The Doctor Podcast | Episode 1 | The Lost Art of Listening

Voiceover: Have you ever been surprised to hear that one of your patients hadn't felt heard or understood?

Despite their best efforts, it is difficult for doctors to always be good listeners.

Dr Rageshri Dhairyawan can relate.

And she can also relate as a patient who has felt dismissed and unheard.

Dr Rageshri Dhairyawan: I felt really ashamed of my experience, and I felt really silenced and I didn't really talk about it for several years. And I really came to blame myself for not talking about it, because I thought if it could happen to me, then what happens to everybody else in that situation who doesn't have the advantages that I have?

The ways that patients and doctors can feel silenced or dismissed in medicine – and how we can change this – is the focus of Dr Rageshri Dhairyawan's book *Unheard: the medical practice of silencing*.

Rageshri: I'm a doctor and I don't always listen well. I really want to, and you know, I want to be a good listener, but I don't always do so. And I really wanted to understand what made it hard for us as doctors to listen better.

Voiceover: Welcome to the first episode of The Doctor podcast,-brought to you by the British Medical Association. Each month we bring you conversations inspired by stories featured in *The Doctor* magazine.

This episode builds on the feature article 'The lost art of listening' by Seren Boyd.

You don't need to have read the article to enjoy this episode but if you'd like to do so you can find a link to it in the show notes and at thedoctor.bma.org.uk/podcast

Dr Dhairyawan is a consultant in sexual health and HIV medicine in East London. Her family moved to the UK from Bombay in the 60s and 70s to work for the NHS.

Rageshri: I think my story is quite a common one in that I come from a very medical family. My mum is a GP with an interest in family planning, and my dad is a dentist. My sister is a GP. My brother-in-law is a GP.

So, I think it wasn't expected, but it was well known. And I think I was really interested in both medicine and research, and I can remember being a child and wanting to cure cancer. That was my aim when I went into medicine. So, you know, small expectations!

But I became really interested in reproductive rights. My mum worked in family planning, and she worked in the only family planning clinic in the town. And I can remember her talking about her job and the importance of contraception and access to abortion.

And I did a lot more reading at medical school about that and thought, this is something I'm really interested in. I fell into sexual health and I was lucky to find it was the right specialty for me. So, I've been very lucky to work with a really diverse range of patients, you know, some really marginalized groups. Lots of migrants, people who live in poverty, gender diverse people.

So lucky to, you know, work in a specialty which has really suited me, and for which, there's much to do. These are patients who aren't listened to a lot in policy. People aren't very open about their sexual health. So, helping to advocate and amplify their voices has been important for me throughout my career.

Voiceover: These patients who Dr Dhairyawan says aren't really heard in healthcare policy were a big motivation in writing her book *Unheard*.

Rageshri: Another motivation was an experience she had as a patient herself.

About 10 years ago, I was admitted to hospital with very severe abdominal pain.

I have endometriosis and adenomyosis, which are very painful conditions. And I was having fertility treatments, in my third cycle of IVF. And, I had really excruciating abdominal pain. And, you know, I was quite used to pain, but this was worse than I'd ever had. And I was really worried that I had ovarian torsion, which is a surgical emergency.

My husband found me on the floor of the bathroom at home, and took me to A&E. They gave me really good pain relief and arranged for a scan. I was admitted under the gynae team, and the scan didn't show I had ovarian torsion, which is a good thing. The medical team thought I had a flare up of my endometriosis from all the hormones I was on.

But whilst on the ward, I was denied pain relief. And I was really made to feel like I was a fraud. Like, you know, I was just asking for strong painkillers, like morphine, because I was wanting that as a drug addict, not because I was in so much pain. And, you know, I pleaded for pain relief. I didn't get it. It took my husband to advocate for me to get the pain relief I needed.

And I remember not wanting to complain more, not wanting to feel like I was more of a nuisance to the ward team. And even after I went home, I didn't complain then. I think I just didn't want to be seen as a nuisance.

