Listening with intent

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Know how to listen and you will profit even from those who talk badly.

Plutarch

ABSTRACT

Listening in medicine is only of value when it is combined with an ability to decipher the patient's utterances and gestures and act upon them

How I learned to listen

On my second medical firm, I had the opportunity to watch an expert listener at work. In the 1960s, Wallace Brigden was one of Britain's leading cardiologists and like almost all his colleagues on the staff at The London Hospital he was an Osle- rian (figure 1). We were expected to be in attendance 10 minutes before the start of clinic and on arrival he would give us a nod before sitting down at the desk. After reminding the sister-in-waiting that he must not be interrupted except for an emergency he would then rise, walk to the door and call the first patient in. After introducing himself, he would usually start with a few pleasantries before asking what it was that had prompted the patient to see her general practitioner. Leaning forward slightly in his chair, he would then attend to the presenting complaint with a lowering or raising of his inquisitive eyebrows. His eyes rarely strayed from the patient's face as he listened in silence. When the patient stopped talking, he would sometimes restate what he had heard to minimise his assumptions. He might then ask one or two open questions like, 'Can you say a bit more about the pins and needles in your left shoulder?', Can I go back to when… or with a squeezing gesture of his hand 'so the pain was heavy and constricting?' He would then pause, open the case notes, read the letter of referral and write down the salient aspects of the presenting history. In his relaxed, unflustered way he would then elicit the medical and family history and conclude the interview with no more than three or four plain questions relating to aggravating and relieving factors of the presenting symptom, its severity, duration and radiation. It was usual for him to probe beyond the purely physical especially in people recovering from a heart attack. His eyes never gave away his thoughts about the diagnosis to either the patient or us. He never interrupted and avoided giving premature reassurances or advice.

After he had completed the examination and concluded the consultation he would often turn to us and ask if we had any questions. After the patient had left he would then try to put into words how he had determined that the symptoms had arisen from the heart. As a cardiologist who always had a stethoscope in his hand Brigden understood better than most the value of listening and its distinction from hearing. At the end of clinic, he encouraged me to go to the wards and pay attention to his patients' stories, record what I remembered then read back what I had written to the patient. Medicine was a personal science and by involving me he got me to understand. For Wallace Brigden, time at the bedside was never wasted.

MEDICAL EDUCATIONAL APPROACHES TO LISTENING THAT ENGAGE THE ARTS AND HUMANITIES

To emphasise to undergraduates that clinical listening is not merely a sensory process, medical educators at McGill University use a musical analogy. They show medical students a musical score while listening to two different musical interpretations. It becomes evident that while the score is identical the musicians colour their interpretation with their choice of instrument and their own lived experience. In the case of a musical concert just as in any communicative act, the listener's interpretation and judgement are an inherent part of the interaction.

Another technique used to overcome bad habits in history taking such as premature reassurances, interruptions, discomfort with long pauses and insufficient use of open-ended questions was to ask the students to read several prepared

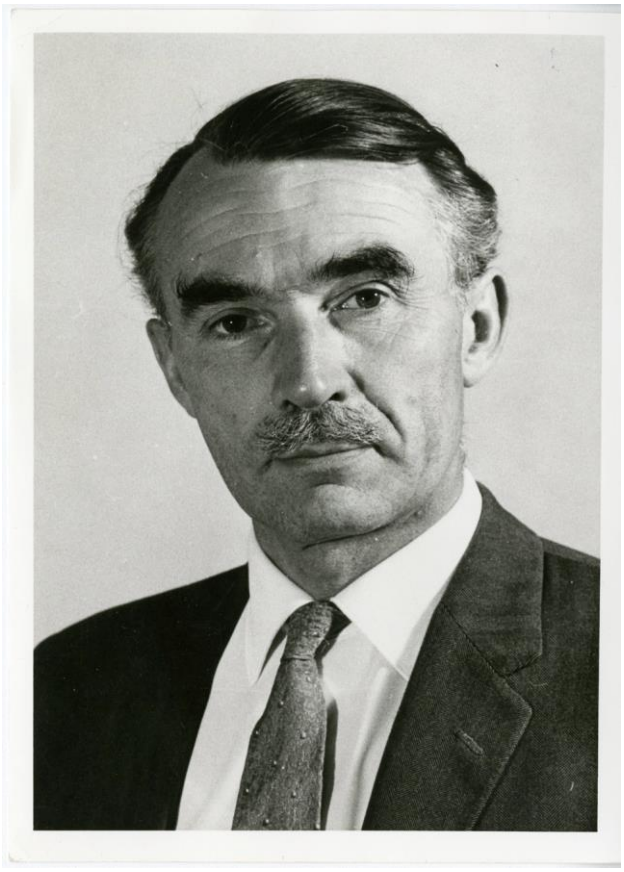

Figure 1 Wallace Brigden in the 1960s (Bart's Health Archives and Museums).

transcripts of a patient's history and after guidance from the instructor then attempt to represent the voice of the patient. Finally, a recording of the patient's authentic utterance was played to the student listeners. During these exercises, the student was encouraged to focus on the rate of speech, the pause to speech rate ratio, the tone, pitch and volume of voice and articulation.[1]

The study of medical humanities should expose students to a climate of thought and reflection and not be preoccupied with narratology and post modernism. Many of its teachers who have no responsibility for making and acting on correct diagnoses see the clinical history in terms of a story set against a background of culture, gender and socioeconomic status, and as Raymond Tallis wrote in Hippocratic Oaths as 'a hermeneutic power struggle with the omnipotent doctor crushing the powerless patient with his version of events'.

