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Beyond the Prescription: A Conceptual and Qualitative Analysis of How Patients in Healthcare Contexts Distinguish Feeling Heard from Feeling Treated

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Abstract

Background: Healthcare provision exists in a multifaceted interaction of provider patient relationships, resource limitation and cultural norms that favor the biomedical authority over patient voice. Although progress in clinical care has enhanced technical care, patients still report that they feel that their provider understands them as much as technically sound treatment. This qualitative research investigates the psychological experiences and differences between feeling heard and feeling treated in healthcare experiences in patients, and suggests a synthesized conceptual framework to relate these experiences to health outcomes.

Methods: A qualitative study design involved semi structured focus group discussions that were held with 28 adult patients in outpatient and primary care facilities of a government teaching hospital in central India. The purposive sampling method was used to recruit the participants. The discussions in focus groups were audio taped, transcribed verbatim and thematically analyzed. During data collection and analysis, reflexivity was upheld in the form of journaling by the researchers.

Findings: Thematic analysis identified three key sub-themes of active listening and emotional recognition in the development of patient psychological safety; (ii) the conflict between efficiency of clinical procedure and the need of the patient to be involved; and (iii) the theme of trust as a mental bridging between hearing and acceptance of the treatment. A proposed conceptual framework traces the route between being heard with the help of psychological safety and relational trust to engagement in treatment and health outcomes.

Conclusions: The care is not assessed by patients in strictly clinical terms. Hearing is a unique psychological experience that relates to empathy or therapeutic alliance but is mediated by cognitive appraisal and emotional validation and culturally influenced expectations of care. Emotionally responsive communication should be taught to the healthcare providers and the power dynamics inherent in clinical communication in Kashmir should be given special focus.

Keywords: patient experience, active listening, patient-centred care, trust in healthcare, psychological safety

Background

Patient satisfaction is widely recognized as a valuable measure of the quality in healthcare, but many of its aspects cannot be measured using clinical measures only. Patients often walk out of their consultations feeling medically treated but emotionally they feel that their symptoms have been neglected or overlooked. This difference which is subtle yet very important, has gained increased popularity in the field of health psychology, medical communication studies and health equity studies (Epstein and Street, 2011).

This difference gains further layers of complexity in the context of healthcare in countries like India, Pakistan and Bangladesh where healthcare systems that can be described as characterised by challenging availability resources, patient to provider ratios and hierarchies in which the physician is perceived as an authority figure whose clinical decision making is rarely questioned (Bhattacharyya et al., 2020). The patients often hold back their concerns during consultation due to deference fear of being labelled, seen or just because the time available to consult with them is so limited that they have no opportunity to express themselves (Bhatia and Cleland, 1995). The structural and cultural context of care therefore cannot be separated from the psychological experience of it.

In the original report on quality in healthcare by the Institute of Medicine, patient centeredness was one of six key dimensions, along with safety, effectiveness, timeliness, efficiency and equity (Institute of Medicine, 2001). The essence of patient centred care is that the providers should not just treat a patient on what is wrong with the patient, but who the patient is, their values and preferences. Although there is widespread acceptance of this principle, biomedical knowledge still takes precedence over interpersonal skills in South Asian medical teaching, a gap documented in studies of medical education across the subcontinent (Dogra et al., 2007).

There is an increasing amount of evidence that the feeling that patients experience in a clinical encounter has quantifiable implications. In a large observational study by Stewart et al. (2000), patient centred communication in the primary care setting was linked to an improved recovery, greater emotional well-being and reduced number of unnecessary diagnostic tests in patients. In a systematic review of 40 studies, Rathert et al. (2013) reported more significant evidence supporting the beneficial impact of patient centred care on both satisfaction and self management, but not on clinical outcomes. Hojat et al. (2011) linked physician empathy scores directly to improved clinical outcomes in diabetic patients, offering the first empirical evidence that empathy functions as a clinically active ingredient in care.

The psychological processes of how feeling heard can be converted into better health behaviour and consequences. Mostly available studies in this field are based on quantitative measures of satisfaction that are not able to describe the nuances of the everyday experience or qualitative descriptions that describe what patient's experience. This research was aimed to fill both of these gaps at once: to generate in depth qualitative data in a clinical setting and to rely on the results of such data as the empirical basis of a conceptual model to trace the psychological pathway between feeling heard and health outcomes.

