The Act of Listening: Perspective of a Hard-of-Hearing Medical Student

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"Do you see these?" asked the attending physician, pointing to the web of small superficial red blood vessels on the patient's torso.

"Yes," a cacophony of responses came from the medical team gathered around the bed.

Another layer of sound hummed in the background: the beeping of intravenous pumps, the rustling of linen, the soft rush of air of compression devices, and a nurse speaking to a patient in the next bed.

"They're (muffled), see how they go white when you (muffled)?" explained the attending physician, pressing her finger into one of the red spots. "This patient suffers from (muffled)."

It was a regular day on a regular round in the hospital ward. The attending physician was explaining how spider angiomas had developed on a patient with cirrhosis. And I, as usual, missed a portion of the lesson.

As we left the patient's room, I quietly asked the student next to me: "Those are spider angiomas, right?"

"Yeah," he kindly replied.

I adjusted the volume on my hearing aid and followed the attending physician to the next patient.

I was born with bilateral microtia atresia, a physical condition that revealed my hearing impairment at birth, unlike nerve-related deafness. In those important early formative years, I was fitted with a bone-conduction hearing aid and underwent focused training by specialists and my parents.

By the time I was 12 years old, I was a veteran of multiple reconstructive surgeries that included constructing ear canals and fashioning outer ears using skin grafts and cartilage from my ribs. After these childhood surgical procedures, I was able to use an air-conduction hearing aid in 1 ear, but the benefits were limited.

In my 20s, I underwent additional procedures, including the construction of a tympanic membrane and anchoring of a bone-conduction hearing aid. The latter operation involved drilling a titanium screw into the mastoid bone over my left inner ear. I now wear an air-conduction hearing aid in my right ear and the bone-conduction hearing aid in my left ear. With these aides, in ideal situations, I can hear within a normal range. But audiograms only measure decibels and decipher nerve vs conduction hearing loss, not perceptions. Through this process, I hear things differently—and I see things differently.

To illustrate the way I hear the world, imagine being on a cell phone in a bustling emergency department on a busy Friday night. The quality of the call is quite clear in patches, but background noises intrude and the cellular connection keeps cutting out. You become frustrated. And so do those around you when you ask them to repeat themselves.

Modern hearing aids are equipped with filters that act like vacuums of background noise and repetitive noise, but the advancements are not yet refined for conductive hearing loss. To optimize my hearing, I need a direct line of vision so I can lip-read. At times, I need the speaker to wear an FM device (a wireless device that is tuned to the hearing aid of the listener).

Although my experience as a patient may have propelled me toward studying medicine, the journey has not been easy. I have had periods of doubt and concern about my ability to navigate through the rigors of medicine. Succeeding in medical school is a big enough challenge without the added obstacle of hearing impairment. However, along the way, I have found that my unique experience gives me a better understanding of the patient's point of view and how vital clear communication is to the practice of medicine.

During a medical internship in the rural Tanzanian village of Shirati, I witnessed firsthand how critical patient education and effective communication can be. A choking infant with progressive malaria was brought to the hospital by his mother. She had fed the infant some porridge, not knowing

how the disease could compromise the gag reflex. When the doctor asked for a suction machine, an oxygen machine was brought instead. The delay caused by miscommunication was fatal.

This incident stayed with me on many levels. It was a teaching moment. Even in the hearing world, people do not always listen. Messages are garbled, assumptions are made, questions are not asked, or directions are not clear. To hear is not the same as to listen. Hearing requires functional ear anatomy. Listening is acting upon hearing; it is a conscious effort to understand and engage in communication. It's ironic that my lack of hearing has improved my listening skills.

My hearing loss has also improved my ability to be my own advocate. Although disability laws may require that equal opportunity is presented to me, my success is tied to my awareness of others and the accommodations I make. I often have to advocate for adjustments in a day-to-day setting. I ask professors to wear an FM device and ensure that I sit in the front of the classroom. I ask peers to repeat themselves. I ask for a clear line of vision so that I can lip-read to support my hearing. Sometimes my self-advocacy has hit closed doors and closed minds. But most often I find that others forget these small voluntary accommodations because my hearing impairment is largely invisible. My speech has little trace of impediment thanks to years of speech therapy. My hearing aids allow me to hold my own in most environments.

I've learned that when I explain with detail what it's like to be hearing impaired, people are more responsive. There is sympathy, which fuels the best kind of communication: for a moment, the listener takes a few steps in the speaker's shoes. This type of listening is what I try to bring to my patients. My goal is to fully understand a patient's lifestyle and concerns. I aim to extrapolate the real reason for his or her visit, not just the chief complaint. Some patients just want to be heard, whereas others have social issues that are manifesting as a physical complaint. Similar to the way I try to use words to convey my experience to my peers, I try to understand a day in a patient's shoes.

Now that I have completed my fourth year of medical school, I see how dynamic and complicated medicine can be. There is never the perfect patient-physician interaction; there are times when the answers are elusive or personality conflicts arise. I try to always remember my own experiences as a patient who has sat in so many doctor offices and occupied so many hospital beds. With each encounter, I ask myself: "How can I connect with this patient within a matter of minutes?" And although I might have to ask patients to repeat themselves, I strive to remember that truly listening brings forth the power of empathy, and I have found that to be the crux of quality medicine. (doi:10.7556/jaoa.2015.100)