Integrating Narrative Skills Training Into the Overall Fabric of an Evidence-based Family Medicine Residency

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NORTHSHORE UNIVERSITY HEALTHSYSTEM
AN AFFILIATE OF THE UNIVERSITY OF CHICAGO

OBJECTIVES

- List skills that are important in the practice of narrative medicine
- Share ideas about how to get faculty buy-in to the importance of learning narrative skills
- Develop ways to facilitate the learning of narrative skills by residents and faculty alike.

as well as clinical care at NorthShore. Our faculty to resident ratio is almost one to three, leading to close and open relationships between seasoned physicians and residents.

Bernard Ewigman, MD, MSPH
Chairman, Department of Family Medicine
University of Chicago and
NorthShore University HealthSystem
Medical School: University of Missouri, Columbia, MO
Residency: University of Missouri, Columbia, MO
Interests: Professional Development Mentoring
Clinical Translational Research

Deborah E. Miller, MD, MACM, FAAFP
Residency Program Director
Medical School: Wright State University
School of Medicine
Residency: St.Elizabeth Family Practice Residency,
Dayton OH
Interests: Resident Education, Women's Health, Medical Ethics
Preventative Medicine, Practice Management

Miriam K. Whiteley, MD
Associate Program Director
Medical School: University of Illinois at
Chicago College of Medicine
Residency: Cook County Hospital Family
Medicine Residency, Chicago, IL
Interests: Obstetrics, Women's Health, Public Health

Gene Combs, MD
Medical School: University of Kentucky College of Medicine
Residency: Psychiatric Residency/ University of Kentucky
Interests: Narrative Therapy

Thomas Triantafollou, MD, MPH, MBA
Medical School: University of Illinois at Chicago
Residency: Geisinger Medical Center Michael Reese
Hospital & Medical Center
Fellowship: University of Illinois at Chicago
Interest: Geriatrics, Internal Medicine

Pooja Saigal, MD
Medical School: Northwestern University
Feinberg School of Medicine
Residency: University Of Chicago (NorthShore) Family Medicine
Fellowship: Andrew Weil Integrative Medicine
Fellowship Program
Interest: Integrative Medicine

Lauren Oshman, MD, MPH
Medical School: Baylor College of Medicine
Residency: Beth Israel Residency Program
Interest: OB, Contraception and Reproductive Health,
Cost Effectiveness and Quality of Care, Electronic
Health Record Optimization, Health Policy

Janice L. Benson, MD
Vice Chair of Education, Department of Family Medicine
Medical School: St. Louis University School of Medicine
Residency: Cook County Hospital Family
Medicine Residency, Chicago, IL
Interests: Underserved Community Medicine,
Faculty Development

Goutham Rao, MD
Vice Chair, Academic Affairs Department
of Family Medicine
Medical School: McGill University,
School of Medicine, Montreal Canada
Residency: St. Joseph Health Centre/University of Toronto
Interest: Childhood Obesity

Carrie Jaworski, MD
Sports Medicine Fellowship Co-Director
Medical School: Loyola University Stritch
School of Medicine
Residency: MacNeal Hospital
Fellowship: Kaiser Permanente
Interests: Concussions, Overuse injuries, Joint injections

Joseph P. Gibes, MD
Medical School: University of Illinois College
of Medicine
Residency: Waukesha Family Practice Residency
Interests: Bioethics, Rural Family Medicine

Victoria Braund, MD, FACP
Medical School: University of North Dakota
School of Medicine
Residency: University of North Dakota School
of Medicine Affiliated Hospitals
Interests: Memory Assessment and Treatment
Geriatric Depression

Mark Drexler, MD
Medical Director Family Care Center
Medical School: University of Illinois at Chicago
Residency: Lutheran General Hospital
Interests: Complementary& Healthcare for the family
(acute/chronic/wellness/injuries and accidents)

Mike Ladewski, DO
Sports Medicine Fellowship Co-Director
Medical School: Midwestern University's Chicago
College of Osteopathic Medicine
Residency: Family Medicine, Resurrection Medical
Center, Chicago
Fellowship: Primary Care Sports Medicine,
Resurrection Medical Center, Chicago
Interests: Sports Medicine, Adult and Pediatric

Family Medicine Residents

NorthShore University HealthSystem

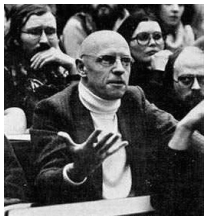
The residents in each class come together to form a close knit group who have developed into a family and established a home away from home in the program. Each has their unique way of exemplifying the core values that make up the foundation of our residency. They are a compassionate group of individuals, representing diverse backgrounds that are all strongly invested in their education, yet always striving for balance in their lives. A wide range of interests and personalities set them apart, but the common goal of success as a family physician unites them.

