“Are You Listening Doc?” Qualitative Examination of Health-Workers’ Best Practice Based Listening Skills.

Seif Sekalala,

Drexel University.

Lisa Brening, Kylee Kasselman, Precious Ohanson,

Fort Hays State University.

Author Notes:

Seif Sekalala is an adjunct professor of communication studies at Drexel University.

Lisa Brening is an assistant professor of nursing at Fort Hays State University.

Kylee Kasselman is a graduate of the nursing program at Fort Hays State University, and a registered nurse in Kansas.

Precious Ohanson is a graduate of the nursing program at Fort Hays State University, and a registered nurse in Atlanta, GA.

Funded by Fort Hays State University (FHSU)’s Office of Scholarship and Sponsored Projects (OSSP) Undergraduate Research Experience (URE) ’19-’20 Award.

Correspondence should be addressed to:

Seif Sekalala,

Email: seifsekalala@gmail.com

Abstract

In this paper, the authors report the findings of the first phase of a two-site international study that examines healthcare providers’ listening skills. Primarily, our investigation was aimed at uncovering the traits and characteristics of effective listening and communication among healthcare providers. Data—i.e., patients’ reviews of healthcare providers—was collected from six general consumer- and patient-review websites, and was analyzed via in-vivo and axial coding. We then triangulated the results from that analysis via a scrutiny of our own experiences, both as providers, and as patients. Ultimately, our analysis uncovered a total of ten characteristics of effective listening and communication among healthcare providers, and the analysis also highlights the importance of shared meaning-making. Research team-members also realized: i) our own hindrances to effective listening—i.e., as healthcare workers; ii) the disconnect between professional experience and listening skills; and iii) the importance of our own and their family members’ experiences as patients vis-à-vis development of effective listening skills, and the informal nature of listening skill development.

Keywords: communication, health-communication, healthcare, listening, online-reviews.

"*Are You Listening Doc*?" Qualitative Examination of Health-Workers' Best Practice-Based Listening Skills

In late-summer of 2016, a 70-year-old lady (the mother of one of this paper's authors) presented herself—accompanied by her daughter—to a primary care physician and his staff in Uganda, with a number of gastrointestinal and other symptoms. These included a lack of appetite, nausea, a running stomach, and an intermittent fever. However, early in their interaction, the physician summarily "diagnosed" the patient's main problem as obesity, dismissing the above symptoms. For the purposes of this paper, it should be noted for emphasis that this provider did not listen to the patient—i.e., giving the patient and her caretaker a chance to divulge the relevant medical history and symptoms. Luckily, the patient—a dual citizen of Uganda and the USA—was able to get a second informed thorough diagnosis from another team of local providers, and they suggested for her to travel abroad for more specialized care.

Eventually, thanks to that referral, the patient was diagnosed with a gastrointestinal stromal tumor (/"G.I.S.T.") in the USA, and was successfully treated via imatinib medication and surgery. The above story is just one of possibly hundreds or thousands of stories that can be collected by both informal anecdotal based research, as well as professional scholarship. And in this paper, we argue that one of the main causes of medical malpractice is a lack—or inadequate utilization—of effective professional listening skills. Indeed, as various scholars have documented, medical malpractice is a common problem all over the world, including the USA and Uganda (e.g., Rubin & Bishop, 2013; Kadimba, Katongole, & Bikaitwoha, 2015).

Based on the results of a supporting study, this paper will tackle the problem ineffective listening in medical settings, demonstrating some of the causes and manifestations of, and some of the potential solutions to ineffective listening in medical settings. The study is the first US

based part of a larger international comparative study between US (as an idiographic example of developed nations'), versus Ugandan (as the counterpart idiographic example of developing nations') medical providers' listening, as well as general communication and quality assurance skills. Using various general and medical consumer review sites such as Yelp, WebMD, and ZocDoc for practitioners in five US central region states' midsized cities, this research team collected and analyzed patients' reviews with a goal of determining their (the patients') definitions and examples of effective communication and listening habits among healthcare providers. Details of the study's findings are provided and discussed in the sections farther below.

Review of Literature

General Survey of Health communication Literature in Relation to Provider-Patient Interactions

General database searches and basic metanalyses (e.g., via Google Scholar and Amazon, health communication journals, and other fora) reveal that health communication scholars and practitioners have to date mostly examined the efficacy of public health messages from providers/practitioners and scholars, versus patients' and the general public's and/or health communication beneficiaries' messages to providers/practitioners and scholars. Some of the relevant search terms that were used for the collection of studies in this review include "health communication," "health provider communication skills," and "health communication for improved outcomes." Altogether, the above-mentioned mainstream sources reflect a dearth of literature on topic of effective listening in patient-provider contexts. In this regard, Biedenharn's (2020) study is an exception. She pinpoints a specific effective method of listening—i.e., the Quaker listening model—which she tested among critical care nurses; her results indicate

improved patient outcomes, and she reports increased job satisfaction by nurses as a result of deep listening.

