HINSDALE * BEHAVIORAL SCIENCE 20TH FORUM

CURLING UP WITH A GOOD BOOK: USES OF LITERATURE IN BEHAVIORAL SCIENCE TRAINING

(INTRO SLIDE WHILE PEOPLE COMING IN) "The patient's story will come to you, like hunger, like thirst" John Stone, M.D., cardiologist, poet

"Through my patients' stories, I learn how and why people suffer, and why they heal" Harriet Squier, M.D., internist

"More stories, less theory!" Robert Coles, M.D. Harvard psychiatrist

I. INTRODUCTION: J & P (5 minutes) (SLIDE)

A. Introduce self— apologize Pat not here ; outline of workshop show of hands - us, ng literature ?

1. Initial overhead testimonials from physicians to the importance of stories in medicine

2. By end of session, hope to have convinced you that literature is one effective way for learning about stories learning to listen to patients s

B. Read poem - Invisible Woman (SLIDE)

1.Introduction: Encapsulates what can be accomplished through the use of literature in behavioral science training

what is poem about ? 2. Poem analysis

a. One level - portrait of delusional, possibly schizophrenic, mental pt.

b. Another level, raises questions about who is insane, and what is sanity

c. Third, gives us - readers - access to mind of patient

d. Finally, explores nature of dr/pt relationship

e. Highlights some of its reciprocal aspects not always obvious to physicians - in - training

C. Goals and objectives of presentation

1. Overall: To familiarize participants with possible uses of literature in behavioral science training

2. Specific (SLIDE): Participants will

a. Become familiar and understand the theoretical basis for using literature as a teaching tool

b. Receive actual literary sources and become familiar with their use in teaching

c. Learn how to structure a successful integration of literature into behavioral science teaching

HANDOUTS

II. WHAT IS THE GOAL OF USING LITERATURE IN BEHAVIORAL SCIENCE TRAINING? (II-V 15 minutes) (SLIDE)

A. To increase understanding of the doctor-patient relationship and the patient's illness experience

B. Thereby increase physician empathy, reduce physician frustration, improve doctor-patient communication, and develop new patient management and interaction strategies

C. Literature emphasizes the importance of listening to patient stories

III. WHY STORIES? (SLIDE)

A. Human beings do not think in terms of differential diagnoses or organ systems

B. Rather, think narratively

1. Narrative is the paradigmatic mode for how experience is shared

2. In their accounts of events, patient stories have chronology, plot, characters, tone, climax, a moral lesson

C. Illness is disruption of one's expected life narrative

1. Patient must incorporate series of losses

2. Must reimagine a different narrative

D. Stories try to make sense from, and find meaning in, the chaos and incoherence of illness

E. Healing power of stories

1. Symbolic healing (Brody)

a. Telling story way of gaining mastery or control over events

b. Knowing s/he has been heard empowers patient

2. Actual healing (Pennebaker)

a. Studies of traumatic events show writing improves outcome

IV. WHY FICTION? (SLIDE)

A. Granted that stories may be important to listen to, but why pay attention to invented, "fake" stories; Why not just listen to patients?

B. Literature should be regarded as a transitional object

1. In this sense, not an end in itself

2. A learning tool to move us closer to better patient care

3. Simpler to deal with than real life - successive approx. of reality

C. Safety of literature

1. No direct clinical responsibility for fictional characters (although we may feel we do)

2. Allows room to safely examine difficult emotions

3. Also allows reader to playfully speculate on different responses

4. Stein's playpen effect

D. Literature as craft

1. Good writing - much easier to detect elements of the story:

a. Plot, climax, denouement

b. Tone, point of view, use of language (images, metaphors), character development

2. Good writing can identify patterns and themes more easily

~~3. Good story also mobilizes our imagination more easily (easier to become engaged~~

E. Narrative knowledge in literature

1. Contrast to logico-scientific knowledge

a. Emphasizes generality, rather than particular

b. Relies on hypothetico-deductive reasoning

2. Limits of logico-scientific knowledge: Sacks (SLIDE): biomedical accounts "tell us nothing about the individual and his history; they convey nothing of the person, and the experience of the person, as he faces, and struggles to survive, his disease... To restore the human subject at the center... we must deepen a case history to a narrative or tale..."

3. Narrative knowledge allows us (SLIDE) "...to understand and be moved by the meanings of singular stories about individual human beings" (Charon)

3. Hints at universal truths through examination of the particular

V. EIGHT-FOLD PATH THROUGH LITERATURE (SLIDE)

A. The Buddha's eight-fold path was intended to free its followers from the ~~kharmic wheel~~ Samsara of suffering; the path of literature helps us understand and compassionately respond to the suffering of others (and self)

B. Literature can help us develop as persons and professionals in the following eight ways: (SLIDE)

1. Creative imagination – so we can see others' reality, understand their suffering

2. Perspectival vision – so we can see other people's point of view: how does someone else experience the events they describe? How does this view differ from the views of other people being described? From our own?

