

## **“Look, Listen and Feel” a new twist in our communication process**

*Fatimah Lateef*

### **Introduction**

Communication, the giving and receiving of information, has evolved over the years. From face to face communication, ‘snail mail’ and traditional land line telephones, we have now moved on to mobile phones, short message service (SMS), multimedia message service (MMS), teleconferencing, e-mail and other internet-based communications. Despite technology making communication faster and easier, many consider these new modalities to be less personal, with some loss of the human touch and rapport present earlier.

In healthcare, paper and written records too are now being replaced by electronic and voice generated records. Patients’ medical history and information are now available at the click of a button. Does this mean doctors and healthcare staff will have less direct communication with patients?

Poor and inadequate communication represents one of the biggest sources of complaints from patients. Miscommunication can lead to misunderstanding which in turn can bring about liabilities for the healthcare fraternity. How do we measure up to the more informed and discerning patients, who have higher expectations, that we encounter in our practice today?

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Correspondence: Fatimah Lateef,  
MBBS, FRCS (Edin)(A & E), FAMS (Em Med)  
Senior Consultant, Director of Undergraduate  
Training and Education, Department of  
Emergency Medicine, Singapore General  
Hospital, Outram Road, Singapore 169608  
Tel: 65 63214972, 65 63213558 Fax: 65 63214873

Email: fatimah.abd.lateef@sgh.com.sg

### **Concept of “Look, Listen and Feel”**

“Look, Listen, Feel” (LLF) is a commonly used and universally known phrase among the medical and nursing fraternity, as it is utilized in the teaching of Basic Cardiac Life Support (BCLS) or Cardiopulmonary Resuscitation (CPR) (American Health Association, 2005), the knowledge of which is a requisite for all practicing staff to know. “Look” refers to the action of looking at the chest for movements. “Listen” is the action of putting one’s ears and cheek, close to the victim’s face area to assess sounds of air movements, whilst “Feel” is the action of feeling for the respiratory air movements over one’s cheek.

Using this phrase, I have developed a new concept to be used in doctor-patient and healthcare communications. It can indeed serve as a memory jerk as the phrase is universally familiar to many.

### **“Look”**

Many of us, in our hectic schedules, “look” but do not see. “Look” means to observe with care and objectivity, so as not to miss any obvious signs, nuances and clues the patients are giving out. Our powers of observation, when put to use, will help us act appropriately and respond accordingly to our patients’ physical and psychological states. Characteristics such as anxiety, discomfort, distress, shyness, aggression, drowsiness or agitation, among others, can be observed. To be able to “look” well, we must be familiar with body language. This becomes a two way process: the body language that we, as healthcare personnel portray, and also observation of the body language of our patients.

Body language can make or break an image and this is indeed true in healthcare providers, who receive and send out non verbal messages all the time. If we do not make a conscious effort with this, we may miss out many of the clues we get during our communications with our patients. Body language is a powerful communicator. A lot of information is obtained from facial expressions, tone and control of voice, hand gestures, presence, absence or lack of eye contact and posture. It would be useful for doctors to make a special effort at

recognizing some of these, as it can make them better communicators and certainly better doctors as well. Besides, if we become more conscious of these non verbal cues from our patients, we would also pay more attention to our own body language. Warm, comfortable gestures, leaning forward to show care, concern and interest, nodding to acknowledge, walking with erect and energized posture are all important for a doctor. Patients will decide on your interest in them, level of trustworthiness and professionalism from your non verbal cues (Stewart et al., 1995). Your tone, pitch, volume, and pace of speaking is said to be proportional to your level of believability. Pausing can help us emphasize a point, although many of us, with our hectic schedules, rush through our conversations with our patients. Silence too plays an important role and we must all learn to be comfortable with it in our communication process (Stewart, et al. 1995; Mateoul et al., 1995).

John Allen Paulus, a professor of mathematics at Temple University, Philadelphia, USA in his book, *A Mathematician Plays the Market*, explained why smart people misread signs of the market (Paulus, 2003). One reason is confirmation bias, in which we see only the good stuff. Similarly in medicine, we may only see the signs and tests' results that support our perceived diagnosis, ignoring those that do not.