Defining the Core Construct: What is 'Feeling Heard'?

Before moving on to the empirical results we must first specify the meaning of the phrase: "feeling heard", as a psychological construct and differentiate it from similar terms with which it is occasionally mixed up.

Empathy does not mean that you simply are heard. According to Davis (1983), empathy is a multidimensional disposition that is based on affective sharing (feeling what another person feels) and cognitive perspective taking (understanding what the other person experiences by putting yourself in his or her position). The provider has the property of empathy. The experience of being heard, in turn, is a patient experience: the subjective experience of the attention to one's concerns and feelings paid by another person. A provider can feel empathy, and not effectively convey it or certain communication behaviours, including maintaining eye contact, inquisitive listening, verbal support, can create the illusion of being listened to even during a short interaction (Neumann et al., 2009).

Being heard is another concept that is contrasted with therapeutic alliance which is a concept created mainly in psychotherapy literature to explain the quality of the collaborative relationship between therapist and client, agreement on goals, agreement on tasks, and the emotional bond between them (Bordin, 1979). Although hearing can play a role in the formation of therapeutic relationship in long term therapeutic relationships, it is a more immediate, encounter level experience, which might or might not occur within a single consultation. It is also asymmetric in critical aspects: unlike therapeutic alliance, which implies the mutual investment, the feeling heard is more about the patients experience of being received.

Psychologically, being heard can be conceptualized as the product of three elements: (1) a sense of attentional focus which implies the sense that the provider is paying attention to the patient as a complete person, not just to his/her symptoms or records; (2) a sense of emotional validation meaning that the emotional state of the patient is recognized without being judged; and (3) a sense of cognitive confirmation which reflects the sense that the experience of having one's understanding of their situation taken seriously and incorporated into the clinical discussion. When the three elements are together, the patient may get what can be termed as full reception. When one of the three is missing, then the patient is exposed to the unique dissonance of being processed instead of heard.

The Conceptual Model

Based on the existing literature and the qualitative findings of this study, we propose the following conceptual model of the pathway from feeling heard to health outcomes:

Feeling Heard	→	**Psychological Safety**	→	**Relational Trust**	→	**Treatment Engagement**	→	**Health Outcomes**

Figure 1. Proposed conceptual model: Feeling Heard → Health Outcomes pathway

In this model, feeling heard gives rise to psychological safety which Edmondson (1999) describes as the feeling that one can talk, reveal and feel safe without the fear of some negative consequences. Psychological safety allows a complete and honest disclosure, desire to ask questions and receptiveness to advice in a clinical setting. This psychological safety in its turn produces relational trust: a patient will trust the clinical judgement of the provider, believe that the provider acts in his/her interest and stay involved in the care relationship throughout the time. As suggested by Street et al. (2013) in their model of communication pathways, trust is the main proximal outcome of positive clinical communication and it directly predicts the treatment engagement, which in this case is called adherence, attendance of follow-up and active involvement in self-management. Finally, treatment engagement is a well-established predictor of clinical outcomes in a variety of conditions (DiMatteo et al., 2002).

There is also an implication of a negative pathway in the model. Lack of feeling heard leads to increased vigilance and emotional threat in patients and also conditions that are not conducive to psychological safety. In such conditions, trust either fails to develop or is weakened, leading to reduced treatment engagement. This disengagement often occurs quietly, through missed appointments, undisclosed changes in medication, or avoidance of follow-up care. Because these responses are rarely captured by standard clinical monitoring, the relational dimensions of care remain largely invisible, despite their critical role in shaping health outcomes at a population level.

Methods

Study Design and Justification

A qualitative research design in the form of focus group discussions was adopted. The reason behind of choosing this method is that focus groups enable the participants to expand on one another experiences which elicit shared and divergent opinions which may not surface during individual interviews (Morgan, 1997). The study sought to gain insights into subjective interpretations of clinical experiences by patients as opposed to quantifying a specific variable and thus a qualitative approach was suitable.

The rationale why focus group methodology was chosen, as opposed to individual semi-structured interviews, has to do with the situation in Kashmir healthcare. One-on-one interviews provide richness but also run the risk of inflating the views of patients who are already eloquent and at ease with verbal disclosure. By comparison, focus groups generate the situation where less vocal participants can be pulled into discussion by the narratives of others, which is especially important in the settings where patients might lack an existing frame against which they can judge their experiences in healthcare as critically. The group process also allows the researcher to witness how patients come to negotiate meaning in a collective way over shared experiences of care which is a theoretically significant process on its own (Wilkinson, 1998).

