NARRATIVE MEDICINE ANTHOLOGY
A COLLECTION FROM THE PERMANENTE JOURNAL
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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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**Narrative Medicine Anthology**

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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 Letter of Condolence

Cecilia Runkle, PhD

“A physician’s responsibility for the care of a patient does not end when the patient dies. There is one final responsibility—to help the bereaved family members. A letter of condolence can contribute to healing a bereaved family and can help achieve closure in the relationship between the physician and the patient’s family … Whether intentional or not, the failure to communicate with family members conveys a lack of concern about their loss.”

In a noteworthy article extolling the value of writing letters of condolence, Bedell, Cadenhead, and Graboys1 outlined why doctors do not regularly write letters of condolence. Reasons included a lack of time, a feeling that they did not know the patient well enough, no specific team member was responsible for writing the letter, a loss for words, and difficulty with their own experience of the loss as a sense of failure.

Generally, in the larger context of medicine, the focus is on cure—not on what to do if a disease cannot be cured. Slow integration of palliative care, relatively few discussions about advanced care planning, delayed referrals to hospice, and reluctance to follow up with family members when our patient dies are all behaviors that show how difficult it is for those of us in health care to focus on dying and death. That is not to say that the will to do more is not there—culture and lack of training may be the culprits.

IN ONE SMALL WAY, YOU CAN MAKE A DIFFERENCE: TO OTHERS AND TO YOURSELF

Bedell et al1 highlight the benefit of writing a letter of condolence as twofold: to be a source of comfort to the survivors and to help clinicians achieve a sense of closure about the death of their patient. In the sidebar on page 2, Dr Mark Geliebter, Martinez, CA, describes how he began writing letters of condolence to his patients and the value this practice has had for him.

If you decide that writing a letter of condolence is a practice you would like to begin incorporating into your medical practice, the following guidelines, adapted from Wolfson and Menkin’s “Writing a condolence letter,”3 may be helpful.

• Address the family member.
  Dear Mrs Wagner, …

• Acknowledge the loss and name the deceased. Dr Murphy and I were deeply saddened today when we learned from your hospice nurse Lois that your mother, Ruth Smith, had died.

• Express your sympathy. We are thinking of you and send our heartfelt condolences.

• Note special qualities of the deceased. It seems like only yesterday that Ruth talked about her love of card playing. I admired her energy and quick wit.

• Note special qualities of the family member. I was deeply moved by the devotion you and your family showed during the period of Ruth’s final illness. Your concern was one indication of your love for her. Although she was a fiercely independent woman, I know she appreciated your involvement and help.

• End with a word or phrase of sympathy. With affection and deep sympathy, we hope that your fond memories of Ruth will give you comfort.

(continued on next page)
Artistic Expression with Dementia

Finally, the words just disappear. Alzheimer’s erases them from the brain so completely that the names of mundane objects like “pen” or “watch” cannot be spoken. As his illness began and progressed, before diagnosis, Dr [Martin] Shearn turned more and more to painting.

A burnished sunset stretched across a sleepy, rugged landscape. A glossy eye unflinchingly stares back. Sixteen hands—opened, emptied, suspended in motion (page 131). The primordial beginning of life.

He speaks in tones of blues and greens and pinks and reds, and he transcribes the internal images with brushstrokes across canvas. He reaches through the fog of his dementia, where the glorious words he had once mastered are obscured, and he connects still—in this inventive way, through this new medium. He continues to do what he has always done as a physician and researcher, venturing beyond the conventional limits of language and medicine to discover and communicate new constructs.

It would be preposterous to pretend knowledge of Dr Shearn’s creative intention or process, impossible to propose an understanding of his art derived from medical theories of disease. Still, much has been written about the relationship between neurocognitive states and artistic expression, and the urge to speculate on that relationship arises here too. After all, we physicians are consummate diagnosticians who daily seek scientific explanations for our patients’ subjective complaints, and we constantly filter those complaints through a focus on pathology. We believe that we can—and even should—discriminate the voice of mind from the voice of body when our patients speak about suffering and distress.

