Trudy Smith:

Hello, and welcome to today's NextSense Institute Podcast. My name is Trudy Smith, and I am the Manager Continuing Professional Education at the NextSense Institute and your host for this podcast. I am so delighted to have this team with us today. **I'm always excited by the research work that comes out of Macquarie University and NextSense, and we've got a great team with us today to talk about their current project**. So we'll get you to introduce yourselves ladies. So Rebecca, can you please start for us?

Rebecca Kim:

Good morning. I'm Rebecca Kim. I am an audiologist, I am a researcher, I am an educator and I'm the current clinic manager of pediatric audiology at NextSense.

Isabelle:

And I'm Isabelle. Hi everyone. I'm trained as a clinical audiologist and I am now a researcher and a lecturer at the University of Sydney in the space of information and services in relation to hearing loss.

Nicole Matthews:

And I'm Nicole Matthews. I'm a teacher and researcher at Macquarie University in the department of media, music, communications, creative arts, literature, and languages. I think I got that right. It's changed names recently. And I'm on the team alongside my colleague, Justine Lloyd, who's a sociologist at Macquarie University. So we're kind of the ring ins from other disciplines, getting the opportunity to learn from the audiologists on our team.

Trudy Smith:

Brilliant. I'm going to start with you Nicole, with that first question. Why do you think listening in the clinic is so important?

Nicole Matthews:

Well, I guess I should start off just by clarifying, because I know you've got lots of expert listeners around listening in the audience, that we're focusing, not on kind of physiological hearing when we're talking about this, but the process of trying to understand what people are communicating and experiencing. So that's the focus of our research and our interest.

And I guess over the last, I don't know, 40 or 50 years, there's been a real political push to make sure that the experiences, the perspectives, the voices of people who've previously been kind of undervalued, set aside, marginalized, have come to the fore. And I think that's really important, that emphasis on giving more people an opportunity to speak about their experience. But the flip side of that I guess, is that it's all very well people telling their stories and often people are asked to do so again and again and again, but people with influence, people who've got positions of power, people who are professionals really need to also be attending to and acting upon the stories that they're hearing.

So I think that's what we really try to do in this research. We're really interested in the ways that health professionals, particularly hearing health professionals might act upon and acknowledge and pay attention to the lift experience accounts. I think often there's a bit of a disconnect between what

happens in kind of clinical settings and what's happening in this wider political scene. We're all aware of the importance of equality and voice in this wider political environment, but I think when you come down to healthcare settings, often people switch off from that way of thinking and focusing on questions of the psychological, the interpersonal, the biomedical.

So what we've been interested in doing in this project is kind of be a bit attentive to that connection. And I guess audiology is particularly an interesting context for these, because in the audiological kind of scene, it feels like people are very aware of the alternative ways that clinical experiences might be framed in the way that audiological profession might be experienced. And I think that's partly because of the presence of the culturally deaf community out there saying, hang on, it's about access and equality and communication, not so much about biomedicine.

So I think that when we talked to people in our focus groups with audiologists and audiological researchers, a couple of years back, we found people were really aware of that terrain of power, but at the same time, there's a little bit of a challenge in bringing together this wider political understanding of social justice and equality, and thinking about it in the space of the clinic where we think it really can make a real difference. So yeah, that's partly why we think it's really important.

Trudy Smith:

Absolutely. And so Rebecca, what are the influences that are shaping the way audiologists listen or don't listen to the lived experiences of their clients?

Rebecca Kim:

Yes. It was really, really interesting with the focus groups because there was a lot of consistency across the different focus groups with the sorts of things that audiologists were reporting that are really shaping their ability to really listen to their clients. So we ended up identifying four different influences on audiologists listening. The first is a medical technical paradigm, which really focuses on the traditional medical model of clinical practice where hearing loss is viewed as a deficit that requires treatment through devices like hearing aids or cochlear implants. In these sorts of settings or with this sort of influence, professional expertise is seen as having priority or the client experience, and professional listening takes the form of structured interviews and responses to professional questions.