The limitations that focus groups inherently hold should be taken into account as well. Social desirability effects and dominant voices within groups can suppress minority views. There is a risk that participants might not be willing to share negative experiences of a healthcare system on which they are dependent especially in setting where they are recruited by the hospital itself. These restrictions were alleviated by explicit facilitation techniques such as by making an explicit

invitation to disagree and use of indirect prompts (e.g., "Some people have reported to us that they felt that their doctor does not have time to see them - has anyone ever had a similar experience?").

Participants

The study eligibility criteria included adults aged 18 years and above who had at least one outpatient or primary care visit to the study hospital within the last 12 months. The participants were excluded to participate in case they had communication problems that could not allow them to participate fully in group discussion. Purposive sampling was also employed so that there was a variety of demographics and healthcare settings such as gender, age, type of condition and urban/peri-urban residence. Contacts with the participants were made through outpatient waiting areas and those interested were informed about the study both orally and in writing. Informed consent was obtained prior to every focus group session through a written consent and verbal consent among the participants with low literacy levels was documented.

Data Collection

A semi-structured topic guide was developed based on the following research question: How do patients psychologically differentiate between feeling heard and feeling treated in healthcare encounters? The guide was written in English and two independent translators translated the guide into kashmiri and urdu and then was back-translated to ensure semantic equivalence. The guide was based on: the general impressions that patients had of their clinical experiences; what they considered to be significant or dissatisfying about their interaction with providers; whether they believed their concerns were acknowledged and what they thought good care would mean to them personally. Interviewees were encouraged to express themselves freely using a language that they were comfortable with.

A total of four focus group sessions were conducted within the hospital, each with a duration of around 60 to 75 minutes. One researcher facilitated the sessions, and the second one was the observer and a note-taker. All the sessions were recorded on audio with the consent of the participants and transcribed subsequently. The transcripts were also included with non-verbal behaviour as observed by the observer (e.g., laughter, hesitation, gestures).

Data Analysis

Thematic content analysis was used to analyse transcripts based on the approach outlined by Anderson (2007). The transcripts were reviewed by two analysts who coded them line-by-line to extract meaningful text units. The shared coding framework was created after the initial focus group and was enhanced in the framework of the following groups. Inter-rater reliability was addressed through a discussion and a negotiation between coders instead of the calculation of a kappa statistic because the aim of the analysis was interpretive richness and not reproducibility. The data saturation was regarded as reached when no new themes were formed in the course of the final focus group. Quotations were chosen to exemplify each theme and sub-theme and were translated into English keeping the emotional register of the original utterance.

Ethical Approval

The study hospital has an Institutional Review Board that provided ethical approval before data was collected. The research was done in compliance with the principles of the Declaration of Helsinki.

All information regarding participants was eliminated in transcripts, and the information was kept in encrypted institutional servers. No incentives were offered for participation.

Results

Sample Characteristics

A total of 28 patients participated across four focus groups. Participants ranged in age from 22 to 74 years (mean age 46.3, SD 14.7). There were 16 female and 12 male participants. Conditions represented included hypertension, diabetes, musculoskeletal complaints, anxiety, respiratory conditions and general acute illness. Most participants had attended multiple appointments with the same or different providers over the previous year. Approximately two-thirds of participants had been seen in general outpatient or internal medicine departments; the remainder were drawn from specialist clinics for chronic disease management.

Themes on the Distinction Between Feeling Heard and Feeling Treated

Thematic analysis identified three core sub-themes from the focus group discussions: (i) active listening, emotional acknowledgement and the construction of psychological safety; (ii) power asymmetry, clinical efficiency and the erosion of patient involvement; and (iii) trust as a psychological bridge between relational experience and treatment engagement. These sub-themes together describe the cognitive, emotional and behavioural mechanisms through which the experience of being heard shapes patients' engagement with care.

Sub-theme 1: Active Listening, Emotional Acknowledgement and Psychological Safety

Across all four focus groups, the quality of listening like its depth, attentiveness and emotional responsiveness was the most frequently raised dimension of what made a clinical encounter feel meaningful. Participants were able to describe, often with considerable precision, the felt difference between being heard and being processed. This distinction was not abstract: it was grounded in specific, recalled behaviours.

