

# Please Hear What I'm *Not* Saying: The Art of Listening in the Clinical Encounter

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*"Not every patient can be saved, but his illness may be eased by the way the doctor responds to him."*

—Anatolle Broyard

## Introduction

Near the end of Anne Fadiman's book, *The Spirit Catches You and You Fall Down*,<sup>1</sup> a tragic account of two cultures at odds with each other, the author tells the story of a Hmong patient who was being referred to a specialist for further treatment and, instead of inquiring about the physician's skill or credentials, he asked, "Do you know someone who would care for me and love me?"<sup>1p275-6</sup> It is an honest question that bears asking, and yet within its naked simplicity lies the deepest complexity. It is not the type of question one responds to quickly or without reservation, but it is one that deserves a thoughtful answer. It would not be incorrect to assume that beneath our own culture's fiercely held value of independence lies the very same question, for when all is said and done, isn't this what every person desires?

Unfortunately, the trajectory of medicine's increasingly one-sided focus on science and technology over the humanities has created an ever-widening gap between physicians and patients, resulting in decreased trust and confidence in a relationship that needs and

depends on it the most. "The price for a technologically sophisticated medicine," says physician Rita Charon, MD, "seems to be impersonal, calculating treatment from revolving sets of specialists who, because they are consumed with the scientific elements in health care, seem divided from the ordinary human experiences that surround pain, suffering, and dying ... Patients long for doctors who comprehend what they go through and who, as a result, stay the course with them through their illnesses. A medicine practiced without a genuine and obligating awareness of what patients go through may fulfill its technical goals, but it is an empty medicine, or, at best, half a medicine ...."<sup>2p6</sup>

Given these upsetting developments, the physician still remains a symbol of hope in a patient's search for relief from pain and suffering. The singularity of the clinician-patient relationship is what sets it apart, for it is the primary conduit by which all else follows. Characterized by a level of physical and emotional intimacy not found outside of the romantic relationship, the clinician-patient relationship connects the experience of illness with narrative meaning powerful enough to affect a patient's course of treatment and quality of life far beyond what one would imagine, oftentimes standing at the center of our most taxing bioethical dilemmas.

## Intimacy Without Intimacy

The clinician-patient dyad forms a relationship that is as unique as it is powerful, as rewarding as it is demanding. It is an intersubjective space fraught with many variables, and the vagaries brought on by illness and the potential chronicity thereof significantly heighten the stakes of such intersubjectivity, for the disruption of one's health and well-being and its accompanying fears and anxieties pose special requirements, obligations and demands that do not exist in other relationships.

The vulnerability of a patient who sits nearly naked under the glare of fluorescent ceiling lights as s/he waits to reveal details of a highly personal nature is such a repetitive scene that it's often taken for granted or overlooked by clinicians, and yet herein lays the paradox of intimacy without intimacy in the clinical encounter. The exposure of a patient's underbelly for the sake of a cure, of redemption, an ease of suffering, or simply a listening ear has traditionally been met with the stance of professional distance, resulting in a relationship of disappointment and compromise, wherein trust is easily breached and suffering is heightened. Yet it is in this very exposure and the intimacy it engenders that an accurate diagnosis and healing lie, for vulnerability is transparency in its purest form.

It is at this juncture of self and other in the clinical encounter that we take the risk of exposing ourselves, where we venture a thousand layers deep into our nakedness with the hope that the clinician standing before us will look past the edge of our wound, listen past the edge of our silence, and “hear the fragmentary language of pain, coax it into clarity, and interpret it.”<sup>3p6</sup> This meeting between two authentic selves is where an intersubjective relationship begins, and the transformative power of telling and listening to the plight of the other takes place.

Vulnerability is a key element on both sides of the clinical encounter, for when each is able to truly “see” the other, a reciprocal recognition occurs, allowing for a more authentic interchange. In a recent interview with physician Pamela Wible, MD, who has devised her own brand of medical practice far afield from traditional practice methods, she says, “The most important therapy I deliver is a human relationship ... I want my patients’ passions listed on their charts. Because if that’s not there, then the only thing I read is ‘endometrial cancer,’ carpal-tunnel syndrome, fibromyalgia, chronic fatigue, and mother died when she was 40 of breast cancer. I don’t want to look at this person and simply think, *she’s doomed*. I want to know what her passion is in life. Who is this person sitting in front of me? ... People come to the doctor for care and end up with a prescription. We need to get rid of this idea of professional distance and let physicians be vulnerable.”<sup>4p6,10,11</sup>

### Breaking Down Barriers

How can a physician shift from the traditional stance of professional distance to one of relationship? How can s/he relinquish that which has

served to protect him or her from the daily horrors of overwhelming pain and suffering in her patients? How can s/he expand the biomedical model to include a patient-centered, relationship-based one?

