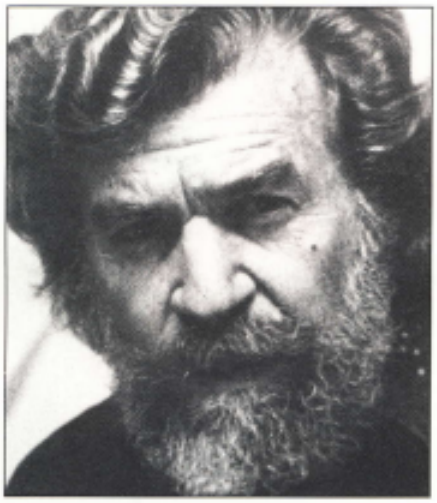
Reclaiming the Lost Art of Listening

– Bernard Levinson



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Curriculum vitae

Bernard Levinson qualified at Wits in 1951. He entered General Practice in the False Bay area of the Cape until 1958. Bernard qualified as a Psychiatrist at Wits in 1960, and for the past fifteen years has devoted himself to the area of sex therapy.

Summary

Patients desperately need their doctor to listen to them, to know that their doctor finally heard fully what they have to say. But doctors became so busy that they train themselves to do many things at the same time; they do other things while listening. And by this, doctors have lost the art of listening. They need to decide for themselves (and believe it) that to listen carefully is a powerful therapeutic tool, that doing is not always necessary. And then, to consciously nurture the art of listening to their patients.

S Afr Fam Pract 1993; 14: 11-14

KEYWORDS:
Physicians, Family; Physician-Patient-Relations; Listening; Case Report

I am standing in the witness box. The magistrate has just led me sentence by sentence into promising I will tell the truth, the whole truth, and nothing but the truth. He sits erect and looks me in the eye. I square my shoulders and deepen my voice. We are both serious. And professional. The accused is a child molestor. Eighteen months ago he had been caught by the police and given a suspended sentence. As a result, he entered therapy with me. For the past eighteen months I have been sending reports on his progress to the probation officer. Unknown to me, he is again molesting a young boy. Again he is caught.

"Did you know he was molesting this child?"

"No your worship."

"How is it possible for you not to know this?"

"He never told me."

"But what kind of therapy is he having?!"

I have a sudden insight. I know what answer he wants to hear. He wants me to tell him the patient is on special medication, that he is being flooded with hormones making all interest in sex impossible, that I am exposing him to a behavioural conditioning with severe shocks each time he thinks of young boys, that I am physically nudging, prodding, bullying and manipulating every aspect of this man's life.

I hear myself saying in a soft voice.

"We talk, your worship."

"Talk!" he shouts. "He could talk to me. He could as easily talk to the prison warders."

I'm aware this is an unfortunate example. Perhaps an unconscious glimpse of what is to come. I have a second insight. I did not tell the truth, the whole truth and nothing but the truth. If I had, the magistrate would have fallen off his chair. The truth is that we don't talk. I only listen ...

How can I explain this to the magistrate?

We have lost faith in listening. We believe only in doing. Being active. Leaving general practice and entering the discipline of psychiatry, the first major hurdle I had to face was to learn to stop doing things. Every patient in general practice demanded

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my active intervention. Now I only had to listen. But how to explain that listening – listening with three ears is a powerful positive therapeutic tool.

Why can't we listen?

We are never taught how to listen. To really listen. We learn at the earliest possible age how to listen with one ear. Behold the small boy pretending to be a horse. He slaps his own behind and gallops around the room. Notice the vigour and aggressive power in each movement.

We have lost faith in listening

The nobility and pride of a great stallion. The horse is inside the boy. The child has become the horse. Behold the child imitate his father. Already he leans forward as he shakes hands, keeping a distance with his body. He looks over your shoulder as he addresses you, and only momentarily catches your eyes as you speak. He is learning the art of listening with one ear. Our parents are the models. Father with the newspaper in one hand, one eye on the television screen, offers one ear to your frantic review of an agonised school day. Mother says, tell me about your day, and continues doing the dozen chores that have to get done.

