

Listening: imperative for patient safety

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Listening in the healthcare encounter is a complex matter—even if it appears easy at first glance. In fact, listening is an underused potential. Listening is about understanding what the patient is saying to draw out the fundamental ideas, while gathering information to find answers and weigh options. Therefore, a culture of listening in healthcare promotes a personalized approach in the diagnostic process. Attentive listening is a way to resist bias, stereotyping, and only keeping to one track while contemplating a probable diagnosis, where there might be more than one. Listening helps doctors to ask the right questions, instead of jumping to conclusions.

Listening is also about showing respect, creating knowledge in a dialogue, connecting, and building a relationship. Listening demonstrates acceptance, promotes problem-solving abilities, increases the self-esteem of the other person, helps overcome self-centeredness, and prevents head-on emotional collisions. Communication skills in healthcare are not held in high regard, however. Listening is defined as the lost communication skill.

Listening is a way of using a higher order of thinking and reasoning, but in healthcare it is largely ignored in research and teaching. Interventions to promote listening in healthcare need to target health care policy, research, and clinical practice. Listening is also about informing patients on how to proceed for better listening in healthcare. Listening policy in healthcare is needed to promote the patient's voice.

Listening is not known to be a physician's strength. Patients are usually interrupted within 10–18 seconds of their opening narrative. Physicians prefer to use rational close-ended questions, effective checklists framing symptoms, and easy diagnostic guidelines. These frames fit how the healthcare system is designed. They and the healthcare design turn physicians into clerical workers, making them go numb in the process. Physicians are reimbursed by how many tests they produce, not on how much time they spend listening to the patient. Therefore, 30% of tests are unnecessary, and only 12% of physicians' time is spent with patients. Meanwhile, 40% of physicians' time is spent on the computer.

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“By the time you’ve defined someone as a patient, you’ve already broken the frame. To reduce their humanity to their ‘patient-ness’ and then to further reduce it to the frame of how they could fit your pre-conceived label” (Mike Rea)

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Today, the culture of medicine and its diagnostic processes are technologically driven. This makes it hard for the art of diagnosis, or art of medicine as clinical excellence. The process of diagnosis is not just about getting one diagnosis; it is also about options. Patients are not informed about how to promote listening in healthcare. Luckily, two physicians have taken the time to explain how to

proceed for enhanced listening on how to avoid misdiagnosis. The challenges they give are a provocation on the typical medical encounter of today. These two doctors want to empower patients in the diagnostic process, and make sure patients are aware of what to ask, what to do, and how to present their patient narrative. Did you know that 80% of diagnoses can be made just by a patient's narrative? The patient narrative is in fact more effective than tests or a physical exam. Studies since the 1950s have repeatedly shown this, according to Dr. Leana Wen.

Dr. Leana Wen has written a book in collaboration with Dr. Joshua Kosowsky entitled *When doctors don't listen: How to Avoid Misdiagnoses and Unnecessary Tests* (2013). The *Wall Street Journal* wrote in its review of this book that one in twenty hospitalized patients die because of misdiagnosis. The problems of misdiagnosis and medical errors can also to be understood as a lack of narrative medicine and health literacy in the culture of healthcare.

Narrative medicine as a communication skill is linked to the use of active listening in healthcare. It is a strategy to make it easier for physicians to grasp the patient in a holistic sense, dealing with the individual stories of patients in clinical practice. Narrative medicine also encourages creativity and self-reflection in physicians.

Health literacy as a communication skill concerns physicians' ability to gather information and speak to the patient in a way that the patient understands. It is about using plain language in the health care encounter, and also making sure the patient has understood the medical procedure and medical recommendations properly. Health literacy includes patient empowerment, and attuning patients to the culture of healthcare. The risks of poor health literacy lead to failures. Health literacy as a strategy creates a shame-free environment by making it easier for patients to ask questions. As a policy or leadership strategy, it needs to be addressed from both sides. This in turn exposes the need for more medical humanities in medical training, and in healthcare generally.

