

# Listening as health care

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## ***What we know already***

*Listening is an essential part of caring practice. Being listened to and telling our story is in itself therapeutic and life affirming. Listening is time consuming and whilst acknowledged as central to care in practice is hard to accomplish given the pressures on health and social care staff in terms of targets, paperwork and protocols.*

## ***What this paper adds***

*The sociological background to listening and its practice in contemporary health services.*

## ***Why this is important***

*Community Chaplaincy listening is based on the assumption of careful, agenda free listening.*

## ***How this impacts on Chaplaincy***

*Chaplains are primarily the bearers and witnesses of stories of suffering and triumph. Understanding the link between wellbeing and the act of listening gives theoretical substance to the core work of chaplaincy*

*Key Words: health care chaplaincy, listening, wellbeing, community, caring*

## **Introduction**

Story telling to help understand the past, act in the present and shape the future is a practice which is integral to our human experience. Story telling as a collective endeavour or an individual practice is at the heart of most meaningful communication. Listening is a core social activity

Since the beginning of human dwelling on earth stories have been the method of transmitting, understanding and changing behaviour. The holy scriptures of all the major faiths, fairy tales, classic fiction, plays and poetry are a series of stories which can be interpreted in order to help us live and understand life better.

## **Listening: an ancient practice in a modern context: understanding the lived experience**

Lived experience, that is, how we live our daily lives is increasingly seen as the most valid way of understanding our world and the main way we seek to understand things. Ethnographic methods of research, historically not the province or interest of the health care world, are now accepted as part of the suite of

relevant methods used to understand health care. Qualitative methods of data gathering help us understand the lived experience by focussing on depth and meaning rather than breadth and statistical significance of relationships.

We understand our lived experiences by talking about ourselves and telling stories about our lives. The telling of our story gives us the context and from this we derive theories about what might be happening. We use story to grasp at our truths. In doing so we use our imaginations. The insights developed through the work of the founding fathers of psychotherapy, Sigmund Freud and Carl Jung and the subsequent “psychoanalytic world” with which we are now familiar, are based on the importance of the story as healer (Hillman, 1994).

This is a departure from previous times. Charles Taylor (2007) in his astounding work on the secular age makes this point. Our lived experience takes precedence over theory as a basis for understanding moral/spiritual lives. This approach is concurrent with the “secularising” movement away from

*unquestionable* belief in God to questioning our belief in God. Understanding our lived experience and the experience of others has become the process and the method by which we try to make sense of our worlds. Heelas and Woodhead (2005) refer to this as the “individualisation” of society.

Ben Okri writes about the importance of the link between story telling, values and actions.

*Stories are the secret reservoir of values. Change the stories individuals and nations live by and tell themselves and you change the individuals and nations. Nations and peoples are largely the stories they feed themselves. If they tell themselves stories that are lies, they will suffer the future consequences of those lies. If they tell themselves stories that face their own truths, they will free their histories for future flowerings.(Okri 2000)*

As testament to this emphasis on the lived experience, story telling and listening projects are flourishing in various parts of our social life. There is a growing emphasis on the importance of story in developing our sense of self and others and in forming resilient and coherent communities. As one example of this, the BBC and the British Library have a joint project currently running which invites people to tell their stories about different aspects of their lives. The intention is to gather oral history which helps us understand the present and future generations to understand their pasts. The strap line to this project is “it is surprising what you hear when you listen” (BBC 2012)

Behind these story telling events and practices is the idea of life review. Carl Jung (1960) was quite clear that life review was a task of mid life and beyond and that this work was an important part of maturation and development. Time should be taken to tell our story and sift through it *and learn from it*.

James Birren (2001), a founding gerontologist, has developed the practice of guided autobiography (GAB) as a way of helping people learn from their past, how to live their lives in the future. Story telling is used to heal and explain and as well as to entertain. Victim

support programmes, reconciliation programmes, indeed much of our social care processes involve hearing the story of others.

Story telling can act as an account, an explanation, an interpretation, the basis of negotiation and a future plan. In most story telling situations there is a listener and a teller.

