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# Listening – a Possibility for Improved Healthcare

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*Abstract: The conversation between a healthcare provider and a patient is one component of obtaining information for diagnosis and treatment. Responsibility rests with healthcare providers to actively lead this conversation so this exchange of information is accurate and complete with nothing added to and nothing left out. The question then becomes, “Do the words of the patient land word for word with their practitioner?”. In the world of “being” or ontology the answer is no. This article will focus on an ontological perceptual constraint known as Already-Always-Listening and introduce the practice of Authentic Listening as access to a transformation in healthcare provider and patient communication.*

Keywords: Healthcare, listening, communication, ontology

Most of us consider speaking as the most important element of human communication. What if it was listening that made the biggest difference?

Let us consider the interactions inside the current model of healthcare. There are many interactions among physicians, patients, other healthcare professionals, administrators, and staff within healthcare just as there are many interactions in each of our daily lives. Some are very important; others are of less importance. However, in terms of patient care, all interactions are important and require an understanding of both the circumstances and the patient. This understanding is acquired by taking a medical history of the patient, reviewing the laboratory and imaging reports, conducting a physical exam, and interviewing the patient.

There are many algorithms available to a healthcare professional for the interpretation of a medical history, laboratory reports, imaging reports, and physical exams. Each of these seem to be dependent on the rational objectivity of the healthcare professional to reach a clear and appropriate diagnosis along with possible treatment options for the patient. From this analysis, it appears that there is no need for the patient to do or to say anything except to acquiesce to or resist the instructions of a healthcare professional. Another way of saying this is that the patient seems to be an object that presents with a riddle of signs and symptoms that require analysis for diagnosis and treatment. If this is sufficient, then why is there a patient interview? Even among medical school applicants, why is it so important that the admission committee members are looking not only for high scores on the MCAT, an ability to give convincing answers to open-ended questions, and a professional appearance, but they are also looking for candidates who demonstrate compassion?

Compassion is a quality associated with the evolution of being human and can be defined as “the feeling that arises when you are confronted with another’s suffering and feel motivated to relieve that suffering” (Goetz *et al.* 2010, 351). The implication is that a healthcare professional is not merely someone working with an object to be probed and prodded but is, in fact, one human being trained in the art of healing who is motivated to relieve the suffering of another

human being. Language therefore is the essential component of this dynamic interaction--the conversations between patients and health professionals--that leads to the possibility of the relief of suffering. The use of language, whether spoken or written, is the primary way of exchanging information among human beings. For language in a conversation to result in the exchange of information, one must be speaking, and the other member of the conversation must be listening. In healthcare, this exchange of information in a patient interview can make a difference if the healthcare professional is listening for the words of the patient that contain the answers to a health-oriented questionnaire and possibly more importantly, for an access to the world of the patient.

Listening is a key factor in the exchange of information in any conversation. There are many kinds of listening that can occur in a conversation. These include listening for agreement, listening for disagreement, listening for fault, listening for justification, listening for the truth, listening for a falsity, listening for facts, listening for a story, listening for specific information, listening for opportunity, listening for closure, listening for support, among many other forms of listening. On one hand, some kinds of listening in a physician-patient interaction can result in a diminished quality of care for the patient and can lead to a poor patient outcome ( "Effects of Poor Communication"; Vermeir, P. *et al.* 2015, 2-3), or on the other hand, other kinds of listening can reduce fear and anxiety in the experience of the patient and open the floodgates of healing that gives the patient an increased capacity to make more informed decisions about their care (Dwinal 2017; Nitzky 2016).

For this discussion, I am interested in two types of listening: what could be referred to as "already-always listening" and "authentic listening." These are specialized terms taken from a body of work developed by Werner Erhard, Michael Jensen, Steve Zaffron, and Jeri Echeverria (2020) called *Being a Leader and the Effective Exercise of Leadership: An Ontological / Phenomenological Model*. Both of these approaches to listening, if distinguished and practiced, have the potential to positively affect the quality of care for the patient.

