

# Preparing medical students to become attentive listeners

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## Abstract

**Background:** The ability to listen is critically important to many human endeavors and is the object of scholarly inquiry by a large variety of disciplines. While the characteristics of active listening skills in clinical practice have been elucidated previously, a cohesive set of principles to frame the teaching of these skills at the undergraduate medical level has not been described.

**Aims:** The purpose of this study was to identify the principles that underlie the teaching of listening to medical students. We term this capacity, attentive listening.

**Methods:** The authors relied extensively on prior work that clarified how language works in encounters between patients and physicians. They also conducted a review of the applicable medical literature and consulted with experts in applied linguistics and narrative theory.

**Results:** They developed a set of eight core principles of attentive listening. These were then used to design specific teaching modules in the context of curriculum renewal at the Faculty of Medicine, McGill University.

**Conclusions:** Principles that are pragmatic in nature and applicable to medical education have been developed and successfully deployed in an undergraduate medical curriculum.

The individual patient should be able to expect a doctor as an attentive listener, a careful observer, a sensitive communicator, and an effective clinician;...

Edinburgh Declaration, 1988

## Introduction

This essay is the second in a series on preparing medical students to become observant, attentive and thoughtful physicians. The first focused on the teaching of visual observation. We now turn our attention to listening. The quote above is extracted from the report of a 1988 conference held in Edinburgh under the auspices of the World Federation for Medical Education and co-sponsored by the World Health Organization; the meeting focused on making the training of physicians more responsive to the health needs of communities. It is appropriate in setting the context for this essay as it underlines the central role that listening has in clinical practice. Furthermore, the specification of listening as a skill distinct from communication provides additional motivation for the explicit teaching of listening skills.

The major complaint that patients have about their encounters with physicians is that doctors do not listen – the evidence is legion (Golman 1991; Chisholm et al. 2006; Boudreau 2008). Unfortunately, the importance that patients attribute to listening has not led to a curricular emphasis on proficiency in listening skills, nor to its recognition as a

## Practice points

- Although attentive listening is critical for effective physician communication with patients, it is often neglected in specific guides to the teaching of communication skills.
- A set of eight core principles of attentive listening can guide the development of specific teaching activities and tasks.
- A basic understanding of language use, especially how it is used to reflect and create meanings, is important for attentive listening.
- A crucially important principle is the necessity to develop an awareness of the inferences generated by the listener during attentive listening.
- The teaching of attentive listening can benefit from the use of audio editing programs which can graphically present the acoustic features of human language viz., paralanguage.

personal education goal amongst physicians. The experience of not being listened to and hence, not being heard, is a major source of patient dissatisfaction and failures in communication are often cited as an underlying motive by patients for lawsuits (Vincent et al. 1994; Levinson et al. 1997). Such observations have served as a strong impetus for the teaching of communication skills in undergraduate medical education.

Excellent and comprehensive textbooks on the nature of communications in the health professions now exist (Lipkin et al. 1995). Several strategies for teaching communication skills have been validated and have resulted in the dissemination of a series of detailed handbooks such as the Calgary–Cambridge Guide (Silverman et al. 2005), the Bayer–Fetzer Approach (Duffy et al. 2004) and the SEGUE Framework (Makoul 2001). The acceptance by medical educators of the need to make communication skills a feature of core curriculum has been salutary. However, most of the teacher and learner manuals make scant mention of the skill of listening. It seems that authors of such materials assume that listening is an innate skill, present early in development and hardly in need of special attention. However, this stance ignores the complexities of listening and misses the special features that characterize attentive listening.

Listening is a complex phenomenon that is part and parcel of day to day life. It is also addressed by many disciplines, the most obvious being music, but also linguistics, communication studies, sociology, education, philosophy and business, to name a few. These disciplines will, to varying degrees, explore many situations where listening is considered significant (e.g. conflict resolution, semiotics, discourse analysis, language development and rhetoric). This situation has led to an impressive array of approaches, each with its favored audience. Examples include: active listening (in the health professions); effective listening (in business and management); analytic listening (in music); empathic listening (in psychotherapy); and dialogic listening (in linguistics). The definition and scope of listening are therefore likely to be highly contextual. Nevertheless, a few key features appear common to all. Listening is dependent upon the physiological process of audition and implies the presence of at least two persons – one of whom is a recipient, a hearer or listener. The Oxford English Dictionary (2008) definition of the transitive verb, 'listen' is: 'to hear attentively; to give ear to; to pay attention to (a person speaking or what is said)'.

Given the cardinal place of listening in the clinical encounter, we set out to develop a set of principles for understanding and teaching listening in clinical medicine. We follow with specific suggestions as to how these skills may be inculcated in medical students.

## Background and context

Our motivation for teaching listening arose in the context of curricular renewal at McGill University. In 2005, our Faculty of Medicine introduced a new curricular component entitled physicianship (Boudreau 2007). Physicianship is not a term in common usage and merits definition; it is a noun, and like the word 'friendship', refers to a state wherein one possesses the knowledge and skills necessary for the function and office of physicians. In this context, the term office refers to an obligation. As understood at McGill, physicianship also speaks to the dual roles of the physician: as healer and professional. Our underlying premise is that the primary mandate of medicine is the care of sick persons and relief of their suffering; this is the focus of the healer role. Professionalism

deliver its services (Crues 1997). Physicianship is enacted through a clinical method, the toolbox of skills necessary for the physician to accomplish the clinician's mandate. It comprises the following skills: observation; listening; communication skills; narrative competence and description; physical examination; clinical thinking and reasoning; and self-reflection. In this article, we focus on listening.

In developing the modules on listening we were guided primarily by the previous work of one of the authors of this paper, Eric Cassell. In the early 1970s, he audiotaped conversations that took place within 800 patient-doctor dyads, many of them over recurrent visits. The transcribed conversations were analyzed and resulted in an enriched understanding of how language works and how it can be used in the clinical setting (Cassell 1985). We were also informed by a review of the medical education literature and enlisted the help of experts in linguistics and narrative theory.

## Course development: guiding principles

As described in the companion paper on clinical observation, we argue for the adoption of four principles in guiding course development for the teaching of clinical skills. These are as follows.

- (1) A curricular blueprint must accept that each element of the clinical method (e.g. listening) is a fundamental and necessary core clinical skill. Consequently, it must be integrated in core curricula, with the requirement that all students will participate in related activities.
- (2) Specific learning objectives must be clearly specified.
- (3) The teaching strategies employed should respect the generally accepted norms for skills teaching, an important aspect of which is the need for repetitive practice. There must also be performance assessments, with both formative and summative intents. Detailed and prompt feedback on performance (in this instance, listening performance), is critically important.
- (4) Medical educators must not lose sight of the fact that they are teaching medicine; in this instance, the focus is on listening and language use, not linguistics. In this spirit, we consider that learning should, in the ideal situation, take place in clinically meaningful contexts.

## Core principles of listening in the clinical context

We have identified eight core principles in what we have labeled 'attentive' listening.

- (1) Attentive listening is a perceptual, cognitive and social act.
- (2) Attentive listening is an active process.
- (3) Attentive listening is triadic: the speaker, the utterance, and the listener.
- (4) Listening attentively involves focusing on word choice.

