

Healing Skills for Medical Practice

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It is well recognized that physicians' relationships with their patients can have healing effects, but the skills in this area of medical practice are understudied. This article reports on research designed to identify a core set of healing skills. The authors interviewed 50 practitioners, who were identified by their peers as "healers," representing both allopathic and complementary medicine and alternative medicine. Interviews were tape-recorded, transcribed, made anonymous, and analyzed independently, and differences were reconciled by discussion. Eight skills emerged as pivotal from the

transcripts of these interviews: do the little things; take time; be open and listen; find something to like, to love; remove barriers; let the patient explain; share authority; and be committed. Mastery of these skills would provide enduring improvements in patient care and reaffirm medicine's calling as a healing profession.

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We thought we could cure everything, but it turns out we can only cure a small amount of human suffering. The rest of it needs to be healed.

—Rachel Naomi Remen

At the center of medical ethics is the healing relationship.

—Edmund D. Pellegrino

All physicians recognize that their relationships with patients can have healing effects. Compassionate, trusting relationships with patients are the chief delivery vehicle for the scientific interventions of modern medicine. Clinicians are concerned daily with convincing people to undergo physical examinations; accept probes into their private lives; endure diagnostic tests; or take medications that are inconvenient, sometimes painful, and occasionally incur risk. Relational skills are fundamental to success in these persuasive endeavors, and relationships themselves have potential therapeutic value—it is described in scientific terms as the "placebo effect" (1) or the "meaning response" (2), as well as in ethical terms, as Pellegrino argues (3). In addition, relationships with patients are a large part of the intrinsic rewards of medical practice.

Despite this recognition, relational skills are rarely studied systematically and are often consigned to the unscientific and mystified "art" of medicine. Although there are numerous books on interviewing (4–6) and studies of physician–patient conversations (7), we know of very few empirical studies of how physicians build relationships that have healing potential.

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INTERVIEWS WITH EXPERT HEALERS

We interviewed 50 practitioners from 3 states who were regarded by their professional peers as especially good at establishing and sustaining excellent patient relationships. Practitioners included 40 academic and community physicians across a wide range of specialties and 10 non-MD practitioners in complementary and alternative medicine. Interviewees ranged in age from mid-30s to late 70s, and 50% of participants were women. We conducted face-to-face, semistructured interviews and made audio recordings of the interviews anonymous. We then independently analyzed transcripts for core themes and content and reconciled any disagreements in our analysis through discussion. The institutional review board at Vanderbilt University Medical Center approved the study, and expert practitioners gave informed consent.

EIGHT THEMES

In response to the basic questions of the interviews ("How do you go about establishing and maintaining healing relationships with your patients? What concrete things do you do to bring this about?"), 8 fundamental themes emerged (Table).

1. Do the Little Things

Small courtesies and congenial manners, such as smiling, shaking hands, acknowledging others in the room, and making eye contact, often turn out to be highly significant, especially at the beginning of a relationship.

One of the things that I routinely do is, when I enter the patient's room, I try to make eye contact and to shake the patient's hand. I will often acknowledge anyone else that they have in the room with them, their significant others. So there are just certain obvious social gestures that are common in any new relationship that I try to establish right away. (Interview 21)

At initial meetings, a small community is forming very quickly and under unusual circumstances. The practitioner has enormous power to set the tone and direction for this little community in the first encounter.

If someone feels connected, then you're miles ahead in terms of being able to affect some sort of positive results or impact on the patient, and so it's really establishing a positive and unique relationship where the patient remembers you. Touch is extremely important, so walking in and shaking hands—and a hand on the shoulder. Those sorts of things are very, very important. (Interview 5)

2. Take Time and Listen

Beginnings that are courteous may show themselves to have been mere formalities unless openings are followed by genuine presence. Patients typically wonder, “Will the doctor listen to me?” A practitioner’s willingness to be still and quiet demonstrates to the patient that there is space.

So my first meeting is to try to get acquainted, and what I know is that it takes time. I may have a thousand things going, but I need to sit down and try to look relaxed. I might even take off my coat, and try to give them body language that [says] “I have time for you.” (Interview 19)

Taking time makes it possible to listen with care to the patients’ answers to practitioners’ questions.

I start teaching in the first encounter, but I spend a lot of time listening to the answers to the questions that I ask, and then I try to let some silence take place, especially in people who are very concerned, so that they can tell me what they’re concerned about. (Interview 8)

An important part of listening is listening for stories—for the narratives that give coherence to patients’ lives.

I found out early on that being able to listen to their life story connected me better with that child and that family, and then we had a relationship. (Interview 3)

Listening is the most important thing, I believe. Asking about them, not just about their disease. Letting them tell their own story without too many interruptions. Caring about the aspects of that story. (Interview 31)

Through listening and caring about patients’ stories, physicians can sometimes reinterpret key parts of these narratives. Stories of suffering can become stories of healing (8, 9).

