Palliative Care Chat – Episode 11 – Interview with Dr. Edmund Tori

Dr. McPherson: Hello. This is Dr. Lynn McPherson and welcome to Palliative Care Chat, the podcast brought to you by the online master of science and graduate certificate program at the University of Maryland. My guest today is very interesting, Dr. Ed Tori. Dr. Tori completed his doctorate in osteopathic medicine at the Philadelphia College of Osteopathic Medicine, followed by a residency in internal medicine at MedStar Union Memorial Hospital where he was both Chief Resident and Resident of the Year. Currently, Dr. Tori serves as the Associate Director of the MedStar Institute for Innovation and he's the Director of the Influence Center. Well, I think that's a pretty intriguing introduction. Good morning, Dr. Tori. How are you today?

Dr. Edmund Tori: Good morning. Thank you for having me. I'm doing well.

Dr. McPherson: Well, we're super excited that you're with us today. Why don't we start with ... I purposefully did not finish reading your bio. Why don't you tell us a little bit about your background and how you got to be in this role in this Influence Center?

Dr. Edmund Tori: Sure, sure. I like so many of my colleagues early on was ... As I was going through my medical training, I felt like I was reaching a point where I was burning out. I think all of us reach that stage at some point and usually we sort of emerge out of it, and keep plugging along, and then it hits again, and then we keep plugging along. Well, for me, I started looking for an exit strategy. I actually tried to leave medicine. I thought I had lost my love of it and I started a few online businesses. When I did so, as a means to try to earn extra income, I realized I had to scale it, so I started learning marketing. While I was still going through my training, I was trying to learn the discipline of marketing. I would call us experts in it and ask if I could learn from them, and have conversations with them, and even visit some of them.

Started using that in my side business, but a side effect was that it had an impact on my relationships at work, my relationships at home. I started noticing improved rapport with patients, with social workers, case managers, nurses, even at home with my wife and kids. I thought to myself, "What is that? I'm not ... It's a marketing principle that I may be applying, but I'm not marketing to my wife." Well, not usually. Sometimes I am. "It's not really marketing. What is it?" That's what started my sort of couple decade long quest of studying influence and rapport specifically, and persuasion, and body language, and things like that. That's what led to A, my rediscovery of my love of health, wellness, healthcare, and patients, because it got back to my why. B, it led to this sort of career path of helping others learn the sciences, plural, and arts, plural, of influence and persuasion.

Dr. McPherson: That's very interesting. As you know, our audience is hospice, and palliative care practitioners, and other people as well, but you mentioned establishing rapport. How can we use the skills that you have honed to build rapport with patients and

families, but quickly and firmly? How can we go from, "Hi, here's who I am. It's nice to meet you," to really getting that deeper talk, or that deeper rapport?

Dr. Edmund Tori: Yeah. That's a great question and it's an important one. I would say, first, I may have to explain a little bit about where I'm sort of deriving the answer from.

Dr. McPherson: Okay.

Dr. Edmund Tori: After studying marketing a bit, I went and studied other influence disciplines, and some of those included the ones that most people think of, and maybe even feel are a little dirty, like sales and marketing, things like that. Then also studies under hypnotists. There's a group among the hypnotists called conversational hypnotists and hypnotherapists. Then other disciplines as well that maybe we can cover later. Specifically, when it gets to rapport, among the group of conversational hypnotists, they actually have a really interesting model for conversation in general. Basically, it starts with a greeting. You enter smalltalk. After the smalltalk, or during smalltalk, you begin to establish rapport.

Once rapport is established, you enter a period of deep talk, if rapport is established, you enter deep talk, and that's where a lot of real therapy can begin, or deeper rapport, better relationship kind of stuff can begin. Now, what's interesting about that group, the conversational hypnotherapists, is that they have accelerators for each of those phases. In other words, you can jump through the greeting, through smalltalk, through rapport. They actually have a series of strategies called instant rapport strategies. Some of them depending on who you learn from, or talk to, or read, they have different terms for them, but essentially they're all these sort of instant rapport strategies. I'll give you one example of those.

Dr. McPherson: Okay.

