3

Listening

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> It is the disease of not listening, the malady of not marking, that I am troubled withal.
>
> Falstaff[1]

This chapter is about listening to patients, their families, and other health care professionals. Listening skills in history taking are examined, and the process of history taking becomes a case study in communication. Listening to insights offered by other treating practitioners (of all disciplines) or fellow professionals is also discussed. Active listening is the first step to understanding and starting on the assessment and treatment process.

LISTENING AS A STARTING POINT FOR COMMUNICATION

Listening is a key component of information gathering. Sometimes the process of listening begins before the patient and doctor meet, since patients may have reputations that precede them, health professionals who know them well, or family members who wish to provide information prior to a first contact. The term 'doctor' is used here because it is shorter than 'health care professional' and less clumsy than acronyms such as HCP. However, the reader may wish to insert another type of health care professional here; the message will be essentially the same.

The words that patients use at the beginning, as at the end, of a clinical encounter are often especially interesting and relevant to the problems that they bring. When a woman's husband arrived late for a joint consultation, her first statement on entering the consulting room was *'He's never there when you need him most'*, and indeed that problem had always lain at the heart of their relationship difficulties.

While such statements often occur outside the formal consultation and outside the consulting space, they can all be viewed as integral to the communication process.

Despite its diagnostic value, doctors often prevent their patients from completing this critically important opening statement.[2, 3] In Beckman and Frankel's 1984 study, patients consulting doctors (81 per cent of whom were residents in internal medicine) were given the opportunity to finish their first statement in only 23 per cent of cases. Doctors' interruptions appear to be innocuous enough; they are mostly questions for **clarification**, or specific closed questions, but the questions tend to have the effect of redirecting the consultation.[4] One might wish to defend the doctors in this study on the grounds that they were listening closely and simply needed to know more about the patient's problem in order to understand it better. However, interruptions made during the critical opening phase of a consultation resulted in patients providing less information overall. The interruptions were found to be associated with late-arising problems that might have been brought forward earlier, had the doctors remained attentively silent. In addition, the doctors' questions, instead of facilitating the consultations, actually led to the doctors taking over the consultation in 94 per cent of instances. Only one interruption out of 52 was followed by the opportunity for the patient to return to their own agenda. Interruptions at the beginning of a consultation appeared to make patients less confident that they would be able to choose the issues that were troubling them, and more likely to allow the doctors to dictate which issues to pursue and which to ignore.

The answer to many of these problems in opening the consultation can be found in the technique of using '**wait time**'. Waiting longer than would feel comfortable in an ordinary conversation offers powerful encouragement for patients to continue to describe their concerns. After waiting until a natural break occurs, the doctor can add a question such as *'and is there anything else that is worrying you?'* This additional encouragement conveys the information that the patient is not limited to a single concern and often results in other major concerns being expressed.

LISTENING AS THE CONSULTATION PROGRESSES

Why might doctors spend more time speaking than listening? Do they believe that early interruptions will reduce the amount of time that a consultation might otherwise require? Do they believe that patients expect them to dominate the consultation? Do they think that 'conversational' speech, with the normal interruptions that we all tend to make, is more appropriate than attentive silence?

The evidence suggests that these beliefs are misguided. Marvel et al. found that patients who were allowed to complete their concerns used an average of only 32 seconds to do so, compared with 26 seconds before interruption occurred. Early redirection is also associated with late arising concerns, which consume more time towards the end of the consultation.[5]

The habit of dominating consultations has become less acceptable to consumers who now seek a more equal partnership in their pursuit of health. Studies of consultation behaviour also make clear that consultations are not conversations, but skilled technical manoeuvres that are part of the diagnostic process. Listening is, in this respect, part of both the science and the art of medicine. In a 'normal' conversation, individuals expect to contribute to the discussion on a more or less equal basis. In fact it is easy to observe that many 'normal' conversations are characterised less by listening than by waiting to speak. Consultations are not debates, and a consultation in which the doctor says only as much as is strictly necessary during the information-gathering phase is likely to yield more relevant and valuable information.

Goldberg et al. found that doctors who demonstrate that they are listening, with good eye contact, relaxed posture, minimal encouragers and withholding information in the early stages of the consultation, are better able to identify signs of emotional distress.[6] Davenport et al. found that these behaviours lead to patients providing doctors with more information.[7] One of the interesting characteristics of doctors who elicit more information is good timing, that is the ability to balance listening and other behaviours such as asking directive or closed questions. Golberg and Huxley have described a series of four filters that help to determine whether or not patients with common mental disorders will be admitted to hospital.[8] The first filter is the patient's own illness behaviour. The second is the ability of the care-giver to detect disorder. The third and fourth are respectively, referral to a mental health service and admission to hospital. The second filter, when the doctor–patient encounter occurs, is the one in which active listening is a critical determinant of care from that point onwards.