3. Be Open

Patients bring their wounds, which Pellegrino (3) called their “damaged humanity,” to the practitioner. It takes courage on the part of the practitioner to be willing to be open to this vulnerability, patient after patient. Yet, our informants argue that it is such willingness and courage that makes healing possible.

Table. Eight Practitioner Skills That Promote Healing Relationships

Do the little things

- Introduce yourself and everyone on the team
- Greet everybody in the room
- Shake hands, smile, sit down, make eye contact
- Give your undivided attention
- Be human, be personable

Take time and listen

- Be still
- Be quiet
- Be interested
- Be present

Be open

- Be vulnerable
- Be brave
- Face the pain
- Look for the unspoken

Find something to like, to love

- Take the risk
- Stretch yourself and your world
- Think of your family

Remove barriers

- Practice humility
- Pay attention to power and its differentials
- Create bridges
- Be safe and make welcoming spaces

Let the patient explain

- Listen for what and how they understand
- Listen for the fear and for the anger
- Listen for expectations and for hopes

Share authority

- Offer guidance
- Get permission to take the lead
- Support patients’ efforts to heal themselves
- Be confident

Be committed and trustworthy

- Do not abandon
- Invest in trust
- Be faithful
- Be thankful

You have to be honest. You might be able to help a lot of times—it depends, but listen to his story. You listen for the wound and you let them know that you have wounds. You are not perfect. (Interview 13)

Part of why this makes healing possible is that when the practitioner models such willingness and courage, the patient has permission to follow suit and offer the same. In this way, immense power is generated.

You know, I might get tearful, or I might get upset, and so I think a lot of physicians, at that point, pull back, become more clinical, and move through it, but if you stretch a little bit, and you allow yourself to feel those emotions, it helps the patient tremendously. It actually is very rewarding, as much as it’s difficult. (Interview 22)

4. Find Something to Like, to Love

“Love” here is not so much an emotion as it is a quality of “heart and soul,” and it manifests most authentically and most powerfully in compassion and understanding. Seeking in every patient a quality, an achievement, or even just a mannerism that can be appreciated or admired mobilizes a healing capacity in caregivers (10, 11). This was a strong theme from our interviews. Yet this compassionate demeanor cannot be a matter of rote behaviors or gimmicks—it must be based in something real.

I took a class with a famous psychiatrist who taught techniques of patient conversation, including recommendations to “lean forward” and to “sit on the front edge of your chair.” I asked: “Wouldn’t it be better to just be interested in your patients?” (Interview 26)

For some practitioners, it is useful to imagine the patient as being like their parent or spouse or their child or grandchild, depending on the age and sex of the patient. Once the caregiver feels empathy and opens to compassion, another realm of care becomes available.

I have a heart and soul which I can offer them, which is the way of bringing them some love. Love is a tough word to talk about when you are talking about doctor and patient relationships. Do you love your patients? I think you have to. Some people don’t want to say that they do, but I think to really get to the point of healing you have to love. You have to be compassionate and understanding and willing to walk the wounded path with them. (Interview 13)

One practitioner spoke for many others we interviewed:

We’re in it for the moment where there’s that double heart open connection of love and truth. It makes my practice doable. (Interview 43)

5. Remove Barriers

Our expert practitioners said that they seek to remove as many barriers to a genuine person-to-person encounter as possible. Barriers can be of many sorts: Some are physical objects, others are attitudes.

I never have anything between me and the patient. I’ve always had my desk up against the wall. (Interview 8)

Removing attitudinal barriers often involves an appreciation of power differentials between physician and patient and an element of humility.

I’m not too good to open a door and roll a patient back into the room, and I’m not too proud to wipe the snot off a crying mother, or empty a trash basket . . . or to do any of those things that the lowest-ranked employee of the hospital does. (Interview 20)

I like to have them understand that I am a human being, that I am not a god. I am a physician. (Interview 13)

6. Let the Patient Explain

Our informants insisted that patients are the best source of information on their condition, and that an essential part of healing is allowing patients’ understanding of their illness to be spoken and received. This, in turn, provides the opportunity for a reinterpretation, which itself is often an essential part of healing. Open-ended questions seem particularly effective.

A good way to get the patient started is just asking them what they understand about what’s going on so far. And that’s a very broad opening; it allows them to either be very scientific and talk about the tests that they’ve had, or it’s an opening if the emotional piece is important to them at that time. It gives them an opportunity to frame it for what they need the most, rather than starting with specific questions about the medical side. (Interview 22)

Then the practitioner can speak back in the language and terminology that is understandable and meaningful to the patient (12). As the patient talks, the caregiver looks for the opening, the place to insert a comment or an insight—the place to go to further the healing process.

