Saving Ourselves, Our Patients, and Our Profession: Making the Case for Narrative Competence in Pediatrics

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> IN THE CURRENT health care environment, residents and faculty members are at increased risk for burnout and depression. Psychological, emotional, and physical well-being are critical in the development of the competent, caring, and resilient physician. Self-care is an important component of professionalism; it is also a skill that must be learned and nurtured in the context of other aspects of residency training.
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> —Common Program Requirements, Accreditation Council for Graduate Medical Education, 2016, VI.C. 367–376, in effect July 1, 2017

IDENTIFYING THE PROBLEM

With these sentences, the Accreditation Council for Graduate Medical Education (ACGME) ushers in a new era in medical education: one that acknowledges self-care is necessary for physicians to competently and compassionately care for others, and that calls to action those charged with training future physicians to provide both the support and role modeling necessary to develop these skills.

A review of the rapidly expanding literature on physician well-being reveals the rationale behind the new requirements. The triad of burnout[1] is prevalent in up to half of all medical students,[2] and these numbers persist throughout residency. A recent survey completed by over 40 pediatric residency programs reveals 54% of pediatric residents report burnout.[3] In a separate study, pediatric residents reporting burnout are more likely to report negative patient care attitudes and behaviors,[4] adding to the evidence that burned-out and depressed physicians are less competent and less compassionate than they otherwise would be in an unaffected state.

It is worth a brief look to our past to find our best path forward. Historically, the romanticized physician ideal included elements of the following: Physician as Hero, the Workaholic, the Composed (unemotional, stoic, detached), and the Wise (all-knowing, may not err or possess weakness). This ideal may be in part attributable to the Flexner Report, responsible for the reorganization of the medical education system in the early 1900s. The report focused on rigorous scientific inquiry and discovery rather than the patient–physician relationship. While progress means acknowledging this ideal to be misguided,[4] it is important to note that physicians historically considered medicine a calling, which is itself protective against burnout.[5]

Physicians today must struggle to find this same degree of meaning in the current era of electronic health records as well as pressure for increased clinical and academic productivity, amid increased regulatory requirements and oversight, and an ever-changing health care system that at times seems at odds with the provision of safe, high-quality care to all patients.[6] Further, ACGME efforts to enhance patient safety by limiting work hours compresses the workload and often comes at the expense of meaningful patient encounters and self-reflection, which are also protective factors against burnout.[7]

EXAMINING THE EVIDENCE

In a survey of non–burned-out physicians, 3 distinct protective domains were identified[8]: 1) job-related gratifications—including patient–physician interactions, physician–physician colleague interactions, and physician–trainee interactions; 2) resilience practices—including self-reflection and seeking help; and 3) attitudes—particularly acceptance, realism, and gratitude. However, simply focusing on physical exhaustion by limiting duty hours and increasing personal time—strategies used by many wellness programs—is insufficient. As we will describe, narrative medicine (NM) can be utilized to address each of these domains, facilitating our capacity to fully reclaim physician self-efficacy and empathy, nurture our ability to take care of ourselves and our colleagues, and maximize our ability to deliver the best care to our patients.

NM is medicine that is practiced with narrative competence, defined as the ability to "acknowledge, absorb,

interpret, and act on the stories and plights of others."[9] Fully listening and engaging in the narratives of others encompasses the core of empathic care, even when distilled down to the narratives of the history of present illness or social history. We benefit from a rich tradition of physician writers including William Carlos Williams, Richard Selzer, Oliver Sacks, and more recently Atul Gawande, Paul Kalanithi, and Abraham Verghese. The remarkable universal appeal of their works to both physicians and lay audiences speaks to their ability to thoughtfully use medicine as a lens by which to understand humanity. Stories of humanity can likewise be used to understand the art of medicine.