We read medical literature that associates creativity with prefrontal dementias, analyzes Willem deKooning’s abstract expressions through the influence of his Alzheimer’s dementia, or interprets Ernst Josephson’s paintings through his schizophrenia. The new genetics fascinate us and lure us into believing that heredochemical factors might explain our personalities, proclivities, and aesthetics. As physicians, we uniquely wander and wonder about the mysterious nexus between mind and body, health and disease, living and dying.

And still, with every available diagnostic tool in hand, we cannot locate human creativity. We cannot tell where it resides in our system of propositions for health and disease, our medical notions about personhood and agency. Looking carefully and analytically at artwork created by people in demented or psychotic “states” does not reveal the vast, inscrutable internal worlds from which this creativity originates.

No matter how hard we have examined the human brain—rummaging through thick clumps of tangled neurons or searching under the dark crusts of a thousand cortical scars—we do not know how people create and why they must. Creativity flows from a source of their being that artfully defies our medical investigation and scientific discourse. Creativity humbles us in our quest to become masters of the psyche and body, and it “re-minds” us of our astounding incapacity to understand the most rudimentary element of our patients’ lives: their exquisite, fundamental aliveness.

I suspect that Dr Shearn was drawn toward the mystery. I imagine that he ventured purposefully into it, with whatever tools he possessed, to create something new—much as he had always done—in his unique fashion and radical, enduring aliveness. ❖
The Nature of Narrative Medicine

Lewis Mehl-Madrona, MD, PhD

The sufferer is a poet in search of metaphors adequate to express his predicament.
— Laurence Kirmayer, MD

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 to let us have more time with patients, family members to be more understanding about our hectic lives. In this respect, we are no different from healers the world over, though the content of our conversations may vary. We may talk drugs while Bantu healers talk herbs. We may talk surgery while a Dene healer talks about a many-day Blessing Way ceremony, but there is a similarity: we are in dialogue. We are co-creating a shared story of healer and patients/families/communities wherever we go. We are immersed in the art of storytelling.

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 endings about people with predispositions who encounter circumstances that lead to illness, progressing toward recovery or death. This is not 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.

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.
Thinking about Thinking and Emotion: The Metacognitive Approach to the Medical Humanities that Integrates the Humanities with the Basic and Clinical Sciences

Quentin G Eichbaum, MD, PhD, MPH, MFA, MMHC, FCAP

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)”—
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 policy makers 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.

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**

Jen 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 recall 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...
Healing the Self Through Self-Portraits  
—A Drawing Workshop

Amy Stein, MFA

Eight portraits line the office wall of Jon, a psychologist and veteran of the Vietnam War who counsels the broken and broken-hearted soldiers in their attempts to return to “normal lives.” Jon describes the treacherous re-entry process through those portraits on his wall—self-portraits, most showing wounds, scars, and strength (Figure 1).

JON’S STORY

Over the last eight years, Jon has attended each of my “Healing the Self through Self-Portraits” workshops in Santa Fe, NM. I wondered why he chose to repeat that process year after year, and why he chose to hang each self-portrait in his office, side-by-side, year by year.

Through this public display, Jon is making a powerful statement. At a time when he was losing touch with his own voice and soul, he said he needed his portraits to affirm and connect to his own reality.

There was nothing else in his life that could do this for him but these drawings.

The subject of most of these drawings is the warrior—sometimes strong, sometimes defeated, sometimes destroyed, always chronicling his dual career as psychotherapist and soldier.

Jon feels that all of these pictures are, “of a guy that I dreamt about long ago and who has emerged in some therapy I have done … as literally the outsider of my soul: he rides on the horizon—my flank. So it is the same guy, but he clearly changes radically, as I evolve—and it has not been a straight path to glory.”