First there’s making comfortable and dropping my judgment, and second, there’s listening, and then third is waiting for the cues, to see where is the invitation? I’m talking to somebody, and you know when they’re ready to hear something. You know, when I am listening, there is just a knowing of when the words can come, and so I wait for the opening. (Interview 39)

7. Share Authority

Many practitioners establish their expectation of shared responsibility for healing at the very beginning.

One of the initial parts of my consultation with somebody is that I’ll tell them, “Today’s visit is all about ascertaining whether I can help you or not. I’ll make some recommendations to you. [But] you will always dictate what you want to do.” (Interview 6)

For this shared responsibility to become shared authority—a rather more difficult relationship to establish—the practitioner must view the patient as a “fellow expert.”

What’s often not recognized is the patient brings a particular level of expertise, too. Who knows more about them than them? And after all, it is about them and how they are able to get better. (Interview 40)

For the patient to be a full partner, however, the practitioner must have confidence that projects itself into the

relationship (2). Patients must trust the practitioner's ability to hold the healing space securely, and to provide guidance as they move together down the "wounded path."

And so, I think a lot of it, for them, is a sense of perceived confidence, and that has to do with the way you interact, the way you speak about options, the confidence that you have in your own skills. (Interview 22)

8. Be Committed and Trustworthy

Our expert informants repeatedly used the word "trustworthy" and connected it to a fear of abandonment. Hence, an intentional plan to sustain the relationship and carry it forward is almost always needed.

One thing I always, always try to do is make sure that every patient leaves with a plan. . . . I will tell patients [this] is one thing you can always count on. You always leave with a plan with me. Now it might not work . . . but as least you have a plan. (Interview 21)

But the plan, whatever it is, rests on a foundation of trust, which is often connected to the previous theme of hearing the patient's story (see "Take Time and Listen").

Healing is about connections, and connections are about listening to people's stories. Listening to people's story is what makes us trustworthy—and as we are found trustworthy, we are able to be more effective. (Interview 3)

The patient's story continues outside the consulting room or hospital. And the practitioner shows his or her recognition of and involvement in that story by promising not to abandon the patient as the story progresses.

Your patients have to trust you. They have to trust that you have their best interests at hand, and there's nothing that solidifies that trust like saying, "I value you as an individual. I value who you are, what you do, and what you contribute to my life, and because of that, you can explicitly trust me and what I recommend to you." (Interview 5)

Note the phrase "what you contribute to my life." One of the most consistent themes of our interviews was that finding meaning in medical practice is fundamentally connected to the capacity for forming patient relationships based on real trust, and that such relationships are the principal reward of being a physician.

DISCUSSION

Although there is wide interest in healing, few empirical studies are available that provide details on how physicians build healing relationships. The Pew-Fetzer Task Force report of 1994 (13) is an early effort at defining this area that includes some themes that our informants also

identified, such as the centrality of relationships, appreciation of power differentials, and the importance of facilitating trust. Two more recent empirical studies are also worth noting. Hsu and colleagues (14) used focus groups of 28 patients and 56 clinicians to seek a definition of healing that would be concordant between these groups. They found some concurrence among the participants around emotional and spiritual dimensions. The importance of relationships was 1 of 5 key themes they identified. Scott and colleagues (15) conducted a study similar to ours, in which they interviewed 6 physicians, and 2 to 5 patients associated with each physician to identify "model components" of healing. They presented their findings as "healing processes," couched as ideals or such concepts as "presence," "partnering," and "healer competencies," and among the competencies, "self-confidence" and "emotional self-management." Advantages of our study include the number of physicians interviewed and the broad range of specialties represented; the inclusion of complementary and alternative practitioners; and a focus on practical imperatives to promote healing, rather than concepts.

Our study has several limitations. We encountered similar patterns of response repeatedly; however, our findings are preliminary, and we were working with a relatively small, selected sample. Our study also lacks comparison with practitioners who were not peer-nominated for having exceptional healing talents. Finally, patient interviews and perspectives were not a part of our study, and they might reveal a different set of core skills. Still, we believe that our interviews reveal a sound preliminary portrait of core relational skills from the practitioner's perspective. An important agenda for further work is to determine whether there is any connection between what practitioners perceive as important to healing relationships and the actual well-being of patients under their care.

Remen (16) reminds us that healing skills remain central to medicine, and Pellegrino (3) affirms that these skills are not just interaction strategies but are essential elements of medical ethics. The benefits of mastering these skills will repay the effort many times over, both in improved patient care and in the ability of physicians to find deeper meaning and fulfillment in their practices.

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