The notion of listening as “good practice” is now accepted in most institutions and organisations. Steve Covey’s fifth habit of a highly effective people and organisations is empathetic listening, the key to good communication (Covey 2010). Listening is well accepted as a positive and indeed important part of organisational and personal development. Listening implies response and appropriate change and it implies civilised discussion about future plans based on mutual respect.

### **Types of listening**

There are different types of listening depending on what is required.

*Obtaining feedback to optimise service delivery:* A Health Board might want to know, as part of its development strategy, if its patients are happy with the canteen, or if they like the new layout for the surgery, or if the new arrangements for making appointments suit them. The patients comfort will improve productivity and satisfaction and is important to the overall operation of the health service. This is often done with patient surveys. (BMA 2009)

*Obtaining information that helps understand the relationship between the individual and the organisation concerned.* For instance Patients are given the chance to talk about themselves and about how their life experiences impact on the requirements of them as patients and how they feel the health service can help them in that. This information is sought through questionnaires with open ended sections or by interview or focus group. For instance Malterud and Ulrikson(2010).

*Where listening is the objective* A qualitatively different form of listening is where it is deep and personal and is intended to support the teller in their

struggle to understand their world. Expectations of change, if there are any, are on the teller not the listener. This dramatically changes the meaning and focus of the listening. The listening is not set up *for* anything. The teller is invited to tell their story and there is no expectation of change, development or outcome on the part of the listener. The onus is on the teller. It is their show, it is entirely teller centred. This type of listening may be something like the soul history described by Hillman( 1994:24). He distinguishes between outward case history story which is about historical biography rather than soul history which concerns experience.

### **Listening as part of health care**

A recurring desire in the experience of people who are undergoing life crises (trauma, separation, sickness, death, loss) is to reminisce and to tell the story.

The experience of illness is a significant life event which people need to talk about. The talking about illness is part of the process of understanding it and accepting the changes that flow from it.

Hospice care leads the way in seeing story and listening as important in the illness journey. One of the core principles in the foundation of hospice care was that health care professionals, working collaboratively, should revitalise their attention to patient and family narrative, in order to respond to their needs. When Hospice care developed in the latter part of the 20<sup>th</sup> century, its founding practitioners sought to promote and deliver care which was based on the needs of patients and their families, over against the routines and procedures of health-care providing institutions and professions. A core objective was that the patient's own story had a determining influence on the care provided. The concept emerged of the experience of illness as a bio-psycho-spiritual "journey" (Saunders 1978), and depended on the component of patient and family narrative, with its determinant influence on the therapeutic responses of health care professionals working together in a multi-professional team.

Walters ( 1996) describes bereavement as a process of incorporating and settling the story of the dead person into the present constructs of those who

remember. This is done through story telling. The story has to be told until it can settle comfortably in the present of the grieving person rather than be banished into the past. In this way the dead person remains comfortably with the living. Without the story telling this "comfort" cannot be achieved.

The idea that illness has meaning is reinforced by Kleinman, a medical practitioner writing in the 1980's.

*"Illness has meaning; and to understand how it obtains meaning is to understand something fundamental about illness, about care and perhaps about life generally.... an interpretation of illness is something that patients, families and practitioners need to undertake together. For there is a dialectic at the heart of healing that brings the care giver into the uncertain, fearful world of pain and disability and that reciprocally introduces patient and family into the equally uncertain world of therapeutic actions. That dialectic both enhances the therapy and makes of it and the illness a rare opportunity for moral education. One unintended outcome of the modern transformation of the medical care system is that it does just about everything to drive the practitioners attention away from the experience of illness."* (Kleinman xiv1988)

Health care professionals and in particular General Practitioners know that listening can be the most effective form of intervention for some patients who are in need of trying to understand their situation. Medical education in general practice and in specialist hospital care has specifically targeted good listening skills as being key to good medical practice and avoidance of complaint and litigation (Hesketh and Laidlaw 2000). Listening is understood to be a key skill in health care. (Arnold and Coran 2011)

The interest in narrative based medicine has been revived and there is a lively debate in the medical and nursing press around the value of narrative based practice and possibility of narrative research. (Greenhalgh:1999). The patient story is key to understanding the patient journey and suffering. Without the patient story the treatment is less effective.

