NARRATIVE MEDICINE ANTHOLOGY
A COLLECTION FROM THE PERMANENTE JOURNAL
EDITED BY TOM JANISSE, MD, MBA

The Permanente Press
Oakland, California • Portland, Oregon
Myrtle Beach Sunrise by John Davenport, MD — This photograph was taken at the house Dr Davenport and his family have rented each summer for almost 40 years. The modest house offers the serenity Dr Davenport tried to capture here. This photograph was taken with a Canon EOS xTi on July 4, 2010. Dr Davenport is the Director of Primary Care Services for Kaiser Permanente Orange County.

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Published 2016 by The Permanente Press
Oakland, California • Portland, Oregon
The Permanente Press is owned by The Permanente Federation, LLC
Oakland, California

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20 19 18 17 16 1 2 3 4 5

ISBN: 978-0-9770463-4-8
Library of Congress Control Number: 2015938123

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Book design by Lynette Leisure
Printed in the United States of America
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Storytelling in Medicine

As a medical student learning about poetics, first from e. e. cummings, I continued to write through residency, fellowships and medical practice. Early on as a medical editor and publisher I began to see and appreciate the value of story and image in medicine—of people seeking counsel in dialogue with a physician or practitioner, and also for readers of clinical and research articles contextualized in narrative.

These works represent a rich compilation of how story becomes primary in communication and relationship with other people. A section of the *The Permanente Journal (TPJ)* called Narrative Medicine houses particular articles that are primarily narrative in nature.

*TPJ* published these collected pieces in the ten years from 2003 to 2013, in the format of an international, peer-reviewed journal of medical science, social science in medicine, and medical humanities—circulated in print to 25,000 individuals quarterly. In 2015, *TPJ* content on PubMed recorded 1.4 million page views by visitors from 187 countries/territories.

Author biographies on each article’s first page were current at the time of first publication, and although the biographies are often not current, they best represent the time, position, and place from which the work the authors created emanated.

I hope that this compendium offers relevant matter for those interested in story in medicine but also for those who would study the evolution of story in medicine.

Tom Janisse, MD, MBA
Editor and Publisher
The Nature of Narrative Medicine

Lewis Mehl-Madrona, MD, PhD

SPEAKING TO SHARE STORY

"When we speak, we usually speak to others and we speak about something (or about others)—and we do both at the same time, and by use of discursive means (such as lexical devices, syntax, ... and gestures)." In essence, we tell a story—short or long. Our conversations are full of vignettes and tales, as are our diversions and entertainment.

Medicine is no exception. When we physicians speak, we speak to each other, to our patients, to representatives of insurance carriers, to administrators, and even to our own family members. When we practice medicine, we are always speaking about something—a patient, a particular medical problem, a procedure, a drug, our own frustrated emotions. And, we are in constant communication with each other and our patients. We are interacting. We are shaping a world as we go. We are using discursive methods to convince others to do things—patients to stop smoking, insurance carriers to pay, administrators and even to our own family members. We are in constant communication with each other and our patients. We are interacting. We are shaping a world as we go. We are using discursive methods to convince others to do things—patients to stop smoking, insurance carriers to pay, administrators to let us have more time with patients, family members, other physicians interact within the plot of diagnosing and curing the illness. Various saboteurs and adverse circumstances exist to potentially foil the plot and affect the happy ending. The story is enacted in each medical encounter to the extent that time and the doctor’s temperament will allow.

CONSTRUCTING STORY

Kathryn Montgomery Hunter (1991) has written a wonderful book about the narrative structure of medical knowledge. She notes that the ancient craft of physicians and healers involved "... pondering the ways that predispositions and circumstances meshed with the laws of nature in a particular case" and in encouraging the patient toward recovery or midwifing his or her progression toward death. This approach is not unlike that of traditional North American healers, whether the circumstance involves a curse or the breaking of a taboo or a spiritual attack. Healers construct stories that have beginnings, middles, and ends about people with predispositions who encounter circumstances that lead to illness, progressing toward recovery or death. Medicine's fascination with eliminating the person from this process and talking about the "natural history of disease" as if it existed independently of the people who suffer with the disease is part of the reification of the disease process into disease entities that has happened in the 20th century and continues into the 21st. We forget that we are still telling a story when we talk about an organ as much as we are telling a story when we talk about a person. The elements of the narrative remain. The characters differ.

