

## *Virtual Mentor*

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### **HISTORY OF MEDICINE**

#### **Learning to Listen**

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*It happened the other morning on rounds, as it often does, that while I was carefully auscultating a patient's chest, he began to ask me a question. "Quiet," I said, "I can't hear you while I'm listening".<sup>1</sup>*

That physician has not shushed a patient, silencing questioning sounds from the lips while focusing intently on the muffled thumps from the stethoscope? Technical listening is a skill that has advanced medicine tremendously in the last 2 centuries. If the staff of Aesclepius was the symbol of ancient medicine, the stethoscope undeniably has become the symbol of modern clinical medicine. While perhaps the most basic of diagnostic tools available to the contemporary physician, this deceptively simple rope of tubing and metal symbolizes the history, style, and content of modern medicine.

At the beginning of the 19th century, the value of percussion in physical diagnosis was recognized by Auenbrugger and Corvisart, leading to advances in the diagnosis of lung and heart disease. Laënnec enhanced the clarity of chest sounds with an innovative solution to the problem of listening to the chest of a stout but bashful young woman. He rolled a tube of papers and placed one end to her chest and one to his ear, thus both preserving her modesty and creating the first rudimentary stethoscope.

Despite its pervasive use in the 20th century, initial use of the stethoscope was slow to gain acceptance by physicians and patients alike. Physicians were wary of relying on information conveyed through instruments and of introducing devices into the physical exam that might interfere with their communication with patients. Patients were suspicious that stethoscopes might reveal more personal information than they intended their physicians to know. Use of the stethoscope likewise required a complete reorganization of how medicine was taught and practiced:

To learn the sounds of disease and their association with anatomical lesions required access to a large number of patients, the presence of colleagues who could teach auscultation, and autopsy facilities to check bedside judgements. All of these could be found in a hospital. . . . As Laënnec wrote: 'It is only in a hospital that we can acquire, completely and certainly, the practice and habit of this new art of observation'.<sup>2</sup>

Once it was accepted as a common element of the physical examination, use of the stethoscope ushered in the era of technological medicine and with it a new way of listening to the patient. Technical listening requires a very specific focus,

indicated—but not of course, exhausted—by the minute but decisive change, whereby the question: "What is the matter with you?," with which the eighteenth-century dialogue between doctor and patient began...was replaced by that other question: "Where does it hurt?"<sup>3</sup>

While the first question elicits the patient's perspective in defining the problem, the second question clearly shifts the responsibility to the physician. Use of the stethoscope, along with the increasing technological innovations of the 20th century, soon threatened to drown out the patient's voice in the clinical encounter. The challenge that this shift posed to the patient-physician relationship did not go unrecognized. At the turn of the century, long before the bioethics movement of recent decades, physicians were cautioned to treat the "patient as person, [by considering] the patient's personal history and social situation in diagnosing and treating organic disease".<sup>4</sup>

Yet despite the forewarning, technological advances coupled with the increasing reliance on the objective data of statistical evidence and measurement came to dominate the clinical encounter. The incongruity of the physician's admonition to the patient in the quote at the beginning of the article clearly captures the paradox of the contemporary clinical exchange—with its focus on the objective symptoms of the body, rather than on the subjective accounts of the patient's experience.

Ironically, with the increasing reliance of physicians on more sophisticated and powerful technologies, use of the stethoscope—once the gold standard in a physician's physical examination—is falling out of favor among the new generation of physicians.

It is a common scene at teaching hospitals today: young doctors ignoring physical examination to the chagrin of their supervisors. At one time, keen observation and the judicious laying on of hands were virtually the only diagnostic tools a doctor had. Now, they seem almost obsolete. Technology like ultrafast CAT scans and nuclear imaging studies rules the day, permitting diagnosis at a distance. Some doctors don't even carry a stethoscope anymore.<sup>5</sup>

In the quest to reach ever-greater percentages of statistical certainty, the new generation of physicians is shying away from subjective observation, wary of relying on the evidence uncovered by their own senses and the unquantifiable descriptions by patients. "Fear of lawsuits is partly to blame, but the fear of subjective observation is stronger. Doctors are uncomfortable making educated guesses based on what they see and hear".<sup>5</sup>

The stethoscope, viewed with skepticism as a means for making a good physical diagnosis a century ago, is in some circles now viewed with skepticism as being too subjective to produce a physical diagnosis with a high degree of statistical certainty.

In a highly technical environment where uncertainty is unacceptable, the remarkable developments in diagnostics and therapeutics, while advancing the state of 20th-century medicine, have nonetheless created a chasm between the physicians' clinical orientation toward disease and patients' experiences of illness. While physicians of the 19th century tended to listen to patients at the expense of the information provided by technical enhancements, 21st-century physicians could be charged with the opposite problem. They are being called upon to learn how to listen to patients' subjective accounts and to incorporate them into the technological framework of clinical medicine.

Most patients who experience illness symptoms develop an explanatory model. More frequently than physicians realize, these attributions involve serious and potentially life-threatening medical conditions. Only a minority of patients spontaneously disclose or "offer" their ideas, concerns, and expectations. Often patients suggest or imply their ideas through "clues." Active listening is a skill for recognizing and exploring patients' clues. Without this communication skill, patients' real concerns often go unrecognized by health care professionals.<sup>6</sup>

The challenge for contemporary physicians, therefore, is to balance and reconcile the patient's subjective account of illness with the objective information about the patient's body produced by technology. The stethoscope, in spite of its simplicity as a diagnostic tool, represents—perhaps now more than ever—the ideals of the patient-physician encounter. Born of a physician's consideration for the feelings and experience of his patient, the stethoscope represents the benefits of technology while exemplifying, literally as well as metaphorically, the intimate and crucial link between the patient and physician. Skillful listening by the physician through the stethoscope reveals the hidden language of the body. The stethoscope also serves as a reminder that learning to listen skillfully to the language of the patient's concerns and experience should be just as important.

## References

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