All of Jon’s drawings are a chronicle of his emotional journey through the warrior issue.

“I was worn down by too many Army stories of soldiers who had grim difficulties and I started to feel my age; essentially I was in an age-role-related quandary,” Jon said.

Jon states, “As medical and mental health professionals, we take on the patient’s toxicity, sometimes blurring the boundaries. In this breakthrough self-portrait process, I experienced a chance to express my authentic voice and true self. I need to remember who I am and be centered in that reality.”

THE WORKSHOP

“This will not hurt at all,” is how I often begin my art workshops for physicians. I look in the mirror and really tried to create my own face. At the moment I was completing the self-portrait, my mother unexpectedly entered the room, looked at my artistic efforts and gasped. She instinctively understood the impact of this portrait. It was at this pivotal moment of creation that the course of my future was determined. At this moment I became a portrait artist who understood the power of portraits to heal.

I share with the group the loneliness and disconnect of my childhood, my unhappy and separated parents, and my isolation. In subsequent years it became apparent that all my most powerful portraits made eye contact with the viewer, perhaps making up for the lack of bonding in my early years.

The eye contact between mother and child has been clearly noted in child development as the most pivotal factor in the healthy development of a child. Children have been diagnosed with failure-to-thrive syndrome and actually die if their needs are not met. My self-disclosure creates a safe environment for others to share their innermost experiences and realities.

Amy Stein, MFA, is a licensed art teacher in New Mexico. She conducts self-imagery workshops nationally for medical and educational organizations. She also serves as a courtroom artist for ABC News TV.
EDUCATIONAL THEATRE PROGRAM MISSION:

“Through arts and education, engage and inspire individuals and communities to make healthy choices.”

You know many of your young patients and families are overweight. Yet, how effective are your 15-minute sessions with each family? How do you overcome the electronic buzz, the marketing messages, the cultural teases, and the whispers of your patients’ peers to get them to eat and live well?

Kaiser Permanente (KP) has found a unique, health promotion strategy that complements the clinical messaging targeted to young people: the Educational Theatre Program (ETP). This program engages children in interactive productions to help them think about the choices they make that affect their health.

During ETP performances, audiences watch schoolmates or professional actors act out scenes about tough topics many of these children face every day, including poor self-esteem, obesity, diabetes, sexually transmitted diseases, drug abuse, suicide, bullying, and others. Sometimes, the actors stop the action and ask the audience how they would handle a situation. Hands shoot up. The children’s honest responses are astounding. (See Sidebar: What They Say About ETP)

Begun in 1985, the award-winning ETP uses theatre to address critical issues children and families face today. Each production shows rather than preaches, through kinesthetic, aural, peer-to-peer learning, and lively interactive “talk-back” opportunities during or after some performances. Scripts are informed by medical, educational, and theatre professionals; community members; parents; and—most important—the children themselves. In addition, each production is intentionally and intensively based on The 40 Developmental Assets for Adolescents from the Search Institute (Minneapolis, MN), which focuses on “concrete, common sense, positive experiences and qualities essential to raising successful young people.”

In 2006, KP’s eight regions invested almost $10.3 million in more than 2500 performances at 1883 schools to reach 539,000 children and 70,000 adults, including parents, teachers, principals, school counselors, and nurses. Through extensive media coverage, ETP also impacts communities. It is one of the largest children’s educational theatre programs in the US.

The regional ETPs interact regularly, sharing research, scripts, set designs, talkback approaches, teacher study guides, and evaluation models. Each region creates or adapts scripts to address local health issues. Most regions operate in-house troupes. The Northwest region is unique in that it has partnered with a professional company, Oregon Children’s Theatre, to deliver engaging, professional-quality shows, from script development and casting through

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Nancy H Stevens, PhD, is the Director of Community Benefits and Health for the Northwest Region of Kaiser Permanente in Portland, OR.

