

TOPIC

Difficult Healthcare Relationships & Encounters

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The Lament, Hidden Key to Effective Listening

By Barry Bub, MD

*Love is a toil and life is a trouble
Riches will fade and beauty will flee
Pleasures they dwindle and prices they double
And nothing is as I would wish it to be.*

Housewife's lament c 19th century

I was introduced to an elderly lady the other day. 'What do you do?' she asked. 'I teach physicians communication skills.' I replied. Her retort was painfully blunt. 'Physicians do not listen, and when they listen they do not hear.'

This comment echoes the virtually general refrain of the public that their physicians do not listen and understand them. The response of the physician population is no less predictable: 'Not enough time.' Yes, some attempt is being made to teach communication and bedside manners to medical students but then they are reminded in their residency training: 'You are now in the real world.'

Many physicians do of course find themselves under great pressure and shortage of time is such an obvious issue that this rebuttal may easily be accepted at face value. Careful scrutiny however, suggests that there is far more to this problem than meets the eye. For example, if lack of time is so problematic, why are time management and practice management so rarely taught in medical conferences? Why is there so little collaboration to save time? Why are so many unnecessary and time-consuming surgeries and procedures performed? How much time is actually saved by careful listening and do patients in fact want *longer* listening or are they really asking for *better* listening?

There are in fact many reasons why physicians do not listen well. Most relate to deeply imbedded myths within the profession that interrupt listening. One example is the myth that medicine is an art and a science. With this split firmly in place, what is considered 'science' becomes funded and taught and what is labeled 'art' is often given scant attention. A good example of this is auscultation. Considered science, students are trained to use their stethoscopes for listening to internal organs. They learn for example to identify abnormal from normal heart sounds as well as what to do when they hear an abnormality. When listening to the person (versus the organ) most physicians function as amateurs not knowing *what to listen for* nor how to respond appropriately. As a consequence, vital communication clues tend to be missed as are opportunities for healing. This has been documented by Wendy Levinson and others when reviewing videotapes of physician-patient sessions.¹

One pervasive narrative theme that is often missed is the lament. People who suffer, complain, cry, mourn, wail—that is, they lament. Usually the lament is vocal, not infrequently however, it is non-verbal with a sigh, a slump of the shoulders, a shrug or a tear. It may be embodied as chronic fatigue or low backache, vague abdominal pain or the condition called multiple functional somatic symptoms. A lament may also be hidden in a cynical comment, a joke, a fixed smile, an angry outburst or it may be born in silence. In other words, a lament is transmitted in many guises. No matter how it manifests however, the lament is always an expression of suffering.

Not surprisingly the word 'patient' derives from the Latin word for 'suffer.' The physical trauma of illness or injury is frequently accompanied by emotional and spiritual trauma, losses and suffering. The old Hassidic quote: 'A small hole in the body, a large hole in the soul' refers to this. Physicians are trained to identify and treat physical pathology, not emotional or spiritual. Laments may be expressed acutely or chronically. Death of a loved one, news of a catastrophic illness or injury may trigger an acute lament with outpouring of emotion. This grief reaction frees up emotions and is the first stage of healing. The appropriate professional response is to make space for mourning and to avoid premature comfort or attempts to demonstrate meaning. Sometimes grief is *disenfranchised*. It is not acknowledged, validated and supported or there may simply just not be enough time to fully mourn. For example a busy executive may suffer a devastating loss e.g. a stillbirth then have to return to work within a few weeks. Mourning is incomplete and grief is buried. When asked how she is, she smiles weakly and responds: 'I'm fine.' She really isn't and grief having to go somewhere, seeps out in the form of a comment here and there and physical symptoms e.g. chronic fatigue.

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Lament, continued from pg. PS 1

Individuals frequently disenfranchise their own grief. I am reminded of a patient who was promoted to supervisor, a position she had wanted for some years. Elation changed to sadness when her former co-workers now excluded her from their coffee breaks and viewed her with suspicion. One day she had to reprimand one former colleague. She came to see me when she began having physical symptoms. Once I made it safe for her to mourn, she had a good cry and together we planned a strategy for her to adapt to her new circumstances.