When providers made sustained eye contact, leaned in, asked follow-up questions and reflected back what had been shared, participants reported feeling respected and seen as whole persons rather than as presenting complaints. Crucially, these experiences were described as producing a qualitative shift in participants' psychological state during the encounter including a reduction in vigilance, an increased willingness to disclose and a sense of being safe to say more:

> *"She didn't just write things down. She actually looked at me and said, 'That sounds really hard.' I didn't expect that. It changed the whole visit for me. After that I told her things I hadn't planned to say."*
>
> *(Participant 7, Group 2, female)*

This account illustrates the mechanism proposed in our conceptual model: emotional acknowledgement produced a state in which the patient felt safe enough to expand her disclosure beyond what she had initially intended. The cognitive appraisal underlying this shift appeared to be: this person is receiving me; therefore, it is safe to show more of myself. This is consistent with Edmondson's (1999) formulation of psychological safety as a perception of the interpersonal climate rather than a stable personality trait.

Several participants made a distinction between a provider who listened to their words and one who appeared to listen to their meaning. The latter involved a quality of attention they found both rare and highly valued, a capacity to receive not just the content of what was said but its emotional significance:

> *"He heard what I said but he didn't hear what I meant. I kept saying I was tired all the time and he kept going back to the blood results. I felt like I was talking to the wall."*
>
> *(Participant 14, Group 3, male)*

This distinction between surface listening and deeper acknowledgement corresponds to what Hojat et al. (2013) describe as the cognitive dimension of empathy, demonstrating understanding of the patient's concerns in a way that is communicated back. In the Kashmir clinical context, this dimension of listening is particularly significant. Patients enter consultations with the cultural expectation that the physician will take charge, diagnose and prescribe; the experience of being invited to express meaning rather than symptoms is therefore a deviation from the script and one that participants consistently identified as the most meaningful aspect of a good encounter.

Non-verbal signals were also prominently discussed. Providers checking computer screens, facing away or appearing rushed conveyed to patients that their presence was an interruption rather than a meeting. In the study setting, these experiences were often compounded by the physical layout of consultation rooms, in which the physician's desk faces a wall-mounted computer screen, structurally orienting them away from the patient:

> *"When the doctor is looking at the screen the whole time, you start to edit yourself. You think, okay, just say the important thing and go."*
>
> *(Participant 22, Group 4)*

This phenomenon which is the self-censoring of concerns in the presence of an inattentive provider has direct implications for care quality. Stewart (1995) found that in a substantial number of consultations patients did not voice their primary concern at all. The present data suggest that attentiveness, or its absence, is a key determinant of this pattern and that its effects are compounded in high-volume public healthcare settings where patients already feel they are taking up the physician's time.

Sub-theme 2: Power Asymmetry, Clinical Efficiency and the Erosion of Patient Involvement

The second sub-theme emerged around participants' experience of the consultation as a structured event over which they had little agency. Many participants described arriving at appointments with questions they had prepared, only to find that the consultation was structured entirely around the provider's agenda. This experience of consultation as a physician-controlled process is deeply rooted in the hierarchical dynamics of South Asian healthcare where the physician's authority is not merely professional but carries moral and social weight (Qidwai et al., 2010; Bhattacharyya et al., 2020).

Several participants described an active sense of exclusion: the feeling that a decision had been reached before they had finished explaining themselves. This was experienced as disrespectful and, in some cases, as unsafe:

"By the time I had explained the context, she was already writing the prescription. I thought, have you even heard what I said? I went home feeling like it didn't matter what I thought."

(Participant 3, Group 1, male)

Behaviourally, this experience produced the outcome the conceptual model predicts: a decoupling of the clinical interaction from the patient's own sense of agency and therefore from their motivation to engage with the treatment plan. The emotional process here is one of invalidation, the appraisal that one's contribution to one's own care is unwanted, which produces not active resistance but passive disengagement.

Participants drew a clear psychological distinction between a provider who explained their reasoning and one who simply issued instructions. Explanation was associated with respect and with the experience of being considered a capable adult. The absence of explanation left participants feeling that their understanding was neither valued nor expected:

"I don't mind when the doctor says this is what we're going to do. But I need to understand why. When they don't tell you, it feels like they're the expert and you're just the body."