Stan Foote is the Artistic Director of Oregon Children’s Theatre in Portland and the Educational Theatre Program collaboration with Kaiser Permanente.

Philip Wu, MD, is a Pediatrician at the Tualatin Medical Office in Tualatin, OR.
Retinal Drawing: A Lost Art of Medicine

LuAnn Dvorak, PhD, LPN; Stephen R Russell, MD

For the retina specialist half of our team (Stephen Russell), finding the “lost” retinal drawings at the University of Iowa was personal. I (SR) was one of the last retina fellows in a line of Iowa-trained ophthalmologists who had, from 1958 to 1988, created formal retinal (ocular fundus) drawings, a form of preoperative documentation. For those 30 years, drawings that took from 30 minutes to 3 hours each were routinely created both to map retinal tears, detachments, and landmarks prior to surgical retinal detachment repair and to rigorously educate the examiners in ocular anatomy and the use of the binocular indirect ophthalmoscope, which Belgian-born Charles Schepens had developed in the 1940s and 1950s.

With lens in hand, examiners could visualize the peripheral retina, a surgically important region that remains difficult to view and document. Achieving visualization of its pathology through both indirect ophthalmoscopy and the discipline required to record its findings, allowed that previously elusive area to be documented in the clinic and operating room far better than during the era of the direct ophthalmoscope, the tool often used by nonophthalmologists who do not routinely receive specialized training with the indirect ophthalmoscope. Edward Ferguson and Robert Watzke, who had learned Schepens’ methods in Boston, brought them to Iowa the “new” viewing technology and expertise in surgical methods, specifically scleral buckling, that allowed indirect ophthalmoscopy to be fully exploited. The drawings immediately became a significant part of the culture in the retina clinic and obtaining them a legendary challenge for “artists” in training.

When I (SR) left my position as the head retina-vitreous surgeon at Saint Louis University and joined the University of Iowa faculty in 1997, I set out to find the roughly 12,000 retinal drawings from files at Saint Louis University and joined the University of Iowa faculty in a line of Iowa-trained ophthalmologists who had, from 1958 to 1988, created formal retinal (ocular fundus) drawings, a form of preoperative documentation. For those 30 years, drawings that took from 30 minutes to 3 hours each were routinely created both to map retinal tears, detachments, and landmarks prior to surgical retinal detachment repair and to rigorously educate the examiners in ocular anatomy and the use of the binocular indirect ophthalmoscope, which Belgian-born Charles Schepens had developed in the 1940s and 1950s.

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When I (SR) left my position as the head retina-vitreous surgeon at Saint Louis University and joined the University of Iowa faculty in 1997, I set out to find the roughly 12,000 retinal drawings from files then stored at an off-site facility. Inspired by the artwork and accompanying essays in the Journal of the American Medical Association, and by the spectacular iris and iridocorneal angle drawings done by prior Iowa faculty Lee Allen (in W Lee Alward’s Color Atlas of Gonioscopy), I sought to somehow commemorate this lost art; however, I soon learned the art was lost, literally lost.

The drawings had been removed from the ophthalmology clinic years before when the practice of formal retinal drawing ended—due, in part, to Medicare’s restrictions on lengths of stay and reimbursement, to advancements in technology, including the increasing use of electronic and digital diagnostic tools, and to changes in retinal detachment management. Nine years and a great deal of detective work later, I (SR) had 19 large boxes of drawings and a plan for the images that were most interesting or most varied in artistic style and historical merit.

We are currently developing a collection: The Lost Art of Retinal Drawing (in progress), which will feature over 120 drawings and a history of the practice and process. Chapters will highlight differences among various artists’ representations of similar diagnoses, and how drawing style and technique evolved over time, how shading—sometimes basic; sometimes sophisticated—was used, and how transparencies and opacities were represented. Although the volume will include drawings and remembrances of artists at only one institution, fundus drawing in its entirety, as an art and a practice, is being celebrated since the technique has become a lost art of medicine. Unlike at the University of Iowa, drawings at other institutions remain embedded within individual medical records or charts, making access to them difficult, which renders the replication of the Iowa collection unlikely.