I'm a South Asian woman. I know there are stereotypes about South Asian women in healthcare, often being seen as very anxious about symptoms. You know, complaining about physical symptoms that are actually all in our head. There are quite a few stereotypes about that. And I was worried that I was being stereotyped as that. So, kind of complaining, even though, for me, the pain was real.

I felt really ashamed of my experience, and I felt really silenced, and I didn't really talk about it for several years. And I really came to blame myself for not talking about it, because I thought if it could happen to me, someone who at that point was, you know, a new consultant in the NHS. I could speak English. I understand how things work. I didn't have a life-threatening disease. Then what happens to everybody else in that situation who doesn't have the advantages that I have? That was one of the reasons why I wrote the book, to kind of break that silence.

We often say the solution to patients not getting the care they need is that they should speak up and shout for better care. But I don't think it's always easy to do that. It can be very difficult when you're at your most vulnerable in hospital, when you're feeling unwell to speak up.

You might be scared to speak up because you might think you get worse treatment if you speak up. So, I think the onus has to be really on us in healthcare to listen to patients and not silence them.

And I think the last reason why I wrote the book was because I'm a doctor and I don't always listen well. I really want to, and you know, I want to be a good listener, but I don't always do so. And I really wanted to understand what made it hard for us as doctors to listen better.

Voiceover: Beyond her own personal experience, Dr Dhairyawan shares several examples in her book about what being unheard in healthcare can look like, and the harm it causes.

Rageshri: I think it’s depressingly very common for patients to be silenced. I've heard patients say that it's happened to them. Colleagues, so this is other medical professionals, have said it's happened to them.

I think we see it all the time in patient safety investigations. We often see that patients have come to great harm because they've not been listened to or believed by healthcare professionals. They've not had their symptoms taken seriously.

If you're repeatedly not listened to by your doctor, it may silence you because you don't want to speak up. There's no point if they don't listen to what you're saying, and it may make you trust your doctor less.

So, I think it really fuels mistrust and also healthcare avoidance. Because why would you go back if you think no one is hearing you when you're talking about your symptoms?

These are all, I think, huge issues at the moment in healthcare which we need to address. And I think better listening is part of that.

Voiceover: In her book, Dr Dhairyawan shares an example from her specialty of HIV medicine on how failing to listen can harm patients.

Rageshri: We have fantastic treatment for HIV now. People live long, healthy lives. They don't pass the virus onto others if they're on treatment, but it does require them to take their medications every day. And that can be difficult to do over a lifetime for lots of reasons.

So, in my book, I have an example where a doctor is seeing a patient, and the doctor can see from the blood test results the patient is clearly not taking their medications. Their viral load is very, very high. But the patient insists that they are taking their medications.

The doctor knows that they're lying, but the patient is insistent ‘I take my pills every day, doctor’. They really want to be seen as a good patient.

The reason the patient hasn't told the doctor what's going on is because, yes, they had stopped their medication. They'd been getting terrible side effects. And it had been going on for months and months. And they had told people at the clinic, but they didn't feel that they'd been taken seriously. They were just told to carry on with the medication, not told perhaps they could switch to try something else.

So, they stopped the medication themselves. They felt better. They told the doctor they were taking them, but the doctor felt that they were lying to them and that made them doubt the patient even more so.

This kind of silencing, I think, can really affect medication adherence. It's something that's happened to me. I've had patients who've sworn they're taking their medication, and I can see, like the doctor in the scenario, that they're clearly not.

And you think, why don't you trust me enough to tell me that you're not taking your medication? And it might not be that particular moment. It may be months leading up to that, or the patient not feeling heard and able to tell their truth to their doctor.

Voiceover: So why don’t doctors listen? Most doctors are trying their best to be good listeners and look after their patients. What are the factors making it hard to listen well?