Dr. Edmund Tori: Essentially, you can learn these on your own as you navigate life if you're observant. The basic principle behind them is anything that you do when you already have great rapport with somebody, that same thing may be used to induce rapport. I'll give an example. When we greet somebody we haven't seen in a long time, we often raise our eyebrows. In hypnosis, they call it the eyebrow flash. We raise our eyebrows and say, "Oh hey Dr. McPherson, how are you? I haven't seen you in years. What's been going on?" If we already have rapport and then we see each other, we raise our eyebrows.

Well, that is one of the instant rapport strategies. If you raise your eyebrows as you greet somebody, even if you're meeting them for the first time, "Oh hi Mrs. Jones, I'm your palliative care nurse. It's great to meet you." That sort of thing. When you raise your eyebrows at the time of the greeting, I don't mean raise them and leave them there, because that looks a little freaky. I don't mean raise them up and down like slimy. I mean raise them as you greet and smile, a genuine authentic smile, as you would somebody you already have rapport, it will help to establish rapport.

Dr. McPherson: That is crazy. Wow, that's so interesting.

Dr. Edmund Tori: Try it. I'm telling you, try it from now on. Raise your eyebrow-

Dr. McPherson: I will.

Dr. Edmund Tori: When you meet someone. Another thing is, if you see ... If you get good at seeing micro expressions, which maybe we can talk about at another point, if you get good at seeing those, another thing to do is to mirror the exact micro expression that someone has the moment they see you. If you mirror it precisely, they won't know why, but they'll feel like you just clicked.

Dr. McPherson: Give me one example at least. You can't leave us hanging.

Dr. Edmund Tori: Well, one time I was walking by a ... After I learned this skill, I was walking by a nurse in the hallway at the hospital I was working at, at the time, and I knew her, but I'd never really talked to her in any sort of depth. As she walked by she said, "Oh, good morning Dr. Tori." I went, "Oh, good morning Sherry," and I mirrored her exact expression on her face. One, her eyebrow went up a little bit. Her mouth cocked to the side a bit. I just did that exactly and mirrored her tone. It wasn't in a mimicking way. It was subtle. She actually called me back, after we passed each other in the hall, called me back down the hall, and she just started telling me about her brother, and stuff that was going on in her life. I don't know. It was surreal. I started practicing that more and it ... Once you become competent at something, all of a sudden you actually have to learn how to turn it off, or else you won't get out of conversations.

Dr. McPherson: Wow. I mean, I don't know if there are examples you can think of from the pain and palliative care hospice, and palliative care [inaudible 00:08:13]. I have several examples that I can certainly share with you if maybe you could use them as illustrative examples.

Dr. Edmund Tori: Sure, let's try it.

Dr. McPherson: Okay. One I just wrote down is, often we'll come across a patient who unbelievably will not tell their doctor, or nurse, or pharmacist that they're having pain, but we can see from observation that they really are having physical discomfort, but they deny pain. How can we build that rapport and get them to be more truthful, because probably there are some fears that are suppressing their ability to tell the true story? What are your thoughts about that?

Dr. Edmund Tori: Right. That's an important observation. If you are able to detect it, then you are also able to mirror it a bit. Many times we hear, "Oh, if you want to establish rapport with somebody, you match and mirror." That's true to a point. It's actually ... It's very true that when you have rapport, you already start to match and mirror. It's what we do when we have rapport, we match and mirror each other. If you do it intentionally, it can be ... If it's detected by the other person, it

can actually break rapport. Sometimes you mirror the other person in a way that it's beyond the conscious attention. If somebody crosses their legs and you immediately cross your legs, then that could be detected, and be viewed as, "Is this person mimicking me? Wait a minute. I just moved my arm and they moved their arm." You don't do that.

What you do is you mirror their state. If you detect that they're in pain, and you are an empathic person, when you empathize, actually feel it for that moment. When you feel it, express it in a way with your body language, or with your tone, or with your pace of speech. If you mirror what they're feeling, they will start to feel more comfortable with you. Now, let me just say this. That when you match and mirror somebody, what a lot of people don't describe is the next step. The next step after matching and mirroring is called pacing and leading. Once you match and mirror somebody, and you establish rapport, you have it, and there's evidence because you're mirroring each other, you pace them to a new ... You lead them to a new better place. For example, if you meet somebody who's angry or frustrated, you experience anger and frustration too for a moment.