In addition to the above-mentioned general focus on the effectiveness of messages from providers/practitioners and scholars—e.g., in public health campaign contexts, many scholars examine a variety of relevant health communication topics (i.e., in the specific context of effective listening in healthcare settings), including provider-patient “small talk” and code switching (Beck & Ragan, 1992); and health literacy (Daniels & Mibei, 2019).

The focus on health literacy in particular is explored in detail. For instance, Shore et al. (2006) explain the need for trust between providers and patients/caretakers as a precursor for effective communication, and Kennedy et al. (2018) discusses the use of targeted narratives for multicultural audiences. Such holistic foci on communication processes can help providers in understanding patients’ general knowledge of vital health information.

The various relevant health communication topics in question also necessarily determine willingness and ability to communicate effectively. For instance, one particularly difficult topic is end-of-life care. Another set of predictors for providers’ communicative actions is analyzed in a study by Roberto et al. (2011), and the authors quantify these predictors via the theory of reasoned action (TRA) and theory of planned behavior (TPB). Whereas the study found that TRA is indeed a valid theory for predicting providers’ behaviors’, TPB’s influence was apparently weaker. In addition to influences such as the above which can be measured in providers’ messaging, variables such as culture, literacy, and low income also contribute to patients’ ratings of their provider-patient communication quality, as Guntzviller, Jensen, King, and Davis (2010) report. Moreover, the low-income variable seems to be exacerbated by young age, white race, literacy, and pessimism, which combined, translate to higher patient activism.

Other Themes of Provider-Patient (/-Caretaker) Communication Studies

Among other medical conditions, researchers have also examined provider-patient communication efficacy with mental health (e.g., Patel, Bakken, & Ruland, 2008). Indeed, the sub category of mental health particularly exemplifies the earnest need for good listening skills.

Finally, in contrast to the minority of studies such as Monaghan et al.'s (2013)—i.e., those that focus on transitive contexts (such as diabetic young adults' switch from pediatricians to adult providers), scholars and practitioners seem to be earnestly concerned with interpersonal and general skills training and quality assurance. Some of the most prominent works in this subcategory include: Wright et al. (2007); and Kennedy et al. (2014).

Synthesis of Findings And Operational Definitions of Effective Listening In Provider-Patient Settings

Altogether, the above studies commendably expand our knowledge vis-à-vis the diverse variables that influence effective provider-patient communication—and to a limited extent, effective listening in healthcare contexts. Regardless, the sub discipline of health communication seems to have a markedly less robust knowledge base in regard to effective provider listening habits (at least compared to other foci of the patient-provider communication ecosystem). And at this juncture, it is important to clearly define what we mean by the term effective listening in healthcare (and other) contexts.

Operational Definitions of Effective Listening. To appropriately respond to the above question, we hereby postulate that it might be important to highlight a clear definition which is consolidated by a convergence of both patients' opinions, as well as healthcare providers' opinions. And in regard to healthcare providers' opinions, we don't just mean their acquiescence to patients' standards. Rather, we are referring to standards that healthcare providers themselves

would expect to be upheld if they (the healthcare providers) were the patients. Consequently, one can draw on various scholars’ research and theoretical treatises to inform this discussion. In this paper, we utilize works by seven sets of authors under two main categories, namely: i) general—i.e., Worthington & Fitch-Hauser (2012), Donoghue & Siegel (2005), and Nichols (2021), and ii)—patient-centric definitions—i.e., Biglu, et al. (2017), Gilligan et al. (2017), Derksen et al. (2013), and Levinson et al. (2013).

i) General Definitions. In the context of general definitions, Worthington & Fitch-Hauser (2012), define listening as “the process of receiving, constructing meaning from, and responding to spoken and/or nonverbal messages (p. 5).” In a further breakdown of the listening process, their “listening MATERRS” model is composed of seven aspects, namely: attention to mental stimuli; full awareness and intentionality; translation to meaning; evaluation; recollection; responding; and staying connected. They also distinguish among various types of listening, including (among others): discriminative; critical; therapeutic; and empathetic and levels, including: passive; selective; active; and empathetic. Surprisingly, selective listening isn’t necessarily a negative practice.

With certain modifications, healthcare workers can use this particular model successfully to diagnose illnesses. In the specific context of healthcare provision, the authors advise providers to improve their listening skills via various techniques, including: 1) awareness of personal schemata, 2) use of immediacy behaviors (“look[ing] interested,” p. 227), 3) attention to distress markers and silence, 4) avoidance of abrupt topic changes, 5) empathy, 6) listening more than talking, 7) ceding some control to patients [and caretakers], and 8) ensuring understanding.

In addition to Worthington & Fitch-Hauser’s comprehensive evaluation, we can glean a few more insights in regard to the various barriers to effective listening from other authors. In

this context, research by Nichols and Strauss (2021) and Donoghue & Siegel (2005) is noteworthy. Donoghue and Siegel (2005) delineate some basic forms of ineffective listening, as well as their causes, namely: defensiveness, attention to personal needs versus the individuals to whom we're listening, eagerness to give advice, and eagerness to judge. Nichols' (2021) major causes (of ineffective listening) intersect with the above authors; i.e., attention to our own needs, prejudiced listening, and defensiveness. As remedies to these problems, the author recommends the utilization of patience and empathy.

