

# "I AM NOT STUPID, I WAS A SCHOOL TEACHER!"

## A Narrative Approach to Teaching Clinical Medical Ethics

By Martin Kohn and  
Joseph Zarconi

Martin Kohn, Ph.D. is Associate Professor of Behavioral Sciences, Director of Human Values in Medicine, Northeast Ohio Universities College of Medicine and Co-Director with Carol Donaley, Center for Literature, Medicine and the Health Professions, Hiram College.

Joseph Zarconi, M.D. is Associate Professor of Internal Medicine, Northeastern Ohio Universities, College of Medicine.

### Introduction

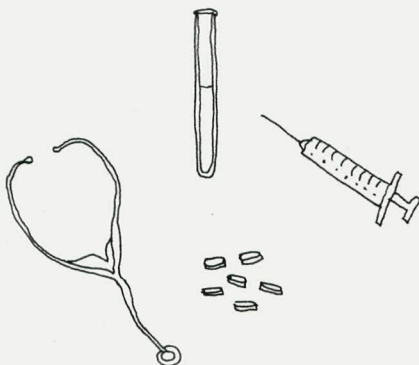
Our shared existence with others and the obligation of the physician to show "compassion to the sick stranger" (Cassell, 1991a) compel us to understand the stories of other persons' lives; especially the stories of their encounters with illness. The "sick stranger" who uttered the words above was suffering cardiogenic shock. Her words became part of an interior monologue story written by a medical student on the team caring for her.

The patient, Mrs. W., made the statement as she was attempting to answer questions on a mini-mental status exam. In nearly every group discussion on story writing, at least one student reported similar abusive exam experiences. This is hardly high drama/pull-the-plug medical ethics, but it is emblematic of the grounded, everyday ethical context of practice we encourage our students to discover.

Seven years ago we developed a medical ethics component as part of a required twelve week internal medicine clerkship. After spending a few years using a principle-based approach we decided to examine the moral matter of medical work through narrative inquiry. Relying in part on the pioneering work of Charon (1986), we began to ask our students to write a

story in the voice of the patient, a story based upon fragmentary evidence of the lived life of the patient. Their interior monologue stories are read aloud along with a conventional detached third-person narrative at the first of two two hour case conferences we facilitate. After the students read their stories and the ensuing discussion is completed, the group decides how the writer should draw out the interior monologue story. Questions such as whether new voices should be added through dialogue, or to hear more from the protagonist are considered. The second case conference provides the forum for reading extended, newly created stories, and subsequent discussion of the medical moral content.

A year after initiating the narrative-based approach, we added a required reading in the introductory session which convenes two weeks prior to the two case conferences. This session, one hour in length focuses on a short story by Ghassan Kanafani (1981), "The Death of Bed Number 12." This story is used as a cautionary tale. That is, although the narrator of the story (a fellow patient of the young man who dies in bed number 12) feels morally compelled to flesh out the dead man's life story, he discovers to his dismay that to understand another person's life is difficult





if not impossible. Similarly, while our attempts to comprehend patients' lives will always fall short, it is vital that we try.

We believe that by knowing the patient more intimately one comes to appreciate the moral nature of medicine, and enjoy more fully the practice of medicine. Author (and patient) Anatole Broyard (1990) claims "a doctor's job would be so much more interesting if he would occasionally let himself plunge into the patient, if he could lose his own fear of falling." Similarly, Eric Cassell tells of the "therapeutic advantage that physicians gain from the jeopardy of closeness to the patient" (1991b, p. 249). Writing in patient's voice is the way to achieve such closeness.

### Analysis of Stories and Case Conference Discussions

A stream-of-consciousness interior monologue is the predominant mode of presenting the patients' story at the initial case conference. Although some students used a more exterior autobiographical style, or a combination of both.

Two primary genres that have emerged from analysis of stories presented at the first case conferences: the "existential/why me/what's going to happen to me" stories and the "lack of respect/what are they doing now/going to do next" stories. A subset within the lack of respect genre is the "confusion

story." In this subset the "waiting for irrefutable evidence is in place before giving a diagnosis/conspiracy of silence" story and the "abusive minimal status exam" story such as that of Mrs. W.