First of all, listening of any kind is defined as: "to be alert and ready to hear something with thoughtful attention, give consideration to, take notice of and act on what someone says, or to make an effort to hear something" (Merriam-Webster.com; Oxford Languages ). However, the qualification of already-always appears to counter this understanding of listening: whereas "already" is defined as "prior to a specified or implied past, present, or future time; before or by now or the time in question," the definition of "always" is "at all times; in any event" (Merriam-Webster.com; Oxford Languages). So combined, already-always listening is a kind of listening that is already there and always there in a person's listening as a running internal monologue (that constant little voice with its commentary in your head) that interprets every word and every phrase heard (or read), no matter who the speaker is (or the text). Beyond just reading about it here, I recommend my reader to consider that they are "listening" to this essay in an "already always" way. For instance, you might be associating this way of listening as I am defining it as something familiar, something you "already know." In fact, "already knowing" is one aspect of the already-always way of listening.

As distinguished in this body of work, already-always listening is an "ontological perceptual constraint"; that is, the source of our listening is

our network of unexamined ideas, beliefs, biases, prejudices, social and cultural embeddedness, and taken-for-granted assumptions about the world, others, and ourselves. This ontological perceptual constraint limits and shapes what we perceive of what is actually there in the situations with which we are dealing. (Erhard *et al.* 2013, 22)

As a consequence, if we do not remove these perceptual constraints, then in any patient-physician interaction we are left dealing with some distortion of the situation we are actually dealing with. As an ontological perceptual constraint, an already-always listening shapes or distorts the occurring or perception (the listening) of the physician for each patient and then impacts the correlated actions of the physician with each patient. This correlated action or response to every moment to moment encounter is based on the physician's or any person's judgments and conclusions generated from past experiences. The "past" consists of every favorable or unfavorable judgment, opinion, or evaluation developed for each circumstance, person, or groups of persons encountered over time from youth to adulthood. And it includes the favorable or unfavorable judgments, opinions, and evaluations they have gotten from their family, religion, culture, and nationality (Erhard *et al.* 2020, 784-786). It is this collective experience of others, based on past interactions and incidents, that determine the physician's already-always listening of a patient in the current moment and it can distort their listening of the next patient in a completely different way in the next moment.

Or said differently, already-always listening can be seen as a filter through which anyone listens. This filter interferes with listening to what is actually being said. In the case of a physician-patient conversation, a physician's filter can consistently question, validate, analyze, qualify, quantify, support or negate every word, sentence, and paragraph spoken by the patient (speaker). Interestingly enough, if a listener (physician) will look closely at each patient-physician conversation, they will find that this filter is already present before each patient speaks and is always there, even after the office visit is completed. For example, in the past a resident may have worked with an influential attending physician who adamantly opposed working with the elderly due to their lack of compliance with any treatment plan. Now as a practicing physician they have adopted the same listening for the elderly. For another example, another way that kind of already-always listen might show up is when a physician has suggested a treatment plan to a patient several times, and each time the patient does not follow through but returns to the doctor with the same concerns and complaints. In this case it might take two or three consistent interactions for this doctor to adopt an already-always listening of they "do not listen to my instructions" or "will not follow a treatment plan" for that patient.

Once the physician becomes aware of the already-always listening they bring to a conversation, they then have the opportunity to set it aside for another possible way to listen. This choice is especially critical in a physician-patient interview where the comments and responses by a patient are essential to complete an accurate diagnosis. It is the choice to be aware of this ontological perceptual constraint, already-always listening, that gives a physician access to a new kind of listening, authentic listening.

A good place to start exploring this new kind of listening, beyond the definition of listening given above, is to define authentic: "of undisputed origin, genuine, based on facts; accurate or reliable" (Merriam-Webster.com; Oxford Languages). Therefore, authentic listening provides a way for a physician to get all the information they need from the patient in an

interview. When listening authentically, they may distinguish gaps in the patient's story of their medical history, and can ask for information from the patient to fill these gaps. A physician's intention with authentic listening can be to create a safe space for a speaker/patient to say (maybe for the first time) everything that needs to be said about what's going on physically, mentally and emotionally that causes them to seek medical help. Authentic listening is a type of listening in which you, as the listener, recreate the world of the speaker. What does it mean to recreate the world of the speaker? It means that whatever is the reality of the speaker is now where you are listening from. You can now interact with your patient from a new perspective, the world of the speaker (patient). Or said differently, authentic listening gives you access to the world of your patient.