Writer and author John Berger, while accompanying an English country physician on his rounds, observed that the physician “never separates an illness from the total personality of the patient ... He does not believe in maintaining his imaginative distance: he must come close enough to recognize the patient fully ... This individual and closely intimate recognition is required on both a physical and psychological level ... The whole process, as it includes doctor and patient, is a dialectical one. The doctor ... must first recognize the patient as a person: but for the patient—provided that he trusts the doctor and that trust finally depends upon the efficacy of his treatment—the doctor’s recognition of his illness is a help because it separates and depersonalizes that illness.”<sup>5p73,74,113</sup>

Physician Sayantani DasGupta breaks down the wall of professional distance even further with what she terms “narrative humility,” which “acknowledges that our patients’ stories are not objects that we can comprehend or master, but rather dynamic entities that we can approach and engage with, while simultaneously remaining open to their ambiguity and contradiction.”<sup>6p981</sup> She encourages physicians to practice critical self-evaluation about issues such as their own role in the story, their expectations and responsibilities to the story, and their honest identifications with the story—how the story distances or draws them closer as it triggers their own stories.

The hierarchical imbalance of the clinical relationship is also ad-

dressed by DasGupta, in that “the socially more powerful player—the clinician—must willingly place herself in a position of some transparency. The clinician must not only see, but be seen, and by doing so, enable herself to see ever more clearly.”<sup>6p981</sup> Practicing this type of deep self-awareness and reflection enhances the physician’s most important therapeutic tool, the self, and as such aids in the development of a more empathic stance with the patient, thereby fostering the type of therapeutic alliance upon which authentic clinician-patient relationships are based.

### Toward a Co-constructed Narrative

In a narrative model of medicine, it is recognized that through a patient’s telling of his/her story of illness, and a clinician’s receiving, representing and interpreting that story, a co-constructed narrative is created. It is also recognized that when a clinician practices with narrative competence, this receiving is acted upon as if one is an empty vessel, whose import is simply to hold and to contain all that is put forth. Patients narratives are stories that may have been told and retold countless times before, or they could be stories that have not yet fallen into the rut of familiar recall, but regardless of their own temporal history, they all contain the same elements of a teller, a listener, a time course, a plot, and a point.

In listening to her patients’ stories, Dr Charon details how she’s had to “follow the patient’s narrative thread, identify the metaphors or images used in the telling, tolerate ambiguity and uncertainty as the story unfolded, identify the unspoken subtexts, and hear one story in light of others told by this teller. Like the reader of a novel or the

witness of a drama—who naturally do all these things seamlessly—I also had to be aware of my own response to what I heard, allowing myself to be personally moved to action on behalf of the patient. I was the interpreter of these accounts of events of illness that are, by definition, unruly and elusive.”<sup>2p4</sup>

Giving and receiving accounts of self is a dialogical process whereby the dimensions of the patient's story may shift and change to accommodate the physician's ability to receive the story fully and in the moment, without interruption or ready judgment. Learning each patient's personal language and responding to it with a language understandable to a particular patient requires astute attentiveness to the nuances of their intersubjective exchange. Cognitive and perceptual experiences are interpreted through language—both verbal and body language: this language is in turn influenced by the biopsychosocial effects of the past, present, and even proposed future circumstances. In addition, multilayered expectations at both conscious and unconscious levels come into play, all of which necessitate a steadfastness of intention and commitment if a mutually beneficial relationship is desired.

