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## THE ART OF LISTENING

*"He that has ears to hear, let him hear"*

*Jesus of Nazareth*

Listening cannot be faked. We can fool ourselves into believing we are listening, but we do not fool anyone else. People know whether we are present and paying attention to them, or if our mind is somewhere else. And that is what listening is really about.... Paying attention to and being fully present with another individual. Listening carefully to the patient's description of his or her problem has been identified as a key behavior in patient satisfaction (1,2). In one study, "a rushed consultation was considered unacceptable." (3)

On the average, American doctors tend to be poor listeners. Our public has come to accept the unacceptable practice of poor listening skills in our health care professionals. Although doctors of chiropractic have been given favorable ratings in the area of communication by some authors (4-8), this does not mean we are good listen-

ers. It would probably be more accurate to say we are just not quite as bad in this area as the competition. This article will explore the art of clinical listening.

Competent clinical listening is an art based on a solid understanding of the basic and clinical sciences and experience with people. Doctors who are good listeners have a reservoir of knowledge and experience that feeds the listening process. The broader our awareness, the more rich and specific our listening will be. We will hear things that others will miss. We will attach significant meaning to a detail that others will dismiss. We will hear what our patient is not saying, and ask clarifying questions that would not enter the mind of another practitioner. We will sense what our patient wants us to hear, and what they may wish to keep from us. We will hear our patients say to us, "You're different. You are actually listening to me. No doctor has ever done that before."

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There are five barriers to effective clinical listening that need to be explored as we consider this skill. The first hindrance is a low value placed on listening. This is often the result of absorbing the values of the third party payor system in this country. It is easy for us to get sucked into this value system and see ourselves as valuable only when "doing something", or ordering something to be "done" diagnostically or therapeutically. This is really a form of low self-esteem. We have forgotten who we are and have given our power away to the bureaucrats. We need to recognize that the most important thing that we offer patients is our wisdom and our understanding of human health, dis-ease, and disease. We listen to our patients because they are the greatest source of information about themselves and the problems they are experiencing. We "mine" this source to get the information we need to apply our knowledge to their situation. "Doing something" that is appropriate totally depends on this process. Incredibly stupid things are done every day in our health-care system because doctors don't listen. When the system's values affect doctor behavior this way, decadence happens. We need to take our power back psychologically and in other ways, and practice with

integrity. Another barrier to listening is a fixation on one's persona. The practitioner who is continually preoccupied with projecting an image (certainty, sincerity, success, whatever) is not readily available. They are off somewhere else in their own little narcissistic world. The excessive focus on "acting like a doctor" or "selling the report of findings" takes energy away from actually being a doctor who is psychologically available for patient care. An element of self-forgetfulness is needed in order to be adequately out focused and fully present for our patient.

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Another barrier to effective listening is a poor model of care. This is the structuring of a practice so as to see as many people an hour as is physically possible, so the doctor has only a few minutes or so with each patient. Often the task of listening is then delegated to ancillary personnel who do not have the knowledge or experience

needed for this process. When the patient does "see" the doctor in this type of practice, that is about all they do. There is scarcely enough time for a quick question or two, a couple of quick maneuvers (called an examination), and something done without much thought (called treatment). It is obvious that effective clinical listening and this model of practice are mutually exclusive. Listening is the enemy here. It takes too much time.

One of the most common barriers to effective listening is arrogance. This seems to be a character trait of many physicians, and D.C.s are no exception. Arrogance assumes that the patient is not a reliable source of information, and that any information that they do provide is not as important as "doctor sources": radiographs, lab tests, exam findings, etc.. "My hands will give me more information than any patient ever could" and "I don't care what the patient says, what do the films say" are a beliefs that get us into trouble because we end up overlooking our greatest source of information. Perhaps the ultimate arrogance is fundamentalism. Whether it is "One Way to God", "One Way to Practice", or any other "one size fits all" belief system, the fundamentalist has no need to listen because they already have the Answer. This is the ultimate barrier to listen-

ing and learning.