With our encouragement, follow-up stories for the second case conference have become considerably more varied. While some stories featured the same voice, many more are in dialogue form: a patient speaking with the long absent child, or the impatient attending, or the confused (or more likely compassionate) medical student. Occasionally, "outlier" stories are written, for example, in the inanimate "voice" of a pack of cigarettes or a DNR status sheet.

### A Pack of Cigarettes Speaking

Here I am. I'm free for you. Take me. I know you want me. You rely on me. Draw me in deep and hold me there. Yeah that's it. I'll make it better. I'm your one true friend. When they knock you down, I'll be there. I've never let you down. They'll try to tell you I'm bad, but what else makes you feel so good. Tell them to quit. You've heard it all before cancer, cancer, cancer, cancer. Oh yeah? George Burns, Burns, Burns, Burns. Grandma understood. She never stopped. 80 years of tobacco satisfaction. And if they get to you and you want t leave me... I promise you'll pay. You'll come back so why leave? So let me be your friend. Let me calm your fear and ease your suffering. You need something to relieve your

stress. And life without me will be empty and you'll get fatter than you already are. You can't live without me.

### Mrs. W. Talking About a Medical Student Who She Mistakenly Believes to Be a Nurse

Why are you asking questions? I don't know. I get so confused sometimes. Why is all of this happening to me? It seems like this is one bad nightmare but I'm awake. I know. I am in hospital and my heart is bad.

Sometimes they say they can fix it, sometimes they can't. So many tests. I wish someone would talk to me. I've been here 2 months I think. That nurse who comes in in the morning says I have been here only 2 weeks. I know she's wrong.

It's been so long since I've seen my husband. These people don't understand he's old he needs me. I wish I could talk to him. He'd understand.

They don't know they don't know anything. Now this nurse is asking me stupid questions like say the days of the week backwards. Why would anyone want to do that? She told me I got it wrong. She doesn't know. I am not stupid I was a school teacher. Sometimes they treat me like I'm stupid. I know the days of the week! I am just tired. Yesterday that stupid nurse asked me to spell the word "world" backwards. I got confused I couldn't do it. I started to cry. They don't know me I'm not stupid. I am just tired and want to go home.



**The External(1) and Internal(2) Voices of Patient(A) and Medical Student(B)**

**First Exchange:**

**1A:** Get the hell out of here! And don't ask me how I feel 'cause I feel bad, just bad. Bad all over.

**2A:** I am in real pain.

**1B:** I know you hurt, you have headaches and joint and muscle aches. They're pretty bad aren't they? You have reason to feel so poorly. I'm gonna order some medication to help you get rid of those pains.

**2B:** Quit yelling at me! I'm not your dog! You can't talk to me like that I don't care how bad you feel. If you don't accept my help, you're not gonna get better.

**Second Exchange**

**1A:** If you dare come in here and wake me up, I'm gonna pick something up and throw it right at your head! And don't think I won't either! I haven't gotten a single wink of sleep. This one over here next to me won't keep quiet. Shut up over there!

**2A:** You've taken away my control.

**1B:** I know being in the hospital isn't always the best place to get some rest. You have to remember to ask for your

sleeping pill if you want it. I won't come back 'till later this afternoon so you might get some rest today.

**2B:** How dare you threaten me like that! You better not even think of throwing anything. I'll have you put in restraints so fast your head will spin. We'll see how you like that!

**Third Exchange**

**1A:** Oh, I'm mad, mad, mad as usual. I'm just tired of all this crap!

Why doesn't anybody do something for me? I just want to know what's wrong with me. Why don't you help me? I still have this darn headache.

**2A:** I'm frustrated and I don't want to feel this way anymore.

**1B:** We are trying to do something for you. We just went through all your problems and what we've done and what we want to do next.

I tried to explain everything. If you want, I'll go over everything again, and you stop me if you have questions. OK?

**2B:** My God! I've been spending hours every-day since you've been here trying to help you get better. Can't you even appreciate that? I've been busting my butt for you and still all you do is complain!

Using the patient's voice as the springboard for our ethics case conferences frequently leads to deeper questioning by the student of his or her personal beliefs and values, less reliance on formalized response patterns, and the desire for formulaic answers. For example, a student concerned about awakening a patient for a test of dubious necessity recounted how he was told by an intern that "your time is more important than theirs." This statement resonated the wrenching feeling between efficiency and compassion students frequently experience in medical training.

