Speaking for Ourselves

Listening catalyses healing

ANNA THARYAN, JENIFER JEBA, RAVI LIVINGSTONE, REENA GEORGE

Among various communication strategies available to medical professionals, listening is most likely to be dismissed as passive and weak and therefore not in keeping with the traditional view of the doctor as powerful and proactive. However, listening is an integral part of the patient–doctor interaction.[1]

Each component of the pathway that leads to a desirable conclusion of the patient–doctor encounter involves listening to verbal or non-verbal messages, to the 'between the lines' content of what the patient says and to the emotions, attitudes and perceptions expressed. This involves not merely the recording of narrated facts and events but includes emotional responses such as compassion in the decisions or responses predicated on listening.

Listening as a communication skill is least likely to harm because it encourages rather than forces. The nature and pace of changes brought about by listening are rooted in the mind of the speaker and are therefore most likely to be suitable to the psychological structure of that mind.

Listening usually provides the data with which to progress to the next step in planning or execution of therapy. This account of the last days of a young girl, dying of a malignant tumour in the chest demonstrates the therapeutic potential of listening. It reveals how listening allows the spontaneous acceptance of loss and the reframing of tragedy. It speaks of how the journey towards meaning and hope can be facilitated by professionals willing to be silent witnesses as well as how much the professional can learn through this process.

Numerous strategies and perspectives are involved in communication in end-of-life care.[2] Sophisticated manoeuvres are essential to effective therapy especially paediatric palliative care.[3] However, there are times when, as medical professionals, we need to get out of the way and allow inherent strength to emerge.

THE ROADBLOCK OF UNRESOLVED GRIEF

The patient was a young girl with disseminated metastatic cancer. She was cachexic and non-responsive. The parents who had supported her through three years of anti-neoplastic therapy were stuck in anger. Unable to accept the inevitability of the death of their child, the father's words held veiled threats. The doctors involved felt misunderstood and found it difficult to negotiate appropriate plans for care.

A psychiatry consultation was sought for professional counselling and to rule out psychopathology. With considerable apprehension, the doctors met with the parents.

Psychotherapy hijacked by narrative

Any plans the doctors may have had regarding the conduct of the interview were swept aside by the torrent of thoughts and emotions hitherto kept pent up within the father. Although he had been given ample opportunity to share his thoughts in the past and he, in fact, had done so with a thoroughness which pained his doctors, he proceeded to retell the narrative of his daughter's illness.

The father, an affluent businessman, spoke of all he had done to save his daughter. He tallied up the money and time he had spent in various religious rituals, prayers for healing, numerous donations and the extended periods of stay in hospital, at the cost of neglecting the rest of his family, who lived in a distant northeastern state. He spoke with indignation about the times relatives and neighbours had been quick to criticize the care and treatment he had provided for his daughter. He referred to carefully maintained treatment records and strict adherence to advice from doctors.

The father's eyes began to fill with tears as he described his daughter's talent as a dancer and how much she enjoyed the classes they had arranged for her. He lingered on the many times they had watched her dance in school and in public functions and seemed to derive comfort from the memory. He laid out before the doctors, the plans he had made for his daughter's ascent into a future brighter than he himself would achieve. He begged to be given hope that they would be realized.

The father's thoughts careened between desperation-driven plans to seek more aggressive treatment and the inertia of hopelessness. He confided that he felt equally abandoned by God and by the medical profession.

The mother of the patient sat quietly while her husband spoke. She shed tears as memories were evoked by her husband's narrative. She was clearly a woman of great inner strength. When her husband became loud and indignant she quietly pointed out to the doctors that despite being a hypertensive, he had not been taking his medicines regularly for a week. She spoke of her other child who had been left to the care of the extended family. She seemed to be reminding herself that life had to move on.

A change in direction

The mother took the lead for the first time and asked whether there was any way to reduce the pain caused by the frequent injections to restart blocked drips. This gave the doctors an opening to explain that it would be possible to stop intravenous injections and hydration but that it would accelerate the decline, especially as nasogastric feeds had been poorly tolerated.

This time when the doctors outlined the steps and the possible course of events that would follow if active treatment were withdrawn, the father seemed better able to listen. He kept silent

Christian Medical College, Vellore 632002, Tamil Nadu, India
ANNA THARYAN Department of Psychiatry
JENIFER JEBA, REENA GEORGE Department of Palliative Care Unit

Bangalore Baptist Hospital, Hebbal, Bengaluru 560024, Karnataka, India
RAVI LIVINGSTONE Department of Palliative Care

Correspondence to ANNA THARYAN; *anna.vellore@gmail.com*

for a while and then requested that even if treatment were withdrawn they not be sent home. He said that the normal lives of the rest of the family accentuated their loss, as they felt completely alone in their tragedy.