Meet them exactly where they are, but then anger and frustration is not a good place to be. Then slowly, after you establish rapport, remove them to that new place. Anybody who's angry or frustrated, the last thing they want is somebody to walk in bubbly and, "Hey, hey, how are you?" They want someone to experience what they're experiencing, so match that moment. It's not an admission of guilt. It's not an admission of a failure of the health system if somebody's frustrated with the inability to get an appointment, or get in touch with somebody, or have someone show up to the house, or maybe the thing was delayed. It's okay to feel the frustration that they feel, because we empathize with them. Of course, this whole time a necessary ingredient is authenticity. If you are not authentic, everything with rapport will fail, because people when patients are vulnerable, and when families are vulnerable, they have heightened authenticity detectors.

Dr. McPherson: Yeah, makes sense.

Dr. Edmund Tori: They can tell when someone's full of it.

Dr. McPherson: [crosstalk 00:12:03], full of bologna.

Dr. Edmund Tori: Yeah, yeah. If it clangs, it breaks rapport further than ... Anyway, so the first of ... I guess the short answer is, meet them where they are with the same emotional state.

Dr. McPherson: Okay. Do you use reflective statements along with that?

Dr. Edmund Tori: Yes.

Dr. McPherson: If somebody ... I can clearly tell you must have pain that's probably 10 out of 10, but you're terrified I'm going to make sure you take an opioid, and you don't

really want to do that. I mean, I can certainly imagine what it feels like to have pain that's 10 out of 10, and I'm not going to be all happy and bubbly, but then what does my conversation reflect?

Dr. Edmund Tori: Okay. Well, that's a good question. This is actually a place ... This is actually a minefield in a way. It's both high-risk, high-reward if you reflect. Sometimes you instead of reflect, you echo. They're slightly different. You are saying or expressing the same thing back. For example, if they say ... If you ask, "How was your day?" They say, "Oh, it's just, ugh." Okay. A little later when you're talking about it and you say, "When you're feeling, 'Ugh,' what's worked in the past to get away from that, or to improve, or ... " You echo what they said, because the reason it's a minefield is if you make a statement that's not true, you will break the rapport.

Dr. McPherson: Sure.

Dr. Edmund Tori: If you say, "Oh, you must be experiencing A, B, C," and they're not experiencing A, B, C, then you ... That actually, essentially you don't get them. Because actually what they meant was, or what they're feeling is something entirely different. It's better to echo until you're sure. Also, when you're having that conversation you can make some assumptions like, "Wow, that must be really difficult to get up and go to the restroom then," right? You ask a little more about something that you can deduce as probably very true for them, and then let them explain more. I don't know if that makes sense, but-

Dr. McPherson: Yeah.

Dr. Edmund Tori: That's-

Dr. McPherson: Yeah, that makes sense.

Dr. Edmund Tori: Yeah.

Dr. McPherson: Well, how about if it's something like ... Okay, so I'm a pharmacist, and I'm always trying to talk people out of medically futile drugs. For example, often if I say ... The patient has probably got several weeks left to live, for example, but the family is insistent because the doctor said, "We have to check the sugar every four hours, because grandma's got diabetes, and maybe give her a shot four times a day." You know that's really putting her more at risk for harm than good, and you're chasing your tail, and it's uncomfortable to do that. How do you build that rapport so that you can get them around to your way of thinking?

Dr. Edmund Tori: Yeah. Well, one thing is ... Actually, this might get into something ... Be sort of some simple rules that we can use.

Dr. McPherson: Sure.

Dr. Edmund Tori: One of the simple rules is to remove objections early. Now, it's worth talking about objections and something else called limiting beliefs. It's worth dissecting those a bit more. Remove objections early, the reason is that when we have a little voice inside of our heads that says, "Oh, this is just a pharmacist." If that's the voice inside of their head, you have to remove that objection, or else they won't hear a word you say from then on. Or if they say, "My doctor walks on water." If that's their belief, then if you don't overcome that, they won't hear anything you say afterwards. A limiting belief usually takes the form of, "I always, I can't, she never, this place always." These sort of statements. "I'm not good at math," is a limiting belief that people often say. "I'm not good at remembering names," a limiting belief. The reason it's a limiting belief is because if you actually believe it, how much action are you going to take? None.

Dr. McPherson: Not much, right.