As well as listening to the patient's words, listening to the tone, speed, volume, and steadiness of the voice is important. Patients are more likely to offer these cues to doctors who listen well.[9] While strong emotional states may be obvious from the patient's behaviour, more subtle variations may not be evident except in vocal changes. Is the tone tentative, irritable, aggressive, or angry? Is it wheedling or obsequious? Is speech slow, accelerated, or highly circumstantial? Does the patient speak softly or loudly? Is there a vocal tremor or any form of dysarthria? Some aphasic disorders develop slowly and can be missed or attributed to psychological factors unless subtle changes are picked up by the careful listener. A range of diagnostic possibilities can be suggested by alterations in speech, and changes may only be evident when patient and doctor are familiar with each other. For example, the difference between a patient's normal speech and speech during an episode of mild depression may not be evident to a person who does not know what 'normal' speech is for this person.

Patients usually bring more than one problem into the consultation.[10] Listening carefully throughout the consultation reduces the likelihood of redirecting the patient towards one specific complaint at the expense of other

concerns. Leaving enough time at the end of the consultation allows the doctor to listen to any last minute concerns, although these final words are fewer if the listening task has been done well in the early stages of the consultation.

LISTENING AND OBSERVATION

The doctor's instinctive reaction to different verbal presentations can contribute valuable information, especially when there is a 'fit' between what is heard and what is seen. A well-dressed, attractive patient may create a visual impression that leads the doctor to overestimate his or her intelligence. The reverse also applies. Listening carefully to the patient's own words can be a more accurate indicator of how well the details of the diagnosis and management plan are understood than reliance on appearances.

Inconsistencies between what is seen and heard can also provide insight into the patient's coping skills. When the psychological mechanism being used is denial, the patient usually maintains reasonable congruency between what is said, how it is said and the accompanying non-verbal behaviours. However, the doctor may be struck by unreasonably optimistic expectations on the patient's part. When patients are simply trying to hide feelings of which they are aware, it may be easier for the doctor to notice the discrepancy and for patients to admit their concerns.

The **Johari Window** has been used to illustrate four states of awareness that underpin human relationships.[11] The clinical task is to discover and manage significant facts about the patient's health status, a task that can only be achieved if the doctor listens well. It is likely that some elements of any patient's health status will be unknown from time to time (Quadrant 4) but an ideal professional relationship, one that is likely to maximise health benefits, can be represented by Quadrant 1. In this quadrant the patient's own insights into his or her health are aligned with those of the doctor. Sometimes patients will deliberately withhold information from the doctor (Quadrant 3) and in this situation, acutely tuned

	Known to self	*Not known to self*
Known to doctor	1 **OPEN**	2 **BLIND**
Not known to doctor	3 **HIDDEN**	4 **UNKNOWN**

Figure 3.1 Modified Johari Window

listening skills are vital. In Quadrant 2, the doctor is aware of information that the patient does not know. This situation is represented by that stage of the diagnostic process in which a doctor receives information from the history, physical examination, or investigations that have not yet been transmitted to the patient. This stage occurs and recurs throughout the clinical relationship, and is the main reason why patients seek the help of health professionals, that is, to uncover important information about their health. Listening is one of major skills of the diagnostic process.

A common situation in everyday consultations occurs when a patient fears the possibility of a serious diagnosis, but also fears that they will look foolish or hypochondriacal if they ask the doctor whether their cough, headache, or abdominal pain might have serious implications. Because of this ambivalence, it is often possible to pick up a hesitancy of tone or a note of false bravado, depending on the patient's personality. Reflecting back to the patient the tone of concern, or the worried look not only leads to a more accurate appraisal of the patient's emotional state, but it also demonstrates how carefully the doctor is attending to what is being said. This is almost certainly the reason why patients reveal more to doctors who are good 'detectors' of emotional disturbance, that is, who operate comfortably in Quadrant 2.[12]

Listening therefore provides both useful information and appropriate reassurance. Patients frequently and justifiably fear that they will not be able to make the doctor listen and understand; that they will not be able to prevent the doctor from jumping to hasty conclusions. Words of reassurance, particularly if offered prematurely, can work against the therapeutic process.[13] Patients do not expect facile responses, but evidence of the doctor's expertise, demonstrated through a careful history and examination and the ability to explain clearly what has been found and what can be done to manage the problem.