I have a recurring sudden giddiness and make an appointment with a young neurologist. He is highly recommended. I accept we are of different generations. I submit myself to his routine with great interest. He takes a history. He does many things at once. He talks to his wife on the telephone. We both smile indulgently. He berates his staff on his intercom. Finally excuses himself and leaves me, to deal with a problem in the waiting room! He writes furiously. I am encountering a professional, highly trained paired-down-to-the-bare-essentials single ear interview. There are many investigations. I agree to a brain scan only because of my own curiosity. I drift into the deeply impersonal world of radiography and unceremoniously, and with little warning, I am rolled into the pitch-dark cigar-tube vault while demon attendants dance a frantic rhythm around my head. No one listens. Also no one really wants to know. I am finally reassured that my symptoms will pass (which they do), but I am left wondering if I could have short-circuited the entire expensive performance if I could have persuaded someone to listen to me.

We rapidly augment this one-ear listening with an unconscious intelligent (sometimes) guess, what the person is saying. The relationship,

Listening with three ears is a powerful positive therapeutic tool

the context, the tone of voice and body language tell us what we think they are saying. But it's only a guess. It could be reasonably accurate. The experienced doctor with a sensitive single ear gets pretty close. It could also be way off the mark. It's the best we can do with one ear.

I watch husbands and wives argue on their side of the desk. They give me a ring-side-seat to one of their endless 'discussions'.

"You're not hearing what I'm saying!" she shouts.

"I heard every word you said – but you obviously haven't heard what I just said . . . "

We learn at the earliest possible age how to listen with one ear

They are both listening with one bunged-up-battered-with-years-of-word-pounding ear.

On rare occasions, and for brief moments, we listen with two ears. On these occasions the subject matter or the interest has to be white-hot. The little boy standing by the door holding a smoking rifle in his arms and an apprehensive self conscious grin on his face while he says "I think I shot granny" – leaves no one in any doubt which way to run, or what exactly he meant. This starts off with one ear and immediately involves two electrifyingly alert ears.

Usually after a question is asked, there are a few moments of true two-ear expectancy as the answer comes. This rapidly slips into one-ear gear if there is no connection between the speakers. We become so skilled at one-ear conversations that we are able to continue our internal dialogue or fantasy, read the notes in front of us, listen to all that the patient says, make a diagnosis, prepare a treatment schedule, without once looking up at the patient . . .

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We all learn early in our lives how to switch onto the automatic listening-pilot, in our daily round of floating through the human encounters that make up our world. We live in a massive matrix of sound. We no longer trust or can tolerate total silence. We fill all our spaces with sound. Music fills the corridors. We have to swim through the deafening sounds of music in many restaurants.

We no longer trust or tolerate silence: we fill all our spaces with sound

Outside there is the endless noise of traffic. Even in the inner sanctum of our minds, the noise of past or future dialogues persist – 'she said' – 'I said' – 'they said'. Listening with one ear becomes a survival technique. 'I think I know what's going on . . . and that will have to do . . .'

I am aware that our patients frequently rehearse what they are going to tell us. The rehearsal is often detailed and intimate. This never appears in the consultation. We confine them to a telegraphic organ recital. These are the unwritten rules for those who are calling for help from busy practitioners. 'Tell it like it is, and be brief'. Our patients are more often than not, left with the sad conclusion 'I didn't tell him everything I wanted to . . .'

Listening with three ears is an entirely different ball game. This takes time and energy. We need new models. It requires a great deal of intense awareness.

Setting the stage for listening

Reading Psalm 46, I am always struck by the fascinating enigma of the phrase – '. . . be still and know that I am God . . .' The author (possibly King David) could easily have said 'be jubilant – be triumphant – be almost anything' – but why still? Could David have really known that only if we are still, ('at peace', 'in grace', 'at one with', 'in harmony with') are we able to communicate with our God. Indeed only if we are still ('relaxed', 'quiet', 'in tune with') can we really communicate with anyone! This is the key. We have to create a silence. Inside ourselves, if not around us. It is only from a base of silence, of stillness, that we are free to listen. If we are still, we are open and ready to hear. There is one proviso. A simple ground-rule that sets the stage. This is the ground-rule that allows stillness its potency.

There is a lovely Buddhist aphorism that says – if you sit – sit! If you stand – stand! But don't wobble! Saying, in this terse way – be totally in the moment! If you are eating – be

We believe only in doing, in being active

in the food – the joy and delight of all tastes and smells. If you are making love, be in your fingers, in the loving. If you are outside watching yourself – the loving is destroyed. If you are listening to the patient, nothing else can exist. You are in their words.