The histories that we physicians take are actually stories told by our patients about their suffering.

Stories have characters who act in space and time within a plot. Stories are ideally performed as is the case for any oral tradition. They are creations or constructions. The histories that we physicians take are actually stories told by our patients about their suffering. The characters (patients, family members, other physicians) interact within the plot of diagnosing and curing the illness. Various saboteurs and adverse circumstances exist to potentially foil the plot and affect the happy ending. The story is enacted in each medical encounter to the extent that time and the doctor’s temperament will allow.

Lewis Mehl-Madrona, MD, PhD, is a family practitioner at the West Winds Primary Health Centre and an Associate Professor of Family Medicine and Psychiatry in the College of Medicine at the University of Saskatchewan in Saskatoon, Canada. Dr Mehl-Madrona provides psychiatric services to the Athabascan Health Authority in Stony Rapids, Saskatchewan, serving Black Lake First Nation and Fond-du-Lac First Nation.
Thinking about Thinking and Emotion: The Metacognitive Approach to the Medical Humanities that Integrates the Humanities with the Basic and Clinical Sciences

ABSTRACT
Medical knowledge in recent decades has grown prodigiously and has outstripped the capacity of the human brain to absorb and understand it all. This burgeoning of knowledge has created a dilemma for medical educators. We can no longer expect students to continue memorizing this large body of increasingly complex knowledge. Instead, our efforts should be redirected at developing in students a competency as flexible thinkers and agile learners so they can adeptly deal with new knowledge, complexity, and uncertainty in a rapidly changing world. Such a competency would entail not only cognitive but also emotional skills essential for the holistic development of their professional identity. This article will argue that metacognition—“thinking about thinking (and emotion)”—offers the most viable path toward developing this competency.

The overwhelming volume of medical knowledge has driven some medical schools to reduce the time allocated in their curricula to the “soft-option” humanities as they tend to consider them an expendable “luxury.” Vanderbilt University School of Medicine, Nashville, TN, has moved away from the traditional conception of the medical humanities as “the arts,” composed of art, music, and literature, toward an approach that integrates the humanities with the basic and clinical sciences, based on metacognition. This metacognitive approach to the humanities, described in this article, has three goals: 1) to develop students as flexible thinkers and agile learners and to provide them with essential cognitive and emotional skills for navigating medical complexity and uncertainty; 2) to elicit in students empathy and tolerance by making them aware of the immense diversity in human cognition (and emotion); and 3) to integrate the humanities with the basic and clinical sciences.

Through this metacognitive approach, students come to understand their patterns of cognition and emotions, and in the group setting, they learn to mindfully calibrate their thinking and emotions. They gain a humbling appreciation of the fallibility of the human mind/brain and how cognitive biases and misperceptions can lead to medical error. They come to appreciate the complex interplay between cognition and emotion, and the importance of cognitive monitoring and emotional regulation.

In the group setting, students also gain a sense of perspective of their thinking patterns and emotions in relation to those of their peers. Perspective taking and mindfulness engender tolerance and empathy, which ultimately serves as a platform for working collaboratively in teams as medical professionals. Students become aware of the social context in which thinking and learning occur, and this further shapes their professional identity. Thinking, learning, and interacting in the group setting ultimately induces a shift from self-preoccupation and an individualistic approach to knowledge toward an appreciation of collective cognition and empathy towards others.

In this article, I describe the metacognitive approach to the medical humanities at Vanderbilt University School of Medicine and how it is designed to develop students as agile learners and flexible thinkers with the mindful capacity for cognitive and emotional monitoring and regulation. Thinking and learning in the group setting of the colloquium ultimately also fosters the student’s professional identity.

INTRODUCTION
In a rapidly changing world of increased complexity, medical educators should direct efforts at developing in students a competency as flexible thinkers and agile learners with the capacity for navigating this complexity and its contingent uncertainties. Such a competency would entail not only cognitive but also emotional skills essential for the holistic development of the students’ professional identity. This article will argue that metacognition—“thinking about thinking (and emotion)”—
The Shared Terrain of Narrative Medicine and Advocacy Journalism

Jon Stewart

In the still uncharted territory of “narrative medicine,” the early conceptual pioneers have planted a number of boundary stakes and flags in attempts to define the width and breadth of the new discipline, in much the way that new medical subspecialties are defined and legitimized. Thus, depending on whom you read or talk to, narrative medicine is about the writing of stories (narratives, actual or fictional) by medical practitioners as a modality to discover and explore the meaning of practice, or to deepen the human dimensions of the patient-physician relationship. Some have defined it from the patient perspective as the therapeutic use of patient-written stories of personal illness.