Just as artifacts from past cultures and faraway lands find their way into museums and galleries around the world, these colored-pencil (and watercolor) drawings emerge as art.

References

LuAnn Dvorak, PhD, LPN, is an Editor in the Department of Ophthalmology and Visual Sciences at the University of Iowa, and a former Visiting Assistant Professor in the Department of Rhetoric at the University of Iowa, in Iowa City.

Stephen R Russell, MD, is the Co-Director of the Retina Service, Clinical Director of the Center for Macular Degeneration, and the Dina J Schrage Professor of Macular Degeneration Research at the University of Iowa in Iowa City.
MELLOWED WITH AGE

PHOTOGRAPH

John E Fortune, MD
Perm J 2007 Winter;11(1):73

This photograph is an interior macro of an 1887 Emerson upright (honky-tonk) piano.
Dr Mills is a retired Pediatrician from the Napa Medical Center in CA. He has been creating narrative sculptural pieces since 2000. This piece was created in 2009 to portray the seduction of alcoholism via the figure and the danger of alcoholism via the shard snakeheads of broken liquor bottles.
This photograph was taken by Dr Hahn late one afternoon while on a safari in the African nation of Botswana. The color of the setting sun was reddened by smoke that filled the air due to fires burning in neighboring Namibia. Although his primary interest in traveling to Botswana was to photograph the wildlife, this landscape-type photograph could not be passed up. Dr Hahn retired from The Permanente Medical Group in 2010. He previously was the Clinical Director at the Sacramento Regional Appointment and Advice Call Center. He has been seriously exploring photography since 2000 and has an interest in both wildlife and landscape photography.
The internal mechanisms and figures of this clockspring-powered automaton are entirely handcrafted. (See it in action at: www.davestudiorama.com/the-snorer.html.) When wound up, the clockspring mounted into the side of this piece drives five cams, each of which manipulates the hand-painted figures much like strings on a marionette. One cam mechanism opens and closes the figures' eyes, another turns the heads or makes an arm swing, and yet another causes the wife to sit up. The result is the following scene: husband because of wife's snoring, pushes her, and goes back to sleep, and then she wakes up shocked before going back to sleep as well.

Mr Dumbrell is retired and lives in Vancouver, British Columbia, Canada. More of his work can be seen at: www.davestudiorama.com.
Evany Zirul, MFA, DO, is a former Ear, Nose, Throat and Facial Plastic Surgeon for the former Permanente Medical Group of Mid-America, (PMGMA) in Kansas City, Missouri. She has retired from the medical profession and is now a full-time artist. She creates drawings and bronze sculptures. She states, “My art is figurative. It is realism expressing the maleness, femaleness, and emotional nuances mirrored by our bodies and our life experiences.” “Modern Woman Torso” was created for the Pink Show in Fresno, CA.
The Physician as Storyteller & Poet: Quick Writes from East Bay Writers’ Workshops

Tom Janisse, MD; Betty Lin, MD

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 Journal; 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
Maggie taught me about silence. Three years ago, with a nasty case of laryngitis, I went to clinic as usual and let patients know that I would be essentially silent during their visit. Most appointments went smoothly, in fact, more smoothly and quickly than usual, which should have been a hint. But Maggie’s visit, to this day, stands out in my memory most powerfully.

I knew her as a type 1 diabetic, accident-prone, morbidly obese, self-deprecating woman who lived in a trailer with her chronically ill, demented mother and her troubled sister and niece. Every previous visit with her had brought reports of conflict, injury, frustration, poverty, and sometimes theft. On the day of laryngitis, I resigned myself to listen passively instead of actively trying to make a difference for the better in this unfortunate woman’s life.