The next influences the business paradigm, the business related aspects came up time and time again, and they were often discussed as barriers to listening to clients. So business models of clinical practice was seen as shaping what can actually be heard and the listening behaviors, a really, really strong theme was the lack of time to actually listen to the clients. And I've got a quote here. One of our participants said, "I think one of the biggest limitations now are basically links to commercialization and making a profit, for even the government organizations and the amount of time that's given to the clinician who works in a system because the appointment times are used to give people, I'm sorry, the appointment times that I used to give people back pretty much halved in a lot of respects." So time is being taken away from the clinician. So they're not able to look after the client in a way that they wanted to.

Trudy Smith:

Sure.

Rebecca Kim:

The psychosocial paradigm focuses on the impact of social interactions and psychological wellbeing. We know that hearing loss is related to multiple psychosocial impacts, for example, feelings of loneliness, anxiety, difficulties with sleep, depression, and the list goes on and on and on. As audiologists we're expected to address the impact of hearing loss on a person's psychosocial functioning, and listening in the clinic is seen as an opportunity for clients to share these experiences and difficulties that can happen at home, in school or in the workplace and how they feel about it. But one of the issues that was raised with audiologists is that once you've got that information, what do you do with it? And sometimes clients are disclosing information that's very personal and something that the clinician might actually feel that they have to act on, but they're not really sure if they can.

So I've got another quote to illustrate that point. One of the participants said, "There have been times where I've had personal stories that border on whether I should be actioning it as a clinician because I'm bound by legal duties to report any abuse, but it's confidential because the door is closed and the person trusts you, and whatever they tell you, they feel confident that either you won't repeat it, or maybe you could do something to help them." So really not necessarily knowing if a client does disclose something in their wider context, we have a responsibility to act on that, **but is the client sharing that because they feel like this is a safe space, or are they sharing that in order to get assistance with these issues?** [Trudy: tricky]

The final paradigm or force that's shaping listening is the social justice paradigm. And the essence of social justice paradigm of listening is moving beyond a focus on the individual or interpersonal frame accounts to become attuned to the underpinning structures that shape and make possible particular social experiences. So it's listening as being attentive to the terrain of power across which lived experience accounts can emerge. **And we're seeking through careful listening to begin to redistribute this power.**

Trudy Smith:

So interesting. I can spend hours just unpacking each those implications. But I guess Rebecca, there have to be practical implications for changing the way that we listen in the clinic.

Rebecca Kim:

Absolutely. If you look at any of the literature, we know that listening to clients and having person centered clinical encounters, shared communication, shared decision-making and more balanced power relationships, that leads to better outcomes for clients, that leads to better patient satisfaction, it leads to better adherence to treatment as well and better patient emotional health. So these things are really, really well-described, but there's also wider implications when clients or potential clients hear lived experiences because hearing the journeys of others can be an additional piece of information for clients when they're deciding what the next step should be for them and choosing amongst the different intervention options.

So from a clinical management point of view, clinicians might hear similar sorts of stories from multiple clients about aspects of services that could be improved. And depending on their employment context, they can then share this information with their managers, act on the information that they've heard and then assess whether or not we could actually improve services for everybody.

Isabelle:

And if we move, there's so much of these points that we could talk about on all these points. But if we move away from the more clinical settings, at a societal level, if we take time to fully listen to the stories of people who live with hearing loss, that can really promote a self-reflection and encourage behavior change. In particular, that can happen if it highlights aspects of discrimination that maybe we hadn't yet noticed.

As a hearing health clinician, our expertise and our professional confidence sometimes can be perceived as patronizing for clients, where we may really feel that our advice is really important and we want to give that advice and it seems super simple. And then we wonder why our clients are not listening or not taking on that advice. And for a number of us in the profession, and it's only when we have experienced hearing loss ourself or a close family member has experienced hearing loss that we have realized how hard it was, even for trained hearing health professionals to change our behavior, and to actually use the advice that seemed so easy to give at the time within a clinical setting. And I think **this is where the power of listening to multiple stories** and perspective can really come, so it can help us. Actually, **it has helped me, and hopefully it can help others to become more aware and empathic powereds instances of injustices and trying to make a better impact perhaps on the society.**

Trudy Smith:

Sure.