The importance of listening and being listened to are displayed in current NHS values. Many of the health

and social care talking therapies are based on story telling. The patient experience or 'patient journey' is seen as central to the process of healthcare that is offered in the NHS. The quality indicators of the Scottish NHS revolve around the quality of the patient experience. As we have seen in this edition Patient Reported Outcome Measures (PROMS), specifically use patient perceptions to inform change, development, rationing and targeting of services.

### **Patient centred policy**

Listening is at the heart of a patient centred NHS policy. The NHS Quality Strategy (2010) understands patient centred care to mean

- Putting people at the heart of NHS Scotland. Those working in the health service will listen to peoples' views, gather information about their perceptions and personal experience of care and use that information to further improve care.
- Building on the values of the people working in and with NHS Scotland and their commitment to providing the best possible care and advice compassionately and reliably, by making the right thing easier to do for every person, every time.
- Making measurable improvement in the aspects of quality of care that patients, their families and carers and those providing healthcare services see as really important.

Patient focussed care and patient centred practice has become a key pillar of the health care service philosophy. Effort is currently being made through training and development to emphasise the importance of patient centred care. (The healthcare quality strategy 2010)

### **Barriers to listening in health care services: the challenge of time**

The collective mind of the western rationalist or dualist is encouraged to think of solutions to problems and to use empirical evidence to measure the success in resolving problems. Our health and social care institutions are set up with this philosophical

assumption off success meaning cure. These institutions are intentionally secular and require rigorous recording of actions and achievement of policy driven targets as part of their governance. Targets and measures are part of the currency of "delivering" health and social care. As the "delivery" of health and social care becomes more and more complex, expensive and sometimes unachievable without deep social change, the language is beginning to change so that concepts like resilience, partnership between health care service and patient, mutuality and responsibility are being introduced. These concepts shift the balance of responsibility from institution to patient and community and are captured in the umbrella concept of "patient centred care". This is a very complex and subtle process by which the impossibility of "delivering" health care is being acknowledged and new ways of helping people when they are ill are being introduced. This is a very slow process. Currently some of the drivers for this are the economic recession which requires prioritising and limitation of spending, limits of science and the ethical dilemmas that arise at those limits, in managing ill health the re-introduction of the sacred and the idea of mystery through the rise in interest in the spiritual aspects of wellbeing and the realities of the ageing population where the adolescent society dominant values of productivity, growth, success and achievement are challenged.

The healthcare professional is caught up in this process of change and challenge in thinking.

In contemporary 21<sup>st</sup> Century society in Scotland we find that careful listening is costly in terms of time and energy. The pressure on staff in the NHS has resulted in a tendency to devolve listening to a specialist group of therapists who, in various ways and to various degrees, can provide space to listen to our story, reflect upon it, make judgements about the story and come up with advice by which behaviour can change. Listening, or talking therapies are now seen as an integral part of the suite of help available to those in some kind of difficulty.

### **The link between listening and wellbeing**

Being listened to, heard and dignified with respect for our story makes us feel better. We are able to experience a sense of well being despite suffering illness. Much of the work of the palliative care health staff is about listening and acknowledging the story of those dying and working with meaning-making and pain relief in the absence of a cure. However, all of us in one way or another feel better if we tell our story, it is heard and even better, understood. To be misunderstood and to misunderstand ourselves through lack of opportunity to tell our story can be demoralising and at worst life threatening.

It is in this context of an increasing interest in listening and a turn towards community wellbeing and resilience to help us in our troubles that health care chaplaincy listening services have developed.

### **Spiritual listening**

“Helping people unravel the events going on in their lives so that they can make meaning, find purpose and strength and a hopeful way forward” (listening chaplain CCL2).