But the combined practices of medicine and storytelling (or writing) surely has more to offer than personal introspection, however worthy that goal. Whether it fits within anyone’s definition of narrative medicine or not, skillful storytelling about issues of health and illness has always served a powerful public role, especially that of education and persuasion: to move public attitudes and encourage policymakers to action through the presentation of hard, science-based argument wrapped in the soft flesh of real human stories of suffering and triumph.

In other words, the newly discovered terrain of narrative medicine overlaps the even larger province of advocacy journalism. They come together wherever physicians and other health professionals employ the techniques of narrative to move people toward change—be it toward healthier lifestyles (quit smoking), improved delivery systems (system integration), incremental public or private policy reforms (increased Medicare reimbursements, pay-for-performance incentives), or comprehensive system reforms (single-payer or its alternatives). Call it what you will, this territory is the soapbox on which health professionals can project their own uniquely informed and credible voices to advocate for their vision of a healthier world.

A good number of brave-hearted physicians who have ventured into this overlapping territory have left memorable marks on the wider world. The Lancet, the first great medical journal, was founded in 1823 by a London coroner, Thomas Wakley, as a tool for exposing and reforming the despotic and nepotistic organizations running London’s teaching hospitals. He went on to use the journal to great effect in exposing the government’s virtual cover-up of the cholera epidemics of the mid-1800s, causing great consternation among government officials and politicians.1

More recent physician inhabitants of the territory have included such giants of literature as Anton Chekhov and William Carlos Williams, who addressed both the mundane and the horrific medical issues of their time through memorable personal essays motivated more by socio-political than aesthetic concerns. Contemporary physician-writers like Robert Coles, Atul Gawande, Abraham Verghese, and Jerome Groopman, writing in the New Yorker, the New York Review of Books and other mid-to-high-brow consumer magazines, as well as numerous books, have raised the art of advocacy-oriented narrative medicine to the lofty ranks of what’s now popularly known as “literary journalism”—the domain defined by masters like James Agee, John Hershey, John McPhee, Calvin Trillin and Tracy Kidder.

Advocacy-oriented medical journalism has nudged its way even into the sacred pages of the modern professional medical and scientific journals, beginning perhaps with writer-editor Donald Gould’s editorship over the British journals World Medicine and New Scientist in the 1960s. Gould may be credited with having penned the shortest, and certainly most inflammatory, medical commentary in recent history with his article in the normally objective New Scientist on a papal encyclical against artificial contraception in August, 1968: “Bigotry, pedantry, and fanaticism can kill, mame, and agonize those upon whom they are visited just as surely as bombs, pogroms and the gas chamber.
EDITOR INTRODUCTION

Pediatrician, writer, editor, and health policy expert Fitzhugh Mullan, MD, is perhaps best known as the founding editor of (and contributor to) the popular column “Narrative Matters” in the influential health policy journal Health Affairs. For many readers of the journal, the column—which features first-person narratives, or stories, that illuminate often-complex health policy issues—is the first thing to turn to when cracking open a new edition.

When not writing or editing, Dr Mullan is the Murdock Head Professor of Medicine and Health Policy at the George Washington University School of Public Health and a Clinical Professor of Pediatrics at the George Washington University School of Medicine. He is also a member of the medical staff at the Upper Cardozo Community Health Center in Washington, DC.

Following graduation from Harvard University and the University of Chicago Medical School (1968) and an internship at the Jacobi and Lincoln Hospitals in the Bronx, New York, Dr Mullan began a distinguished medical, academic, and administrative career. It has included serving as Director of the National Health Service Corps in Washington, DC; Scholar-in-Residence at the Institute of Medicine; senior medical officer at the National Institutes of Health; Director of the Bureau of Health Professions; and, in 1991, promotion to the rank of Assistant Surgeon General (Rear Admiral). In 1996, he retired from the Public Health Service and joined the staff of Health Affairs, where he continues to edit the “Narrative Matters” section.


NARRATIVE

Jon Stewart (JS): You’ve been involved in health policy and politics right from the beginning of your career. How did you come upon this very personal, narrative approach as a way to discuss something as abstract and academic as health policy?