Dr. Edmund Tori: Right. You have to overcome that limiting belief. If somebody says ... I'll come back to a palliative care example in a second, but an easy one is when you deal with genetics. Some people think genetics equals destiny. If somebody says, "I can't lose weight, it's genetic." Well, if you don't get past that, they won't attempt to lose weight, right? There will be no attempt at doing it. You could do that with questions, which are super powerful. We could talk about how ninja questions can be. You could say, "Wait a minute. Isn't your sister thin? Didn't she lose a lot of weight?" "Oh, well she's a health nut." "Okay. Well, so if you were a health nut ... " Then pause, right? You started to break down the limiting belief and all of a sudden that possibility blindness becomes like, "Oh, maybe I can see a different possibility. It may not be one I want, but it's at least a different possibility." You start to break away from it.

When it comes to patients, let's say ... Let's go back to that example of somebody thinking they need to take their shots because the doctor said. Well, sometimes you can go back on that with questions. Questions are really powerful. Saying something like, "Well, did your doctor talk to you about what happens if your sugar gets too low? Did they talk to you about that? Did they ... " Then say, "Oh, well ... " That leads into another question, right? Or it leads into another path of conversation that can lead you to where you want to go. The point is, if you don't remove the objection, or at least start to address it, then you won't get very far. One of the best ways to remove an objection is to put it out there before they put it out there, okay? Put it on the table first. Our tendency is to sort of ... If something is there, we try to sweep it under the rug. Like, "Oh ... " Don't do that.

Instead, put it on the table and then take it off. For example, "Your doctor is an incredible physician. I know this. I've worked with him, etc. I know five weeks ago he told you that this was a good thing, but things have changed and I'm sure if we talked to him now about blah, blah, blah." You see, so you put it on the table and then take it off. You say, "I know you might think you should take this medicine, but when things change and ... " Or you could also tell a story of a similar experience before with the same doctor, right? Where it had the

outcome you wanted, so tell a story about that person. Remove their objection early, is really important.

Dr. McPherson: You can't leave me hanging. How would I counter somebody who says, "I'm not listening to you. You're just a pharmacist?" How am I going to take the legs off of that one?

Dr. Edmund Tori: That's a great one. You actually ... The ideal situation is to get there before the person ever brings up that objection. If there's a way you can know it ahead of time. For example, there's lots of ways to attack that. One might be, and this is something we should all think about, there's stuff that happens before a conversation, okay? Before you even engage the person. If this is at a counter, or if it's during an encounter, there's this time before you actually engage them.

Well, if you're on the phone, or having a conversation with somebody, and you can demonstrate your expertise, or that somebody is calling you for that expertise, you can disarm it. For example, if you say, "Oh ... " Let's say you're talking to a colleague, "Yeah, I was just talking to Dr. so-and-so, he had some questions, or she had some questions about X, Y, Z, medication, and I was advising her on how to properly dose that," right? If you have that conversation with somebody off to the side before actually engaging, it establishes that doctors call you for the advice, right?

Dr. McPherson: I see. Okay.

Dr. Edmund Tori: That's one way. When it's very direct, that is actually much more challenging and I would say that's where you have to focus on instead of going after what they just said, go after rapport, because if they say that, the rapport isn't there. You go after establishing rapport first, before trying to combat that direct-

Dr. McPherson: My inclination [crosstalk 00:21:05] would be to use humor to say something like, "Oh, come on. This is not my first rodeo." Is that okay?

Dr. Edmund Tori: Yeah. Humor is something that ... Its power comes from its ability to break patterns. If people have a pattern, it's sort of like the thought of ... The definition of insanity is doing the same thing over and over again expecting different results. That's a pattern. Humor works by breaking patterns, so you think it's one thing, and then it's another thing. Whenever there's a pattern interrupt, or a break in a pattern, that is an opportunity to learn, and an opportunity to establish rapport much deeper. It's also a tricky spot. If you're ... I assume, if you use humor now and then, you're good at reading the person who is appropriate to use humor with.

Dr. McPherson: Sure, sure. You can't do it inappropriately.

Dr. Edmund Tori: Right.