Beyond the above considerations of basic definitions, what are the "key ingredients"—so to speak of—of effective listening? In this regard, available literature suggests some key variables, such as Berman and Chutka's (2016) study's rubric for provision of effective listening related feedback to healthcare provider trainees. Consequently, in the data analysis stage (as discussed farther below), we utilized that study's rubric to compose each of our own individual sets of in-vivo codes, with which we analyzed the patients' reviews.

[Please Insert Table 1 Here]

ii) Patient-Centric Definitions. In addition to the above general definitions, our current research is informed by studies that specifically seek to understand how patients define good listening behavior (in healthcare provision settings). Some of the most prominent studies in this context are those by Biglu, et al. (2017), Gilligan et al. (2017), Derksen et al. (2013), and Levinson et al. (2013).

First, Biglu et al.'s study highlights the correlation between physicians' communication skills—specifically, "devoting the appropriate time for visiting the patients, [and] explaining diagnosis and treatment procedures," and patient satisfaction. However, the authors didn't find a correlation between effective listening and patient satisfaction.

Similarly, Gilligan et al.'s (2017) study didn't identify effective listening skills as particularly important. Rather, they highlight importance of clear communication strategization—i.e./e.g., to make sure that patients clearly understand their options for treatment; and empathy.

However, unlike the above two studies, the results of Derksen et al.'s (2013) and Levinson et al.'s (2013) studies highlight the importance of empathy. Apparently, there is a correlation between physician empathy and patient satisfaction; empathy also alleviates patients' anxiety and distress, and it can lead to significantly better clinical outcomes.

Research Questions. After considering all the above studies and relevant knowledge-syntheses, and based on our own experiences as both patients (and caretakers) and healthcare providers (and/or providers-in-training), we decided to investigate patients' detailed descriptions and evaluations of effective listening across two international sites, i.e.: 1) five contiguous central region US states (Colorado, Kansas, Missouri, Nebraska, and Oklahoma) and 2) the aforementioned East African country—i.e., Uganda. In this paper, we report the results from the first site's investigation. RQ 1 (for the US central region test site): In the five US central region states in question—i.e., Colorado, Kansas, Missouri, Nebraska, and Oklahoma—what are the traits and characteristics of effective listener healthcare providers, according to patients' online reviews?

Method

Qualitative Data Collection and Analysis

Altogether, the research team collected a total of 118 data-units—i.e., patients' reviews of providers in the five aforementioned central region states (CO, KS, MO, NE, OK). We then

utilized an analysis method based on the principles of grounded theory analysis (e.g., Strauss & Corbin, 1994), as well as open/in-vivo coding, and 2) axial coding.

Finally (as we explain in detail farther below), we triangulated this data using autoethnographic experiences. These experiences were garnered in reaction to prompts we carefully composed for ourselves, to help us vis-à-vis the gathering of potentially-insightful of personal experiences—both as healthcare providers, and as patients or caretakers.

Data Gathering and Analysis Procedures

Research Study Funding Details And Researcher Roles

The principal investigators of this US phase of the research study were two instructors from the communication and nursing departments respectively, of a large university in one of the five central states listed above. Using the proceeds of a small undergraduate research grant, the principal investigators recruited two undergraduate students from the nursing department, who were each compensated for their participation via scholarships. It should also be noted that IRB approval was secured prior to the collection of the students' autoethnographic data.

Public Data—i.e., From Patients' Reviews On Consumer Feedback Platform Sites (e.g., Yelp, ZocDoc, etc.)

The main data gathering method was the collection of extensive public health worker review data off websites such as Yelp and ZocDoc. This resulted in a total collection of 118 data units, i.e., evaluations/critiques of healthcare workers and/or facilities in the five central region states in question (e.g., table 2's display of a sample data-unit). After achieving an ideal saturation level vis-à-vis raw data findings, the faculty-student team embarked on a two-part analysis framework, entailing open/in-vivo, and axial coding.

Based on their initial overview readings of the raw data, the team members each formulated four separate but distinctly similar sets of open code schemes, which were reflective of all the themes the research team detected from their early readings of the data. These sets of code schemes were devised individually and in a "blind" brainstorming fashion. In other words, the team members did not consult each other in that (individual open code) brainstorming, nor did they see each other's codes until the end of the open coding analysis phase. As indicated by table 3 farther below, the individual team members' open codes—based on the Berman and Chutka (2016) study, and the researchers' informed intuition—varied. "Researcher No. 1" had 8 codes; "Researcher no. 2" had 16 codes; "Researcher no. 3" had 19 codes; and "Researcher no. 4" had 15 codes.