I indicated to her that I wouldn’t be able to speak during our visit and, with that, she was off and running. For the first time since our first visit, ten years ago, Maggie told me the story of her abusive father, her “silent” mother, her deliberate decision to gain weight in order to repulse her father’s advances after she heard him express an aversion toward fat women. She told me about protecting her younger sister, with whom she was now living, by offering herself as bait to her father until her sister was old enough to defend herself. She imitated the words and voice he used to initiate physical contact and how, to this day, despite his death, she can still hear his voice.

I think it took her all of ten minutes to explain her life to me. She expected nothing in return but my attention. She left the office in what seemed a remarkably lightened mood and told me it was the best visit she had ever had with me.

Since that day, Maggie is still my patient, now taking two hours to travel by bus one way to my new office. She never complains about the distance and she’s never late.

Since that day, Maggie exercises and diets on her own and has lost over 100 pounds. She is highly compliant with her medication regimen and her chronic disease is in optimal control. She has not fallen down or injured herself accidentally again. Maggie placed her mother into skilled nursing care, helped her sister raise her daughter, set and enforced behavioral guidelines in their home, and became a fine seamstress. I treasure the pillow she made for me; I try to imagine placing it firmly over my mouth whenever I feel the urge to tell someone how to live without first understanding something of his or her life.

Laura Morgan, MD, is a family physician working in primary care in the Northern California Region for the past 13 years. She has authored Surviving and Thriving at Kaiser Permanente, a manual for physicians, and continues to seek ways to improve the quality of professional life for her peers.
Stories

Homecoming

Geoff Galbraith, MD

The rush was consuming. Dire straits, but things were going well, so far. Lights brighter, new energy. Lines in: arterial, CVP, drips, vent settings, Foley, fluids, not unlike initiating a sea journey, sails up, rudder, trimming into the wind, watching the flutter disappear, clearing the lines, no confusion. (Are we OK? Can’t really ask if there’s anything I’m forgetting?) Is the family here?

The rush was consuming. Dire straits, but things were going well, so far. Lights brighter, new energy. Lines in: arterial, CVP, drips, vent settings, Foley, fluids, not unlike initiating a sea journey, sails up, rudder, trimming into the wind, watching the flutter disappear, clearing the lines, no confusion. (Are we OK? Can’t really ask if there’s anything I’m forgetting?) Is the family here?

I entered the waiting room, just outside the unit, unlikely juxtaposition to an outdoor balcony lanai, with daytime oceanfront views over the Ala Wai Yacht Harbor, down the Waikiki coastline, to Diamond Head—city lights, soft breeze. Prepared to be confident and considerate. So many tourists crash on their well-deserved Hawaii vacations, sad.

Husband seated on the edge of a chair, daughter in her twenties, standing, looking anxious. I introduced myself and confided, “It looks like she’s had a heart attack. She’s doing as well as can be expected. We shocked the heart once and she came right out of it, but she’s quite ill.” The history: “seemed like indigestion or maybe a flu. We’re all tired.” “Doctor, my wife is a Christian with strong faith. We have strong faith and trust in God’s will.” (Reassurance? How should I relate to this declaration of faith?)

“Let’s go in, then.” I’ve explained the visually difficult scene: patient (beloved mother and wife) unresponsive—breathing machine, tubes, transducer, monitoring equipment, and various medications to control the heart rhythm and keep the blood pressure up. "The first 24 hours will be critical." Standing on one side, too much stuff on the other, concerned, the daughter with gentle tears, husband stolid, expressionless, not looking away. I reviewed the medical equipment to reassure, in some way lessen the horror. "I'll be here with her all night and will keep you informed of any changes."

Around 2 am, things getting better. Blood pressure up and able to decrease toxic pressor meds, slowly, gently, watching the monitors. "She’s got urine." (Good sign, kidney perfusion … she does seem to be moving forward on her own).