Fitzhugh Mullan, MD (FM): The first time I thought about it in any conscious way was when I joined the editorial staff of Health Affairs in the latter part of the 1990s and conceived of a column devoted to narrative writing, what we now call the “policy narrative.” I realized then that much of what I had written over a number of years was policy narrative, even if I hadn’t planned to do it. In my second book, especially, Vital Signs: A Young Doctor’s Struggle with Cancer, I was writing about medicine from the other end of the stethoscope, coming from a very personal perspective. So I was a practitioner of the policy narrative long before I’d ever used that word.

A STORY OF UNCOORDINATED CARE

JS: You wrote a wonderful piece in Health Affairs about the death of your father that spoke very eloquently to the issue of uncoordinated care. Can you recap that story and tell us how you came to write it?

FM: Going through what turned out to be a terminal experience with my dad was kind of an eye opener to me in that I lived...
Reflective Writing in the Competency-Based Curriculum at the Cleveland Clinic Lerner College of Medicine

J Harry Isaacson, MD; Renee Salas; Carl Koch; Margaret McKenzie, MD

ABSTRACT
The Cleveland Clinic Lerner College of Medicine of Case Western Reserve University is a five-year medical school where the major emphasis is to train physician investigators. In this article we describe our experience with reflective writing in our competency-based medical school, which has reflective practice as one of the nine core competencies. We outline how we use reflective writing as a way to help students develop their reflective practice skills. Reflective writing opportunities, excerpts of student pieces, and faculty and student perspectives are included. We have experienced the value of reflective writing in medical school education and believe elements of our program can be adapted to other training environments.

INTRODUCTION
The Cleveland Clinic Lerner College of Medicine (CCLCM) of Case Western Reserve University is a five-year program with a major emphasis on the training of physician investigators. First- and second-year students receive basic science and clinical research training that culminates in a master level research thesis completed during years three to five. The medical college opened in July of 2004 and is now in its fourth year of matriculation with the first class to graduate in May of 2009. The class size of 32 allows for intimate learning environments. Students learn the basic science curriculum in seminars and problem-based learning groups. Additionally, students begin their clinical experience early in the first year when they are assigned to a longitudinal outpatient clinic preceptor for a half day every other week during year 1 and weekly during year 2. This is combined with communication skills, physical diagnosis, and clinical correlation sessions. All students participate in seminars and small groups that focus on professionalism, ethics, and other topics relevant to the role of physicians in our society. These seminars occur weekly in the first two years and several times per year in years three to five.

Reflective writing is integrated throughout all five years of the program. Instead of traditional grades, a competency-based portfolio assessment system is used. Students are assigned a “physician advisor” who helps guide them through this process. Funding for the maintenance of the physician advisor program is provided by the medical school because of the commitment to this portfolio form of assessment. Reflective practice—a core of the nine competencies—is defined: Demonstrate habits of analyzing cognitive and affective experiences that result in the identification of learning needs, leading to integration and synthesis of new learning. To this end, writing serves either as a stimulus for further development or a way in which to perform reflective practice.

This article describes our experience with reflective writing. We review here a way to help students develop their reflective practice skills with six writing opportunities (Table 1) and six student examples to demonstrate both the value of writing and that the elements of our program can be adapted to other training environments.

<table>
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<th>Table 1. Reflective writing opportunities</th>
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<td>Portfolios</td>
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<td>Patient journals</td>
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<td>Professionalism seminars</td>
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<tr>
<td>Web logs</td>
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<tr>
<td>Forums for sharing spontaneous pieces</td>
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</tbody>
</table>

J Harry Isaacson, MD, is an Internist and an Associate Professor of Medicine and Director of Clinical Education at the Cleveland Clinic Lerner College of Medicine of Case Western Reserve University in Cleveland, OH.

Renee Salas is a fourth-year medical student at the Cleveland Clinic Lerner College of Medicine of Case Western Reserve University in Cleveland, OH.

Carl Koch is a fourth-year medical student at the Cleveland Clinic Lerner College of Medicine of Case Western Reserve University in Cleveland, OH.

Margaret McKenzie, MD, is an Obstetrician/Gynecologist and an Assistant Professor of Surgery and Chair of the Physician Advisor Council at the Cleveland Clinic Lerner College of Medicine of Case Western Reserve University in Cleveland, OH.
The Power of Reflective Writing: Narrative Medicine and Medical Education

Samir Johna, MD; Ahmed Dehal, MD

Perm J 2013 Fall;17(4):84-85

It was a good reminder that as physicians, we may not always be able to fix patient problems, but we can certainly be loving and supportive. It reminded me that good medicine takes into account the whole person including body, mind, and spirit and not just the sum of its parts.

