How Becoming a Doctor Made Me a Worse Listener

It was a winter night while I was working as a public radio reporter. I was sitting on the carpet in a candlelit apartment, holding a microphone up to a woman who was crying. The woman sat next to her husband, who was about to deploy for more than a year. They had recently gotten married. “I found this man to have a wonderful relationship with, after a lot of trial and error,” she said, her eyes welling with tears. “Will we still be in love when he comes back?” Her husband’s face was blank. He patted her back stiffly. A kitten wove between the woman’s feet, a present from her husband to keep her company while he was gone. I sat there for an hour, listening through long pauses as she found the words for what she was feeling. A clock ticked somewhere. The wind howled outside.

The town where I worked didn’t salt the roads in the winter, and I remember driving over thick sheets of ice as I returned to the radio studio that night. My story was due the next day, and I needed to write. I listened back to my recording, much of which was silence and crying. While the goal of the story was to show the human impact of war, I hesitated to broadcast what had felt like an intensely private moment. I played, rewound, replayed. I wondered if the story would help the woman by generating empathy, hurt her by exposing her vulnerability, or accomplish nothing. I ultimately chose a short audio clip to include in the story. Her sniffles were punctuated by tiny meows.

What I loved about reporting was listening to people as they navigated some of the biggest moments of their lives. But in the weeks after that interview, I thought more about my hesitation to air it and discovered I had developed a new conviction: that the act of listening was an intrinsic good, a recognition of another person’s complexity and value, and that broadcasting what I had heard had become less important to me.

A few months later, I decided to become a doctor.

In medical school, there were entire courses on listening. My classmates and I studied the ingredients of the medical history. We learned how to use it to explore most-likely and can’t-miss diagnoses. Patient actors placed demands on our emotions, and we learned to respond in ways concordant with a new persona: the “professional.” On clerkship rotations, when we brought these skills to patient care, I felt affirmed in my decision to change careers. Patients’ lives and illness experiences were fascinating to me, and it felt meaningful to use that information to treat them. I decided to go into neurology, with its detailed history taking and examination, in part to ensure that listening to patients’ stories remained a central part of my medical career.

Then I entered residency. What I hadn’t accounted for was how those stories would be flattened by the pace of the work.

Recently, when I was on call overnight, I examined a man with 3 months of urinary retention and paresthesias. He had already seen a half dozen physicians and had received a magnetic resonance image (MRI) of his brain and spine without a diagnosis. Scared and frustrated, his family drove for hours to our emergency department for another opinion.

I asked about his symptom trajectory—what happened first, what happened next—but he and his family frequently digressed into telling me what other doctors had said and how wrong they were. The 3 pagers on my hip went off every few minutes. My interview style became increasingly directive, as I attempted to pull the family back to the history necessary to move forward with his care. By the end, I had effectively trained them to speak the way I wanted. When a son interjected with a complaint about a previous clinician, the patient’s wife would shush him and say, “That’s not what the doctor wants to hear.”

Eventually, I got my history. I got my examination. I recommended another MRI that diagnosed him with cauda equina syndrome. He was admitted to the neurosurgical service for a preoperative workup. I never saw him again. The following morning, after I’d signed out, I found I couldn’t stop thinking about him: What had the other doctors told him? What was it like to be getting sicker without knowing why? Now I was alone, clicking around in his chart to satisfy my curiosity. Why hadn’t I just listened in the first place?

The easy answer is that I felt I didn’t have the time. I had been the only neurology resident overnight in a busy tertiary care center, facing an unpredictable number of emergencies and interruptions. If things weren’t chaotic in the present moment, they were likely to turn chaotic in the next. I had to be efficient, focused, and restrained.

Now, as the adrenaline washed out, I felt a stone had been overturned, and I couldn’t look away. I glanced over the charts of the other patients I’d met overnight, allowing myself a few minutes to reflect on the larger arc of their stories. That transfer patient who had been diagnosed erroneously with conversion disorder: to what extent had her race and gender influenced the
misdiagnosis? That puzzling case of a patient who communicated using American Sign Language: Were her symptoms getting lost in translation? I would never learn the answers to these questions. It was as if a chasm had formed between me and the radio reporter who could sit on the carpet and listen to a woman cry for an hour, just to understand what it was like to be left alone with a kitten when your husband goes to war.

And I hadn’t noticed. Maybe that was because I was still connecting to patients. I still choked up when they cried, felt joy when they rejoiced, felt moved by and grateful for my work, and generally felt good about the care I was providing.

But as I moved through my next days in clinic, I began to notice the unconscious tricks I had developed to maintain a connection under time pressure. A whole set of expressions played out across my face during history taking—nonverbal concern, nonverbal gentleness, nonverbal apology—a time-efficient method of conveying empathy even when I was asking directed questions, controlling the type and volume of information I received, and, at times, interrupting. Sometimes I apologized to patients for my style of interviewing, explaining that I wanted to make sure I understood things clearly so that I could treat them. I apologized because I didn’t like communicating this way. I can’t imagine it felt good to them.

What’s strange is that, at the end of these visits, patients often thanked me for my concern and detail-orientedness. They may have interpreted my questioning as a sign that I was interested. But was I?

Interest is a multilayered concept in medicine. I care about patients, and I am interested in their stories in the sense that they contain the information I need to make the best possible decisions for their care. Interest motivates doctors to take a detailed history, review the chart, and analyze the literature. Interest leads to the correct diagnosis and treatment. Residency rewards this kind of interest. Perhaps as a result, looking around at my co-residents, it’s in abundant supply, even when time is tight.

But I realized I was losing touch with a more expansive state of interest, that of sheer curiosity, the honest, open-ended desire to learn more about other people and their experiences. Curiosity leads our attention to undifferentiated details both small and large, “important” and “unimportant.” We notice gestures, cadence, patterns of thought. We open ourselves to injustice and suffering but also to connection and beauty. Curiosity is pleasurable. And it requires spaciousness, an unhurried feeling. I hardly ever felt that spaciousness on service or in clinic.

Reflecting on that moment of curiosity crystallized on call, I decided to adopt a new habit: I now make a point of asking patients one question born of curiosity alone, without regard for the plan of care. This is a kind of meditation. It requires me to locate my innate interest in other people. And honestly, it may only be possible now, as a fourth-year resident, as I’ve become less afraid and more efficient.

I tried this out recently with a new clinic patient, an older man with several new diagnoses who was so upset about his state of health that he nearly wheeled out of my clinic room seconds after wheeling in. I helped calm him, got the history (which required frequent redirection), and we made a plan to treat his new neurologic condition. As we wrapped up, I asked him why his wife had stayed behind in the waiting room. “She has dementia,” he replied. “Hearing about my problems stresses her out. And she’s so good to me. When we wake up in the morning, she has no idea what day it is, but the first thing she says to me is, ‘What can I do today to make you happy?’” He started to cry. “Forty-seven years. I love her more than anything in the world.”

After that, I felt at ease with this man. As I showed him out, he shook my hand and said, “You’re alright, doc. You did a good job.”

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