LISTENING AND CLARIFYING

Although **minimal encouragers** are the most effective method for eliciting the patient's concerns at the beginning of a consultation, clarification is usually essential as the consultation progresses. Clarification demonstrates that the doctor is attending to what is being said, helps patients to be more precise about their symptoms, avoids ambiguity and encourages them to elaborate on elements of particular interest to the doctor. Listening and observing serve as the foundation for clarification for both doctor and patient. For the doctor, listening combined with observation provides the starting point for accurate diagnosis and appropriate management. Remembering items of information from past consultations allows the doctor to demonstrate that what has been said has been carefully listened to, and provides the patient with further evidence that the

doctor will integrate relevant information as needed. For patients, attentive listening provides reassurance that their concerns are being taken seriously. This generates trust that enables patients to bring forward more details that might otherwise embarrass or frighten them.

LISTENING AS A THERAPEUTIC INTERVENTION

The therapeutic importance of listening is clear in the various forms of psychotherapy for which listening is the mainstay. It has been exploited by alternative or complementary medicine.[14] However, listening is part of every clinical interaction.[15] It is the basis for accurate reassurance when nothing seriously wrong can be found, and it is the basis for reassurance that help is at hand. It is particularly important when no further medical intervention is possible. In the field of palliative care, Maguire has demonstrated some of the problems that health care professionals experience when it comes to dealing with dying patients.[16] In one study, patients were found to be highly selective in what they disclosed to nursing staff, showing a strong bias towards disclosing physical symptoms. Concerns about the future, their appearance during the illness, and their loss of independence were withheld more than 80 per cent of the time.[17] Patients make their own judgments about what doctors, nurses, and other health professionals can bear, just as they choose to withhold information from family and friends. The capacity to listen empathically to all of a patient's concerns, but particularly to concerns about death and dying, is a powerful therapeutic intervention.

There are four key aspects of human experience that give rise to most of the concerns that humanity shares. Irvin Yalom summarises them as four 'givens': *'the inevitability of death for each of us and for those we love, the freedom to make our lives as we will, our ultimate aloneness and, finally, the absence of any obvious meaning or sense to life'*.[18] Because of their fundamental importance, it is possible to listen for the words that patients typically use to express issues of deep concern. Expressions of concern about unexplained symptoms or compromised function foreshadow their fear of death. Whenever patients use words like 'choices' and 'decision' they are acknowledging the dangerous side of free choice, and are usually seeking expert advice and support. 'Aloneness' is never more acutely felt than when a diagnosis of serious illness seems possible. Children may express their aloneness as unexplained tummy pains or a refusal to go to school. Adolescents may express it by the parsimony of their language when dealing with health professionals whose ability for genuine empathy they doubt. Finally, questions about the meaning of life become increasingly significant with the passage of time or when a serious illness occurs. Even patients who have a deep religious conviction may find themselves questioning the security of their place in the world. Inevitably the careful

listener recognises one, but usually more of the words that convey these fundamental concerns in all but the briefest consultations.

The therapeutic benefits of listening are available to both patient and doctor. Listening to patients' deepest concerns is a great privilege. Patients' stories arise out of a range of experiences that may have included wartime experiences, deprivation, suffering, loss and grief, courage, and achievement. Careful listening enables the attentive doctor to benefit personally and also to act as a faithful witness, carrying information from one patient to another. A patient who has survived a difficult illness and who has found a way of coping can benefit another patient via the doctor who tells the second patient (with due regard for confidentiality) a little about the experiences of the first. Doctors probably rank second only to family members as recipients of this experience and understanding.

Doctors also derive important but less uplifting insights by listening to patients' stories of greed, jealousy, intimidation, anger, manipulation, sadness, and helplessness. Listening can be a life-saving skill if it enables the doctor to detect the situations in which a patient's reference to suicide or violent intent is more than an expression of extreme emotion without intent.

PROBLEMS WITH LISTENING

Listening can be compromised by the listener's fatigue, by denial, by prejudice, by the repetitious complaints of the hypochondriac, by the challenge of confronting the difficult patient with some truths and by the doctor's own personal worries, particularly if they are similar to the patient's.

Although some of these problems are inevitable at times, there exists an ethical obligation to approach the consultation fully prepared to devote attention to the patient's concerns. This may mean careful attention to the daily and weekly schedule in order to provide sufficient time for each consultation and for breaks. In the public health system, the doctor's control over pressures in the workplace may be limited, but some doctors nevertheless convey to patients respect and attentive listening, even when time is very limited. In the sphere of privately funded health care, fear of losing patients, personal greed or unrealistic expectations of how much consulting can be done within a certain time-frame, are chiefly responsible for setting up situations in which the doctor is too busy to listen properly. In both the public and the private system, acquiring the emotional maturity to listen well is the doctor's greatest personal challenge.