Later, out of those separate but similar sets of open codes, the team formulated a list of 10 axial codes to unify and/or pithily describe all researchers' open codes in one set, as listed and defined in row three of table 5 below. These codes/descriptions comprehensively defined the various positive sentiments expressed by patients on the consumer review websites, in reaction to the commendable communication, listening, and other related skills that the healthcare workers demonstrate in their interactions with patients and caretakers.

[Please Insert Tables 2, 3, 4, & 5 Here]

Coding

Having studied the relevant literature—including the above rubric by Berman and Chutka, and after discussing our own understandings of effective listening by providers—i.e., from a patient's point of view, the team "blindly" brainstormed separate in-vivo codes. In other words, despite the fact that we all agreed in general vis-à-vis what it means to be an effective

healthcare-worker, we wanted to critically examine our individual meanings in detail. However, in the end, our meanings were very similar, as table 4 above demonstrates.

Meaning-Negotiation and Convergence

In the axial-coding stage, we decided to divide ourselves into two sub-teams/pairs for optimal performance. Each team member also revealed their individual sets of in-vivo codes, which the team consolidated into one set of axial codes, as displayed on row three of table 5.

Thereafter, we randomly assigned—i.e., using a random-number-generator—each researcher a set of data-units for axial-coding, but we agreed that it would be completed in pairs. Subsequently, each sub-team/pair met and discussed the findings further, and we all executed our axial coding on the pre-assigned data units.

Overall, the most important takeaway from the axial coding stage was the importance of shared meaning-making in the clarification of the definition(s) of effective listening. Whereas multiple individuals—i.e., patients—might agree fervently that a provider is a great listener, it is very likely that each of those individuals/patients will perceive and/or interpret that reality differently. For further explication/demonstration of this argument, please refer to table 6 below. In that example, the individual research-teams agreed with each other's definitions a total of three out of 4 times—i.e., for text-fragments 1, 2, and 3. However, the details of their agreement were unanimous or identical for only two of the text-fragments, i.e., fragments 1 and 2.

[Please Insert Table 6 Here]

In-Person Data Gathering Cancellation (Due to the COVID-19 Pandemic), and Improvisation With Autoethnographic Data

Unfortunately, face-to-face (interview) data gathering method had to be canceled due to the marked disruptions caused by the COVID-19 pandemic. In light of this contingency, the team

had to devise another way of supplementing the data gathered from consumer review websites. Such secondary data gathering and analysis methods are important for quality assurance purposes vis-à-vis validity and reliability of research results (e.g., Wrench et al., 2019). Ultimately, the method that was devised for this secondary data gathering (and grounded analysis), was the use of autoethnographic reports by the two nursing professionals-in-training (P.I.Ts), as well as the P.I.T's nursing department professor-mentor. To enable these autoethnographic reports, two sets of autoethnographic data were collected.

The first set (of autoethnographic data) was a series of responses to structured prompts/questions, which were designed based on: i) the literature review data; ii) team members' general personal experiences as both patients and professionals/P.I.Ts; and iii) raw and grounded analysis-derived results from the above-mentioned consumer feedback site data. The second set (of autoethnographic data) was assembled via unstructured stories of positive and negative experiences of encounters with providers, both in the USA and other countries. In part two of the results section farther below, we present some excerpts and an overall summary of the professional/P.I.Ts' responses to the autoethnographic experience prompts.

Results

Results Part 1: Patients' Reviews And Perceptions of Effective Listening And Communication Among Healthcare Workers

In this section, we present the research-analysis results via a framework that utilizes the three definitive characteristic-sets outlined in the paragraph below. Studied via an analytical lens of those three characteristic-sets, what are some of the healthcare-workers behaviors–as described via patients' reviews–that might be indicative of effective listening and communication skills? In addition to using all research-result data-units in general, this analysis

will be applied to 12 particular data-units (out of a total of 118 units; i.e., 10.16% of "n"), which we chose randomly, via the use of an online random number generator.

Each data-unit is composed of a varying number of multiple patients' reviews about the same healthcare provider–or a set of providers at the same facility, as well as the healthcare worker's/workers' staff–i.e./e.g., front office/reception, nursing aides, or even billing clerks, etc. For instance, of the 12 data-unit samples used for this section's close reading, sample 1 has eight (patients') reviews, sample 6 has 3 reviews, and sample 10 has eight reviews.

The three sets of characteristics we can use to comprehend these particular patients' reviews (in the context of effective listening and communication for healthcare provision) are: 1) general characteristics, derived via textual-analysis; 2) previous studies' characteristics of patients' perceptions of effective listening and communication among healthcare workers; and 3) the current study's characteristics, derived from the research team's data-analysis–i.e., via in-vivo and axial coding, and the autoethnographic-experience review of research-team members–i.e., healthcare workers' (/workers-in-training), who have also received medical care from fellow professionals, and who can relate to the healthcare workers being critiqued by the healthcare consumer-reviews.