— A third-year medical student

There is no doubt that medicine is an art and a science. Today, practicing medicine as science is probably much easier than practicing medicine as art, in light of the dazzling advances in medical technology and informatics. Even before technology gained the upper hand, patients were healed by physicians when most of the remedies were useless if not harmful, and when remedies were driven by theories that did not stand the test of time.¹ To some extent, the art of fostering the sacred physician-patient relationship might have played a major role in the dramatic healing process.²

The physician-patient relationship is not limited to a comprehensive history and physical examination, a diagnostic workup, and the final discussion about a plan for action. Medicine requires that the physician establish deep connections by which s/he can dive deep into the crying soul of the patient. Healing an ailment is a complex process that must address two domains: disease, which is the alteration in the biologic structure and/or function of the body; and illness, which is the psychological and social aspect of the ailment.³ Proper healing starts with open communication between physicians and patients. Patients draw on physicians’ attributes of honesty, integrity, empathy, and compassion to share their stories as they strive to heal.⁴

Narrative medicine offers a unique framework to explore and manage the complexity of healing. Its impact extends beyond the physician-patient relationship and into the relationships between physician and self, physician and colleagues, and physician and society. It is no wonder that many medical schools and residency programs have incorporated narrative medicine in the form of reflective writing into their curricula.⁴

Our learners, students and residents, are encouraged to be engaged in reflective writing as they search to understand what medical practice means to them, their patients, their colleagues, and society at large. Learners meet with the first author (SJ) on a regular basis to discuss and analyze their short, open-ended narratives. They are frequently asked to reflect on events of their choice that had a lasting impact on them, negative or positive, at any institution where they rotated. We (SJ and AD) are mesmerized by the insight of the learners and depth of their reflective capacity in their quest for self-identity, ideals, and values as they enter the complex environment of medical practice.

It is only fitting to share some excerpts from learners’ narratives about valuable lessons from rich experiences in which they found themselves deeply immersed.

One learner ruminated over the discrepancy between what we preach and how we act. He described his negative experience tagging along with his attending physician in a busy outpatient clinic. He wrote:

I saw a 45-year-old patient with an advanced hepatocellular carcinoma. He came with his wife to learn about the results of his liver biopsy...
The Physician as Storyteller & Poet: Quick Writes from East Bay Writers’ Workshops

STORY TO STAY ALIVE

An Oregon naturalist, Barry Lopez, wrote in his Native American tale, Crow and Weasel, “The stories people tell have a way of taking care of them. If stories come to you, care for them. And learn to give them away where they are needed. Sometimes a person needs a story more than food to stay alive. That is why we put these stories in each other’s memory. This is how people care for themselves.”

WRITING STORY

In this issue we publish 15 original stories and 2 poems written in 10 minutes with minor edits for clarity by physicians and practitioners at 2 writing workshops in Oakland, CA in 2009 and 2010. The workshops explored the use of reflective writing to support and sustain a satisfying medical career. The prompt was simple: recall a meaningful moment in your practice with a patient or colleague; it could be connecting, uplifting, sad, even traumatic, or enlightening, and previously unexpressed in writing.

Why do physicians and practitioners write stories? And why tell them to a group of unfamiliar colleagues? People write to learn from their experiences, to express the meaning of their life’s work. Although we remember our stories, we may not understand them until we write them on paper, and move them out into the world.

RELEVANCE OF STORY

Underlining the original premise for these workshops—that supporting physician health and overall well-being has never been more important—numerous studies indicate that approximately one of three physicians experiences burnout at any given time. In addition, growing evidence supports the importance of physician wellness above and beyond the benefits to the individual physician. Links to improved patient outcomes and increased physician retention are two examples. Writing is a powerful tool to discover meaning and to promote self-understanding, and because psychological conflicts are linked to specific changes in our bodies, narrative writing can be of therapeutic value to physicians.