Isabelle:

Bringing that back to the four framework or perspective that Rebecca has described before, we know that within hearing health, the field is always balancing the medical, the psychosocial and the business aspects, but we need to balance up together with more cultural aspects. And we know that there are multiple cultural implications for some of the people that we work with. And we need to ensure that we understand clients' experiences within their wider cultural context. And that's **not just culture in regards to the deaf culture**, which is definitely an important consideration, but **it extends to balancing other cultural affiliations and perspectives about communication, identity and disability**.

Trudy Smith:

Sure. So do you have a set of concrete things that hearing health professionals can do to change things in their clinic room?

Isabelle:

And I think it comes back, I touched a bit on it already within the aspects of reflective practice. So we know when we look around and talk to the clinician and go to conferences, the hearing health profession is really keen to shift things, to make changes and just having your podcasts for example, is a good demonstration of the value we're putting on listening to stories. But within a clinical setting, we know there are structural reasons that make those changes really difficult. So we might be in an employment structure that brings some limitations, or there are regulations or financial aspects that will influence what we feel we can do or cannot do with those stories.

So one step might be to make a conscious shift. It's just to think about making a shift in our mindset when we meet clients to be open to the idea that maybe we don't already know all the story that people will tell us. So when we see eight or 10 clients a day, similar stories might come back and often we see those patterns and we almost group them together. But to think about it as, maybe for us, it might seem like we've already heard it, but for the client, it is their story. And it is really important for them. And it's very personal, and sharing it is not easy. So to keep really an open mind, and I know many clinicians are already doing that, but to consciously think, maybe I'm going to hear a different perspective, the assignment to be fully there for the client while they share that.

And during our focus group, our participants seem to be really learning from one another as the discussion evolve and how they reflected about the story. And that really speaks to the importance of reflection during and after the practice. And there are studies out there as well that show how reflective practice is something that can be developed and can help improve services. And this is something I have brought within my classes as well with students to try to practice and think when there's a new situation to just stop and think, okay, what has just happened to be able to articulate that? What information have I heard and how do I feel about that information? What is new? What was confronting? How do I feel about that?

The next step is to try to understand how it fits with my knowledge or prior beliefs and my expertise, and to think about why is this situation different? Why doesn't it fit so well with what I thought? And from there is, if I have the opportunity to have this encounter again to replay what just happened, what could I do differently? What would it be? And maybe if I see a similar client or in the future, is it something that I could try to change or try a different approach? That's really the essence of reflective practices.

We know that there are many hearing health professionals that are really wanting to hear those stories. And our respondents even told us they had to chase those stories, so they don't just appear. You have to look for them. So when you're talking Trudy, asking about examples of where those stories could be found and what we could do to change practices, as I said, your podcast, great place to start to listen to various stories.

Trudy Smith:

[inaudible 00:16:09].

Isabelle:

YouTube clips, there are movies, new stories. Many community group have newsletters. So to register to their newsletters and read about both stories that they're very generous in sharing. If you're on Twitter, there are also many Twitter communities of deaf and hard of hearing adults, where there are sometimes very critical perspectives on services, and perhaps we can learn from listening to these perspectives.

So personally it can be confronting. I try to see these really as opportunities to try to step out from wanting to give advice and more to bring my focus on trying to better understand the perspective and difficulties of people who hearing loss is their everyday reality. And I hope that by doing that, my work and our profession can have a greater impact. So I hope that was a bit more practical.

Trudy Smith: #reflecting-well

It was really practical, but I'm really conscious that taking that time to reflect on conversations and reflective practice, that requires time. And we've already talked about today that clinicians are having less time for their appointments. And so, often that means that they have less time for the appointment. They also have less time to then reflect on that appointment because they're going straight into the next one. So there's actual, real structural changes that need to occur to enable practitioners to be able to be reflective and take the time to let a client tell their story and then to work out the best way forward for that client.