A study published in the *Journal of Medical Humanities*, "What is the Role of the Arts in Medical Education and Patient Care? A Survey-based Qualitative Study" (2018) showed that 72% of American medical students at Harvard Medical School (HMS) are positive about integrating health humanities into medical education. This is because medical/health humanities in healthcare can promote a listening approach by means of enhancing diagnostic skills, medical knowledge/fund of knowledge, creative thinking, cultural competence, visual and observational skills, empathy, and increased humanism.

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"Know your past medical history, your past surgeries, your allergies, medications that you're taking. That should be second nature to you. If it's complicated write it down." (Leana Wen in Everyday Health)

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The problems of medical errors and misdiagnoses relate to several major findings uncovered in the major report "To Err is Human: Building a Safer Health System," by The Institute of Medicine (IOM) in 2000. Its findings correspond to the discussion in the book by Drs. Kosowsky and Wen. Common faults that lead to medical error are: failure to diagnose, delayed diagnosis, incorrect diagnosis, failure to order appropriate tests, failure to address abnormal results, failure to address atypical

presentations of unusual problems, bias toward patients with correct or incorrect psychiatric diagnosis, failure to communicate, failure to review medical records, poor professional rapport, failure to use clinical information, failure to avoid first impression- or intuition-based diagnosis, and lack of differential diagnosis.

“A substantial difference exists between hearing and listening, On the one hand, hearing is merely an involuntary physical response to the environment, Listening, on the other hand, is a process that includes hearing, attending to, understanding, and responding to spoken messages.” (Eugene D. Fanning)

In 2013, Dr. Kosowsky tweeted: “More evidence that misdiagnosis has nothing to do with tests and everything to do with communication.” Dr. Kosowsky attached an article from *MedPageToday* entitled “Errors Traced to Initial Patient Visit” (2013), based on two studies from *JAMA Internal Medicine*, showing some startling numbers: 80% of all medical errors have to do with breakdowns in the physician-patient encounter, and more than 40% of these errors involve two or more breakdowns in the process. Most primary care visits are followed by unplanned hospitalization, or revisits to primary care within 14 days, or visits to the emergency department. In 85.8% of the cases, a different physician saw the patient on the return visit. Alarming, 51.6% of errors were discovered because the original signs and symptoms did not resolve. In 34.8% of these, the error was discovered due to the evolution of the original signs and symptoms. In 22.6%, however, the error was discovered due to the appearance of new symptoms. Finally, in 64.7%, the primary symptom at the initial visit was directly related to the diagnostic error.

A philosophy of listening can clarify the imperative of listening

Among Western thinkers, Plato was one of the most important philosophers of listening, since his dialogues are accounts of his listening to Socrates. Professor of education and social policy expert Sophie Haroutunian-Gordon discusses Plato’s *Symposium* dialogue between Socrates and Diotima in her article “Plato’s philosophy of listening” (2011). Sophie Haroutunian-Gordon investigates the role of the listener and speaker in relation to Socrates as a questioner and seeker of knowledge, and how it is possible to find a philosophy of listening with the help of Plato. A philosophy of listening according to Plato is an invitation to question listening and speaking in four steps. Firstly, the aim of listening is to address a question to which one does not know the answer. The first aim of listening is to identify a question that cannot be resolved by just one person. The resolution lies in working to understand what the other has to say. Secondly, the nature of listening concerns itself with how questions are addressed by listening. The nature of listening involves reasoning, inferences, consequences, exposing error, and forming the question one is trying to resolve. Thirdly, Plato discusses the role of the listener, who forms a question that is even more eager than the initial question. The role of the listener needs to be understood from the point of view of modifying or resolving the question from what has been heard. The role of the listener is not just to draw implications about the immediate meaning, but also to find the meaning about the statements. The fourth step in Plato’s philosophy of listening concerns the relationship between the listener and the speaker. The role of the speaker is to prepare the listener to listen to what is going to be said, while the role of the listener is to show the speaker what needs to be said in order for the listener to attend.