This two-part program focused on the use of creativity as a means of dealing with the stress of a medical career, enhancing coping skills, increasing job satisfaction, strengthening the ability to attend empathetically to a patient’s experience of illness, and improving overall general health and well-being. One must first care for oneself before being able to care for others. The agenda for the first workshop focused on the techniques of reflective writing, observational experiences, and experiential exercises using the visual arts to complement and expand our familiar forms of written communication. The second workshop was designed as a train-the-trainer for those interested in advancing the technique of reflective writing and bringing workshops to their respective medical centers in Northern California. Used together, these workshops resulted in new insights, appreciation, and acknowledgment as validated by participant comments, such as: “I was surprised by uncovering the importance of unconscious memories,” “The stories were compelling, and I enjoyed hearing them,” and “Great connection, and great stories.” Of note, as a result of these workshops, an East Bay Writing Group was established and has met several times.

THE PERMANENTE PRESS WORKSHOPS

The Permanente Press (TPP) has now led over 1000 physicians and practitioners across the country through a writing workshop where each wrote and shared a story. Many of these have been published in one of several TPP publications: The Permanente Journal; Soul of the Healer: Art & Stories of The Permanente Medicine Anthology; a medical literary-arts e-journal, leaflet; and previously published stories have been collected together in an anthology: Narrative Medicine Anthology (available from The Permanente Journal Web site: www.thepermanentejournal.org). Comments from participants at these other workshops include: “This workshop affirms the work we do as clinicians.” “Elucidates the value of the story in clarifying issues and meaning of clinical encounters.” “Inspirational. Rediscovering what is human and meaningful in our daily lives and careers is a very good antidote to becoming jaded and cynical.” “This workshop opened up my eyes to how important my stories can be.” “The training/sharing I had today will help change how I view each patient interaction.” “Quite amazing how somewhat emotionally distanced physicians and caregivers can be brought out so quickly.
and profoundly.” “I know the people around my table better in two hours than I know the colleagues I work with everyday.”

TRIBUTE TO WRITERS

We publish these stories and poems as a tribute to the writers who opened their hearts and became vulnerable in expressing deeply meaningful moments in their clinical practice, and even personal lives, through writing and sharing with others at the workshops, and who now make their stories public for others to learn from. Enjoy these stories and consider writing one of your own to gain insight, understand an experience, or feel a sense of release and fulfillment. The stories will take care of you and others.

References

Making Dad Comfortable

Roger Baxter, MD – Infectious Disease Specialist and Co-Director of the Kaiser Permanente Vaccine Study Center in Oakland, CA

Image: Cold winter snowy walk, bare trees, along the Genessee River in Rochester.

My father had been ill with a mystery illness for several years, but still the call that he was admitted to the ICU with pneumonia was unexpected.

My mom had handled things well previously, a woman who always tried to see the bright side of things; now she was terrified.

Oakland to Rochester flew by.

I arrived in the ICU at the University of Rochester Strong Hospital. I felt strangely comfortable, at home, in the ICU, from years of attending on ID. The residents approached the doctor-son of their patient. Almost the first words were to see if we wanted a “full code.” Seeing my past, and all the family members I had approached with this question, I stopped to consider, and then said, I needed more information. I needed to see the x-rays, talk to the attending, but until then, he was to remain a “full code.” As I reviewed the films, the awareness dawned that this was cancer, not pneumonia, and this was truly the end.

We moved Dad to another floor, used CPAP to keep his O2 up, and called the family. The hospital residents ceded authority to me, as did my family, and we set about making Dad comfortable as we gathered around. The responsibility then and now seemed overwhelming, as I had (in my mind) to decide between life or death.

Outside the hospital was the Genessee River, wintry, cold, barren with a large graveyard across the way. I walked through the snow, processing and crying, letting go and remembering, dealing with my needs and those of my family. We’re five siblings, all very different, and until then had hardly spoken to each other in ten years. Now we came together to bond again, share and agree; connect.

Bare branches overhang swift water and ice. The bridge was empty.

His Eyes Said It All

Gloria Yu, MD – Pathologist, Fremont Medical Center, CA

What struck me were his fading blue eyes and gold-rimmed spectacles. He was quiet. In fact, he did not say anything the whole time. He was a good-looking man about 30 years old. I was asked to do a liver biopsy on him. His abdomen was swollen with an enlarged liver and ascites. Even without a word, I knew he understood that he was a hopeless case. His eyes said it all. Later, after I made the deadly diagnosis of high-grade lymphoma, I found out that he died the previous evening.
Stories Tell Us What We Need To Know: Perspective for Ethical Dilemmas
— The Story Study

Tom Janisse, MD
Perm J 2004 Spring;8(2):82-85

Portions of the text, and the first story study, are excerpted from Ethics Rounds 2003-04 Winter;13(14), and from The Permanente Journal 2003 Winter;6(1) and The Permanente Journal 2004 Winter;8(1).