The final barrier to listening is being overly "map identified". We all build mental maps to deal with the complexities of reality; and clinical reality can be quite a wilderness to get lost in! However, sometimes we look at our maps too much, and ignore the scenery in front of us. When this becomes a clinical habit, we "name that tune" far too early in the song, and then turn off the music, pigeon-holing our patient before we have really heard them. We get away with this sometimes, but not nearly as often as we think we do.

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Maps change. The highway through the Columbia Gorge used to be called I-80 twenty years ago. Now it is called I-84. Our clinical "maps" need continual revision or they, too, become outdated. For example, it is inadequate to think only in terms of dermatomes, and not consider the more relevant sclerotomal and myotomal "maps" when considering pain referral patterns. Is that exquisitely tender place on the patient's sternum a Travell sternalis trigger point, a Jones AT4 counterstrain tender point, a C.V. 17 acupuncture point, a Chapman's pyloric stenosis neurolymphatic reflex center, a viscerosomatic reflex tenderness from myocardial ischemia, a component of metastatic disease,

or just a sore spot on the sternum? It is always good to remind ourselves that "the map is not the territory." There are few things as beneficial as setting the maps down and taking a good walk in the wilderness of clinical reality. This is how better maps are made.

How do we become better listeners? The same way we treat our patients: eliminate the barriers. Listening is a natural expression of being a healthy doctor. If it is not present, we are "subluxated" by ignorance, low self-esteem, poor models, greed, narcissism, arrogance, fundamentalism, or map focus. Take the foot off the hose. We cannot become competent clinical listeners until these barriers, and the reasons for them, are addressed. Beyond this, it is helpful to remind ourselves of the following:

- 1) The most important thing that we have to offer patients is our understanding of human health, dis-ease, and disease. We are a resource of knowledge, wisdom, and skill. The broader and deeper our awareness, the better doctor we are.
- 2) The patient is the greatest source of information

about him or herself and the problems they are experiencing. We tap into this resource by listening, so we can apply our knowledge to their particular situation. We mine this resource with specific questions to further clarify the clinical picture. This information engages our clinical thinking process and provides a context for the physical examination and ordering, or not ordering, diagnostic tests and/or imaging.

- 3) Listening takes time. Time can be saved by designing a thorough intake form and using it wisely. Time can be saved by being focused in our questions and by redirecting the patient who goes off on tangents. But... listening takes time. And if we don't schedule enough time to be able to listen we are not going to give good care. Period.

Listening has many benefits for those who practice. In addition to the information we gather, listening itself can be therapeutic. The person with persistent rib pain may metaphorically need to "get something off their chest." The person with back pain may be metaphorically carrying a heavy burden that they need to talk about. A few minutes of listening may be more

therapeutic than any adjustment we could give. Psychological risk factors have been shown to be a reliable predictor of surgical success or failure in chronic low back pain patients (9). These same factors are present in a manual practice, and by listening we are able to have a pretty good hunch about who we are going to be able to help with chiropractic care and who may need other approaches.

Listening is the basis of the doctor/patient relationship. Without it, what are we really doing, anyway? There is no relationship, just a mutual understanding that we are going through the motions of a silly game driven by third party payors. It is my belief and experience that the practitioner who has superior manual skills and who is a good listener can practice independently of third party payors. Many people today are willing to pay cash for good care.

Probably the most valuable benefit of listening is the education it provides, for listening is a school like no other. Listening is how we integrate and expand as a doctor. It is from this place that we exercise our clinical thinking muscles. All of our knowledge and experience comes into this act, and this can be quite rewarding. Even enjoyable. We enter the frontier of our

own individual learning by the process of listening. Our patients become our teachers about their particular reality with a disease or clinical disorder. We learn what we can help and what we can not help-if we listen. And not just clinically. There is the dance of personalities, roles, and expectations that is fertile ground for personal growth as well. If we notice ourselves, as an observer might, we will learn much. Because listening is a school like no other, and the learning goes deep, all the way to the bones.

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