On other occasions we explored the resentment felt by health care providers toward persons whose presumed "weakness" brought on their disease. One student revealed with sadness how he had noticed himself changing, catching himself in his self-dialogue referring to some patients as "assholes." The student's disclosure led to a discussion on whether or not the physician is obligated to have positive assumptions about the patient as they enter her/his narrative. Other explorations have centered on issues of power and ego, especially in recognizing one's limited capabilities, ethical principles such as beneficence and autonomy, and rules such as truth-telling.

Another enlightening (and entertaining) aspect of the post-story discussion period comes when the physician facilitator anecdotally shares a maturational lesson from her/his training period and current



practice. Hensel and Rasco argue that "personal, well-focused [stories] derived from the immediate clinical setting" (1992, p. 500) are an effective way to teach students and residents. Convincingly they argue that storytelling by the mentor helps the novice learn to live with and admit to mistakes and "helps to create the kind of atmosphere necessary for continuous improvement" (p. 502). These physician-generated stories meld well with student's personal accounts: losing patients with whom they developed close relationships, learning the underlying reasons for patients' self abuse or addiction, and discovering the hidden complex person inside a difficult and abusive patient.

### The Story of Alice

We met Alice during the Physical Diagnosis Rounds of the Internal Medicine Clerkship. She was 51, White, a "frequent flyer." A "hopeless drunk in for the umpteenth time" for a tune-up on her way to the grave. She was a museum of end-stage alcoholic liver disease. And from the tone of the resident's description, she was one of those most frustratingly futile, hopelessly self-destructing patients that cause many of us to roll our eyes and wonder why we should even continue to provide care.

In the hallway outside her room, in a round robin fashion, the students and I listed the eighteen or so physical stigmata of alcoholic liver disease, and we entered the

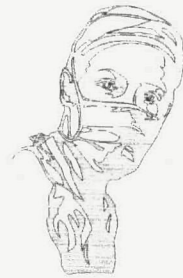
room half knowing what we'd see. She was slight, apprehensive, yellow, protuberant. Her umbilicus was visible under the covers. I asked her about her drinking. She described incredible daily intakes of alcohol for many years. I asked when she began drinking alcohol, and she related a most sensational story. Alice was a young mother, happily married, devoted to her nine and twelve year old sons.

Her husband had a decent job, and she worked raising her sons. She loved those boys.

On a spring day off from school, the boys decided to play on the property of a nearby asphalt plant. They often played there on weekends. This day though, there were workers, and trucks, and industry. Shortly after the young son won the race to the bottom of a deep pit of gravel, the older boy turned to see a huge vehicle at the precipice plowing the gravel into the pit. He won the race out, and watched as his brother was buried in gravel. One boy died that day, and part of the other boy died as well.

The surviving child had many problems in the years to come. He was deeply disturbed, and his parents lost control of him. In a few years, his psychiatric health was so unstable that he was institutionalized, where he remains still. His father handled the loss of his sons poorly. He ran away. Alice doesn't know where he is now, or even if he is alive. It was shortly after he left that Alice began to drink whiskey. And

ever since. In excess. Hopelessly. We thanked her for sharing her story with us and somehow, couldn't bring ourselves to the examination for shifting dullness. We'd already had our lesson from Alice, and we took our leave.



### The Story of Charles

Charles was an elderly Black man not well known to me on the weekend I rounded, covering for his physician. He had been on dialysis for years, and I had encountered him before. I remember him as a "wise guy" type, who always made sarcastic remarks about the money doctors make, and the privileges they enjoy. He was pleasant but quite cynical. Most visits were more comfortable if kept brief.

He'd been admitted for heart failure and was recovering nicely. There was little to do for him over the weekend while he was entrusted to my care. All I had to do was write a note, "continue present management," and move on. When I introduced myself that day, he began to speak in what sounded to me like fluent Italian, apparently having taken note of my Italian name. Recognizing that I didn't understand, he



sarcastically asked if I spoke Italian, which I did not. I asked him how he came to know the language, and he told a fascinating story of how he studied music extensively for years in Italy as a young man. He became an established musician and toured Europe trying to "pick up with" a number of orchestras. He was completely unable to find stable employment because he was Black. There was no way anyone would hire a Black musician in those days, he explained. Frustrated, he eventually returned to the United States, sought employment in a factory where he remained employed until his kidneys failed, at which time he lost his job. He never went back to his music. "But brother, I loved those days," he said.