Narrative in Ethics
We hear stories and tell stories every day we practice medicine without appreciating that the resolutions we seek in ethical dilemmas often unfold from the stories of our patients, their families, and our colleagues. A story holds so much life, and knowledge in context leads to better understanding. Yet, misguided, we search for detail in chemical blood levels, shadows in a radiographic image, rising and falling numbers on a graphic. More distracting are assumptions and perceptions from our single-minded perspective.

Relevance of Narrative Medicine
Physicians and health care professionals who read and write narratives of clinical encounters can improve their diagnostic and communication competence. By listening closely to patients’ stories, physicians and health care professionals broaden their perspective and organize and integrate complex situations, leading to solutions to dilemmas. Stories clear the mind.

The Value of the Subjective
In medicine, we often speak of wanting objective data or evidence, thereby relegating the subjective realm to ineffectuality or to marginal value at best. Using S.O.A.P. notes, however, belies this devaluation. “S”—the subjective—is the history, the story. It is in this area, our medical elders constantly remind us, that we will find the diagnosis 90% of the time. Further, the subjective and objective are interdependent and, when embedded in a context, lead to the assessment and plan of care.

Story as Case Study
Using a clinical case study as educational methodology is embedded in medicine as a highly effective, relevant, and engaging intervention. It brings to life the interdependent factors at play in the application of medical knowledge in context. The story study is a dramatized case study that gives you an experience and, because of that, experiential knowledge and a lived perspective.

Several elements enhance the effect: you witness people’s behavior; you hear their perceptions and beliefs expressed in dialogue; and, when beliefs and behavior are linked, your understanding improves.

Stories clear the mind.

The following two narratives are excerpts from short fiction based on true stories. They are annotated with clinically relevant commentary related to common ethical lapses, issues, and dilemmas. Assess the value for you of the story study approach to broaden your perspective and your understanding of clinical encounters.
INTRODUCTION

To compel learners to examine past experiences with death and address future concerns and expectations regarding caring for dying patients the University of Iowa Carver College of Medicine incorporated reflective writing into a primarily didactic preclinical curriculum. Details of the complete curriculum were published in the *Journal of Palliative Medicine* in 2005.\(^1\) In the current paper, we present five years of experience using reflective writing exercises as part of the end-of-life curriculum for second-year medical students and physician assistant students. Discussion focuses on the role and outcomes of the reflective writing exercises to understand its value, with a specific focus on comparison of “out-of-class” (OC) versus “in-class” (IC) reflective writing to enhance educators’ understanding of the most effective writing situation and tools.

Several reviews of the literature noted the importance of incorporating curricula on end-of-life care into medical education.\(^2,3\) As part of this training, it has been argued that learners need to be aware of their own attitudes about death and caring for patients at end of life.\(^3\) Reflection can be an especially useful tool as it compels learners to examine the context, the meaning, and the implications of their attitudes and experiences about death.\(^2,4\)

METHODS

Since 1998, the University of Iowa, in Iowa City, has provided a required ten-hour didactic education module (reduced to 6.5 hours in 2004) for second-year medical learners and physician assistant learners on end-of-life care as part of their fourth semester Foundations of Clinical Practice course. During the didactic sessions, in this education module, learners are exposed to central concepts of palliative and end-of-life care, including: management of pain and nonpain symptoms, hospice and palliative care approaches, bereavement and physician self-care. A variety of evocative materials are incorporated into the lecture sessions—videos of patients and parents dealing with end-of-life issues, poems, and stories conveying positive experiences with death.

ABSTRACT

**Introduction:** This paper examines the use of reflective writing in a preclinical end-of-life curriculum including comparison of the role and outcomes of out-of-class (OC) versus in-class (IC) writing.

**Methods:** Learners were required to complete one-page essays on their experiences and concerns about death and dying after attending a series of end-of-life care lectures. From 2002-2005, essays were completed OC and in 2006 and 2007 essays were completed during the first ten minutes of small group discussion sessions. Essays were collected and analyzed for salient themes.