Rageshri: When I was researching the book, I thought the reasons why we don't listen would be down to bias. We know that certain minoritised groups are less likely to be listened to.

So, for example, women, people of colour, people who are gender diverse, etc. But actually, during my research, I found that not listening to patients is actually ingrained.

This silencing and not listening well starts off in our training in different ways. We are trained in Western medicine to use a medical model where we treat diseases and not people.

And although that can have its advantages, it means, you know, we can have a distance from our patients so we can maintain objectivity. It does take out some of the humanity and holistic care that we could be providing, and it really affects the power balance between doctors and their patients.

So, it makes us the experts because we've had the training, we have the medical expertise, but it devalues the expertise that patients have in their own bodies. They know their bodies best. We need to better value their own experience with their own bodies. So, if they know something's wrong, we should believe them.

And this kind of ingrained disbelieving of patients, I think, is ingrained in medicine. So, we learn the language of medicine in medical schools. We learn to write notes like ‘patient denied’ or ‘patient claimed’. So, we see it in the language of medicine, in that we inherently doubt patients right from the start.

I think in medicine, we're also taught about what I call the ‘ideal patient’ in the book. We are taught that if a patient has a disease, they present in a certain way, and that's what we expect. And when patients don't present in the way that we expect them to, we doubt them.

And there's lots of reasons why patients don't present in the way we expect them to. So it may be that they want to keep a stiff upper lip. They may be very distressed but want to hide that. It may be due to cultural reasons. It may be because they're neurodiverse.

When they don't act in the way we expect, we doubt them. And it makes us more skeptical of what they say.

I think we also don't really value listening. As healthcare professionals, we like to fix people. We want to make people better.

But actually, what if we understood that listening in itself is therapeutic? We may not be able to fix the patient in front of us. They may have a condition in which we don't know what

to do, or they may not be a treatment that we can advise. But actually just listening to them, that act of witnessing their suffering may be therapeutic in itself.

And I think that's actually something we find very hard to do. It can be very uncomfortable to listen to someone that we can't fix, but I think we need to be better able to do that.

Voiceover: Dr Dhairyawan shares how there is an implicit hierarchy in medicine, with doctors sitting at the top.

Rageshri: This hierarchy limits listening – to both patients and other healthcare workers.

We see it, as I said, with the patient-doctor relationship, that power imbalance of, you know, that real 'paternalistic doctors know best' because we have the medical expertise.

I think we see this in the medical workforce as well. And I think in our training, we are treated quite differently to other students. We kind of know that, you know, we are the top of the tree of the hierarchy. We've had the best grades to get into medical school.

We know that we are going to be the ones who are going to be responsible for patients at the end of the day. So therefore, we think we know best.

But perhaps if we had some sessions at university with nursing students, other allied healthcare professionals, we might get to know them and better value their expertise as being different to ours, but equally as useful.

And that might reduce some of that hierarchy we see on the wards, which I think can have a real impact on patient care and means that we often don't question the most senior doctors when we should.

Certainly, when I was training, we didn't know much about the social determinants of health, and we didn't really understand why patients perhaps don't behave in ways that we expect them to.

So, I think about this in my care. I might be thinking, oh, a patient needs to lose weight because it would be better for their health generally. You ask a patient to go away and try and lose weight, they come back to you, and they haven't.

And, you know, you might think, gosh, you know, they haven't followed the dietary advice, they're not exercising. You might start to blame the patient for not behaving in the way that you've asked them to.

But actually, perhaps this patient has got three jobs, perhaps they are doing night shifts. Perhaps they don't have time to cook well, they don't have the money to get healthy food. They don't live in an area with green spaces.

So, I think not understanding the social determinants of health means that we can victim blame our patients for not having those healthy behaviours that we expect them to.

And probably the last thing I'd say about our medical training is I think we could have more room for the medical humanities.

We often think of medicine being a science, but it is also an art as well. And that art of medicine, I think, you know, helps us understand patient narratives, storytelling, which helps us understand the patient in front of us.