'If your only tool is a hammer, everything looks like a nail.'[19] The listening doctor's knowledge base influences what is heard and how that information is interpreted. Personal prejudices are also relevant. Women, who constitute a larger proportion of ambulatory patients, are particularly likely to be perceived as '**heartsink**' patients.[20] Doctors who characterise more of their patients as

causing a heartsink reaction were found to have lower job satisfaction, lack of training in communication skills and a greater perceived workload.[21]

An example of this danger posed by bias can be illustrated by the experience of the gynaecologist who was consulted for the first time by a woman aged 50 who complained of headache and depression. The gynaecologist attributed these symptoms to the menopause. Six months later the woman died from a brain tumour that could have been diagnosed and treated if the gynaecologist had examined her fundi, noted the marked papilloedema and referred her to a neurosurgeon. The gynaecologist's listening ear was attuned to a limited number of histories. Had the woman consulted a neurosurgeon, his or her familiarity with this presentation could have led to immediate diagnosis and treatment. The fact that in some countries such as the USA gynaecologists operate as primary care providers increases the possibility of premature closure on such symptoms—the hammer and nail problem. Listening must be accompanied by an active inner process of questioning, hypothesis generation, sifting, differential diagnosis, and hypothesis testing. Premature closure can have tragic consequences.

Other problems with listening include the competing needs to feel in control, to impress, and to transmit important information. Understanding that there are limits to patients' ability to absorb information at any particular time can result in a better balance between listening and informing.

LISTENING TO FAMILY AND TO OTHER PROFESSIONALS

Listening to people other than the patient can facilitate understanding of the patient's problem, but it will inevitably introduce an element of bias. The advantages of obtaining such information should clearly outweigh this inevitable disadvantage. Preconceptions about the nature of the clinical problem, including preconceptions gleaned from other health care professionals, can compromise accurate diagnosis. It is important to balance the value of listening to others against the value of forming one's own view, based on the patient's own story.

Listening to the contribution of patients' family members requires special listening skills. Anxiety may lead family members to exaggerate symptoms in order to ensure that their parent, spouse, or child receives prompt and sympathetic attention. On the other hand, family members find it extremely frustrating to have their input discounted. The axiom in paediatrics is that *'every mother is a world expert in her own children'* and there can be no justification for ignoring the information that parents bring.

Listening to insights offered by other treating practitioners of all disciplines or by fellow professionals can be extremely helpful, since every observation is filtered by our own biases. These same biases can make it difficult to accept the advice of colleagues, and taking the time and effort to explore the reasons for

such reluctance can lead to particularly valuable insights. Asking oneself why one finds it difficult to consider certain opinions voiced by other professionals can yield valuable self-knowledge. Nursing staff often find it frustrating when doctors appear not to listen to their opinions,[22] and women working within any occupational group are aware that they are less likely to be 'heard' than men.

LISTENING IN DIFFERENT ENVIRONMENTS

The emergency room, home visits, and crowded wards all pose different challenges for the listener. In each case there can be considerable distractions. Whenever possible, distracting features of the environment should be removed. These may include visual distractions, family members, and excessive noise levels. Even the act of drawing curtains around a bed can enable the listener to hear the patient more easily, even when the noise level remains the same. Wherever possible a quiet space should be used. Television and radio turned off for the duration of the interview. If circumstances permit, it may be better to obtain a brief history and return later in the hope of fewer distractions. When this is not possible, documenting the context may be an important element of the medical record, making it clear that the circumstances, being less than ideal, may have compromised the doctor's opportunity to listen to the patient's story.

One special context for listening occurs when both patient and doctor know that the patient has a serious illness. Maguire et al. have shown how hard it is to maintain a listening attitude at this time.[23] The doctor's psychological adjustment is important,[24] and this underlines the need for professional care-givers to attend to their own emotional well-being before they can be free to listen openly to their patients.

CAN LISTENING SKILLS BE TAUGHT?

Listening skills are only one of the communication skills that can be taught.[25] An attentive posture, lack of hurry, appropriate eye contact, and minimal encouragers all contribute to the listening state.

A simple method to prevent precipitate action is taught to beginning parachutists: take a breath and repeat the words *'Not now, but now'* before pulling the cord. Medical students and inexperienced doctors can apply this rule in order to achieve an appropriate 'wait time', especially in the early stages of a consultation. Audiotapes and videotapes of consultations can be used to find out whether or not patients are being interrupted or redirected during consultations.

Recognising the key words that refer, directly or indirectly, to death, key decisions, loneliness, or questioning the meaning or significance of illness can

unearth a rich lode in the search for better understanding of each patient's individual concerns and the significance of their individual experiences.[26] Again, tape recording can be valuable as a means for reviewing consultations for messages that may have been missed.[27] These supporting activities can help the clinician to maintain the habit of **reflection** that is critical to the development of finely tuned listening skills.[28]

NOTES

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