I spoke with the daughter and husband several times that night, another visit to the bedside, this one lighter, more hopeful … her heart seemed to be coming back, life force (… and I was feeling relieved, with not a little pride; me, the nurses, the team felt encouraged in our mission to save a life). On the last stop, I heard the husband softly say, as if to himself, “I hope this is what she wants.” (Leaving, hmmm … what did that mean? … I misheard …)
When they bury me in twenty years
I hope someone remembers
to gently place
my heart in the casket,
the heart cut out last year,
the one that now floats in formaldehyde.

Two billion beats without a pause:
can one ask for more?
❖

Joseph Gascho, MD, is a Professor of Humanities and Medicine at the Penn State Hershey College of Medicine in PA.

Figure 1. Apical four-chamber echocardiogram; left ventricle (LV), right ventricle (RV), left atrium (LA), right atrium (RA); the atria are elongated, a finding common in transplanted hearts. The letters "x" and "y" depict sites where the atria of the donor heart were sutured to the native heart.
In 1992, Oregon Health and Sciences University (OHSU) introduced the Principles of Clinical Medicine (PCM) course with the intent of providing medical students early in their training with a patient-centered care context. Students are enrolled in this two-year longitudinal course at the same time they are learning basic sciences. PCM consists of two components: a weekly preceptorship in which students spend four hours each week with a community physician and four hours in classes focusing on the knowledge, skills, and attitudes involved in providing patient-centered care.

One of the goals of this curriculum is to help students develop cultural sensitivity. This is not an easy task. To do this we must walk a fine line between teaching salient characteristics of various cultures, which may be regarded as “stereotyping,” and giving vague advice about the importance of treating all patients with equal respect and trying to understand their worldviews.

Another goal is to develop students’ ability to reflect thoughtfully on key issues affecting their future practice of medicine. Students engage in group discussions with their peers and physician group leaders; they also are required to write a quarterly essay to encourage self-reflective thinking and writing.

We have also developed the assignment of an “ethnographic interview.” Students are given the opportunity to interview a patient from an ethnic or cultural background other than their own. They are then asked to relate the patient’s situation and to reflect upon the experience within the context of what was learned during the PCM quarters, including a discussion of US health care policy and economics. This assignment moves the students out of their comfort zone and enables them to learn things about patients and cultures that they never would otherwise. We consider it to be the best opportunity we offer to promote the practice of culturally sensitive medicine. Our faculty continue to be amazed not only that students learn so much, but that they often write so eloquently about these experiences.

William L Toffler, MD, is a Professor and the Director of Predoctoral Education in the Department of Family Medicine at Oregon Health and Science University.

In Search of Home: From Home to Homeless to Housing

Lianne Lin

THE ETHNOGRAPHIC INTERVIEW THE PRESENTING SITUATION

Kathy is a 58-year-old Caucasian woman living in a 55-bed transitional facility for women, most of whom have escaped from domestic violence household or have crossed paths with the judicial system. I met with Kathy through the volunteer coordinator of a program to “help serve people’s basic needs as they transition from homelessness to housing.”

With a group of students I volunteered to make dinner at a transitional facility for men. We had a chance to talk with a few of the residents there. They were very open and shared their lives with us. Hidden in their stories are the secrets of how they became homeless. For many of them only minimal health care need is met. Since I haven’t had much experience with this subset of our population, I thought it would be a great learning opportunity to chat with one of them more in depth. The volunteer coordinator gave me a choice between a men’s facility and a women’s. I chose the women’s.

THE INFORMANT

Kathy was a friendly and pleasant woman. She clearly indicated that she would only volunteer her own information and no details of her family would be shared. She was born in Portland, OR, and her family moved to Albany, OR, when she was eight years old. She lived in Alaska and in California; returning to Portland 28 years ago.