Listening with three ears

You have set the stage. You've made yourself relax. You are actually sitting deep in your chair with your entire body. You are still. The patient is talking. You have switched off the rest of the world and you are totally in the moment. Now what?

Now comes some of the secret painful things that were lost in the process of growing up and learning how to relate.

Look the patient in the eye. Face to face dialogue is the only meaningful communication. If both you and the patient look at the illness – side-by-

We learn early in our lives how to switch on to automatic listening – on to pilot!

side, like the passengers in the front seat of a car, it may seem comfortable – but it lacks the total sharing of facial expression. We forget how we hold our patients with our eyes – especially if we are unable to reach forward and hold them in our arms. Only the eyes are left.

Offer yourself. This is the hardest part. Hard, because part of the trick of offering oneself is to lose oneself. To put aside your own importance, your own needs at that moment. Your status. Your world and your special place in it. To be real, what you are offering is a fellow human being sharing an intimate moment.

We are partly saved believing the pain belongs to the patient. The appendix is theirs. The fear is theirs. We even console ourselves in the belief that this aloofness will provide us with a clear uncontaminated objectivity to make cold, logical, far reaching

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decisions for the patient. This is not what the patient needs or wants. Only when the matador feels the bull's breath on his face is he able to engage, to bond into the dream-sequence that has any meaning. Mesmer coined the word, 'in rapport'. Only if we are 'in rapport' with the patient will they say everything they need to say – and will have the relief of knowing that someone finally heard them out.

I am always surprised when I search frantically for the wise words that will resolve the problem – only to find that the patient already feels better. Just being able to talk to someone who really heard is all they really wanted. This is not an easy lesson to learn. The need to make things immediately good, is a powerful driving need inside all doctors. As the patient starts talking, the process of 'what should I do to make it all good', starts in our heads.

Envoi

The magistrate asked the wrong question. If he had looked into my eyes and calmly asked –

"Why my dear doctor were you not listening with three ears?"

It is I who would have fallen off my chair. He would have been absolutely correct. I had listened with only one ear. If I had really been listening, without a shadow of a doubt, I would have known he was in the process of molesting another child.

1993 Emergency Medicine Update

The University of the Witwatersrand will once again be providing a series of comprehensive post-graduate Emergency Medicine Updates for doctors and emergency care workers in both hospital and private practice who wish to improve their knowledge and skills in the management of clinical and life-threatening emergencies.

The Updates will be held over four weekends, covering a wide spectrum of clinical topics with the aim of raising the standard of practise of emergency care. Over 80 different presentations will be given by experts in their field, ranging from relevant anatomy through to clinical skills, protocols, practical procedures and the use of emergency equipment and techniques, of relevance to all members of the medical profession and allied disciplines.

Intense interest has been shown in these weekends over the past 7 years from doctors throughout South Africa and neighbouring states. We are again expecting over 300 delegates to participate in the 1993 sessions.

The dates for the 1993 Updates are as follows, each weekend commencing at 18h00 on the Friday, through to 13h00 on the Sunday.

Accident and Trauma Management Update – 26/27/28 February 1993

Medical, Neurological and Psychiatric Emergency Update – 23/24/25 April 1993

Surgical, Anaesthetic and Environmental Emergency Update – 25/26/27 June 1993

Obstetric, Gynaecological and Paediatric Emergency Update – 20/21/22 August 1993

In view of the many new and controversial topics which will be discussed, the sessions are particularly suitable for doctors wishing to attempt the College of Medicine's "Diploma in Primary Emergency Care examination (Dip PEC (SA))", but are open to all doctors and those wishing to update or improve their ability to effectively handle clinical emergencies.

Participants may register for each weekend separately (R175,00 per weekend) or for the complete course of 4 weekends (R550,00 for new participants or R475,00 for participants who have attended previously). A late registration fee of R600,00 per course or R200,00 per weekend is applicable to registrations received within 7 days prior to commencement of the weekend. The registration fee will be tax deductible, and includes all teas, lunches, cheese and wine and numerous handouts. In order to register; your full name, postal address, telephone number and registration fee (payable to "Emergency Medicine Update") may be sent to: Dr W Kloeck, Emergency Medicine Update, Department of Family Medicine, Wits Medical School, York Road, Parktown, 2193.