**Results:** Between 2002-2007, reflection essays were gathered from 829 learners, including 522 OC essays and 307 IC essays. Essay analysis identified four major themes of student concerns related to caring for dying patients, as well as student reactions to specific curricular components and to the use of reflection. IC essays were shorter and less polished than OC essays but utilized a wider variety of formats including poems and bulleted lists. IC essays tended to react to lecture content immediately preceding the writing exercise whereas OC varied in curricular components upon which they focused. OC essays have the advantage of giving learners more time to choose subject matter, whereas IC essays provide a structured time in which to actively reflect. Both formats served as catalysts for small group discussions.

**Discussion:** Writing exercises can effectively provide an important opportunity and motivation for learners to reflect on past experiences and future expectations related to providing end-of-life care.
Introducing Healing Circles and Talking Circles into Primary Care

Lewis Mehl-Madrona, MD, PhD, MPhil; Barbara Mainguy, MA

ABSTRACT
We report on the incorporation of a North American aboriginal procedure called “the talking circle” into primary care in areas serving this population. Communication is regulated through the passing of a talking piece (an object of special meaning or symbolism to the circle facilitator, who is usually called the circle keeper). Twelve hundred people participated in talking circles in which 415 attended 4 sessions and completed pre- and postquestionnaires. Outcome measures included baseline and end Measure Your Medical Outcome Profile version 2 forms. Participation in at least 4 talking circles resulted in a statistically significant improvement in reported symptoms and overall quality of life (p < 0.001 and effect sizes ranging from 0.75 to 1.19). The talking circle is a useful tool to use with Native Americans. It may be useful as a means to reduce health care costs by providing other alternative settings to deal with stress-related and other life problems.

INTRODUCTION
Talking circles, peacemaking circles, or healing circles, as they are variously called, are deeply rooted in the traditional practices of indigenous people. In North America, they are widely used among the First Nations people of Canada and among the many tribes of Native Americans in the US. Healing circles take a variety of forms, but most basically, members sit in a circle to consider a problem or a question. The circle starts with a prayer, usually by the person convening the circle, or by an elder, when an elder is involved. A talking stick is held by the person who speaks (other sacred objects may also be used, including eagle feathers and fans). When that person is finished speaking, the talking stick is passed to the left (clockwise around the circle). Only the person holding the stick may speak. All others remain quiet. The circle is complete when the stick passes around the circle one complete time without anyone speaking out of turn. The talking circle prevents reactive communication and directly responsive communication, and it fosters deeper listening and reflection in conversation. It also provides a means for people who are prohibited from speaking directly to each other because of various social taboos to speak and be heard. Healing circles have been used for recovery from alcoholism in aboriginal communities, especially when the traditional spirituality of those communities are perceived to conflict with the assumptions of Alcoholics Anonymous (AA).

The talking circle process is a unique instructional approach that can be used to stimulate multicultural awareness while fostering respect for individual differences and facilitating group cohesion. The creation of the talking circle is often credited to the Woodland tribes in the Midwest North America, who used it as a form of parliamentary procedure. “The symbol of the circle holds a place of special importance in Native beliefs. For the North American Indian, whose culture is traditional rather than literate, the significance of the circle has always been expressed in ritual practice and in art. The lives of men and women, as individual expressions of the Power of the World move in and are nourished by an uninterrupted circular/spiral motion. This circle is often referred to as the Medicine Wheel. Human beings live, breathe and move, giving additional impetus to the circular movement, provided they live harmoniously, according to the circle’s vibratory movement. Every seeker has a chance to eventually discover a harmonious way of living with their environment according to these precepts.”

Lewis Mehl-Madrona, MD, PhD, MPhil, is the Director of Geriatric Education for Maine Dartmouth Family Medicine Residency in Augusta, ME, and is also affiliated with the Coyote Institute in Augusta, ME.

Barbara Mainguy, MA, is a Creative Arts Therapist and Reiki practitioner. She is an Education Director at the Coyote Institute in Augusta, ME.
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Storytelling in Medicine

Presented here are several forms of narrative in medicine—essay, commentary, case study, journalism, stories, poems, journals, and research—that seek to make a point, explore the particular, gain perspective, or discover meaning in medicine more powerfully through relating a story than by exposition alone.

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Edited by Tom Janisse, MD, MBA

PRINTED IN THE USA

US $19.95

The Permanente Press
Oakland, California • Portland, Oregon

Cover design by Lynette Leisure

ISBN 978-0-9770467-4-8

PRINTED IN THE USA