Divorced, she raised two children by herself. Her son, age 25, is in the military. Her daughter, age 22, is studying psychology in college. Kathy also has an older sister who lives in Lincoln City, OR.

Kathy seemed attentive and willing to share her story with me. She mentioned that she has a hard time concentrating if too many questions are asked at once. Nevertheless, she answered the questions appropriately and rarely seemed to have problems focusing.

Lianne Lin is a third-year medical student at Oregon Health and Science University.
ABSTRACT

Introduction: Narrative approaches to psychotherapy are becoming more prevalent throughout the world. We wondered if a narrative-oriented psychotherapy group on a locked, inpatient unit, where most of the patients were present involuntarily, could be useful. The goal would be to help involuntary patients develop a coherent story about how they got to the hospital and what happened that led to their being admitted and link that to a story about what they would do after discharge that would prevent their returning to hospital in the next year.

Methods: A daily, one-hour narrative group was implemented on one of three locked adult units in a psychiatric hospital. Quality-improvement procedures were already in place for assessing outcomes by unit using the BASIS-32 (32-item Behavior and Symptom Identification Scale). Unit outcomes were compared for the four quarters before the group was started and then four months after the group had been ongoing.

Results: The unit on which the narrative group was implemented had a mean overall improvement in BASIS-32 scores of 2.8 units, compared with 1.0 unit for the other locked units combined. The results were statistically significant at the p < 0.0001 level. No differences were found between units for the four quarters prior to implementation of the intervention, and no other changes occurred during the quarter in which the group was conducted. Qualitative descriptions of the leaders’ experiences are included in this report.

Conclusions: A daily, one-hour narrative group can make a difference in a locked inpatient unit, presumably by creating cognitive structure for patients in how to understand what has happened to them. Further research is indicated in a randomized, controlled-trial format.

INTRODUCTION

I wanted to explore the possibility of incorporating narrative ideas into a conventional locked psychiatric unit in the southwestern United States. Narrative approaches emphasize a storied understanding of people’s behavior rather than a categorical understanding such as conventional diagnoses provide. It seemed a worthy challenge to start a group that would involve patients who mostly had multiple repeated involuntary admissions to construct new frameworks for understanding their experiences and their recovery. In a narrative approach, current and future behavior is understood as following logically from the plot of the stories in which the person lives. Such understanding facilitates the construction of alternate stories, which leads to different and more desirable outcomes.

Howe wrote that no one belief system could reveal the entire truth. A story can capture multiple belief systems in ways that can lead to constructive behavior change. White stated that people experience problems because they are restrained in some way from taking a course that would ameliorate their distress. This is referred to as “negative explanation.” The population for which this group was designed was steeped in deterministic explanations of defective genes and chemical imbalances. Having alternate explanations that could empower them to make personal changes to prevent undesirable future outcomes could be helpful.

O’Neill and Stockell opened the way for therapists to apply narrative methods to non-family groups. When people in their groups discovered that they could challenge the subjugating story about themselves as defective, however minimally, they begin to develop an alternative knowledge, or a reauthored account, of their lives. Standard approaches, particularly in the field of cognitive behavioral therapy and serious mental illness, typically do not make reference to such techniques or constructions of therapy. If psychotherapists incorporate notions of subjugation into our work, then, as Mullaly suggested, we can attempt to use transformational knowledge to change society from one that creates and perpetuates poverty, inequality, and humiliation to one more consistent with values of humanism and egalitarianism.
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 are often called hochokah in the Lakota language, which means a sacred circle and is also the word for altar. The hochokah consists of people who sit together in a talking circle, in prayer, in ceremony, and are committed to helping one another and to each other's healing. Hochokahs may participate together in purification and other ceremonies and usually camp together when traveling to larger gatherings, such as the sun dance. 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."
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.

Storytelling is an art of medicine.

Storytelling is Medicine

This anthology is four books in one:
- A book of essays & research,
- A book of poems,
- A book of stories, and
- A book of works of art.