At this point, after one and a half hours of impassioned pleading, the father broke down and sobbed. He fell on the floor with his face turned away from the doctors and for the first time his anger gave way to the brokenness that was driving his agitation and accusations.

The mother, at this point, asked permission to go back to her daughter's bedside.

A spontaneous resolution

The following day, the father of the patient came to the doctors and requested discharge as they had already booked their tickets to return home.

The doctors were relieved that the family had moved on. They were left with a feeling of closure. All this, without needing to intervene to any great extent.

LEARNING BY LISTENING

The journey of this family shows that the simple task of listening had catalysed the resolution of grief. Through active listening that recruits the emotions as well as the intellect of the listener the doctors could move from defensive planning to empathic understanding. From the unfolding of layers of emotion, the doctors recognized that the father's self-esteem had thus far hinged on the extent to which he could control and direct his life. It was therefore difficult for him to accept that his best efforts were not good enough to save his precious daughter. Anger or resistance shown by the father was not primarily an indictment of their role. The same energy that had driven his search for a cure had been redirected into courage to drop the anger and resentment that was blocking the journey towards acceptance of loss. Inner strength had been released from the bonds of grief. As they watched broken-hearted parents relinquish a control they had already lost, the doctors recognized strength within their pain.[4]

The simple act of listening to the father while he retold his story allowed him to retrace the thoughts that formed the context for the emotions.[5] The articulation of thoughts allowed logic to knit together the fragments and dissect out guilt and regret. Thus freed, the mind took on the task of grappling with and accepting reality. In this case the result was the accelerated pace at which the parents accepted discharge.

To undertake risky and difficult procedures, to work day and night, to study and research the frontiers of science is accepted as necessary. To be with, listen to, and join the search for meaning in the ashes of loss can be perceived as inimical to the role of the 'powerful', 'life-saving' professional.

Medical training encourages giving but perhaps does not emphasize the giving that takes place through receiving. Listening is a way of helping through receiving. Listening carefully while a person speaks conveys a sense of affirmation and validation and encourages the person to dig deep into the mind beyond the superficial narration of events. It creates the space required to allow the holistic perspective to emerge, the true self to be revealed and the strengths to emerge from behind the scars.[6] It empowers the speaker to seek his or her own solutions rather than be overtaken by the direction of the other. It allows the listener to be guided by the needs of the speaker rather than by a narrow checklist. Listening recruits the truth and integrates it into experience. It keeps the facts and figures of the database of our profession firmly anchored in their relevance to the whole human being.

Listening takes time. Unfortunately, the effort required to avoid listening also takes time. The story that is not heard will repeat itself. The unhealed patient will make repeated attempts to find relief. Each repetition makes the doctor more resentful. The cycle continues, perpetuating beliefs in the doctors that communication is a waste of time and in the patient that doctors do not care.[5] Angry accusations and litigation are more likely to occur when doctors are too busy to listen.

Doctors who care, are sometimes subject to the dangers of over-ownership or the assumption of primary and central responsibility for curing and saving everybody in need. To those who are willing to bear witness and listen even when no action is possible, is granted a glimpse of the resilience within grieving souls even in their darkest hour. This insight is an antidote against the common error of over-ownership and prevents burn out. The power of the antidote lies in the realization that although the best efforts of medical practice fall short of the ideal, there is an inherent strength and meaning to life. We are encouraged to hope in the power of life.

Healing and cure are not synonymous. A person whose fracture has united satisfactorily might remain wounded by the memory of the accident, of insensitive communication by professionals, or by financial debt. Conversely, an unavoidable death is not necessarily a medical failure, and the family may seek healing beyond the physical. In both scenarios, the 'poultice' of active listening can drain the abscess of grief, and begin the process of healing and resolution.[6,7]

REFERENCES

1 Silverman J, Kurtz S, Draper J. Initiating the session. In: *Skills for communicating with patients*. London:Radcliffe Publishing; 2005:45–7.
2 Arora NK. Interacting with cancer patients: The significance of physicians' communication. *Soc Sci Med* 2003;**57:**791–806.
3 Feudtner C. Collaborative communication in paediatric palliative care: A foundation for problem solving and decision making. *Paediatr Clin North Am* 2007;**54:**583–607.
4 Frank AW. Just listening: Narrative and deep illness. *Fam Syst Health* 1998;**6:** 197–212.
5 Johnston O, Kumar S, Kendall K, Peveler R, Gabbay J, Kendrick T. Qualitative study of depression management in primary care: GP and patient goals, and the value of listening *Br J Gen Pract* 2007;**57:**e1–e14.
6 Jackson SW. The listening healer in the history of psychological healing. *Am J Psychiatr* 1992;**149:**1623–32.
7 Gibbons MB. Listening to the lived experience of loss. *Pediatr Nurs* 1993;**19:**597–9.