1–General Textual-Analysis-Derived Characteristics

Details—I; e.g., clinic's entire staff and factors such as wait time, vs. doc's listening alone. In their online reviews, patients provide holistic critiques related to several aspects of providers' care, including their support-staff, and wait-time. In fact, wait-time is a prominent element among patients' reviews. For instance, among the 12 data-unit samples in question, the characteristic of wait-time comes up in four different units. And among the entire data set–i.e., among different research team-members' data units, this topic shows up severally. For instance,

from research team-member 1's data, a search reveals 10 instances of wait-time mentions by patients.

Details—II; e.g., about providers, and the core characteristics/traits—in patients' own. words—that define effective listening. But beyond such minor characteristics–i.e., time and support-staff, what can we identify as examples of patients' perceptions vis-a-vis core characteristics/traits of effective listening among healthcare workers? In this context, in addition to the details that we provide under the other characteristic-sets below, one can sum up patients' perceptions of effective listening and communication among healthcare workers as follows: among other characteristics, effective listening and communication is indicated by behaviors such as kindness and empathy/sympathy; demonstration of respect and individual-attention—i.e., treating the individual versus treating a disease; conscientiousness vis-a-vis learning the causes of patients' ailments; and collaborative approaches with patients, versus autocratic tendencies.

Below are some specific examples of these traits, derived from patients' reviews:

- From data-set sample 2: *"Dr XX honestly cares for his patients. He has taken the time to listen to my health concerns. He is willing to try different approaches to your health care that may be a bit alternative from the standard medical treatment. He seems to have an open mind and tries to treat the patient, not just the symptom."*
- From data-set sample 3: Dr. X "*...remembers you from visit to visit*."
- From data-set sample 5: *"The doctor was very considerate and took time to help me deal with my husband's stroke. He had the ability to answer my questions so I understood what was being done"*

Particular (/general) reason/ailment/context as described by the patient, and particular solution by provider. In addition to defining the general core characteristics of

effective healthcare-worker listening and communication, we can also strengthen our understanding of the topic via an examination of what can be termed as “patient stories.” By this term, we’re attempting to answer the following question: what are some of the precise contexts/ailments that compel patients to seek healthcare-workers’ help?

And of course, the stories are numerous and unique. Below are two particular examples from the data-set sample.

- Example 1, from data-set sample 5: in this case, the story is pithy. Incidentally, the reviewer is a caretaker, speaking on both their own behalf, as well as the patient–i.e., her husband: *“The doctor was very considerate and took time to help me deal with my husband’s stroke. He had the ability to answer my questions so I understood what was being done”*
- Example 2, from data-set sample 6: this story is more complex; the reviewer provides a general background/context, as well as the ailment or problem that arose from that context, which compelled the reviewer to seek help. The reviewer also provides the end-result of her encounter with the provider: *I'm 56 years old and have more menopausal symptoms than most women. The HRT has given me my LIFE back!! Dr. XX is thorough and I have NEVER had to wait more than 1 day to get a call returned. I have always been treated with friendly respect either when I go to the office or call. I recommend Dr. XX to everyone who needs help.*

Effects—i.e./e.g., health outcomes, patient’s sentiment toward providers, and recommendations of providers for other patients, etc. Generally, patients’ descriptions of effective listening and communication explicitly indicate good outcomes, and positivity toward providers/facilities. And because of their good impressions of the providers, patients habitually

recommend those providers to fellow patients. In fact, this last effect–i.e., recommendation of effective providers–is demonstrated dramatically in this data-set sample–i.e., of 12 data-units. Out of that total number of data-units, the word "recommend" shows up in a total of 13 instances!

2–Previous Studies' Characteristics

Beyond the above introductory characteristics, a review of our data reveals a variety of behaviors/traits/practices that have also been identified in previous studies—i.e./e.g., as discussed in the literature review section farther above—as demonstrative of effective listening and communication. A close study of those studies' referenced characteristics reveals a total of at least 13 clearly identifiable traits. Reflective of their typology as discussed farther above (in the literature review section), one can group these 13 traits under three major categories, namely: 1) general definitions, 2) ineffective listening, and 3) remedies of ineffective listening and patient-centric definitions. For instance, below are five examples of various review excerpts, listed under their respective feedback's categories.

- **For category 1–i.e. general definitions; listening more than talking:** *"He is very easy to talk to and he listens to what you have to say… I had my first new visit with him a few months ago and what a wonderful experience. He was not rushed, listened carefully to what you had to contribute to the visit and I was blown away by this personal contact with him."*
- **For category 1–i.e. general definitions; particularly, attention to distress markers and silence, and from category 3–i.e. remedies of ineffective listening–particularly, active listening (e.g., attentive sensing):** *Very friendly guy. Diagnosed a skin condition (that I didn't even bring to his attention) that several other physicians have misdiagnosed*

for years. I thought that was pretty interesting. Has a great bedside manner and I felt very comfortable in his care.