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“Have listeners let the speakers know what they need to say in order to engage their attention and draw inferences about the meaning of what has been said. In short, are listeners and speakers working together to form and address questions of shared concern?” (Sophie Haroutunian-Gordon)

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How do we recognize the best qualifications of listening in the healthcare setting? The relationship between the patient and doctor is often up for debate in terms of the lack of listening. The lack of a listening culture is a deep and complex question. There are many reasons for the lack of listening, and many have to do with the rational culture of medicine, plus the Western basis of thinking and acting.

How did we end up in this situation? Listening is often included among communication skills, but the role of the listener is never in the spotlight. The paradox of listening in healthcare is that it puts the patient as the first speaker, and gives the patient power over the situation. All too often, patients are interrupted, or are just given a diagnosis to get things moving—often even the wrong diagnosis that then eliminates further listening.

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“At some point, the real bar should be whether or not you can actually listen to patients and talk to them.” (Dr. Stephen Klasko, in the CNBC)

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We also need to consider the polarity in the culture of discourse and listening. The Greek term *logos* can be understood as part of the foundation of how the body of knowledge in diagnosis is structured (the discourse). Within the philosophy of listening, *logos* does not correspond to the notion and capacity of listening; it is closer to rhetoric, word, speech, and the order of knowledge, reason, and discourse. The problem at hand is explained in the philosophy of listening as a shortcoming in Western thought that ignores the listening processes. In the philosophy of listening, the concept *legein* is explained as a better option, since its meaning is of a different nature. *Legein* takes into account sheltering, gathering, and receiving, and is close to the cognitive idea of proper hearing. Culturally and historically, there has been an imbalance between these two concepts: *logos* has worldwide acceptance, whereas *legein* has been disregarded.

The fabric of listening

The art of listening has its own fabric. Listening has certain core values. I have compared two books, *Active Listening* and *Solving Tough Problems*, both concerned about listening, which conceptualize differently, but lead to similar conclusions.

Central ideas of listening in the book *Active Listening* from the Center for Creative Leadership shows an active listening skill set that corresponds to the idea and culture of *legein*:

- Pay attention: body language, nonverbal affirmation, the other person, frame of mind
- Hold judgment: open mind, practice empathy, acknowledge difference, be patient

- Reflect: paraphrase information, paraphrase emotion
- Clarify: open-ended questions, clarify questions, probing questions
- Summarizing
- Sharing

Adam Kahane shows us in his book *Solving Tough Problems* some other general concepts and explanations to create a good listening culture:

- Openness: experience something new from others, open listening is the basis for creativity
- Reflectiveness: gives new ideas about others and oneself, reflective listening is about hearing the contribution of ones' own voice
- Empathy: listening with total presence

When doctors don't listen

Physicians Dr. Leana Wen and Dr. Joshua Kosowsky have written the book *When doctors don't listen*. Its most important parts are the practical guidelines to optimize listening in healthcare. Conceptually, the practical tips and steps for action to make doctors more attuned to patients' narratives align with the fabric of listening. This can also be called the practice of *legein*. Listening as *legein* in healthcare is about avoiding everything that may lead doctors astray from the patients' own descriptions and experiences. Drs. Wen and Kosowsky clearly expose the different steps that correspond to the four categories in the Platonic philosophy of listening. In practice, the book *When doctors don't listen* gives the reader practical tips and reflections showing how the role of the speaker can prepare the listener, and how the role of the listener needs to be created in order for the listener to attend. The tips and reflections are a means to go beyond cookbook diagnosing (using only prefabricated questions and fitting the patient into the healthcare system instead of listening properly to the patient), artificial intelligence, algorithms, and formulas that lead to inaccurate diagnoses, absurd healthcare costs, and unhappy patients. The role of the listening physician and the role of the speaking patient are very needed in order to make healthcare attuned to the individual patient instead of worse case scenarios and a generic diagnosing culture. A culture of attentive listening steers away from the pitfalls of cookbook medicine, where there is usually a misplaced emphasis on the chief complaint, whereas a diagnostic process is more complicated than that. In medical practice, there also tends to be an unshakeable belief in science that can serve as an obstacle to listening.