The challenges inherent in the textuality of this interchange, in the nuances and in the limitations found within language itself must be addressed. Social psychologist Alan Radley points to the significance of what he terms, “*the moment—the space-time it creates*, and the semantic potential with which it invites others to engage.”<sup>7p101</sup> Contemplative practices such as Zen or Tibetan Buddhism refer to this as “the present moment,” or “mindfulness,” and Radley applies this concept in his explication of its

importance in context, describing it as “an opening into the idea or the feeling in terms of which suffering is exemplified. The moment is a fragment, a figuration, of a world of illness.”<sup>7p103</sup> It is impossible however, to observe these particularities without being fully present, for it is only within the power of presence where such nuanced communication can be received and subsequently responded to; and yet cultivating such presence is not easy.

The Buddhist nun, Pema Chodron, suggests the method of “bringing your awareness to your breath to strengthen your ability to be there openly and with curiosity,”<sup>8p61</sup> while Charon details a very conscious process of developing a “state of attention,” which she describes as “complex, demanding, and difficult to achieve ... I try my best to register the diction, the form, the images, the pace of speech ... I pay attention—as I sit there at the edge of my seat, absorbing what is being given—to metaphors, idioms, accompanying gestures, as well as plot and characters represented for me by the patient.”<sup>2p132,187,188</sup>

To successfully navigate a stream of discourse is to be acutely aware of subtle particularities, to develop a felt sense by using one's internal and external landscape as guideposts. In working toward an understanding of a patient's inner world of pain, the clinician must be astute to what is said of that pain, and what is not said, what the body is saying, and what the person is saying. This requires an acute sensitivity of knowing when and how to come into a story, and when and how not to come in. It is an organic process that uses the senses and your response to them—what's happening inside of you as well as outside of you, while

simultaneously being attuned to what's happening with the patient. This is an unconscious process that we all practice in our daily interactions with others, but in the clinical encounter this process reaches a more conscious level, where the interplay between medical objectivity and human subjectivity must be a balanced one, with the intention of building a relationship of authenticity and trust, a relationship that will stand the test of time.

To practice the art of listening fully, the physician must be at once healer, witness, mother, father, confidante—forever treading the fine lines between his or her professional self, his/her witnessing self, and the patient sitting before him on the exam room table, a fellow human being who has come to him for help. It is at this moment, at the nexus of telling and listening where the practice of narrative medicine is realized, where its hallmarks of attention, representation, and affiliation begin. It is important to remember that the effect of the physician's own narrative as s/he listens (facial expression, tone of voice, body language, etc) will in turn influence the patient's narrative, acting as an ever-present mediating force upon the intersubjective dynamic and subsequent course of the encounter.

By engaging in the simple yet complex act of listening, the physician can provide a safe haven for the patient's fears and anxieties—a trustworthy container for all the shifting emotions borne from the experience of illness. S/he provides that which medical technology can never provide—a human touch. It is the kind of connection that comes from being present with another, from giving our full attention so that we may listen not only with our minds, but with our hearts as well.

## Conclusion

Patients' stories are not always easy to listen to, and conversely, not always easy to tell. However, by recognizing the difficulty of putting words to physical and psychic pain, and then the effort involved in communicating those words through a coherent story, physicians offer the gift of being open receptacles for these stories, of offering positive regard for the characters within the stories, and then daring to imagine what it must be like for the patient to live in that story. The clinician also offers safety, confidentiality, and above all, patience, for patience is often needed to coax the story into being, to welcome it instead of stifling it, no matter its many incantations. Contrary to popular belief, the simple yet complex art of listening is, in and of itself, a

clinical intervention, for the healing that comes from being listened to is often greater than any cure. Listening constitutes the very heart and soul of the clinical encounter.

While listening for elements of the patient's story with which to craft an accurate diagnosis, it is important to remember that the patient is also listening, but is doing so with a very different ear and a very different objective. A patient's listening is motivated by a universal need—the need for compassion, the need to be heard, the need to be recognized. From a specific tone of voice or nod of acknowledgment to perhaps a hand on the shoulder, the patient can readily hear if the person in the white coat standing in front of him or her is someone special, is someone willing to go beyond the white coat to a shared,

frail humanity—is in fact someone who cares, someone who cares enough to listen. ❖

## References

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## Let the Sick Man In

In learning to talk to his patients the doctor may talk himself back into loving his work.  
He has little to lose and everything to gain by letting the sick man into his heart.

—*Intoxicated by My Illness, Anatole Broyard, 1920-1990, American author, literary critic, and editor*