MEDICAL HUMANITIES: CAN POETRY AND THE ARTS MAKE BETTER DOCTORS? TAIWAN PRESENTATION

SLIDE 1: TITLE: Hello, everyone. More than a half century ago, my husband and I spent a year traveling in Asia, including 3 weeks in Taiwan. For one of those weeks we stayed in a Ch'an monastery and we will never forget the hospitality and kindness of the monks, as well as the delicious food they shared with us.

I'd like to thank Anna and Peggy for extending this invitation to me; and my thanks as well to Yassmin for her help in coordinating. It is an honor to be speaking with you this evening (well, evening for me; late morning for you) and I so look forward to exchanging ideas with you all.

SLIDE 2: OVERVIEW. My formal presentation is divided into 4 parts – a brief overview of medical humanities followed by a deeper dive into narrative medicine and narrative listening. I'll then present a summary of the MH programs at UCI and conclude with highlighting obstacles to teaching medical humanities as well as possible solutions. Following this lecture, you'll have a chance to break into small groups and talk amongst yourselves, addressing either one or more of these questions or your own thoughts. We'll wrap up with 15 or 20 minutes of a large group Q&A

SLIDE 3: WHAT IS MEDICAL HUMANITIES? I know from Yassmin that we have a diverse group of participants in this session, which is wonderful. Some of you are medical humanists, some social scientists, and some academic physicians. To make sure we are all on the same page, I'm going to start with some definitions.

MH is a big umbrella and there are many definitions of Medical Humanities. This is my definition: MH engages various humanities, arts, and social sciences to study a range of issues related to health and illness. To do so MH invites critical thinking and emotional engagement around topics such as:

- **Patients' illness experiences**
- **The doctor-patient relationship**
- **Physician self-care**
- **Social determinants of disease/ how social justice and equity concerns intersect with medicine**

SLIDE 4: TWO WAYS OF KNOWING One way of approaching an understanding of MH is through epistemology, contemplating the nature of knowledge. I am not a philosopher, so to the philosophers out there, I apologize. Nevertheless, although this is a vast oversimplification, it is possible to think about two primary ways of knowing: logico-scientific and narrative. Both are valuable, one is not better than the other, but they have different purposes and uses.

SLIDE 5: LOGICO-SCIENTIFIC KNOWLEDGE is based on: Objectivity; Replicable procedures; Universal rules and Generalizability; and results in a Biophysical understanding of disease

SLIDE 6: ANATOMY – logico-scientific knowledge looks like this

SLIDE 7: NARRATIVE KNOWLEDGE derives from the assumption that Realities are socially constructed through language, stories and images; that Multiple truths exist; Narrative knowledge prioritizes

storytelling across multiple humanities, arts, and social science modalities; and produces a Biopsychosocial/cultural/structural understanding of illness

SLIDE 8: ANATOMY LESSON – narrative knowledge looks like this (READ POEM)

SLIDE 9: WHAT IS TRUER THAN THE TRUTH? - Narrative knowledge may be understood through this old folk saying: It implies that there are deeper truths that mere facts cannot always access, that are only discoverable through storytelling.

SLIDE 10: TRUTHS FROM THE MEDICAL HUMANITIES – They remind us to

- **Pay close attention to the richness, particularity, and nuance of patients**
- **Acknowledge the important role that creativity and imagination play in medicine**
- **Maintain empathy for multiple perspectives in patient care**
- **Not to be afraid of emotional connection and engagement with patients**
- **Place patients in the structural context of their lives**

PAUSE FOR QUESTIONS

SLIDE 11: NARRATIVE MEDICINE Now I'd like to turn to the topic of Narrative Medicine, a subject that my own work focuses on, and specifically the concept of Narrative Listening.

Narrative medicine is the ability to critically understand and be moved by the patient's story - Rita Charon, M.D., Ph.D., the founder of the narrative medicine movement in the US

One of principle tenets of narrative medicine is Listening to the Patient's Story. When doctors listen deeply to their patients' stories, they are better able to build trust and better meet their needs.