Historically there have been several medical eras of diagnosing. The current era is that of depersonalized diagnosis. The question is therefore whether the fund of knowledge in medical science needs to be elaborated on to make way for better integration of a communicative value for a smoother diagnostic process.

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“Listening is crucial to gaining complete understanding of situations. Without this full understanding, one can easily waste everyone’s time by solving the wrong problem or merely addressing a symptom, rather than a root cause.” (Brigette Hyacinth)

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The BMJ Leader (Erwin Loh, 2018) reported that artificial intelligence is very accurate in certain cases, and useful for interpretative imagery. Physicians still outperform algorithms in diagnostic accuracy by 84.3% vs. 51.2% of AI diagnostics, however. Even if IBM Watsons can quickly analyze large amounts of patient data, these artificial intelligence analyses are hard to translate into “real world clinical practice.” At the same time as BMJ Leader published its results, Babylon Health announced that an AI algorithm scored higher than humans on the written diagnostics test: 81% for AI vs. 72% for humans. The problem with digital information, though, is that information might not always be correct or up to date. The patient, on the other hand, will always be the best latest update, and have the most accurate account.

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“In practice, she (Diana E. Forsythe) once told me, late at night after a long AMIA (American Medical Informatics Association) meeting, most medicine is ten parts culture to one part real science. From a medical anthropologist’s point of view, a good deal of what happens in healthcare is invisible to most clinicians. Imagine that. (Tom Ferguson, e-patients—how they can help us heal healthcare)

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The World Economic Forum has noted that since 2015, artificial intelligence skills are at a steady seventh place in healthcare, with artificial intelligence steadily augmenting in this sector. The top five countries with the highest penetration of artificial intelligence are the United States, China, India, Israel, and Germany. The World Economic Forum estimates that the amount of work done by machines will jump from 29% to 50% by 2025.

When Dr. Leana Wen did a book presentation of *When doctors don’t listen* in the independent bookstore Politics and Prose in Washington D.C. in 2014, she explained why her book is especially important to her, and how she wants to help others avoid unnecessary tests that lead to complications and hospitalization, or how to avoid not getting the right diagnosis in time. The first two stories in the book are her personal ones. Number one is about when she treated a man who had chest pains, and who was put through unnecessary testing, hospitalization, and complications from testing, and who did not get more information out of healthcare than he had put in. Even if he had become worse due to these procedures, however, he still felt lucky because so much was going on. Number two is about her own mother, who was wrongly diagnosed several times, and then her correct and lethal diagnosis was delivered too late. Dr. Wen’s mother died of breast cancer that would have been treatable if her mother had known to speak up, and if physicians had not been biased by incorrect medicalization. Dr. Wen also explained that she, and her mother, were both afraid she might lose her job for writing this book.

Prescriptions for patients: how to make doctors listen

Drs. Wen and Kosowsky create eight pillars for patients to get the right diagnosis from their doctors. The processes and tips they give are attempts to make the patient's voice break through in the diagnostic process. The eight pillars are the same as Plato's fourth criteria: how the speaker (patient's voice) can prepare the listener (physician) on the role of the listener to make the listener attentive. The patient actually has to check on everything the physician is trying to do, even during the physical exam. This can seem annoying to a physician, but it should be embraced. The patient will help the physician get the right diagnosis at an earlier stage. By activating the patient, the physician will perform better in the complex stages of trying to reach a correct diagnosis, differential diagnosis, or at least be communicative about the working diagnosis. The eight pillars, then, are a way of developing a working diagnosis. As a patient therefore needs to grasp how a diagnostic process works. Drs. Wen and Kosowsky explain that it is useless being "a good patient" (i.e., a silent one), since this will lead to inferior care. "Medical care is not a popularity contest," they state; rather, it is about life and death.