THE BUGLE OF A BLACK SWAN

The cause of a neurological malady is rarely presented on a silver platter but when given the opportunity to speak openly and without fear patients and their family can not only guide you to the correct diagnosis but reveal hidden agendas, describe phenomena not recorded in the medical literature and even contribute new insights into disease mechanisms.

Twenty-four years ago, a 42-year-old Polish man from Gdansk who worked as a plumber was referred to me at the Middlesex Hospital with a stiffness that had been getting slowly worse. As soon as I called him in from the waiting room it was obvious he had the signs of parkinsonism. He was hesitant to rise from his chair, and as he walked in he had a hang dog posture with flexion of his motionless arms at the elbows. When I greeted him at the entrance to the consulting room, I was struck by his fixed anxious stare. Apart from the fact that he was adamant that he had been completely well up until 2 months ago the history gave me no clues to the likely cause. There was no history of a febrile illness before the onset of his symptoms and no known exposure to toxins or neuroleptics. His girlfriend corroborated his story. Examination revealed that he had moderate progressive slowing of speed and amplitude on finger tapping bilaterally, a mild intermittent tremor of two fingers of the left hand at rest and he scuffed his feet when walking up and down the corridor.

I told him that he had Parkinson's syndrome and that I wanted to do some tests to find the cause. His job was in jeopardy so I decided to start L-DOPA (co-beneldopa 12.5mg/50mg t.d.s) and told him to double the dose after

Figure 2 (A) San Ling's in Goodge Street. 2 (B) Luo Fo mu root (Rauwolfia verticillata).

a week. I made him an appointment for 6 weeks time. An MR scan of the head came back normal and blood and biochemical tests found no evidence of systemic illness.

On his return to the clinic, he strode in with a smile on his face and informed me that he was cured. The only abnormal sign I could now find was mild cogwheel rigidity at the left wrist. When I expressed my pleasure and a hint of surprise he told me that his girlfriend, had asked him to enquire whether the Chinese herbs he was taking for stress and high blood pressure might be the cause. He then showed me a small white canister with Chinese writing on it that he had bought from San Ling's on Goodge Street close to the hospital. He was my last patient of the morning and although I felt a causal relationship to be unlikely I accompanied him to the shop where the owner told us that the herbal medicine was called verticil in English and that it was made from the roots of a Rauwolfia species (figure 2A,B). Reserpine, the alkaloid present in the roots of this family of evergreen shrubs is known to deplete brain catecholamines and was marketed fifty years ago in the West as an antihypertensive before it was realised that depression and iatrogenic parkinsonism were the side effects.

I told him to stop the Chinese herbs immediately and taper off the L-DOPA over the next 4 weeks. At final follow-up, he had fully recovered without the need for long-term dopaminergic replacement. I felt pleased I had listened to his casual remark at the end of the consultation and gone the extra step to follow a clue.

FINAL WORDS

Despite his well known adage, 'Listen to your patient, he is telling you the diagnosis, William Osler wrote much less on how to take a history than he did on the other foundational skills of observation and examination.

Attentive listening is different from hearing and requires great sensitivity, intuition, patience and versatility. Our antennae, as well as our ears, are needed to make diagnostic sense of what is being said. All words are populated with intentions and there are no neutral words. In Through the Looking Glass, Humpty Dumpty says scornfully to Alice that when he uses a word it means just what he chooses it to mean, neither more nor less. In similar vein, Joseph Conrad wrote that 'Half the words we use have no meaning whatever and of the other half each man understands each word under the fashion of his own folly and conceit' Listening with a third ear involves taking notice of word choice as well as tone of voice and associated gestures.

The pressure to see more patients in less time and the distraction of computers and smart phones has contributed to a diminution in focus. In some medical specialties, the medical interview has become little more than a series of closed questions and scales filled in by the patient while waiting to be seen. Ironically, as health technology with its veneer of certainty has advanced, patients have become ever more desperate to be heard and for their laments to be acted on.

As I have slowly lost my grip on the latest medical literature I have become a much better listener and probably a better neurologist. Although I still take pride in my clinical acumen and consider a missed diagnosis or a false label as a serious error, I better appreciate the impact illness has in rupturing a patient's hopes and dreams. Listening is not only important in making an accurate diagnosis but also in coming to understand the treatment choices our patients decide to make and the lives to which they must inevitably return. Being heard is a transformative ritual that facilitates healing.

Key points

- Attentive Listening is a transformative ritual that facilitates healing but to be diagnostic it requires the ability to know what part of the narrative can be ignored and what is important.
- Listening is different from hearing and requires great sensitivity, intuition, patience and versatility
- Whenever possible listen to what the family have to say as well as the patient.
- History taking also involves asking the right open ended questions.
- It is not uncommon for the most important diagnostic clues to come right at the end of the story.

Further reading

Bernard Lown. The Lost Art of Healing: Practising Compassion in Medicine. Ballantine Books. New York 1996.

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