#### **"Listen"**

Listening is a crucial part of good and effective communications. Often we ask questions and expect certain answers from our patients, and we rush through and never really listen to their answers. In our conversation and history taking, we must listen for the 'unspoken words'. This is again very similar to being aware of non verbal cues which were discussed earlier. If we were better listeners, perhaps, all the clues will help us make more accurate and spot-on diagnoses. After all, making an accurate diagnosis is a creative process and not only an application of book knowledge. We would need to get all the possible clues to assist us solve the problem and get the diagnosis, as stated by Rheumatologist, Dr. David Podell, "Medicine is all about solving the mystery. Sure you can do it for the patient, but it's also the most powerful pleasure in medicine." Doctors must hear the stories of their patients in their own words. They must learn to respect and take seriously a mother's theory of what she thinks her child has.

#### **"Feel"**

Feeling is all about being able to empathize with the patient. Empathy refers to the sharing of the emotional state of the other person. It enables us to look through the eyes of our patients. It is different from sympathy, where there is usually less emotional connection. Empathy is more

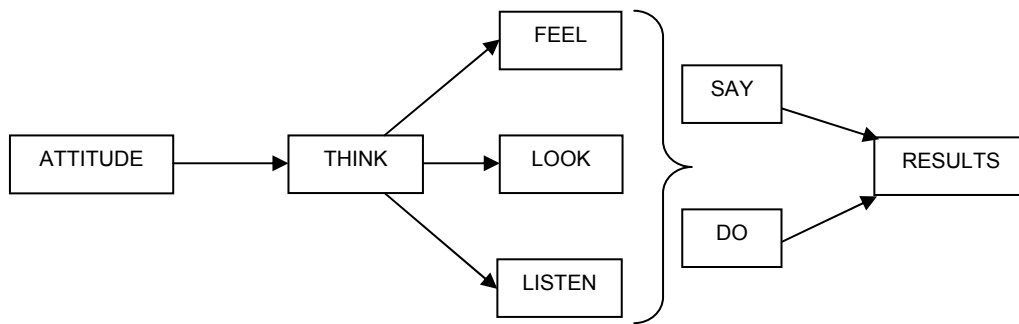
effective when it is offered as opposed to when it is asked for by a patient. When a doctor can develop the ability to empathize and apply it broadly, it will become one of the most profound ways to connect with any patient. While empathizing, one must avoid categorizing, passing quick judgments or blocking other messages. Empathy will continue to develop in us if we develop our good, active listening skills and the ability to do self-reflection. In today's world of rapid changes and high technology, where time is considered precious, many would view empathy as a 'soft and fluffy' word. It is an essential part of the doctor-patient relationship which we cannot do without. It is up to us to train the next generation of doctors and share with them the power of empathy and 'feeling'. Doctors are only humans and have their own 'feelings' on certain issues which can be colored by their values, culture, background and upbringing. Thus, it may take some time and experience to be able to 'feel' beyond a particular stereotype. How a doctor feels about a patient can have a major effect on the care provided to that patient. Certain characteristics can form associations in our minds just as stated by Jerome Groopman (2008), 'Patients and their loved ones swim together with their physicians in a sea of feelings. Each needs to keep an eye on a neutral shore where flags are planted to warn of perilous emotional bouts'.

#### **Attitude and the learning cycle**

What we do with the LLF concept can be tailored to fit our individual practice. What we do with it has a lot to do with our attitude. LLF can affect what we say and do, which in turn affects the outcomes and results. Attitude as we know, affects our thinking process (Figure 1). The concept can be incorporated into communications training program. Role playing which is an effective mode of training and learning can be very effective in illustrating the concept and its application. The learning cycle comprises of the following phases:

- a. Exploration: of the concept of LLF through lectures, demonstration and discussion. Self-trial or a trial on a few known colleagues can also be carried out as a test.
- b. Concept introduction: introduce the concept with simple ideas and explanation. How and in what context the idea is 'sold' to others is crucial.
- c. Concept application: this involves the application of new knowledge and information in our work and clinical context. There will be fine tuning based on feedback from the end-point users. Evaluation is an important step.

**Figure 1: The power of attitude on LLF**



It certainly pays to focus time and energy on communications as we know today that good and effective patient-doctor communication is one of the key determinants of patient related outcomes in medicine (Zollman, 1990; Steffe, 1983).

### Conclusions

Using LLF in our day to day communications with patients should become second nature. "Look" will remind us to seek and make observations through the 'widest lens' possible. We must "listen", not just to what is spoken but also the unspoken clues our patients give out as we learn to "feel" how they feel with more sincere passion. The LLF framework can be used to promote great service. It can be readily remembered by healthcare providers and at the same time make the patients feel they have a special edge in their receipt of care, just as Jerome Groopman (2008) puts it in his book, 'How Doctors Think', "we need to question and listen and observe and then learn to think differently, especially in cases where symptoms persist despite multidisciplinary consultation".

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