Dr. McPherson: That makes sense. Hospices and hospitals, patients either discharged from the hospital, or the family after the patient's death, they get these surveys, and the surveys are ... Particularly in hospice, for example, the CAP survey is, "Did the team communicate well with you? Did they help you manage your loved one's symptoms?" For example. You mentioned when you and I spoke previously, your six simple rules of engagement. You just shared one of them with us with removing the objections. Do you think you could go through those six and thinking-

Dr. Edmund Tori: Yeah.

Dr. McPherson: We're not trying to be deceitful by any means, but we do want to form that warm relationship. I have to tell you, hospice nurses are pretty awesome at doing this-

Dr. Edmund Tori: Yes, they are.

Dr. McPherson: As well as the aides. Families love the aide. You want to run through your rules and maybe use that as an example?

Dr. Edmund Tori: Yeah, sure, sure.

Dr. McPherson: Great.

Dr. Edmund Tori: First, the reasons for simple rules of influence is simple rules are ways of ... There's a tendency nowadays to script things, or to put a lot of things into checklists. Well, the human-human interaction is dynamic. It does not belong in a checklist when you're dealing with sort of emotions, and rapport, and things like that. That is ... You are unique, the patient is unique, the setting in which you're interacting with them is unique, the time of day, the thing they recently experienced. All these things factor in. We use simple rules because if you have a simple rule, or a simple guide, that guideline will help you implement it in your way. In other words, if I tried to do what everyone else is doing, and it's not coming from me as an authentic action, then that will be detected. That will be ... That lack of authenticity will be apparent. Use simple rules and then have people apply them in their own way.

The first of those simple rules is to manage your state. This, by far, is the most important piece of influence. In fact, all of influence, or most of influence, can be bucketed into three main things. States, frames, and patterns. The state that people are in, yourself first, is absolutely central. If your emotional state, your mood, if you are in a state that is optimum for the interaction, you will have better rapport, you'll get a better history, that person will be more honest with you, they'll respond to your suggestions, and your advice in a more appropriate way. The reason it works is because when your word choice, your body language, all of that stuff, your tone, your inflection, all of that is state-dependent, right? Even the stories you have available to you in your memory are state-dependent.

If you are angry, because you just had an argument with somebody, and you walk in, and now you're going to try to have a conversation about some other topic, the anger that you're feeling now will impact your word choice, and your body language. If you just looked at your phone, and somebody sent you a funny text, and then you go in to have an end of life discussion, your body language is going to be clanging with the situation. The key is to manage your state. Some people manage their state with meditation. Some people manage their state with prayer. Some people manage it by having photos of their loved ones on their desk, or in their wallet. Some people manage their state by watching a YouTube video. In my case, what I do is I use a doorknob as a trigger.

Every time I touch a doorknob I remind myself that somebody is on the other side of that door, and I need to be in the optimum state for that encounter, whatever that is. If it's a meeting, it's my wife after a long hard day at work, or it's whatever. I have to manage my state before I walk in there. A classic example is when I was walking in the hospital, walked by the nurse's station, and somebody says to me, "Watch out Dr. Tori, his wife's a doctor. She's been at the nurse's station all night. She's called Patient Advocacy. She's called the hospital President and da, da, da," right? That prep, in air quotes, is actually setting me up for a battle, because if I go in there believing any word of that, if I go in there thinking this person is confrontational, or what have you, my body language is going to say so. My word choice, my tone, all that stuff is going to say so.

Manage your state is absolutely key. It's essentially, get your game face on. If you're going to play football, before you go out there onto the football field, you get your game face on. You're not reading Hallmark cards to my dear wife, you're getting ready to tackle somebody, so go get ready to tackle somebody. If you're going to have an end of life discussion, get your game face on. Get into the state. There's optimum for that. Then all the other stuff, then you don't need to read all the body language books, and all the intonation, and cadence, and pace of speech. You don't need to study any of that if you just manage your state. That's the most important one. That's why I spent the most time on it. The others we'll go through them quickly.

The second one is make them comfortable. Now keep in mind, simple rules are for you to do it in your way. You make them comfortable in the way that you make people comfortable. If you do it with light humor, go for it. If you do it with a really empathic moment and sitting down, go for it. We don't have to script that everyone sits down. You do it in your authentic way. You make them comfortable. Now, sometimes you might make them comfortable by saying, "Mrs. Jones, this is an awesome. We're going to take great care of you." Sometimes you do it by saying ... By making them comfortable by getting them to talk about something they love.

