Physician as listener

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> Your face is full of attention, full of listening. How I remember that face!.… How you trusted your power of listening, your state of attention.… I know now that this is why you devoted yourself to medicine.…
>
> —*Jacob Needleman*[1]

… well, interesting that you should ask, but, yes, there have been several such incidents that stand out for me. May I tell you one of them? The first happened a few years ago, when a patient taught me an important lesson. I met a middle-aged Native* gentleman on one of my regular visits to a nearby native community. This patient had come in because of a chalazion. When we finished discussing that issue, I asked him whether he had any other concerns; he said there were none. The waiting room was quiet, and I knew no one else was waiting, so we chatted. After years of visiting the community, the man and his name were unfamiliar to me. "So where are you from, what brought you this way?"

As it turned out, the fellow had come from another part of the country to visit a cousin, but the cousin was away. Because it was a cold fall day, I asked the patient where he had spent the previous night. He said he had slept in an unheated barn. It was October. When asked how that was, he responded "not very good." In fact, he had tried to hang himself that morning in the barn just before coming into the clinic to discuss his eye problem. The rope broke. He heard there was a doctor visiting the community, so he came to see me about the lump on his eye. We talked about his depression, I admitted him to the community hospital, and arranged for counseling.

I was rather shaken to think what would have happened had the clinic been busier, as it often was, or had we not chatted about his unfamiliar name. I learned that listening has a lot to do with practising medicine.

In training family medicine residents and medical students, we often describe our role as "listeners." We focus on how well they "listened" to the patients that day. The learner and I often discuss how to relax during an interview so we can listen better. Despite the fact that physicians spend a lot of time listening, not much has been written about this skill, even though patients identify it as crucial.[2]

What role does listening play in family practice? Is it a skill we can learn or teach? If so, how? Does a typical family doctor evolve over his or her career, from a "doer" to a "listener"? Do we move from a biomedical to a patient-centred paradigm[3] while training as family doctors? Does the evolution of the role of physicians[4] parallel this developmental[5] change? And finally do we listen on two levels at the same time: one, the disease detective, the other an interested fellow human being?

Historical development of medicine

Centuries ago, western medicine followed the shift[6] in society's faith in religion to faith in science. Medicine evolved from the simple classification and naming system of Sydenham to what is usually referred to as the biomedical model.

The mechanistic nature of this biomedical model was tempered by systems theory,[7] which introduced concepts, such as homeostasis and feedback, approaching an organic model. This mechanistic or scientific[8] paradigm remains central to modern medical conceptualization. Causality has evolved: bad vapours gave way to biochemical, infectious, genetic, and multifactorial processes. Evolving technology is a tool and, some would say, a central determinant of our societal infrastructure, engendering a culture of compliance[9] and one-way communication.

Parallel to these conceptual, cultural, and technological developments is another stream of thought: patient-centred medicine,[3] which finds its home in family medicine. Patients present with issues and problems that might be disease-related or involve diagnosis. The starting point here is patients' experience of illness, their personal context, and resources. Familiar terms, such as diagnosis, give way to problem solving.[4]

Native is used in this article to refer to the indigenous and aboriginal inhabitants of Canada and their descendants.

← FOR PRESCRIBING INFORMATION SEE PAGE 424

Patients therefore lead the discipline of family medicine beyond a simple biomedical perspective[10] into a generalist or patient-centred approach. Ian McWhinney outlines how family medicine uses this approach in the 1996 Pickles Lecture[11] by describing its four elements:

- the doctor-patient relationship defines the discipline,
- generalists think in terms of individual patients rather than generalized abstractions,
- its basis is an organismic rather than a mechanistic metaphor (ie, concepts of growth, healing), and
- patient-centred thinking thereby transcends the dualistic division between mind and body.

Historically, we have two divergent paradigms of medicine and subsequently two approaches to how we listen to our patients. One is patient-centred and the other is disease-based. How do they affect our listening? How are they involved in our development as physicians?

Development of physicians

… Why, yes, I do recall another incident that has stayed with me since my medical school days. During a rotation in family medicine, I had assessed an older patient for a simple medication renewal and was followed back into the room by my family medicine preceptor. The patient was a retired railroad man. After dealing with the presenting complaint, the physician sat in rapt attention as he asked the patient about his life, why he had moved to this area, his career on the railroad, and his retirement as a single man.

This struck me as odd or at least medically unnecessary, as it did not directly concern the presenting complaint. The image has stayed with me: the patient sitting with his back to the window, the sun streaming in through the blinds, and the physician with one elbow leaning on the desk and a smile of satisfaction, intently listening to the patient's story. It was years before this made sense to me.

Lifelong medical education is both a socialization and an educational process.[12,13] How we listen is affected by why we listen and how we think. Medical learners are engaged in a series of developmental tasks[5] throughout and even beyond their training.

Is it true that "Only after students have mastered the biomedical approach do they become comfortable again to talk with patients about what the patient wants to talk about?"[5] Developing a knowledge base and a comfort level with the emotional tasks of their personal and professional growth will play a large role in physicians' ability to listen to what patients have to say.

In a family practice, patient-doctor relationships develop over time. Students and residents are in a different situation. Patients are new to them. They are inundated by disease classification, physical examination, and consolidation issues, often at the same time. As educators, we need to be in tune with learners' developmental issues and how they affect listening and learning. Ultimately, we are their role models as listeners.[14] "One way to teach it (listening) is to listen to the students."[15] Beyond educational circumstances, listening requires a degree of self-knowledge:

> Understanding the emotions is person to person, and we cannot attend to another person's emotions without attending to our own. The key is still attentive listening. To listen to a person with total undivided attention is one of the greatest gifts we can bestow. It is listening not only with our ears, but with all our faculties, especially with an open heart.[15]

Over a clinician's career, self-knowledge will develop along with issues of problem solving,[16] boundary maintenance, and personal and professional identity,[5,17] which require "an internal change of heart;… one's inner life affects one's ability to listen."[15]

> There is a thrill in making a good diagnosis, and there can be beauty in a radiograph. But this is not the same as a feeling for the patient's experience of illness—and patients are very quick to sense the difference. If we are to be healers as well as technicians we have to… walk hand in hand with our patients through the territory.[15]

If relationships are the hallmark of family medicine,[11] then listening is its currency. We listen on several levels: intuition, verbal or non-verbal cues, emotional transference, relationship with a patient, knowledge of family and community setting, intellectually, professionally, and clinically. Listening is a developmental process for both medical practitioners and learners involving our clinical knowledge and our compassion.

A chaplain colleague of mine wrote: "If someone talks, you sit still and listen. If someone holds your hand or weeps on your shoulder, these are silent words. Listen, enter into the pain, and wait."[18]

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