- **For category 2–i.e. ineffective listening; including attention to personal needs vs. one's interlocutor, i.e. in this context the patient, and eagerness to give advice:** *Dr. XX is amazing to say the least. He's very caring and courteous! XX.i He's even seen me for a [sic] unplanned appointment during his lunch break when he doesn't accept patients. So happy I have him as a cardiologist! The only thing I would say is a con is sometimes I feel rushed and I don't like that because then I forget to ask questions I have and I don't like that at all then when I leave I have to call the nurses to get the answers, etc. That's the only thing I would change. I trust him so much.*
- **For category 3–i.e. patient-centric definitions; e.g., devoting the appropriate time for visiting the patients, [and] explaining diagnosis and treatment procedures," and patient satisfaction:** *Dr. XX is outstanding. She listens and remembers you from visit to visit. She takes time to listen and advise. She does not ever rush you and explains possibilities and options if you need them. She is kind and compassionate. She is an amazing doctor.*

3–Current Study's Characteristics of Patients' Perceptions of Effective Listening and Communication

Finally, a close examination of our data clearly highlights several examples of the characteristics we delineated via in-vivo and axial coding, as well as triangulation with our own autoethnographic experiences. For emphasis, it should be noted again in earnest that these autoethnographic experiences are derived from both: i) our professional capacities as healthcare providers—or providers-in-training, and ii) from our previous encounters with fellow providers

for help, i.e. for both ourselves and/or our family members as patients. Altogether, the characteristics we identified are:

1) Listening,

2) Attentiveness, or focus on the patient, effective nonverbal behavior—i.e., indicative of good listening,

3) Time; takes time, patience, doesn't rush, thorough,

4) [Helping patients feel] comfortable, [having a] good vibe,

5) Care, concern, empathy, compassion,

6) Info provision; answers questions, educating, explaining,

7) Respect & trust, patient is able to voice opinion in regard to decisions, teamwork,

8) Competency, knowledgeable, thorough,

9) Information gathering, asking questions,

10) Other [characteristics/traits/techniques of effective listening].

Specific data-derived examples. Below are three exemplary data-unit samples, purposely chosen from the 12 units under close examination in this section. Under each patient's review, we note some of the relevant traits that can be identified from the above list of 10, using the characteristics' list/index numbers.

Results Sample 4

- I am a long-term patient of Dr. XX (15+ years), and recommend him highly. I find his style very professional, and that he is easy to talk to, ask questions of, and warm in personality. I have never been less than satisfied with his care, and I owe him for keeping me on track with timely preventative (sic) checkups - one of

which found colon cancer (thankfully, early enough that surgical remediation resolved it for me). I really can't place too high a value on the fact that his advice and guidance probably added years to my life.

(*Characteristics highlighted, among others: 4, 5, 6, and 8*.)

…

- We have been seeing Dr. XX for quite some time. He is always very curious, answers our questions, has wonderful bedside manners, and is extremely pleasant.

  (*Characteristics highlighted, among others: 4, 5, and 9*.)

Results Sample 6

- Dr. XX and his staff have gone above and beyond to make sure that I feel the best that I possibly can if there is ever a problem. I am able to contact Dr. XX anytime day or night with any questions or concerns. I have been to many doctors seeking answers and I have never felt better until I was under Dr. XX's care.

  (*Characteristics highlighted, among others: 8, 10—i.e., easy accessibility to provider, 4, 5*.)

- I have been a patient with Dr. XX for about 1 1/2 years. Unlike some other comments, I am a REAL patient. I'm 56 years old and have more menopausal symptoms than most women. The HRT has given me my LIFE back!! Dr. XX is thorough and I have NEVER had to wait more than 1 day to get a call returned. I have always been treated with friendly respect either when I go to the office or call. I recommend Dr. XX to everyone who needs help.

  (*Characteristics highlighted, among others: 8, 2, and 7*.)

Results Sample 8

- Very helpful in explaining all my options and making me comfortable in the decisions made.

  (Characteristics highlighted, among others: 7, and 6.)

- Dr. XX was attentive and patient. He was simply awesome.

  (*Characteristics highlighted, among others: 2, 3, 8/10—i.e., "awesome"*.)

- Dr. XX is the most amazing surgeon. His care, consideration, and expertise are unmatched. He always listens to patient concerns, comes up with the best course of action, and makes you feel comfortable.

  (*Characteristics highlighted, among others: 5, 1, 8, and 4*.)

Results Part 2: Professional/P.I.T.s' Responses to Structured Autoethnographic Questions And General Autoethnographic Prompt

Sample of professional/P.I.Ts' unstructured and structured autoethnographic response. As we note in the introduction farther above, our main concern in this paper is the apparent deficit of effective listening and empathy among numerous healthcare providers, despite the commendable care with which most providers try to do their work. In this section, we share a further reflection on this topic, derived from some of our answers to the unstructured and structured autoethnographic prompts introduced above.