You see a picture on the wall, when you go in for that visit, start talking to them about that. "Oh, I see you have a grandson, da, da, da." Talk to them about their grandson. You make them comfortable. Once they're comfortable, then everything else flows. Essentially, another way of thinking about that, the first

one is manage your state, making them comfortable is manage their state, okay? By comfortable, I mean comfortable with the situation, with the environment, with the interaction. Essentially, work on rapport. Your state first, then rapport, then the rest. The third one is remove objections early, which we mentioned earlier.

The fourth one is to move people with what already moves them. Move them with what already moves them. Now, this is an important rule, because we in healthcare tend to focus on data, okay? Data is important. Data, evidence, logic, reason, it's important, but it's not necessarily how to move people. We move people with emotion. Emotion occurs with emotion. McDonalds has a formula, change the moods first and the minds will follow, okay? That formula, most influencers work on that. If you change the mood first, the mind will follow. How do you change the mood? You change the mood based on what already changes their mood. An example of that would be if you're describing some cardiac thing to somebody who's a plumber, I would hope you'd be using plumbing analogies, okay? Well, the same thing goes.

If you're talking to somebody about their heart failure, and their quality of life, you might talk to them in the context of what that means to them. What's important to them. If for them the most important thing is for them to be able to sit through an entire football game without huffing and puffing, or without having to get up and use the restroom, well then talk about it in that context. In the context of the football game. Not the physiology. Not the data, right? Use data to determine where you want people to go, like you want them to take that medicine, or you want them to avoid that medicine, because the data says so. You move them to that spot with emotion and [crosstalk 00:30:58].

Dr. McPherson: Okay. Because I could offer an analogy. For example, I'm always yapping about stopping the dementia drugs to someone admitted to hospice who has very severe advanced disease. I could talk about the data all day long saying, "It's not helping. It's dropping the heart rate. She's at risk for falling," but what would move the adult daughter would be more, "This medication causes so much nausea and you're knocking yourself out making these amazing meals, I would love to see her be able to eat these awesome meals you're making." Is that an example?

Dr. Edmund Tori: That is an example, yeah. Move them with what already moves them. That's what would move her, right? Another thing that would move her is getting her to answer a question that's rhetorical. Like, "Could you imagine what it's like to sit there with all that nausea? I imagine that affects her ability to sleep. Haven't you ever not had enough sleep and been ... Not had your wits about you, etc.?" Asking questions also is another way. When they answer their own question, that moves them also when they think it's their idea. Move people with what already moves them. Typically, it's emotional. Not always. If you're talking to clinicians about data, that's okay because sometimes that's what moves them. In general, move people with the emotion. For the clinician, data is emotional at times, right? That's okay, so use it then.

Dr. McPherson: Okay.

Dr. Edmund Tori: Yeah. The next one is to remark about the remarkables. This is especially important for teamwork and nurturing relationships between others. Remark about the remarkables means essentially spread good gossip. Let's say, you're a palliative care aide and you are about to ... You know that somebody's coming to visit later. The palliative care nurse is coming, and you know who it is, and you know you happen to think they're highly skilled, or have an awesome personality. If that's the case, say it. Say, "Oh, John is coming and he is an incredible palliative care nurse. When my mother was sick, he was the one that took care of her. I have never seen anybody like this." Set him up for success.

If the physician's coming, or the contact is some sort of subspecialist and she's incredible, say it before they get there, because then you set them up for success. Also, if somebody says something good about somebody, here's the power in it when you remark about the remarkables, is that when you say it, it feels good. When they hear it, it feels good. When they actually meet the other person, if they spread it, that feels good for all parties involved, right? When that palliative care nurse, John, walks in, and hears that the aide ... The patient says, "Oh yeah, they were just telling me how awesome you were, what incredible care you took of their mother." That will make that encounter better for the caregiver, right? And for the one being cared for, and it will improve your relationship with them.

Dr. McPherson: Wow, it's a win-win.

Dr. Edmund Tori: There is no reason ... This is like win-win-win-win if you remark about the remarkables for others. Then the final one is to design out pain, and design in awesome. Design is really important and you experience this every single day of your life in multiple settings, but we just gloss over it. If you've ever pulled on a door that was a push door, that was not your fault. The door handle was designed poorly. The fact is, you shouldn't have to think about opening a door, but if you go and you pull on it, it's because the handle informed you that it's a pull door. The same thing goes for all kinds of things in our lives. The number of ... It could be any device we interact with.

