The art of not listening

One of the most gifted psychologists I know has the knack of going to the heart of the matter in any conversation. This can be irritating at times as it makes everyone else feel so plodding. Usually it is impressive, because it saves his patients and colleagues so much wasted time and misplaced emotion. It seems a knack that is well worth acquiring, but if you ask him how he does it, he says ‘I just tune out a lot’.

It is arresting to think that not listening might be a crucial professional skill. During our basic training as doctors, we spend a great deal of time learning how to listen carefully for patterns of description that fit particular diseases. Later, as we develop the art of consulting, we realise how important it is to pick up not just the verbal signals of pathology, but the words in between that hint at such things as disappointment, anger, pleading or despair. I spend a great deal of time in my work as a medical educator in helping experienced doctors notice how much they normally miss, and in training them—through supervision, group work, video analysis or role play—to improve their capacity to pay attention to what patients say. How strange, then, to hear a renowned psychologist disclose the secret of his expertise as ‘tuning out.’

The claim still makes sense, at many levels. In biological terms, for example, we are coupled structurally with our environment so that we only notice those forms of information that affect our survival. (We do not see air, for example, simply because it is always there.) Similarly, in social terms, we are habituated to pick up the cues that matter most in our own milieu, but will miss a huge amount if transposed to unfamiliar settings or cultures. Roles make a difference too: if one of my children complains to me about an ailment, I listen in a way that is entirely different to how I would listen to a patient. All listening, and all hearing, are innately selective.

In a professional context, I suspect that what we call good listening is in reality a process of conscious, decisive, and closely monitored filtering. Good listeners may in fact be the people who are exceptionally aware of missing a great deal, accept that this is inevitable, and act accordingly. They manage to make deliberate choices, rather than accidental ones, about what to hear and not hear. They know that some words are clearly weighted by important markers such as repetition, intonation or emotion whereas other words are—relatively speaking—just noise. Conversely, bad listeners (apart from those who just can’t be bothered) may be those who are possessed by the illusion that they can catch everything if they try hard enough. They treat all words as equal, and so they end up responding to random cues rather than significant ones.

Words, however, are not all. True listening involves many organs of sensation apart from the ears. Most obviously, people’s faces and bodies speak to us as much as their voices if not more. Most doctors will be aware of changes that can take place in the atmosphere of the consulting room, and even possibly in the smell. Many will be familiar with a range of alterations in their own physical state during consultations, ranging from a sense of calm to an urgent desire to pass wind. This too is information, in the form of what psychiatrists call counter-transference. During the moments in consultations when we are not actually listening in the literal sense, we are almost certainly picking up vast amounts of this kind of information, although we may be doing so at a purely intuitive level. We may even connect such impressions with something the patient has said, and later convince ourselves that we have acted only upon what we have ‘heard’.

There is another process that is common in consultations too: the active decision to stop listening when we have heard as much as we need to know. Obviously this can be done crassly, and often is, especially when doctors lose interest in their patients as soon as they have established the diagnosis. But there is also a more creative way
of withdrawing one’s attention. It occurs when you need time to formulate something appropriate to say to the patient by way of medical information or advice, and you know that you will do better if you have an internal conversation with yourself rather than continuing to try and listen to what the patient is saying.

I had exactly this experience recently when a patient had told me enough for me to believe that his problems at work arose from conflict avoidance. Having reached this view, I knew that listening to any further narrative from him would only make it harder for me to put this proposition to him, rather than easier. I ignored the rest of what he was saying, and used the time instead to choose a form of words in my own mind that I hoped he might find palatable and helpful. The stratagem seemed to work, and I found a way of putting my idea to him that was neither avoidant nor confrontational. I don’t think I would have achieved this if I had slavishly followed every detail of his lament. To use my colleague’s metaphor, I might never have got onto his wavelength unless I had tuned out first.

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