Voiceover: Beyond training, Dr Dhairyawan says there are other systemic and institutional factors that don’t support good listening.

Rageshri: We work in institutions which don't really help us to listen well to patients. And there's lots of reasons for that. We often don't have enough time with patients to really listen to all their concerns.

And often we are doing clinics where we are seeing lots and lots of patients without any breaks so we can get decision fatigue. So, thinking about perhaps how we could incorporate a very short break in the middle of a busy clinic would mean that we have time just to, you know, go to the toilet, have a quick snack, and then get back to it and be better listeners with more energy after that break.

I think we work in systems in which we no longer have so much continuity of care as we used to have. And I talk about this in the book with general practice.

The patient-doctor relationship is so, so important. But it's something that's built up over time. It requires respect from both sides. And you get to know each other's ways of communicating. And it makes healthcare much safer and much more efficient because you're not starting from the beginning when you see the same person.

But unfortunately, the way in which healthcare policy has been laid out in the last few years means that it's much harder to see the same doctor. If you go to your GP practice, you may be very lucky if you get to see the same doctor every time.

So, thinking about how we can better promote continuity of care I think would really help with listening. And I'm very lucky in my specialty. I do HIV clinics. I've been seeing the same patients, you know, sometimes for 15 years, and I have 20 minutes with them, which feels like an absolute luxury.

So, I know the advantages of having time and seeing the same person. And it makes our jobs more enjoyable. and I think that's a really important part of it as well.

Voiceover: While patients can be silenced and feel dismissed, doctors can also be silenced – minoritised doctors more often than others.

Dr Dhairyawan shares her own experiences of feeling unheard in the workforce and explains how silencing minoritised doctors means silencing minoritised patients.

Rageshri: In the first year of COVID, there was a lot of talk on Twitter about the emerging inequalities we were seeing with ethnic minority groups being more likely to get severe COVID. And I really wanted to tweet about how this was not new. We see racial health inequalities in many other conditions, and we've done so for decades.

So, for example, in my specialty of sexual health and HIV, we've seen unequal STI rates in some ethnic groups for 60 years, 70 years, and nothing has changed. So, I really wanted to show that this was not new. And my research and advocacy for years had been on racial health inequalities. I felt I had the expertise to talk about this.

So, I tweeted a long list of racial health inequalities in other parts of medicine, and I referenced everything so you could link to the study. I took ages doing this tweet. And then the first response I got was from someone I didn't know who said, 'Is this correct and has this been medically fact checked?'

And I was like, hang on, my bio on Twitter says I'm a consultant. It says where I work. You know, clearly, it's been medically fact checked. I'm a doctor. I've got all the references there. But you still don't believe me. So, what is it about me that makes you think I don't have the credibility to, you know, create such a list and show such evidence?

But you still don't believe me. So, what is it about me that makes you think I don't have the credibility to, you know, create such a list and show such evidence?

And it made me reflect on other times where I've been, you know, perhaps not treated like a doctor. So, again, during COVID when we were redeployed to the COVID wards, we were all wearing scrubs, and I'm very short. I can look quite young for my age. Short Asian woman.

And whenever I walked onto the ward, people wouldn't think I was the consultant at all. So, they would treat me as a more junior member of staff, which, you know, is not the worst thing in the world. But when it happens to you every day, it does get quite wearing on what was already a very stressful situation. It made me feel very junior and often quite undermined at work every day.

Over my 20 years as a doctor I've learned, you know, lots of strategies to get over that . And certainly now, you know, as a consultant, I know my colleagues very well. I'm well

respected in my specialty. So, things are very different. But it was interesting how COVID took me back to that position.

So, I think, you know, minoritised doctors often don't feel heard in medicine. And I think that's a real issue when it comes to career progression. So, if you continually don't get heard in your job or taken seriously, you know, you're less likely to apply for leadership positions.

