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Listen: When words don't come easy

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ABSTRACT

Objective: Listening is at the very heart of communication in healthcare, but largely ignored in research and teaching. This paper presents different perspectives on listening within the context of healthcare and its implications for goal-directed communication.

Methods: The assets of listening are examined from several angles (the listening patient, the listening health professional, and the listening self) and illustrated by the results of relevant research.

Results: Listening is a multidimensional concept and serves different purposes in healthcare. To benefit fully from its potentials, the listening attitude and skills of patients and health professionals need to be enhanced through interventions at the level of policy, practice and research. Results from research evaluating creative and innovative ways of strengthening persons' listening skills are encouraging.

Conclusion: Listening has underused potential which can be boosted by interventions directed at the level of healthcare policy, practice and research.

Practice implications

For healthcare practice, it is helpful to keep in mind that listening involves more than hearing what the other person says; one also needs eyes, a heart, and undivided attention.

1. INTRODUCTION

In many research and teaching projects that aim to improve medical communication, one tends to treat communication in a reductionist way by focusing on distinct aspects such as providing empathy, information-giving or reassuring. These are, without doubt, important communication elements that need to be cherished and promoted, but move away from what can be considered an essential and basic requirement in every human interaction, namely the very art of listening. The

moment people meet and start to exchange thoughts, feelings and information, listening becomes indispensable. In medical encounters, listening is relevant for fulfilling the affective as well as the instrumental communication needs that patients bring forward in a more or less explicit way. By listening, a health professional indicates that the patient's voice counts, whereas a listening patient makes clear that he or she appreciates an expert opinion. Listening is, however, no easy task to accomplish. After all, does a health professional hear the message the patient wants to convey, and how does he know? What is the meaning behind another person's words? The present paper provides an overview of different elements and perspectives that are central to the concept of listening and depicts listening from angles relevant to healthcare practice. By clarifying the meaning and value of listening, a more goal-directed use of this partly neglected concept in daily healthcare might be achieved.

2. LISTENING PERSPECTIVES

In their white paper, Bodie et al. present five perspectives on listening (Table 1). Of these perspectives, listening as social interaction has the most obvious relevance for healthcare interactions [1]. Another perspective on listening, being an act of acquiring the perspective of the other person, appeals more to ethical principles and should as such be considered as a prerequisite for good person-centred clinical practice [2]. Unfortunately, the perspective of the other person is not often explicitly sought nor considered in interactions between health professionals and patients. This has partly to do with a perceived lack of time ("I already have to spend so much time on explaining the treatment"), but also because long term healthcare relationships – incorrectly – do not seem to require this ("I have known this patient for such a long time, I know how she feels about having to take this medication") [3]. Needless to say that in every medical encounter listening is needed to, at least, ascertain oneself if there are relevant circumstances that have forced a person to change his perspective, in this case the patient's attitude or point of view on taking the prescribed medication. In addition, many patients are confronted with a talkative health professional who does not allow them much space to interrupt or have a say themselves, even though, in the hippocratic oath – with which every physician is obliged to comply – listening to a patient is key to good clinical practice [4] ; [5]. What would one gain from putting listening higher on the agenda of every medical interaction? Janusik and Imhof provide four dimensions of listening relevant for healthcare interactions: information acquisition, relationship building, learning, and evaluative listening (Table 2) [6]. Every listening dimension has its own working mechanism and objectives. In their paper, Janusik and Imhof also present an adapted systems model on listening [6]. In this model, listening – as the (non)verbal facilitation of patient talk [7] – produces desirable outcomes (e.g. empathy, self-disclosure, understanding) provided that personal factors of the listener (e.g. knowledge, ability, memory span) as well as characteristics of the listening context (e.g. objectives, power conversational rules, speaker characteristics) are taken into account. Clearly, listening is no unidimensional concept. Besides, not only ears matter when listening attentively, but listening is something for which one also needs eyes (patient-directed gaze), a heart (compassion), and undivided attention. This is clearly depicted in the traditional Chinese character for listening which is nowadays

still used in Hongkong and Taiwan (Fig. 1). Given this multidimensionality, a good listener does not only 'hear' content, but also underlying emotions, *meta*-communication, atmosphere, etc. What is more, listening can not only be looked upon as an interpersonal act, relevant from the point of view of both patient and health professional, but also from an intrapersonal perspective, i.e. the listening self.