Palasha Ahmed, MD — Resident Class: 2014 Chief Resident
Monica Fuchs, MD — Resident Class: 2014
Alex Jovanovich, MD — Resident Class: 2014 Chief Resident
Frank F. Karantonis, MD — Resident Class: 2014
Betty Lo, MD — Resident Class: 2014
Sheri L. Pierce, MD — Resident Class: 2014

Bianca Dube, MD — Resident Class: 2015
Mandeep Sehmbey, MD — Resident Class: 2015
Tanuja Sharma, MD — Resident Class: 2015
Nicole Steineke, MD — Resident Class: 2015
Eze Uzoaku, MD — Resident Class: 2015
Christian Yousted, MD — Resident Class: 2015

Anthony Cipolla, MD — Resident Class: 2016
Samantha Eller, MD — Resident Class: 2016
Richa Garg, MD — Resident Class: 2016
Cindy Iglesias, MD — Resident Class: 2016
Won Woo-Chris Lee, MD — Resident Class: 2016
Simren Singh, MD — Resident Class: 2016

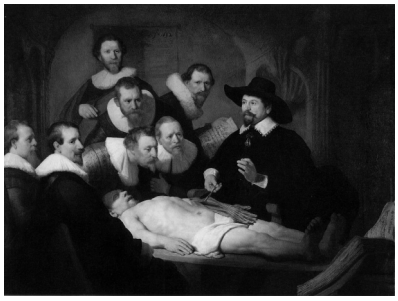
A story from Michel Foucault



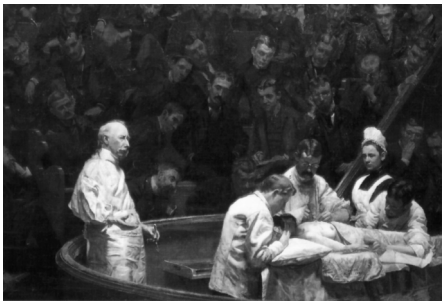
- Michel Foucault studied the ways that the ideas, categories, and practices that we take for granted as "true" change in different historical eras.
- The next few slides tell a story from his book "The Birth of the Clinic."

Scientific medicine owes much to the study of cadavers.

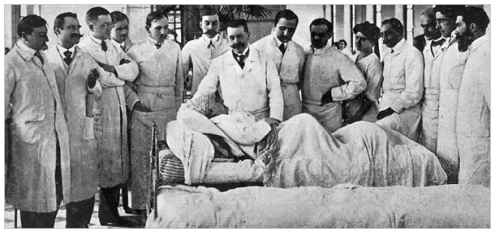
In the anatomy lab, we developed a tradition of teaching: The wise professor shares his expertise while the dutiful students watch, listen, and learn.



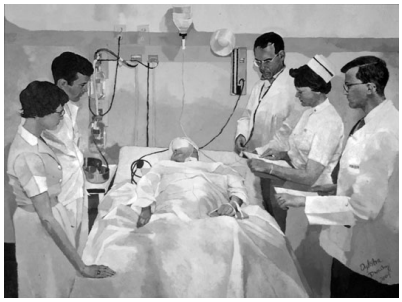
The tradition continued in the operating theater: The professor dispenses expertise, the students watch, and the patient lies still as a corpse--a "docile body" objectified in the "medical gaze."



The same tradition has carried over into clinical rounds.

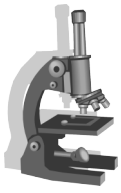


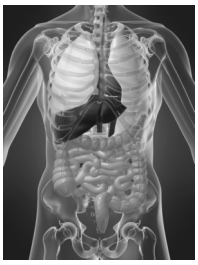
Even today, we like to display our expertise on "compliant" patients.



A good patient is a docile body; a person who follows "doctors orders."