And it means that we end up with a leadership that is not very diverse as well. And I don't think that's very good for patient care. Minoritised doctors and healthcare professionals are very good advocates for people from minoritised communities. So, without them being heard in medicine, it means that their communities aren't heard, and these communities remain very underserved.

Voiceover: When we listen to minoritised doctors, we're better able to listen to minoritised patients.

Dr Dhairyawan shares an example of how this works in practice.

Rageshri: So, I'm going to give the example of sickle cell disease, which is the most common genetic condition around the world and which predominantly affects people of black ethnicity. And this is something that I think has been really under-researched and patients have been underserved when it comes to policy over the years.

But when we look at who have been the activists in getting better care, it has been nurses and doctors who are of black ethnicity. So, they've really worked hard to advocate for patients with this condition.

And because of that, we now have promising treatments for sickle cell disease, and it's really impacted on training of all healthcare professionals. I think if those healthcare workers of black ethnicity had not advocated for patients with sickle cell disease who were also predominantly of black ethnicity, we wouldn't be where we are.

Voiceover: So where to now? What can we do to be better listeners, and create conditions for better listening? Dr Dhairyawan shares what she'd say to doctors in positions of power, and what they can do in their workplaces.

Rageshri: So, I think if you're in a leadership position, think within your own team. For example, if you're in a meeting whose voices are being listened to? We've all been in meetings where it's always been the same couple of people talking, and some people don't say a word.

So, really making sure everyone gets the opportunity to speak. Perhaps within your team, if there's someone who regularly doesn't talk, approaching them before the meeting and saying, 'Is there anything you'd like me to include if you don't want to say it yourself'.

If you're a leader, really think about mentorship and how you can bring up people behind you. Look at how you can bring in those opportunities to debrief and have supervision as a team.

I think if you're a policymaker thinking about how you can promote continuity of care, is there anything you can do to make better listening environments, be that around time, breaks or private spaces for those conversations?

If you work in policy, how can we incentivise listening? With patient outcome measures, really rethinking how we think about productivity.

Most importantly, I think we really need to think about listening to patient voice at a wider level. So, we need to include patient voice in all aspects of service development, healthcare policy, in our education, in research and in our training.

But I think we need to do that in a way in which it's meaningful. Not just inviting a patient along to talk about their lived experience and then not acting on what they say. We need to actually make change happen, so they know that it's worth speaking up.

And also making sure that we're doing it in a way that is not harmful to patients and making sure they're remunerated. So, making sure they get paid when they're involved in policy and training. Making sure they're trained to be on these boards. So, they've had the additional skills training that they might need. So, they feel they're as equal as everyone else on these boards.

And also making sure that we're providing pastoral support because I think if we're asking anyone to talk about their lived experience, in many cases we may be asking them to talk about traumatic experiences again and again. So, making sure we're providing pastoral support for them so that it's not more harmful.

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Voiceover: Dr Dhairyawan's book contains a lot of practical advice for both doctors and patients. Here, she shares some of those tips for doctors on how to be better listeners in their next patient consultations.

Rageshri: When you're listening, try not to give advice. Let the patient finish what they're saying before you jump in. It's very easy to cut someone off because you know, you've got

something that you think will help them but actually just listen to them and sometimes that can help them come up with, you know, the solutions themselves. So that's one thing.

The other thing I would say is listen with curiosity and humility. They may be saying something that's very valid, which you haven't actually thought of before and previously you may have shut them down. But let them speak, and think, you know, their point is valid even if you don't necessarily agree with it.

And one thing to say on this book is, although the message of this book is listen – listen to patients, listen to the voices of minoritised people – it doesn't necessarily mean that you have to agree. So, you know, you don't have to do everything your patient tells you, but you do need to listen to them and make them feel heard.

And if you disagree, then you need to explain why you disagree. Give them time to think about it, and that will open up the conversation rather than shutting it down.

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