These eight pillars by Drs. Wen and Kosowsky will help patients get a correct diagnosis:

Tell your whole story

The most important thing is to let the patient tell their story.

Your story is the key to your diagnosis. How is your daily life affected by your illness? What were you doing when the symptoms started? Has this illness prevented you from doing things you normally do? The story needs to include the timing of symptoms, the pace of change, the onset of symptoms, their severity and changes over time, and their chronology; surprising changes need to be emphasized.

If your doctor is not listening, start over, interrupt when interrupted, ask your own questions, explain what worries you most, and, if you need to explain yourself better, create a worksheet where you draw everything out, using simple language; if there is a diagnosis you are concerned about making, be sure to explain this.

In your story, you will need to be clear about your primary symptom, which should be written down as your chief complaint. If you have multiple symptoms, be careful about making them your chief complaint.

Insert yourself into the doctor's thought process

To make sure you get the right diagnosis or diagnoses, you have to break the culture of silencing from the doctor's side. Make sure to integrate your story into your doctor's thinking process, asking questions as the doctor goes along. If your doctor is not really listening, or plays dumb, make sure to find out what diagnosis your doctor is working on, and find out how this diagnosis corresponds to your symptoms, or what is missing, and find a way to partner with your doctor.

Participate in your physical exam

Before the physical exam starts, make sure to have a conversation about what your doctor is looking for, and make sure the findings correspond to your diagnosis; if there are abnormal

findings, ask what they mean, making sure you are a part of your doctor's thought process throughout.

Make the differential diagnosis together

It is paramount for you and your doctor to make a differential diagnosis and working diagnosis together. As a patient, you have to integrate yourself into the diagnostic process. If you are having problems with a differential diagnosis, speak up and ask for clarification. If none of the diagnosis makes sense to you, it will likely lead to a bad treatment plan.

Partner for the decision-making process

At this stage, it is important to narrow down the possible diagnoses. Make sure your doctor explains what diagnosis they are looking for before sending you for testing. Discuss options before you consent to any testing, and make sure you are clear about the working diagnosis. If there seems to be a need for more tests, be sure to ask why. If your doctor will not explain, ask what they would do if they were the patient.

Apply tests rationally

Do not just consent to tests. Make sure their risks, benefits, and alternatives are explained to you beforehand. If you have concerns about tests and your doctor is not answering you, rephrase your questions. Ask if the tests will confirm or rule out the working diagnosis, or the definite diagnosis.

Use common sense to confirm the working diagnosis

At the end of the visit, you should have reached a working diagnosis with your doctor. If the working diagnosis does not really make sense, ask more questions about your symptoms and their course. Get a grasp of *why* and *how* questions at this point. Ask what else can explain your symptoms, and what the doctor actually knows about the working diagnosis at this stage. Be careful if your doctor only appears to be focused on one diagnosis.

Integrate diagnosis into the healing process

Once you have a diagnosis, find out as much as you can about it. Find out the natural cause of the illness. What should you expect of it? What are the warning signs if the diagnosis is wrong? What should you be on the lookout for? Make sure you know what your doctor knows, and find out about several options before you start any treatment.

Patient participation and empowerment is key to patient safety. Drs. Wen and Kosowsky have given advice on how to enhance a listening strategy for getting a correct diagnosis at an early stage. Many patients today struggle in their healthcare settings, because they do not know how to act in a healthcare encounter. These eight pillars for enhanced listening in healthcare by need to be discussed more openly and often to help create a better culture of listening in healthcare.

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