ataxia rigidity and specifically tremors in right upper extremity.

She had seen three other neurologists for the problem and was receiving the appropriate medication with little benefit. Her tremors interfered with her activities of daily life thus she could no longer bring utensils to her mouth to feed herself and had become home bound because of the embarrassment of being seen in public.

Upon examination she had the symptoms and signs of Idiopathic Parkinsonism with tremors being the main component 10Hz tremor affecting her dominant side especially the right arm. She was ataxic and need a quad cane to ambulate.

I reviewed her MRI/CT and EEG studies as well as other ancillary tests and concurred with the diagnosis.

I then felt she was comfortable enough to discuss her life and her experience of the disease and the social embarrassment it caused her.

On closer questioning of her social history it turns out she was deeply depressed even suicidal ideation was due to her 10 children having left home to start their own families and although they visited her she felt useless. I then asked her if she had any hobbies and she volunteered that prior to marriage she was a sculptress but since having a family and children she had no time and let it go.

After 30 years she suspected she might not rediscover her old skills however I tried to convince her that her depression and feeling useless might be lessened with a return to this creativity.

She agreed and returned to me 6 weeks later.

She had taken up sculpting and her mood was improved. The most dramatic feature was a lessening of the tremors (despite being on the same dosage of medicine).

Six months later she was still holding her own and doing well with no further deterioration in tremors or symptoms.

I learned a number of lessons from this case.

1. The suicidal ideation and depression which was usually part of the syndrome, and organically based improved with treatment strategy.
2. Despite the objective testing confirming the diagnosis any improvement in her tremors was unpredictable given the medications and the ongoing progressive nature of the disease hitherto.
3. Here was a disease that was in the neurological sphere of disorders with objective evidence in the brain of organic pathology yet her return to her vocation caused a significant subsiding of her tremors whereas prior she could not even feed herself.
4. Was it possible that the split between the mind and the brain, between organic disease ad "psycho-somatic" actor networks reflections of disease was not so clearly demarcated and that even well documented hard wired neurological diseases had components that were influenced by intangible forces.

Conclusion

The current standard way in making diagnoses is to look only for clusters of biological markers that were taught in medical training that implied significant points of information to make a diagnosis and to ignore the rest as filler. Protocols for specific diagnoses are specific in terms of the correct history needed and the student becomes a listener restricted to trained models in each category of diagnosis.

Our model differs since it privileges all information patient wishes to reveal and resists the filtering effect of learned behaviors.

The technology of medicine forces the doctor to streamline the exam and differential diagnosis to fit the categories demanded by the gatekeepers who will authorize the testing like CT MRI or angiogram based on the specificity of the diagnosis for all sorts of reasons including informing the radiologist what to look for, pass the criteria set by the payors and provide a uniform system of statistical analysis for measuring metadata.

This fails to explain many of the disorders that defy either analysis using histological methods or genetic markers. After the entire technology of diagnostic methods used there remain many diseases and syndrome refractory to easy diagnosis nor management.

We are suggesting a different behavioral ecology where an openness and sensitivity to medical care begins with the patient and a humble listening with a new ear to the complaints in ever widening circles of relevance omitting no item because it does not meet the usual classical medical diagnostic paradigm.

These case reports demonstrate, if only anecdotally, the importance of close and empathetic listening that opens up evidence of the human experience of pain and suffering and the anguish that surrounds the illness. It also allows the listener privy to behavioral actor networks that do not fit into the conventional history taking needed for classical diagnostic categories. It is precisely the syndromes that defy histological, genetic or imaging markers that are better informed by these intangible pieces of the puzzle.
Once rapport is made the patient reveals the biography of the illness in ever greater and widening circles allowing the listener to glean pearls that

will form an alternative network and new diagnostic picture most likely without a label or ICD10 diagnostic code attached.

A clinic designed to provide a healing space where active intent listening takes place then becomes the crucible where new possibilities unconstrained by the current actor networks that impose themselves and restrict such new paradigms to operate, will flourish.

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