Where buttons are on elevators, for example. We might push the emergency call button instead of the actual floor button because of where it's located. It occurs in electronic records. If it's designed poorly, it actually encourages error, or it makes error more likely. The same thing goes for our encounters. Where you are sitting, where you are standing, how you've designed that encounter, it matters. If you're about to have a heart-to-heart conversation with somebody who does not open up emotionally, you may need to design the encounter slightly differently. I'll give you an example that ... I mean, this has a little bit of a gender thing associated with it.

Dr. McPherson: Okay.

Dr. Edmund Tori: That is, that sometimes men don't open up. There's always the example of the father who doesn't talk to his son, or the clinician, the male clinician that doesn't feel ... That clearly has an issue when his leader is a female, or something. These are very real situations. What happens ... One of the things that has become clear in a lot of influence circles, is that if you design the encounter slightly differently, you make that other person ... You put them at ease. For example, if you look at the male, let's say, father-son, they don't talk much. You know what? They sit in front of that football game and they do have conversation, or they go fishing and they do have conversation there. You know what's similar in both of those situations? Is that they're facing a way from each other. They're not face-to-face.

Some people don't do well with the face-to-face conversations. In that case, you would just simply design your encounters slightly differently. If they're on a couch, sit next to them on the couch and face away as you have the conversation. They might be put more at ease. The way to find that out, is to become good at detecting comfort and discomfort, rapport and lack of rapport. If you hone your skills at detecting when somebody is feeling comfortable and connected, then you'll know when they're not. That gets to a skill called calibration, or micro-calibration. Essentially, a lot of times we think, "Oh, I tried. I tried to do something and then it didn't work, so now oh well, that didn't work," and then we walk away. You don't do that in conversation, right? In conversation, you try again, and then you try again, and then you try again.

Let me give an example. One time my wife sent me a funny video, and I shared that video with some colleagues, and I was using it in my influence training, and somebody said, "That video kind of ... " It was a conversation between a male and a female and in it she thought that the woman appeared to be not intelligent, okay? She was offended by the video and my first response was, "Well, yeah so my wife sent that to me. She thought that was funny." Actually, that was a failed influence attempt. That didn't work with her. That didn't move her, right? I kept going. I said, "It's interesting that you thought that it makes the woman look bad. I actually think it's the opposite," because in that conversation the guy's trying to get the woman to do something, and she doesn't do it. I said, "Well, let's look at it. From his point of view, he didn't accomplish his goal," and so I go through that, and that's what moves her.

Conversations are like that, interactions are like that. You tweak until you get it right. In some influence circles, they call it micro-calibration, because they're always ... A salesperson is always trying to get you to the sale, right? Or to like the product. In seduction, they're trying to get you to make sure you're interested in them. If they see signs of disinterest, they try something different until they see signs of interest. We should be doing the same thing, but with comfort, and rapport. Are they comfortable with us or not? If they are not yet comfortable with us, we need to try something slightly different. Maybe move your position. Maybe change your tone. Maybe do something else. A quick example is, one time I was seeing a patient and I said to him, "Mr. Jones, we're

going to get a chest x-ray," and he had had cardiac surgery." I said, "Mr. Jones, we're going to get a chest x-ray."

Off in the corner of my eye I saw his wife put her hand over her [inaudible 00:40:02], just below her neck. That's a sign of discomfort. It's a sign of concern. I saw that through the corner of my eye. I turned to her and I said, "Oh, it's okay. He just had heart surgery so there was surgery on his chest, so it's just ... This chest x-ray is pretty routine and we're just looking for a positioning of things, and stuff like that." She said, "Oh, it's not that. It's just that I'm parked in two hour parking and I didn't know how long this would be," right? The point is, I detected the discomfort, I addressed it, and even though I was wrong, that's okay because then she revealed why she felt that way. You see? It actually ... Anyways, my point is get good at detecting discomfort and then design your encounters so that they are more comfortable for the person.

Dr. McPherson: I see.

Dr. Edmund Tori: That's where design comes in.