[TABLE 1] [TABLE 2] [FIGURE 1]

2.1. The listening patient

The starting point for a perspective on the listening patient is the, rather cognitively oriented, definition from The International Listening Association which indicates that listening is "the process of receiving, constructing meaning from, and responding to spoken and/or non-verbal messages" [8]. Listening clearly poses high demands on a person's attention and participatory skills and also seems to be highly context-dependent [9]. In the context of being seriously ill, listening requires extra effort from patients, as emotional arousal and physical symptoms interfere with the attention required to listen [10]. While there are patients who, during their illness trajectory, evolve from a state of being an overwhelmed and passive listener to that of being more actively engaged and attentive, especially for older patients and those with lower health literacy skills this process often falls short [10]. Our survey among 1314 patients with a chronic illness shows that about half of them experience barriers in communicating with their health professional and more than one out of three would welcome some sort of support (e.g. a personal coach or question prompt list) to enhance their communication skills [11]. One of the barriers that patients experience is that of being so preoccupied with momentary concerns and fears that listening becomes impossible [11]. Such communication barriers are especially prevalent among patients with an inadequate or limited level of health literacy, i.e. 12 and 47 percent of the European population, respectively [12]. This group of people includes many persons with a lower level of education. Stress-induced limited health literacy may, however, also be a temporary state in higher educated persons; a phenomenon that so far has not received much attention in or outside the consulting room. By enhancing their communicating skills, patients' communication self-efficacy may increase which is likely to result in improved 'listenability' [13]. Patient's communication skills can be enhanced in different ways. On a policy level, patients and patient organisations can professionalize their expertise as patient. In the Netherlands, different courses for patients are being offered for this purpose, ranging from communication skills training courses and courses aimed at enhancing the input of the client perspective in research and training to learning to provide peer support. On a practice level, a patient coach [14] or a preparatory web-based intervention can enhance patients' communication skills needed for an effective medical interaction. Examples of the latter are PatientTIME and Patientvoice, computer-tailored interventions consisting of videorecorded best communication practices, a question prompt list, and a facility through which patients can listen back to their own audiorecorded medical visit [15] ; [16]. These interventions, which we have developed and evaluated with increasing input from the end-users, appear to be well-used and accepted and to change patients' attitude towards their role and participation in medical visits [17]. On the level of research, patients' input is sought more and more too. Traditionally, clinical studies are performed *on* patients. This has

gradually moved from research *for* patients (patient centred research) to research *with* patients (person centred research). Characteristic for the latter type of studies is that patients contribute to setting research agenda's, collecting data and interpreting results. Apart from research methods, a patient's voice can also be incorporated – instead of taking for granted – in study designs. An example of a more person centred design is the patient preference trial (PPT) [18]. A PPT examines the causal effects of choosing a treatment rather than being randomly assigned to a treatment and thus represents more closely the conditions of usual clinical care [18] ; [19]. This is highly relevant as, especially in case of highly preference-sensitive treatments, a specific preference for (or against) one of the treatments under study may moderate treatment efficacy and acceptability [20]. As a consequence, there may be treatment effects that result from patient preferences and not from therapeutic efficacy [21]. A traditional RCT does not listen to a patient's treatment preference but makes an assumption of equipoise; the treatments under study are considered to be equally desirable. A PPT explicitly examines this role of treatment preferences and may increase a patient's feeling of being listened to. Still, this does require a professional who listens to a patient and who is capable to elicit patient preferences even in a stressful context of being seriously ill.

2.2. The listening health professional

In today's Western medicine, the patient's voice counts and so do his preferences, needs and values [15]. To make their voice count, patients need a health professional who listens to them. In their study in women with breast cancer, Harris and Templeton show that listening on the part of physicians is indeed a highly valued communicative act [22]. For patients, listening has three functions: 1) Listening is an essential component of clinical data gathering, and indispensable for making a diagnosis, or for choosing a therapeutic intervention; 2) By being stress-reducing, listening is a healing and therapeutic agent; and 3) By communicating respect, listening is a means of fostering and strengthening the doctor-patient relationship, (provided that listening is authentic) [23]. This means that when a health professional does *not* listen, the quality of care is threatened. After all, clinical data gathering may fail resulting from selective hearing, wild guesses and interruptions and from relying on notes or text books instead of current symptoms or patient records; healing and therapeutic power is lost resulting in less effective interactions and more ineffective reassurances; and the doctor-patient relationship weakens, as patients get the message that their opinion does not matter, which may result in dissatisfaction, suboptimal adherence, doctor shopping, second opinion and a diminished trust in medicine [24]. Teaching health professionals to listen effectively should therefore come first in communication training courses, either by enhancing their listening techniques, by promoting a listening attitude [25] or both. The results of a pilot study by Martin and colleagues suggest that listening should be taught as an attitude [25]. Compared with a group of medical students trained in the *technique* of listening, the group trained in listening as an *attitude* responded better to patients' feelings, as perceived by participants as well as observers. Such an attitude is likely to thrive most when one is conscious of one's own inner voice.