<u>But there are Different Ways of Listening</u>

- **Listening medically – identifying the signs, symptoms, and information to make the differential diagnosis**
- **Listening narratively – hearing the patient's "history of present illness" as a story, with the same interest as you might read a novel or a play**
    - **Drama, comedy, tragedy**
    - **Character, plot, beginning and ending**

SLIDE 12: LISTENING *WITH,* AS WELL AS *TO* THE PATIENT'S STORY

- **Listening *to* the patient's story – Instrumental; Acts upon the patient; Is driven by the physician's agenda; it exacts information the doctor considers relevant and discards the rest**
- **Listening *with* the patient's story – Mutuality; Collaboration; Being present with, accompanying the patient through the particular narrative of their HPI**

SLIDE 13: A STORY DOESN'T HAVE TO TAKE A LONG TIME – Physicians often say they don't have time to listen narratively; and it is true that time is always something doctors never have enough of.

Nevertheless, narrative listening is best understood as an attitude of mind and heart rather than a time-intensive process.

To illustrate this, I'd point out that Stories aren't necessarily novels.

Here is an oft-cited example of a 6 word story attributed, probably apocryphally, to Ernest Hemingway: For sale. Baby shoes. Never worn.

If doctors are really listening, people can tell them stories in a single sentence –

SLIDE 14: WHY LISTEN NARRATIVELY?

- **When you listen narratively, you are able to:**
    - **Understand more deeply why the patient is telling the story**
    - **Develop emotional connection with the patient**
    - **Appreciate the whole person of the patient**
    - **Create the possibility of helping the patient construct a better story**

SLIDE 15 – HELPING PEOPLE CONSTRUCT BETTER STORIES

Helping people construct new and hopefully better narratives might sound presumptuous, and it is an idea that always must be approached with a great deal of care and humility.

Often it is enough just to listen or to witness another's story – just by sharing their story, people themselves sometimes begin to edit and revise their story in more congruent and healthy directions. Sometimes a patient with Type II diabetes will tell her story, listen to the telling, and conclude I need to make some changes. Help me figure out how!

^CLICK But according to the ethicist Jodi Halpern, the definition of clinical empathy is that, while deeply grasping another's story, the physician may sometimes glimpse elements of a "better" story.

^CLICK What do I mean by "better?" A story that…

Makes more sense for the person given their medical and social circumstances; provides more meaning; gives more hope.

Think about this story: "Insulin will cause me to go blind" – a caring doctor can hear this story, respect its logic, but gently offer a more accurate and hopeful narrative.

Or think about this story: "Maybe a Phase One trial will cure my stage 4 metastatic pancreatic cancer." After listening to the person's hopes, fears and longings, the physician can help them find a story that allows for the possibility of dying while also contemplating how the life remaining to them can best be lived.

SLIDE 16 WAYS OF HELPING PEOPLE CREATE NEW STORIES Narrative co-construction involves a process of shared imagining, in the words of my colleague emergency medicine physician Dr. Megan Osborn, "dreaming together" – in effect, it is saying to that ill person, "Given where you are, what can we envision for you in the future? What might this look like? How can we make this happen?"

In narrative listening, the physician views herself not as the author of the story (a very physician-centric approach) but as a collaborator or co-editor (more person-centered), facilitating the ill person's exploration of their own values and priorities; and helping that person choose a story line that best supports what lies closest to those core beliefs, principles, and desires.

Further, in attempting to help another create a better story, the physician must also recognize their own story and how it intersects with that of the person seeking care. Do the characters, plot, or theme trigger responses in the physician that might limit optimal co-construction? For example, if the person telling the story tells it in ways that make the physician feel "this person does not care about their health," then the physician's frustration or judgment, perhaps emerging out of their own personal narratives, may get in the way of assisting the ill person to develop a new story.