(Participant 18, Group 3, female)

This resonates with research on shared decision-making and with Elwyn et al.'s (2012) three-step model which positions the exploration of patient preferences as fundamental to respectful and effective care. In the South Asian context, full shared decision-making is often structurally impossible within the available consultation time but participants' accounts suggest that the minimal act of explaining clinical reasoning without inviting debate can significantly change the psychological experience of the encounter.

A dimension of power asymmetry specific to female participants in this setting concerned the expectation that they would attend consultations accompanied by a male family member who would speak on their behalf. Several participants described encounters in which the provider addressed questions and explanations to the accompanying male relative rather than to the patient herself:

"My husband was there and the doctor kept telling him what I should do, what I should eat, what I should take. I was sitting right there. I felt invisible."

(Participant 19, Group 3, female)

This gendered dynamic represents a structural barrier to feeling heard that operates independently of individual provider communication styles. It is embedded in the social expectations of the clinical setting and reflects broader patterns of female marginalisation in public life in this region (Bhatia & Cleland, 1995). Addressing it requires not only individual level communication training but institutional attention to the norms that structure who is expected to speak in clinical encounters.

Sub-theme 3: Trust as a Psychological Bridge

The third sub-theme concerned the role of trust in shaping how patients integrated the emotional and clinical dimensions of their care. Trust emerged not as something patients brought to appointments but as something actively constructed and sometimes damaged within the consultation itself. The pathway from feeling heard to accepting and following through on treatment was, in participants' accounts, mediated by this relational trust, consistent with the conceptual model.

When participants felt that their concerns had been genuinely understood, they described a greater willingness to accept the provider's clinical judgement, even where uncertainty remained. The emotional experience of the consultation appeared to modulate the cognitive process of accepting advice:

> *"After she actually listened to everything I was worried about, I felt like, okay, I trust what she's telling me. If she hadn't taken the time, I probably would have gone home and looked it all up online and scared myself."*
>
> *(Participant 26, Group 4, female)*

The cognitive mechanism here is significant: feeling heard reduced the patient's need for independent verification, not by suppressing doubt but by providing a relational foundation that made the provider's judgement trustworthy. This is consistent with Street et al.'s (2013) conceptual model identifying trust as a key proximal outcome of positive clinical communication that then predicts treatment-relevant behaviour.

Participants also described how breaches of relational trust affected their subsequent behaviour. The most significant behavioural outcome was not formal complaint or expressed dissatisfaction but quiet withdrawal from the healthcare system:

> *"After that appointment, I didn't bother going back. What was the point? He'd already made up his mind before I walked in. I just dealt with it myself."*
>
> *(Participant 11, Group 2, male)*

In the Indian public healthcare context, this withdrawal has a specific cultural dimension. Patients who lose trust in a public facility do not simply seek care elsewhere; many access informal practitioners, traditional healers or over-the-counter pharmacy consultations instead, particularly in peri-urban areas where private specialist care is unaffordable (Jeffery, 1988; Balarajan et al., 2011). The cost of relational failure in public healthcare is therefore not simply a matter of patient dissatisfaction but of diversion to care pathways that may be less safe and less effective.

Trust was also discussed in relation to continuity of care, which is structurally fragile in the study setting. Participants who had been seen by a consistent provider described this as foundational to feeling safe enough to be honest. Those seen by different clinicians on successive visits described having to invest the entire consultation in providing background, leaving no time for the actual concern that had brought them:

> *"When you see someone new every time, you spend the whole appointment giving the background. By the time you've explained everything, the appointment is over and you haven't even got to what you came for."*
>
> *(Participant 5, Group 1, female)*

Discussion

Summary of Findings and Conceptual Contributions

This paper aimed to gain an insight into how patients in Kashmir general healthcare setting psychologically differentiate between being heard and being treated and to base this differentiation on a conceptual framework. The three sub-themes identified, active listening and psychological safety, power asymmetry and the erosion of involvement and the mediating bridge of trust are a

consistent psychological pathway through which communicative experience is converted to health-relevant behaviour.