P.I.T 1 Response Excerpt:

Bad Experience (USA)

One time, I went to the hospital to see a urologist and the doctor came in to talk to me about my issue. He asked me to explain what was going on and as I explained, I noticed that he was kind of inpatient and trying to finish my sentences, instead of him just letting

me say and describe what my situation was. He also got carried away with asking me questions about where I was from, based on the accent he heard. I was trying to describe in detail my situation so that maybe he could have more insight to come up with possible ways for effective treatment. This is because I had seen two doctors in the past about the same issue and it still was not resolved. So, I was hoping to get another set of views about the issue, and had hoped that with more details he could have a different perspective. However, he seemed to be in a rush and wanted to just let me off with some prescriptions, even though I had told him I was familiar with what he was about to prescribe and that I had used it in the past, but it never helped. It is like he did not listen and still prescribed the same medication, and I left feeling and knowing that a year from that time I would probably be going to visit another doctor for the same problem.

Good Experience (South Africa)

One time in South Africa, I visited a gynecologist and at first, I felt very uncomfortable about seeing a male gynecologist, because I wanted a female. However, it turned out to be a pleasant experience. He paid attention and showed sensitivity and understanding to the issues being discussed. He made sure I was comfortable, and he let me unburden everything I was concerned about. He went through various plan-of-care options, and kept the focus on what I was okay with. I later had two follow up appointments with him, and each visit was even more pleasant. He never rushed me, and he made me feel like I was the only patient he had. He made sure I left feeling optimistic, and was always up to date on my situation and remembered everything we had talked about in the next visits.

Conclusive Summary of responses to professionals/P.I.Ts' structured autoethnographic questions. Overall, the main themes that arose from research team's nursing

professional’s/P.I.Ts’ structured autoethnographic question responses can be summarized in five statements, namely:

- Counterintuively/paradoxically, regardless of experience, the nursing professionals/P.I.Ts all report general sporadic and systemic hindrances to effective listening,
- Related to the above point, healthcare knowledge/expertise does not automatically translate into effective communication and listening skills,
- They report that their own and their family members’ experiences as patients have been very helpful in their (professionals/P.I.Ts’) development of effective listening skills in their workplace settings,
- Regardless of the presence of some forms of formal training, most training vis-à-vis communication and listening has been received informally, and
- Poor listening skills can result in severely poor outcomes.

Discussion

Main Contribution of Study to the Study of Listening And Comparisons to Previous Findings and Current Theory

Main Contribution of Study to the Study of Listening. In this study, we attempt to systematically study the meaning of effective listening behaviors among healthcare providers, both from a general point of view, as well as the point of view of patients and provider-patients. It should be noted for emphasis that the study was inspired by the experiences we have endured as patients (who also happen to be healthcare providers), as well as the experiences we have observed among our families and friends.

First, we identify various factors that hinder effective listening in the context of healthcare provision—e.g., impatiently composing responses as patients explain their ailments,

and empathy-deficits, particularly with patients that we think might have unnecessarily endangered themselves (e.g., via overeating or substance abuse). We also realize that most training vis-à-vis communication and listening has been received informally, and that poor listening skills can result in severely poor outcomes. With the above findings in mind, it is easy for us to empathize with the concerns of healthcare consumers, as revealed by their reviews from sites such as ZocDoc and Yelp.

Comparisons to Previous Findings and Current Theory. The above findings contribute significantly to the current body of knowledge in the subfield of effective listening behaviors among healthcare providers. In particular, the provider-patients’ autoethnographic responses and the patients’ reviews suggest that the concept and practice of empathy is vital.

This particular finding can help scholars and healthcare providers vis-à-vis attaining a holistic abstract understanding of how to listen and communicate effectively regardless of specific (sub-)context. By “(sub-)context,” we are specifically referring to topics such as health literacy as discussed by Shore et al. (2006); end-of-life care as discussed by Dunlay et al. (2015); and influences of demographics and socio-economic status on patients’ ratings of their provider-patient communication quality, as discussed by Guntzviller, Jensen, King, and Davis (2010). Overall, this study’s findings also support the various theories discussed farther above, i.e., both those in the general category, and the patient-centric definitions.

Limitations

Paradoxically, the above-discussed main contribution—i.e., evidence/testimony of effective listening behaviors via patients’ own words, is also the main limitation of this study. It should be noted that patient-reviewers often have an agenda; for emotional reasons, they feel compelled to criticize or praise a provider, and they cannot be trusted to represent the views of a

majority of a provider’s patients. Readers should thus note that this study is the first part of an ongoing study, and that we intend to follow up with future studies, executed as rigorously as possible via a variety of methods, both intensive (/qualitative, such as those employed in this study), and extensive (/quantitative).

Conclusion

All-in-all, the above findings imply that the most important but easily-forgettable role that providers around the world should keep honing—which is indispensable to their actual craft, is to be good/empathic fellow human beings to the patients they serve. And in this paper, we argue that listening is a vital tool for that task.