Health care chaplains have long known that the art of listening is a central part of pastoral care. Chaplains central work is to listen. However in health care chaplaincy the listening is not prompted by a need to hear about specific health issues or symptoms. Spiritual listening is listening to someone who is in some way trying to make a connection between their health and wellbeing and their current circumstances, who is making existential enquiries of their world. This is a particular way of offering patients a patient centred service. The patient talks, and the chaplain listens.

Sometimes the teller wants to refer to God, transcendence, numinous and soul journey. Listening to these stories is part of the professional skills and abilities of the healthcare chaplain.

### **Chaplains as listeners**

Swinton ( 2002) identifies the unique qualities of the chaplain to be in the ability to retain and remind people of the mystery and wonder of God and do so through the use of story telling and listening.

In theological terms listening and waiting are important concepts that are mediated by discernment. Reflective practice encourages listening to oneself and observing and understanding professional practice through reflection. Those trained in theology have learnt the importance of story as a vehicle to express knowledge, understanding, spiritual realities and faith (Frank 1995, Nouwen,1972).

The Scottish Healthcare chaplains’ consensus statement specifically identifies listening and story telling as a core function of the chaplain.

- ◆ Engaging in a therapeutic listening, talking and being present with people in difficult times.
- ◆ affirming that fear, anxiety, loss and sadness are part of the normal range of human experience in healthcare;
- ◆ establishing trusting relationships in which others can explore hard questions relating to mortality, meaning, and identity;
- ◆ helping people to (re)discover hope, resilience and inner strength in times of illness, injury, loss and death.

A recent study of the work of palliative care chaplains (Coates 2010) shows that the eliciting, upholding and representing the patient narrative in the multidisciplinary team was a key task for healthcare chaplains and of key importance in the continuing care of the patient.

The challenge for those entrusted with the task of spiritual care is therefore to foster a climate in which people can reflect on and share their life stories; to be helped to see these in the context of a journey, and to be alert to clues whereby their story may find links and resonance to a faith story.

Core skills, knowledge and attitudes for the chaplain are

- a) to be fully “present” (Kelly 2102and Speck 1988),
- b) to give time
- c) to provide non anxious presence (Newell 2008).

### The changing role of the health care chaplain

In his seminal work "Hospital the place of Truth", a study of healthcare chaplaincy in the 1960's, Michael Wilson laid down the challenge to healthcare chaplaincy. The primary task of the hospital, he wrote,

*is to enable patients, their families and staff to learn from the experience of illness and death, how to build a healthy society*

This is a very powerful call to arms for healthcare chaplains. Since then healthcare chaplains in Scotland have moved away from part time Church sponsored visiting to full time, NHS appointments with the spiritual care needs directive (HDL 76 2002) formalising the role of spiritual care in health care. The healthcare chaplains are on a journey of development and professionalization.

Chaplains are having to compete in the NHS market place for professional identity as part of the NHS health service staff. The last 10 years of health care chaplaincy in Scotland have been characterised by trying to confirm "what chaplains do" and how they contribute uniquely and usefully to the patient journey. CCL offers a very clear and specific role which is understood by other health care staff and which requires skills and knowledge that are at the heart of pastoral work.

Recently the spiritual needs of patients and indeed staff have received more attention and the recognition of the relationship between spiritual, socio economic, psychological and physical wellbeing is increasingly understood. (Wilkinson and Marmot 2003)

### Conclusions

In order to be in the healthcare professional tent, health care chaplaincy needs to show that it is a useful addition to the health care services using methods of research likely to produce evidence for good practice which are robust and acceptable to the orthodoxy of the health care service. In order to do good work within the tent, chaplaincy practice must have integrity and be patient centred.

CCL is a way forward for chaplaincy in terms of both methods of evaluation and service practice. It can provide reliable evidence that health care chaplains are providing a service that is patient centred and positive for patients and their general practitioners.

CCL is not just good for patients, it is good for Chaplains who want to secure a role in primary health care which is recognised, stable, can be evaluated and which is truly patient centred.

Chaplains have the scope to lead the way with programmes such as CCL which demonstrate the importance of patient centred care and the use of values based reflective practice as a means of achieving it.