SLIDE 17: EVERYTHING IS HELD TOGETHER WITH STORIES - Illness pushes us all toward disintegration and dissolution. It is our stories that can hold us together and bring us back to our lives. If we're lucky, confronted by illness we learn to make new stories on our own. But when we are able to share our stories with physicians who know how to receive them and really hear them, we will be more likely to construct better, more satisfying, and meaningful stories.

PAUSE FOR QUESTIONS

SLIDE 19 MEDICAL HUMANITIES AT UCI: I'm now going to switch gears and present a summaryof medical humanities courses, course components, and activities at UC Irvine. For clarity, we have an undergraduate/graduate campus and also a medical school. We have worked hard to develop curriculum and programming on both campuses and to try to build collaboration when possible.

On the main campus (undergrads and graduate students) we have created an undergraduate medical humanities minor and a graduate student medical humanities emphasis, We have also established a Center for Medical Humanities, which provides seed money for faculty and graduate student research, Finally, we have a campus club, Healing through Humanities, whose members are pre=medical and pre-health professional students with an interest in arts and humanities. They meet monthly for readings and discussion, and do an annual project. This past year their project involved collecting life histories from people in a retirement community and people in a community-based hospice program.

SLIDE 20 SCHOOL OF MEDICINE MH ELECTIVES; literature and medicine; art and medicine; improvisational theater; history of medicine; Art of Doctoring

SLIDE 21 SCHOOL OF MEDICINE REQUIRED CURICULAR COMPONENTS – Kindness/Mindful Medicine curriculum; Clerkships – Family, Peds, Internal Medicine; clerkship curriculum emphasizes reflection, artmaking and storytelling

SLIDE 22 – SOM OTHER MH ACTIVITIESStudent humanities-based research – summer stipends and 4th year elective

Special events – Symposia (Poetry of Hope and Healing); Medical Student Art Exhibit; Theatrical performances

SLIDE 23 – SOM AND CAMPUS: LITERARY AND ARTS STUDENT-RUN JOURNALS; Plexus and The Scribe; this past year's themes: Emergence and Resilience

PAUSE FOR QUESTIONS

SLIDE 24 – INSTITUTIONAL OBSTACLES

Lack of leadership/administration understanding of MH – educate, engage; prestige programs

Resistance to providing curricular time – recruit powerful allies who can advocate for your cause

Demand for empirical research to justify support – educate about qualitative research, portfolios; document use of such evaluative processes at other prestigious institutions

Lack of funding – find funding; donors

SLIDE 25 OBSTACLES COLLEAGUES

Lack of understanding – educate, faculty development; enlist as ally; co-teach

Collaboration (or its absence) – MDs can feel humanists are saying to them, "You're not a nice person"; PhDs can feel like strangers in a strange land; immersion; radical understanding of other's point of view; share joint project

SLIDE 26 OBSTACLES STUDENTS

Waste of time – not why I came to medical school; acknowledge; connect with core values (why *did* you come? – show how humanities can get them back there)

No immediate value – acknowledge, empathize (working so hard, why spend time that has no immediate payoff?); suggest humanities can have some immediate benefits in terms of handling difficult patient interactions, connecting to patients, enhancing their own wellbeing through writing, art, maskmaking

I'm not a poet, artist, actor – normalize; none of us is; but there's still benefit to be gained

I feel vulnerable – support; reframe – sometimes there's value in taking risks; offer alternatives – write on a less personal topic

Slide 27 OBSTACLES SELF

Loss of professional identity – This is something a lot of humanists in medicine worry about; expand your horizons, learn new ways of thinking, but stay connected to your roots; through professional organizations; make your own hybrid identity

Imposter syndrome – am I really doing any good? Making a difference?;reaffirm your value through professional presentations and publishing; don't overlook positive feedback; ultimately trust yourself

Discouragement – humanities in medicine can be a lonely road; seek support from colleagues both in and outside of humanities; find healing in – the arts and literature!

SLIDE 28 – QUOTE FROM STANFORD PRESIDENT