3. Sensitivity to language, tone, repetitions, omissions, inclusions - helps in recognizing ambiguities, interpreting signs and cues, forming conclusions from incomplete data, and understanding hidden meanings

4. Capacity to be fully present, to give full attention – bearing witness

5. Emotional engagement – the risk of moving closer to, rather than farther from, the patient; as Anatole Broyard put it, the risk of not feeling anything is sometimes greater than the risk of feeling something

6. Sense of mystery – literature gives us some sense of the depth and complexity of experience, so that we can see the mystery rather than simply the puzzle of experience; helps us to retain our sense of awe

7. Whole person understanding – the ability to place patients within the context of their life-story and personal values

8. Reflection on experience – the ability to make sense of and draw lessons from events that have occurred

VI. LITERATURE IN BEHAVIORAL SCIENCE (5 minutes)

A. Overview of three year behavioral science curriculum (3 SLIDES)

1. Family physician - clinical management

2. Psychiatrist perspective

3. Expert - domestic violence, substance abuse etc.

4. Last session is literature

B. Description of specific content modules (SLIDE)

C. Modules completed (eating disorders, alcoholism, geriatrics, sexuality, stress in residency, difficult patients, doctor-patient relationship

VII. STRUCTURE and TEACHING METHODS: VIDEO EXAMPLES
(video segments, 30 minutes)

A. Overview of structure: (SLIDE)

1. Time – 45 minutes of noon conference
2. Frequency – once a month
3. Readings –
   a. Brief so can be read on site
   b. "Kindergarten" read-to format
   c. Rotational reading
   d. Multimodal format (poetry, role-play, round-robin read)
4. Number – 3-4
5. Authors-
   a. Physician authors (credibility issue)
   b. Patients
   c. Prize-winning authors

oral reading - communal tradition
speaking w/voice of pt.
contemporary writing

B. Teaching Methods (SLIDE)

1. Open-ended discussion questions (PACKET)
2. Start with basic orientation questions (what's happening; point of view, speaker; tone)
3. Summary of message(s); and reaction to message
4. Encouragement of different opinions (does anyone see it differently?; what would selection be like from different point of view?)
5. Expression of feelings (how does narrator feel?; how do you feel about narrator, other characters?; how would you feel about being this person's physician?)

use Invisible Woman as example

① **STRESS-IN-RESIDENCY VIDEO** – Read poem
   a. What's going on? (sarcasm, semi-guilty, fun)
   b. Tone - satiric
   c. Who is Audience - civilians
   d. Personalizing - judgment re choices; distancing response
   e. Interpretation (J) - pain beneath humor
   f. Resident Disclosure - live like squirrels
   g. Interpretation (resident) - cry for help
   h. Theme - need to be perfect - fear of asking for help

② Eating Disorders
Do Roleplay first
5 ♀ ♂

6. Take-home message for clinical practice (ideas about doctor-patient interaction, patient management) - **CROSS-CULTURAL VIDEO**
   a. Pat - missed appointment
   b. Fast forward to resident story
   c. Main point - resident reflects on his empathy and understanding of both patient and resident pts of view
~~7. **Eating disorders (role-play + group discussion)**~~

C. Role of facilitator

1. Establish ground rules
   a. No right or wrong answers
   b. Encourage differences of opinion
   c. Opportunity to explore emotional responses
2. Create open, nonjudgmental atmosphere

3. Express positive regard and respect for all opinions
4. Stimulate discussion
5. Provide interpretation
6. Self-disclosure
7. Link to clinical experience
8. Encourage playful speculation (Balint); imagination

D. Special problems

1. Group will not participate -
   a. 5 second pause;
   b. Reframing question;
   c. Asking specific person;
   d. Modeling
2. Group criticism
   a. Literary selection is not relevant to residents' experience (doctors don't make housecalls any more)
   b. Message of literature is not relevant (we've learned to deal with difficult patients; most ethnic patients don't hold cross-cultural health beliefs)
   c. Literature is not aesthetic (literary criticism)
   d. Selection is not saying what facilitator says it's saying (poem written from physician pov isn't cold and detached)
   e. Author is not credible (never practiced, homosexual)

VIII. ROLE-PLAY (20 minutes) 11:20 a.m.

(2) A. Difficult patient – Doc in a Box (read as role-play)

1. What's going on?
2. What did it feel like to be Dr. Webb; wife?
3. What's point of view? Why is that important? (suppose story told from pov of husband; of wife?)
4. What is tone?
5. How did you feel about Dr. Webb; about wife; about patient?
6. What would be other ways to approach this situation?

(1) B. Difficult patient - Conversion poem (read and discuss)

1. How do the doctors initially feel about patient?
2. How does the family doc feel?
3. How does the transformation occur? What is the hook?
4. How can you look for hooks with other difficult patients?

IX. Q & A (10 minutes) 11:50 a.m.

* FM column announcement
* Stein announcement STFM predoc