When I left his room, I opened his chart and described his progress:

"Feeling better. Dialyzed yesterday without incident. No further shortness of breath. Continue present management."

I signed my name, closed the chart, and began to walk away. But feeling as though I had said very little about the person I had just seen, I returned to the chart, and wrote as an addendum:

"Incidentally, fascinating to find out that patient studied music and language for four years in Florence, Italy, in his earlier days"

I walked off wondering what all the other doctors would think of that note.

### Story Writing and Resident Training

Keller (1977) has called for medical educators involved in residency training to critically examine value questions that emerge out of practice experiences. He advocates translation of "character and conscience into clinical wisdom" (p. 109). Literature and imaginative writing are means of achieving this goal. Maccio and Garcia-Shelton (1985) claim "there is no province of medicine where the use of literature is more natural than family practice" (p. 32). We believe story writing exercises naturally complement the educational program of primary care residents. Gayle Stephens, founder of modern family medicine, confirms the connection between medicine and the human arts by pointing out that "the foundation of human reality is not mere protoplasm, the stuff that modern medicine knows so well; it is sentience and language and meaning and other beings that distinguish human reality. Protoplasm is a substrate for them." (1989, p. 107)

Shafer and Fish (1994) in their anesthesia residency training program wanted to find out "whether the use of imagination and writing could provide some overlap" (p. 125) of the phenomenological worlds of physician and patient. Their study, using patient and resident-generated stories, shows how writing exercises lead to greater self-reflection in residents, especially when focusing on the patient's

perspective. They concluded that "...the potential changes in practice that the residents report are in fact not related to the technical aspects of anesthesia, but rather to issues of confidence (either feeling more confident or expressing more confidence to the patient) and reinforcement of the importance of a "good" patient-doctor relationship. (p.140)"

We agree with Skolnik's (1988) statement that "maintain [ing] the level of curiosity and sensitivity for people that originally attracted one to the field...is of quintessential importance to medicine, to one's patients, and to one's self" (p. 511). This orientation to the human dimension of care carries heavy responsibility for primary care residency training programs, especially in light of Stephens' (1989) twenty-year educational assessment of family practice training: "We hoped to produce compassionate physicians — we've had to settle for producing less cynical ones" (p. 108). We use story writing as a means of identifying with patients and understanding their lives and their suffering. We believe this leads physicians-in-training closer to Stephens' ideal of the compassionate healer.

### Conclusions

In medical education, most prevalent is a principle-based or problem solving approach. A case containing a moral quandary is presented for discussion. The quandaries are identified and then rules or principles are appealed to as



action guides. This deductive approach fashions itself after medicine's scientific side.

A narrative-based approach to medical ethics teaching is not as clear cut as the principle-based approach. It begins and seeks to remain in stories of individuals rather than seeking universal understanding. Narrative approaches, are more akin to the art of medicine. The goal of those involved in this approach is the attainment of phronesis, practical wisdom rather than ultimate truths.

Practical wisdom in the clinical setting is built upon a rich variety of experiences such as guidance from mentors of good character, interpreting the stories of those giving and receiving health care, and the ability to call upon moral imagination, in the ordinary and extraordinary events one faces in medical practice. The orientation of a narrative approach is facing rather than solving problems. We seek to engender in students the willingness to courageously turn one's human face toward the fragile, often tragic, human condition.

The benefits from this story writing exercise could be applicable at all levels of physician education. Many of our conferences have been psychologically therapeutic. We've had a number of students begin to work through the grief of losing patients after taking on their voices. Sharing anecdotal stories that now regularly appear in discussions has added important dimen-

sions to professional identity development. The intensive residency training period is, a time in which identity is significantly affected (Keller, 1977).

Student-generated stories, some mundane, most creative, remind students of the power of imagination and creativity as they face the acculturative pressures of efficiency and standardization. Novak (1972) suggests that because the experiences which doctors and patients bring to their interaction "diverge dramatically, what we need are methods for opening up those dramas to effective notice" (p. 23). Writing fictively in the clinical setting can do this and "move us to attend to elements, aspects of our reality that might have been otherwise invisible and inaudible" (Greene, 1987, p. 11). □

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