Based on these definitions, authentic listening can be further defined as a practice to develop the ability of a listener to listen to and to hear the words of the speaker as the reality of the speaker, with nothing in the way. So, what does this mean? Authentic listening is not a listening that you will get correct/right the first time you try it, therefore it must be practiced. The mastery of authentic listening will take time and for everyone that length of time is variable. In other words, the practice of authentic listening means that you are actively engaged in the process of looking for and discovering your already-always listenings for each individual (patient) or in any interaction. It is only after you deal with your already always listenings that you can listen authentically. And the time that it will take for you to develop your ability to listen authentically will vary for each individual and for every situation because there are two tasks at hand: 1) identifying and setting aside your already-always listening of that person (patient); 2) developing your ability to listen authentically.

So, what does this practice of authentic listening look like? This is simple to describe yet not so easy to implement. To listen authentically is to listen to what the speaker is actually saying and hear these words without adding your interpretations. Begin to notice all the interpretations you add to what is being said, and practice setting them aside. Do not add your own thoughts or already-always listenings to what is being said, for example: noticing when you are saying to yourself, "oh, I can see that this conversation is going nowhere, I have other patients waiting and I wish they would get to the end of the story of their medical past, this is good, this is bad, this is poor grammar, they do not know what they are talking about, or a better word they could use is..." Whatever thoughts you have about yourself, what's going on in your own life, or an already-always listening you have, you can choose to set them aside. A useful practice might be to thank your brain (the little voice that asserts the variety of prepackaged judgments and evaluations for its commentary), and then return to what the speaker (your patient) is actually saying. This practice is called bracketing. Bracketing is the action of "setting aside all concepts, theories, beliefs, and the like that could distort one's direct, real-time experience," in this case authentic listening (Erhard *et al.* 2018, 2).

How will you know that you have listened authentically? One indication is that the speaker will likely stop repeating parts of their story (medical history) that they have already spoken. Your patient may just stop speaking even in response to your asking if there is anything else to be said to complete the story of their medical condition. The speaker (your patient) may end their office visit with an acknowledgement of you (e.g., "thank you for your help, I feel better after talking about my condition today"). The speaker may seem more relaxed and you

may feel as if you have created a partner for healthcare rather than an adversary or neutral observer.

At first as you practice authentic listening, you may find that you must keep returning to being present in the conversation with a speaker (patient). If you find yourself wandering off to your own thoughts during the conversation or you miss something that is said, ask the speaker to repeat what they said and tell them that you were distracted during that part of the conversation. There is no need to apologize; just say, “could you please repeat that part when...” and return to listening authentically.<sup>1</sup> Do you have to practice authentic listening with everyone? That is a choice you will have to make. But if you did, consider the possibilities of understanding and ability to respond authentically in all the important interactions in your life.

Here is a suggestion: try on authentic listening with your patients just as you would try a new medical records system to see what happens. Or try it out in the moment to moment living you create with those you care about in your personal life. Imagine the possibilities if each physician were to practice authentic listening with each patient. You may find that your 15-20 minutes with each of your patients is now a conversation rich in useful information and one that generates well-being. The possibility you create is transformed conversations that produce a positive impact on patient satisfaction, patient adherence to recommended treatment, and patient self-management of chronic disease (Levinson *et al.* 2010, 1311; Pierce 2019).

In closing, here is a quote from the late Sir William Osler, a noted Canadian physician, a founder of Johns Hopkins Hospital, and also called “the father of modern medicine,” that sums up the context/intent of this essay: “It is much more important to know what sort of patient has the disease than what sort of disease a patient has” (qtd. in Asnani 2009, 357; *Profiles.nlm.nih.gov* 1998).

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<sup>1</sup> To rephrase a statement attributed to the late Marjie Parrot, a Wisdom Course Leader and Consultant for Landmark Worldwide, “Practice listening and when thinking, stop thinking and return to listening.”

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