And it bears repeating that in both our roles as healthcare professionals (/or professionals in training) and scholars—as well as healthcare consumers, we are grateful and appreciative towards healthcare providers worldwide. Ultimately, our remedy to the problem highlighted herein—i.e., ineffective listening and communication, is the deliberate theorization, study, and continuous practice of effective listening, especially via the confirmation of mutual understanding or meaning, as well as paying attention to patients’ (and/or other interlocutors’) feedback.

References

Berman, A. C., & Chutka, D. S. (2016). Assessing effective physician-patient communication skills: "Are you listening to me, doc?". *Korean journal of medical education*, *28*(2), 243–249. https://doi.org/10.3946/kjme.2016.21

Biedenharn, D. Clare. (2014). *A Study of Critical Care Nurses' Listening Behavior through the Application of the Quaker Listening Model*. [Doctoral dissertation, Garrett-Evangelical Theological Seminary]. RIM Database. https://rim.atla.com/node/37435

Charon, R. (Nov 20, 2001). Narrative Medicine. Annals of Internal Medicine, 135, 10, 930.

Beck, C. S., & Ragan, S. L. (1992). Negotiating Interpersonal and Medical Talk: Frame Shifts in the Gynaecologic Exam. *Journal of Language and Social Psychology, 11*(1-2), 47-61.

Daniels, F., & Mibei, F. (May 20, 2019). Health literacy knowledge and experiences of nursing students at a South African University. *Africa Journal of Nursing and Midwifery, 21*(1), 1-15.

Denise, M. K. M. B. A., John, P. F. M. D., & David, J. G. M. D. (April 30, 2014). Improving the patient experience through provider communication skills building. *Patient Experience Journal, 1*(1), 56-60.

Donoghue, P. J., & Siegel, M. E. (2005). Are you really listening? *Keys to successful communication*. Sorin Books.

Dunlay, S. M., Foxen, J. L., Cole, T., Feely, M. A., Loth, A. R., Strand, J. J., Wagner, J. A., ... Redfield, M. M. (2015). A survey of clinician attitudes and self-reported practices regarding end-of-life care in heart failure. (Palliative medicine.)

Guntzviller, L., Jensen, J., King, A., & Davis, L. S. (January 01, 2011). The Foreign Language Anxiety in a Medical Office Scale: Developing and Validating a Measurement Tool for

Spanish-Speaking Individuals. *Journal of Health Communication, 16*(8), 849-869.

Kadimba, E.G. Katongole, S.P. Bikaitwoha, E.M. (2015). Medical Litigation in Hospitals in Kampala, Uganda. *International Journal of Public Health Research. 3*(5), 204-208.

Kennedy, M. G., McClish, D., Jones, R. M., Jin, Y., Wilson, D. B., & Bishop, D. L. (September 01, 2018). Effects of an entertaining, culturally targeted narrative and an appealing expert interview on the colorectal screening intentions of African American women. Journal of Community Psychology, 46, 7, 925-940.

Kennedy, D. M., Fasolino, J. P. & Gullen, D. J. (2014). Improving the patient experience through provider communication skills building. *Patient Experience Journal, 1*(1), 56-60.

Monaghan, M., Hilliard, M., Sweenie, R., & Riekert, K. (December 01, 2013). Transition Readiness in Adolescents and Emerging Adults with Diabetes: The Role of Patient-Provider Communication. *Current Diabetes Reports, 13*(6), 900-908.

Nichols, M. (2009). *The lost art of listening : How learning to listen can improve relationships* (2nd ed.). Guilford Press.

Patel, S. R., Bakken, S., & Ruland, C. (2008). Recent advances in shared decision making for mental health. *Current Opinion in Psychiatry, 21*(6), 606–612. https://doi.org/10.1097/YCO.0b013e32830eb6b4

Roberto, A. J., Krieger, J. L., Katz, M. L., Goei, R., & Jain, P. (2011). Predicting Pediatricians' Communication With Parents About the Human Papillomavirus (HPV) Vaccine: An Application of the Theory of Reasoned Action. *Health Communication, 26*(4), 303-312.

Rubin, J. B., & Bishop, T. F. (2013). Characteristics of paid malpractice claims settled in and out of court in the USA: A retrospective analysis. *BMJ Open, 3*(6).

Shore, J. H., Savin, D. M., Novins, D., & Manson, S. M. (April 01, 2006). Cultural aspects of telepsychiatry. *Journal of Telemedicine and Telecare, 12*(3), 116-121.

Strauss, A., & Corbin, J. (1994). Grounded theory methodology: An overview. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 273–285). Sage Publications, Inc.

Worthington, D., & Fitch-Hauser, M. (2012). *Listening*. Old Tappan: Routledge.

Wrench, J., Thomas-Maddox, C., Richmond, V. P., & McCroskey, J. C. (2019). *Quantitative research methods for communication: A hands-on approach* (Fourth ed.). New York: Oxford University Press.

Wright, K. B., Frey, L., & Sopory, P. (2007). Willingness to communicate about health as an underlying trait of patient self-advocacy: The development of the willingness to communicate about health (WTCH) measure. *Communication Studies, 58*.