The proposed conceptual model of this study builds on the existing frameworks in two significant aspects. First, it identifies the psychological processes perceived attentional focus, emotional validation, cognitive confirmation, by which communication behaviours create the sense of being heard, and goes beyond descriptive to interpretive explanation. Second, it situates this pathway explicitly within a structural context: the power asymmetries, resource constraints and cultural hierarchies that characterise Kashmir public healthcare modify each step of the model. Being heard here is not merely an issue of provider disposition but rather, a negotiated effort to create a clinical space that is structurally neglectful of relational interaction and in favour of efficiency and authority.

The finding that active listening leads to psychological safety and that this safety leads to more complete disclosure resonates with previous research by Stewart (1995) and provides specificity to the process. Patients participating in this study reported a qualitative change in their internal state when they felt received which then allowed them to take communicative risks: to express concerns that they could not have brought up otherwise, to express skepticism about a suggested treatment, to note non-adherence to a prior prescription. All these revelations are clinically relevant; all of them habitually concealed during situations when patients do not feel secure.

The efficacy vs involvement sub-theme has a gendered aspect added, which is a contribution peculiar to this cultural situation and is not covered in the existing body of patient experience literature which relies mainly on Western, individualistic healthcare environments. The systematic diversion of clinical communication to the male relatives of the family, as opposed to the female patients, is a kind of structural non-hearing which is not dependant on the individual provider behaviour but must be addressed at the institutional level.

Clinical and Policy Implications

The results imply various practical recommendations to clinical practice and healthcare policy in Kashmir contexts. On the side of the individual provider, the fact that active listening and emotional recognition consistently remain important determinants of patient value implies that even minor behavioural changes such as maintaining eye contact, expressly recognizing an issue and transitioning to clinical evaluation, shifting communication towards the patient instead of the family members, can have a tremendous impact on patient experience. These behaviours can be taught and no extra consultation time is needed.

On the institutional level, the gendered relations revealed in the current study imply that there should be a clear instruction to clinical staff members regarding patient directed communication. Environmental barrier that can be modified through physical layout of consultation rooms, i.e., shared rooms, is an environmental barrier that has not been adequately addressed in quality improvement efforts in this area.

The implication of the model that the failure of trust results in silent disengagement instead of expressed dissatisfaction has significant implications to quality monitoring. Expressly dissatisfaction based patient satisfaction surveys, which measure the overlays of expressed dissatisfaction, are likely to grossly underestimate the relational burden of bad communicative care. Monitoring engagement behaviours such as appointment adherence, prescription uptake, and

follow-up attendance can serve as a proxy of relational trust in healthcare systems aiming to improve outcomes in this regard.

Strengths and Limitations

One of the strengths of this study is that it combines the qualitative data with conceptual model development and offers both empirical and theoretical frameworks. Cultural particularity of the research context is not a weakness, but a contribution: the Kashmir public healthcare environment sheds light on the mechanisms, especially the meaning of power and gender, which remain unseen in the literature that has been done in high resource environments of the West.

The sample was selected because it consisted of adults who were able and willing to take part in group discussions in a hospital, which might not be the entire spectrum of patient views. The least represented may be patients with lower health literacyand most economically marginalised patients. The format of the focus group might have silenced the voices of dissent, especially concerning criticism of a hospital where the participants continued to be treated. The use of facilitation strategies aimed at reducing social desirability was put in place and cannot completely counter this.

Like any other qualitative study, the results are not to be statistically generalizable but conceptually transferable. The identified themes align with the patterns reported in the literature on the general patient experience and the conceptual framework that they represent is suggested to be used as the foundation of further empirical testing instead of an established framework.

Conclusions

In this study, patients were consistently and clearly distinguished about being heard and treated. It is not a difference of preference or sense; it reflects underlying psychological processes and has noticeable behavioural consequences, shaping how patients engage with care, the extent to which they disclose concerns, and their adherence to treatment. The conceptual model proposed which shows the pathway of feeling heard (through psychological safety and relational trust) to treatment participation and health outcomes which can be used to understand such processes, as it can also be used to plan interventions to reduce them.

In the South Asian scenario of healthcare, this relational dimensions of the care is operating within a context of power, constraint and cultural hierarchy that cannot be disconnected of the personal experience of a clinical encounter. Filling the gap that is between being heard and being treated in this case is not only a question of personal communication skills training but the institutional recognition of the structural conditions under which large numbers of patients and some of them virtually impossible can be heard.

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