2.3. The listening self

Listening to oneself seems an essential step in becoming an effective listener. Such experiential learning (i.e., learning through reflection on doing) can for instance be accomplished by looking back at one's own video-recorded medical visits. In a study on the content and process of communicating about medication use and adherence, we conducted such reflective practice interviews with 20 general practitioners (GPs) to find out what reasons they had to communicate about these topics with their patients during video-recorded medical visits the way they did [25]. For many GPs, watching and commenting on their own visits was a real eye-opener, they had no idea that they were so easily distracted and moved away from the patient as often as they did. A similar methodology was successfully used with patients in so-called stimulated recall sessions supported by video-recordings of patients' own medical visits [26]. Apart from these types of self-assessment, people also learn from receiving ratings of their own performance. For the assessment of listening, one can use different measures that each captures a different aspect of listening such as the Listening Styles Profile (LSP-16) [27], the Conversational Listening Span (CLS) [28] and the Listening Concepts Inventory (LCI-R) [1]; [29], or assess a person's Listening fidelity [30]. Listening skills can also be measured by observing these behaviors in daily practice. The 7-item 5-point Likert-scaled Active Listening and Observation Scale (ALOS) has been developed for this purpose and has, for instance, been applied on 524 video-recorded GP consultations with patients with minor ailments [31]. The results show that, in view of GPs' listening skills, there is room for improvement; in about one out of three consultations the GPs did not listen attentively and showed to be distracted and in two out of three consultations, no exploring questions were asked [31].

3. DISCUSSION AND CONCLUSION

3.1. Discussion

In today's healthcare with its emphasis on shared decision-making, patient engagement and participation, the patient's voice counts. However, for various reasons, health professionals do not appear to listen enough to the patient's voice. Besides, within the physically and emotionally stressful context of being (seriously) ill, listening is not easy to accomplish for patients either. In this paper, I have described that interventions on the part of the patient as well as the health professional are needed to give the act of listening the attention it deserves [32]. After all, listening serves many purposes in healthcare and may produce desirable patient outcomes [23]. Besides, patients value a listening professional highly [22], which has therapeutic benefits in itself. I have argued that, to be effective, listening interventions should not only be directed at the professional-patient interaction, but changes are also needed at the level of policy and research. How such interventions should be done, is not clear yet. Whereas the pilot study by Martin et al. suggests that a training focused on a listening attitude has more effect than a training in listening skills [25], Jagosh and colleagues recommend both, i.e. a focus on "the skill required in listening attentively but also to the values, beliefs, attitudes, and intentions of physicians who choose to listen to their patients" [23]. In the selection process for students who want to enter medical school, more and more attention is given to how they value and perform different communication tasks, such as listening [33]; [34]; [35]. This may lead the way to more person-centred training programs with,

depending on the outcomes of the selection tests for a given individual, more or less emphasis on listening as a technique or an attitude. Given the results of previous studies, these training programs should at least reserve ample time for reflection on a person's own listening skills.

3.2. Conclusion

Listening in healthcare has underused potential which can be boosted by person-centred interventions that take individual capacities and motivation into account. In addition, to have a person's voice count more, listening should also be incorporated in policy measures, research methodology and study designs.

3.3. Practice implications

Apart from the teaching implications mentioned above, it is important to bear in mind that listening is an act for which one needs ears, eyes, a heart, and undivided attention. For those who feel that applying these prerequisites is too difficult to accomplish in busy, daily healthcare, it is important to keep in mind that, as pianist Alfred Brendel has put forward, the word *listen* contains the same letters as the word *silent*.

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TABLES

Listening perspectives [1].

Listening as social information processing
• A task carried out in a social, interactive, or communicative environment
Language learning
• Language acquisition
Listening as an ethical endeavor
• An aid in acquiring the perspective of the other
Listening as experiential
• A natural and creative process
Listening as social interaction
• Communal activity, therapeutic listening

Listening perspectives [6].

1. Information Acquisition
– comprises intentional and active information processing
– causes a high cognitive load
– needed for storing and retaining information, drawing conclusions
2. Relationship Building
– showing care
– building and maintaining a relationship
– needed for helping, comforting, bonding
3. Learning
– connect incoming stimuli with prior knowledge base
– needed for learning, interpreting, analyzing, understanding
4. Evaluative Listening
– needed for answering, arguing, conceding, being critical



Fig. 1. The traditional Chinese character for listening.