Dr. McPherson: Wow. Boy, I can tell you've put a lot of work into this and you did assure me you're writing a book on this, right?

Dr. Edmund Tori: Yes, I am. Yeah.

Dr. McPherson: We can all cite your book and-

Dr. Edmund Tori: A couple.

Dr. McPherson: Yeah. Well, I wish you would hurry up and do it, because I'd really like to read it.

Dr. Edmund Tori: Okay.

Dr. McPherson: I'm not just trying to manipulate or micromanage you here. Well Dr. Tori, anything else you want to add? This has really been ... It's so interesting talking to you. We could talk for three days. Anything else you'd like to end with?

Dr. Edmund Tori: I would end with maybe just asking everyone to evaluate how they use questions. Here's why. A question must be answered, so meaning in your brain you cannot help but answer it. If I asked you, "How old are you now?" Don't answer it. How old are you now? You answered it in your brain. You thought of the answer.

Dr. McPherson: Right.

Dr. Edmund Tori: Your patients, and their loved ones, and your colleagues work the same way. Questions are powerful because they must be answered in their brain, but not only that, they direct attention. When you ask a question about something, you

direct attention. If you're asking about pain, you're drawing attention to pain. If you ask about comfort, you're drawing attention to comfort.

Dr. McPherson: That's a great point.

Dr. Edmund Tori: Be careful where you draw attention.

Dr. McPherson: I agree.

Dr. Edmund Tori: Your questions can be super powerful. Also, when someone answers it, it's their own idea. They came up with it. [crosstalk 00:42:28] How you ask your questions will change the answers you get, so change the way you ask questions. If I asked you, "Can you afford this?" That's very different than asking, "How might you afford this?"

Dr. McPherson: Ah, that's true, that's true.

Dr. Edmund Tori: If I asked you, "How might you afford this?" You start thinking, "Oh, I could sell the stuff in my garage. I can finish that book. I can sell the recording of this podcast," right? All of a sudden you have a bunch of ideas that come out of a question. Whereas, the other one [crosstalk 00:42:56] shut you down and it was a yes-no. Anyways, so the power of questions ... I would just say for everyone, in addition to rapport, focus on rapport and managing your state, also pay close attention to your questions, because your questions may help or hurt you in your interactions.

Dr. McPherson: As a hospice or palliative care provider, instead of me saying, "How bad is your pain on a zero to 10?" Maybe I could use the scale that says, "How much relief has this new analgesic regimen brought you?"

Dr. Edmund Tori: Yeah, exactly. [crosstalk 00:43:25] Ask about the relief, ask about the comfort. Even in terms of pain, I would actually be careful about the words you use. If you use pain it may be different than discomfort for that person. Discomfort, by the way, subconsciously also has the word comfort in it, so you can keep focusing on comfort and that is sort of a better place to be. How you ask your questions about it, you may say ... I'm trying to think of a better way of saying this, but you could just ask a question like, "Did that make you a little bit more comfortable?"

Dr. McPherson: Oh, good, good.

Dr. Edmund Tori: Right.

Dr. McPherson: Good, I like that.

Dr. Edmund Tori: The moment they say yes, they commit actually, and will ... They'll focus on the improvement, rather than on where they are now. It's sort of like if I said to my son, "Don't jump on the bed." Where does his attention go? It goes to jumping on the bed.

Dr. McPherson: Right to jumping on the bed.

Dr. Edmund Tori: Instead, draw attention to, "Hey, why don't you ... Hey, that new book we got on dinosaurs, why don't we read that book? Sit down on your bed and read the book," right? Draw the attention to the thing that you want-

Dr. McPherson: [crosstalk 00:44:56] The better behavior.

Dr. Edmund Tori: To go to.

Dr. McPherson: Got it.

Dr. Edmund Tori: Right.

Dr. McPherson: Dr. Tori, you are the bomb. I think you're awesome. I have so enjoyed talking to you, the second time now, and I very much would like to thank you for joining us on our podcast, and thank our audience. In wrapping up again, this is Dr. Lynn McPherson. This presentation is copyright 2018 the University of Maryland. For more information on our completely online master of science and graduate certificate program in palliative care, or for permission requests regarding this podcast, please visit Graduate.UMaryland.edu/Palliative. Thank you.

Dr. Edmund Tori: Thank you very much.