Isabelle: #reflective-mindset #consider-if-you-heard-the-full-perspective

I see that as a mindset. I see that it can take more time, it's also practice and we can apply that in multiple facets of our life of thinking well, when something is a bit different, unexpected to just stop and think, have I heard the full perspective? Is there something else that could help me reframe what just happened, and if I would do it again. So it doesn't necessarily take time, but it's often to stop habits that we have in being in that professional expert role in reflecting on how it could be done differently.

Trudy Smith:

Yeah. Very good point. Well, I know that some of the research was focused on audiologists. Nicole, I imagine the same issues arise for other health professionals as well?

Nicole Matthews:

Yeah, I think so. And I think, drawing on what you've been saying Trudy about the, as Isabelle said, there's space for reflective practice for individuals within the existing constraints. But I think one of the things that's really come out when we've been looking at the way lived experience accounts have filtered their way into lots of particularly health contexts is that those lived experience accounts can feed into lots of different spaces. So the clinic is one of those spaces, but professional education, initial education and retraining in service education, service improvement is another space.

When myself and my colleague Naomi Sunderland were working on our book on digital storytelling in health a couple of years ago, we found out that in the UK, in the Wales NHS, there's a real focus on using lived experience accounts in the governance processes. So at that high level where there's a little bit more, I guess, breathing space in a sense to think through the implications. So whenever there's a board meeting in the Wales NHS, it starts off with the lived experience accounts. So it might be a service user. It might be a digital storyteller giving an account that's been recorded. And that sort of sets the tone and sets the agenda, maybe shifts focus or points towards the ways in which services do or don't mesh together well, the disjunctions between them. Those kinds of things kind of shifts attention in a really useful way.

So I guess if part of what we found in talking to our super reflexive, super thoughtful, and keen to learn audiologists was that there are these structural barriers in some senses to enabling lived experience accounts to feed into those clinical encounters, the part of the solution of that is to kind of identify some of these structures. Actually, some of the people we talked to I'd say were kind of professional activists in some senses, who really did say that there were things that needed to be changed in the wider scene in order for them to do their job properly. So I think some of the ways in which lived experience accounts have kind of worked is at that political level or at the level of

governance and education, which feeds into all of that work, but that's right across the board, I think. So it's not just in audiology.

I guess it's been a real privilege for me as a person who isn't an audiologist and hasn't had those professional trainings is just to see how much audiologists that we spoke to really cared about making sure I did a decent job and were really aware of the power that they held themselves, where they were positioned in terms of the kind of terrain apparent. I think that was really impressive. We also had a chat with quite a few people in the focus groups who had lived experience of being hard of hearing themselves, being hearing aid users. So they were not just drawing on their professional experience, but also drawing on their experience as service users.

So I think that that reflexivity is kind of important, but I do think people were talking about the ways that identifying those kind of issues about the commercial pressures within audiology or shifts to a more, I guess, less professionals in managerial positions, I guess in audiology clinics. That was another theme that came out, and the problems that might bring in terms of not having mentoring or opportunities to go, hang on, this came up, what do I do? This person has disclosed domestic violence in the clinical context, what do I do about that?

So I guess the broader context for lived experience accounts across health and in other areas as well, is that if we're identifying shared experiences through listening to clients, then there's opportunities to shift that not only in individual professional practice or individual encounters with clients, but also at these broader structural levels. And it does seem that audiologists in particular are keen to do that, to act in those ways and to try and push towards more socially just as well as efficient arrangements.

Trudy Smith:

Absolutely. When we look at the power of the shutout report is what inspired the NDIS. And so I think there is real power in lived experience and valuing those stories, collecting those stories, looking for the patterns and then using that to leverage for change. And so I think the work that you're doing is incredibly powerful and we look forward to seeing more in this area. So thank you so much ladies for your work and for sharing with us today. And for Justine as well for her involvement in this. So we appreciate your time today in making us aware of this. Thanks so much.