Many people lament. Nursing home patients frequently lament their losses by being cranky, complaining incessantly and failing to respond to treatment of their physical symptoms. Indeed, they may have many losses – independence, health, mobility, bodily functions, friends, family, self esteem, privacy – the list is seemingly endless. Physicians, too, lament in this era of managed care and loss of autonomy. Described as the ‘Physician Moaning Syndrome’ it can occur wherever physicians congregate. Regardless of the etiology, this chronic lament can be identified by its themes of negativity, loss, hopelessness, helplessness, loneliness and social isolation, nostalgia, absence of meaning, shame, anger, guilt. Like a tape that is played over and over it is often long, repetitive and preoccupied with self.

The chronic lament is mostly counterproductive, alienating rather than drawing others closer. Like a foreign body in a wound, it draws attention to itself and inhibits healing rather than facilitating it. Only when genuine emotion is felt and expressed, can the lament begin to shift into constructive action. In other words, when the chronic lamenter experiences sadness or weeps in the course of talking, this is a positive sign.

Once the listener recognizes that he or she is hearing a lament, the effective response is to empathize with the underlying emotions, validate the losses and to **avoid attempts at fixing the problem**. In this situation, listening is actually therapeutic. This hands off approach, is counterintuitive for physicians since it is very different to treatment of disease. If anything, suggestions might be offered that empower the lamenter and relieve isolation e.g. in the case of the nursing home patient with multiple physical complaints, the physician might validate her losses and then ask: “Since I can’t take care of all your problems, how can I be most helpful to you?” This response invites a partnership and the sharing of power.

As indicated earlier, it is not only patients who lament. Caregivers, employees, nursing staff, colleagues and even spouses lament. When physicians learn to appreciate laments for what they are and master effective counseling techniques, then hopefully their frustration will lessen with improvement in their own personal and professional satisfaction and well-being.

Perhaps the time will come when patients such as Jedaiah Berdesi of the 14th century will no longer complain: “*When you are in need of a physician, you esteem him like a god; when he has brought you out of danger, consider him a kin; when you have been cured he becomes human like yourself; when he sends his bill you think of him as a devil.*”

¹ W. Levinson, R. Gorawara-Bhat, J. Lamb. “A study of patient clues and physician responses in primary care and surgical settings. *JAMA* 2000; 284:1021-7.

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Book Review***The Field Guide to the Difficult Patient Interview***

By Frederic W. Platt and Geoffrey H. Gordon

Lippincott Williams & Wilkins • \$34.95

Reviewed by Souzan E. El Eid, MD

In a sense, this book is no exception to the rule of judging a book by its cover. Its title, “The Field Guide to the Difficult Patient Interview” does not do justice to its clear, excellent content of a step-by-step guide to both general and specific interviewing techniques conducted by a doctor obtaining information from a patient through a variety of situations. I first thought it was about difficult patients but soon found out it is about much more. It is all about communication!

Information is presented as a manual. Each chapter follows evidence-based medicine to address a **Problem**, relevant **Principles**, **Procedures** to follow and **Pitfalls to Avoid**. A **Pearl** at the end concludes each chapter.

A **problem** occurs when a conflict is created during a doctor-patient interview: whether it is time pressures, listening clearly versus misunderstanding, wrong perceptions, multiple presenting problems and prioritizing them, incomplete presented information, different cultures, emotional issues such as sadness, fear, anger, delivering bad news, etc.

Principles outline the basic rules a good doctor should abide by: being patient, a good listener, empathetic, able to organize and prioritize, familiarizing oneself with different cultures, non-verbal communication awareness, etc.

Procedures provide actual techniques for dealing with the problem – with an abundance of examples of doctor-patient questions and answers, scenarios leading to a mutual understanding and getting the story right – all leading to a correct diagnosis.

A listing, of **pitfalls to avoid**, provides a clear outline of what not to ask, say or portray – with, again, multiple examples provided.

The **pearl** is a one-sentence conclusion to each chapter summarizing and reminding the reader of what is essential.

I found this book an easy reading, 5 P’s manual – written in a scientific way, yet teaching an art that is rarely taught in medical schools. The art of listening, being available, empathetic, dealing with difficult circumstances, building a rapport and ultimately creating harmony and mutual trust can, the authors show, help doctors get to the basis of the presenting problem, reach a correct diagnosis, and achieve a healthy therapeutic and preventative outcome!□