The technical medical model focuses on pathology in organ systems, not so much on people in a social context.





Patient as Docile Body

- This approach works well for problems with a clear diagnosis for which we know an effective treatment.
- If I have acute appendicitis, I want to be treated, initially, as a docile body.

Patient as Docile Body

- HOWEVER, when we want people to actively participate in dealing with their problems, we need to interact with them as something other than docile bodies.

Problems with Technical Medical Practice

- It invites us to assume in all cases that a person with a complaint has a diagnosable disease.
- It invites us to think of our job as doing something specific to cure disease or relieve suffering, thus focusing us on stories of disease and suffering.
- It invites us not to expect anything other than "compliance" from people who come seeking help.

Problems with Technical Medical Practice

- It can shape us toward believing that people "have" a specific organic disease when they don't.
- It can lock us into a distanced, "objective," expert position.
- It can blind us to opportunities for real compassion, which requires "feeling together" and putting ourselves in the other person's shoes, understanding their experience.

Problems with Technical Medical Practice

" ' Illness possesses a profound meaning . . . and the doctor must evidently be attentive to not divorce illness from its meaning.' Unfortunately, biomedicine cannot tell us what the meaning is . . . Denying meaning that is there is certainly counterproductive, because it leads us away from healing."

Raymond Downing (2010). "Ellul & Medicine," from The Ellul Forum, Issue 46, p. 21.

Cheryl Mattingly's Classification of Medical Story Types

- Detective Stories
- Fixing a Broken Machine Stories
- War Stories

Cheryl Mattingly's Classification of Medical Story Types

- **Stories of Personal Transformation**
  - These are the stories that people tend to find meaningful, especially when their problems are chronic, life-threatening, or complex.

Narrative Practices

- Seeking an empathic understanding of how the illness affects the person's life and relationships.
- Putting oneself in the other person's perceptual position.
- Using "double listening" so that you are hearing stories of hopes, commitments, acts of resistance, and successful struggle alongside the problem story.

Narrative Practices

- Reflecting both kinds of stories back and recording them so that they become part of the "official history."
- Cultivating a comfort with complexity.
- Focusing on understanding rather than fixing. (A "not knowing" rather than a "knowing" stance.)
- Keeping track of "insider" knowledge and skills so that you can share them with others who have similar struggles.

Narrative Practices

- In a "decentered" way, telling people about the effect of their stories on you personally. Do their stories inspire you? Teach you about how to deal with similar problems? Remind you of important memories and connections in your own life?
- Looking for opportunities to share stories of the above with colleagues.

Integrating Narrative into the Residency

- In the Lecture Series
  - Periodic lectures on Narrative Medicine
  - Twice-a-year "55 word stories" exercises
  - Looking for opportunities for making a narrative point or two in the context of other topics, such as ethics, M & M conferences, any and all case presentations, etc.

Integrating Narrative into the Residency

- In the Psychiatry Rotation
  - Narrative write-up of one continuity patient (see handout)
  - In notes on consults,
    - no abbreviations
    - full sentences
    - written understanding of hopes and fears
  - Observation and discussion of Gene's narrative interview style while sitting in on outpatients.

Integrating Narrative into the Residency

- On the Inpatient Service
  - Gene attends morning rounds at least once a week
  - Each admission H&P includes a statement of the patient's hopes and fears concerning the hospitalization
  - Complex patients provide multiple entry points for a narrative focus on both the story of their illness experience and of their victories/accomplishments in the face of illness.

Integrating Narrative into the Residency

- In the Clinic
  - The pace and volume here present the biggest challenges
  - Complex patients provide the best opportunities. (Almost all attendings are good at referring these folks for joint consultations.)
  - Life transitions (birth, marriage, diagnosis of chronic disease, death) provide opportunities that we can take advantage of.

Useful Attitudes and Practices in Promoting Narrative Medicine

- Think small and go slowly; don't try to convert everyone to the narrative gospel in your first ten contacts with them.
- Build small counter-practices into your daily required activities, such as record-keeping and furniture arrangement.

Useful Attitudes and Practices

- Look for people with purposes and values similar to yours, and find ways of linking with them to pursue the purposes, even if their approach is not "officially narrative."
- Share stories of success in a de-centered way, with thought about context and timing.