### References

BBC 2012 <http://www.bbc.co.uk/radio4/features/the-listening-project/listen>

BIRREN J E & COCHRAN K N 2001 *Telling the stories of life through guided autobiography groups* Baltimore Maryland USA John Hopkins University Press

BMA 2009 *Developing General Practice: Listening to Patients* General Practitioners Committee June

CHRISTA L. ARNOLD & JUSTIN J. CORAN 2011 Are You Listening Healthcare Providers? Suggestions for Listening Skill Building Education for Healthcare Providers *Listening Education 2/2011* © International Listening Association, [www.listen.org](http://www.listen.org)

COATES S 2010 Upholding the Patient Narrative in palliative Care: the role of the healthcare chaplain in the multidisciplinary team. *Scottish Journal Of Healthcare Chaplaincy* Vol 13 No 1.

COVEY STEVEN 2010 *Empathetic Listening : the key to communication from the Seven Habits of highly effective people* A vook production available on Kindle.

FRANK A 1995 *The Wounded Story-teller* Body, Illness and Ethics Chicago and London The University of Chicago Press

GREENHALGH T AND HURWITZ B 1999 Why study Narrative *British Medical Journal* 318 (7175) 48-50

HEELAS P AND WOODHEAD 2005 *The spiritual revolution: Why religion is giving way to Spirituality* Oxford: Blackwell Publishing

HESKETH E AND LAIDLAW J 2000 *Questioning and Listening* Scottish Council for Post graduate medical and dental education.

HILLMAN JAMES 1994 *Healing Fiction* Putnam, Conneticut, USA, Spring Publications Inc

JUNG C AND READ H 1960 *The collected works of C G Jung Vol 8: The structure and Dynamics of the Psyche.* London: Routledge And Kegan Paul

KELLY E 2012 *Personhood and presence: self as a resource for spiritual and pastoral care.* T and T Clark International

KLEINMANN 1988 *The Illness Narratives: suffering healing and the human condition* New York, Basic Books.

M. WILSON 1971 *The Hospital - A Place of Truth,* University of Birmingham Institute for the Study of Worship and Religious Architecture

MALTERUD K, ULRIKSEN K. 2010 Obesity in general practice: a focus group study on patient experiences. *Scand Journal of Primary Health Care.* Dec;28(4):205-10 Epub 2010 Oct 14 Research Unit for General Practice in Bergen, Norway

MOWAT H AND SWINTON J (2006) *What do Chaplains do?* Scottish Government, Health Quality Dept. available from [www.mowatresearch.co.uk](http://www.mowatresearch.co.uk)

MOWAT H BUNNISS S AND KELLY E 2012 Community Chaplaincy Listening: working with General

Practitioners to support patient wellbeing *The Scottish Journal of Healthcare Chaplaincy* Vol 15 (1)

NEWELL C 2008 Better Dead than Disabled? When ethics and disability meet: a narrative of Ageing , Loss and Exclusion in *Ageing Disability and spirituality : addressing the challenge of disability in later life* edited by Elizabeth Mackinlay, London and Philadelphia Jessica Kingsley Publishers,

NOUWEN H 1990 *The Wounded healer* New York Image Books

OKRI B 2000 *Commission on the future of multi cultural Britain*

SAUNDERS C 1988 Spiritual Pain *Hospital Chaplain* 102

SPECK P 1988 *Being There* London SCM Press

SWINTON J 2002 'Reclaiming Mystery and Wonder: Towards a narrative based perspective on chaplaincy.' *Journal of Healthcare Chaplaincy* pp223-236

Taylor C 2007 *A secular Age* Cambridge Massachusetts and London, England The Belknap Press of Harvard University Press

THE HEALTHCARE QUALITY STRATEGY for NHSScotland 2010 [www.scotland.gov.uk/Publications/2010/05/10102307/4](http://www.scotland.gov.uk/Publications/2010/05/10102307/4)

WALTERS T 1996 A new model of grief: bereavement and biography *Mortality* 1:1 7-25