Evidence demonstrates the utility of NM in a number of different contexts along the medical education continuum. Medical students participating in a 1-month NM elective reported their training enabled skill development in communication, collaboration, and professional development. Students further reported improved reflection skills and an enhanced understanding of self.[10] In another study, medical students randomized to reflective writing demonstrated improved emotional awareness compared to those randomized to clinical reasoning after simulated patient encounters.[11] A required written reflection combined with discussion incorporated into a 4-week family medicine clerkship rotation ultimately resulted in greater nuanced understanding of cross-cultural discussions and improved medical student confidence.[12] After a required, intensive NM curriculum, second-year medical students expressed enhanced perception of others, self-awareness, critical thinking, and even pleasure.[13]

While the literature on NM in graduate medical education is sparser than that at the undergraduate medical education level, much can be traced back to the birthplace of NM, Columbia University, where Rita Charon and colleagues have built a master's program in NM. Sayantani DasGupta, a pediatrician at Columbia, has studied the effects of teaching cultural humility through NM and found that program participants had improved self-reported understanding of cultural diversity, medical culture, and physicians' attitudes and behaviors in practice.[14] Like clinical medicine, NM improves with practice and dedication. Below, we focus on two elements within narrative: physician as reader and physician as writer. We chose these elements because they can function both independently and synergistically to enhance narrative competence.

Physician as Reader

We can use the concept of vicarious experience—a second source of knowledge gained through some means other than direct experience—to enhance empathy.[15] Empathy is a skill that can be learned and enhanced through engagements with narrative, particularly works of fiction.[16] The degree to which vicarious experience occurs depends on readers' degree of narrative transportation—that is, the degree to which they are transported into the story and emotionally drawn into the protagonist's (patient's) narrative.[17] Empathy is thus the tool that leads readers to engagement, reflection, and behavior change, and positively feeds back as the more empathic physician seeks deeper engagement in vicarious and real experiences. Vicarious experience is both cognitive and affective, and does two things: it allows individuals to understand social experiences they have never experienced, and it teaches them to examine their own stereotypes and reflect on potential biases, setting off a host of positive responses. Vicarious experience leads to empathy for the characters via engagement, insight, and reflection.[18,19] Experiencing empathy for characters in stories increases its occurrence in real life.[20] Empathic physicians connect at a deeper level with their patients than their nonempathic counterparts, which offers protection against burnout, leading the empathic physician to find deeper meaning in work and increased well-being.[5]

Physician as Writer

The practice of writing in and of itself also provides significant benefit. Wear et al[21] delineate a clear framework for understanding reflection. Reflection encompasses elaboration and interrogation of an experience, complicated mental processing of issues for which there is no obvious solution, and ultimately transformative action. Narrative writing can fit well into this framework of reflection. Physicians and trainees may initially have a stage of prewriting where they gather information, merely pondering their many experiences and observations. Meaning does not merely happen but rather requires significant thought, and the process of writing is a means by which to "'word the world' into existence."[22] Grappling with the uncertainties of experience through writing requires an analysis of oneself. Through the process of self-interrogation, writing is able to produce new ideas rather than just simply writing about an idea.

Our hope is to urge physicians to write but not merely as a recapitulation of events or a retelling of facts. Rather, writing should intimately describe how an observation, an event, a conversation, or an interaction has shaped one's worldview, and how individual physicians have drawn meaning and implications for their future practice. Importantly, writing as a physician should not be an individualistic pursuit. It requires sharing one's writing with others, mentorship, and repeated permutations of discussion and critical analysis. In this sense, writing begets more writing. As physicians write and share, these conversations and discussions lead to more thoughtful writing, ideally producing behavior change via enhanced empathy, self-awareness, and self-efficacy.[23]

Conceptual Framework

We offer the guiding framework of Haidet et al[24] for incorporating the humanities into medical education. This systematic review and metasynthesis offers a "conceptual model on which to inform design, evaluation and research of the arts to promote humanism and other learning outcomes in medical education." This framework recognizes that many humanities-based teachings are dependent on the talents and interests of individual instructors and lack reproducibility, strategic planning, or overall curriculum design. The conceptual model of Haidet et al, presented below with overlay of our own, recognizes 4 main themes identified

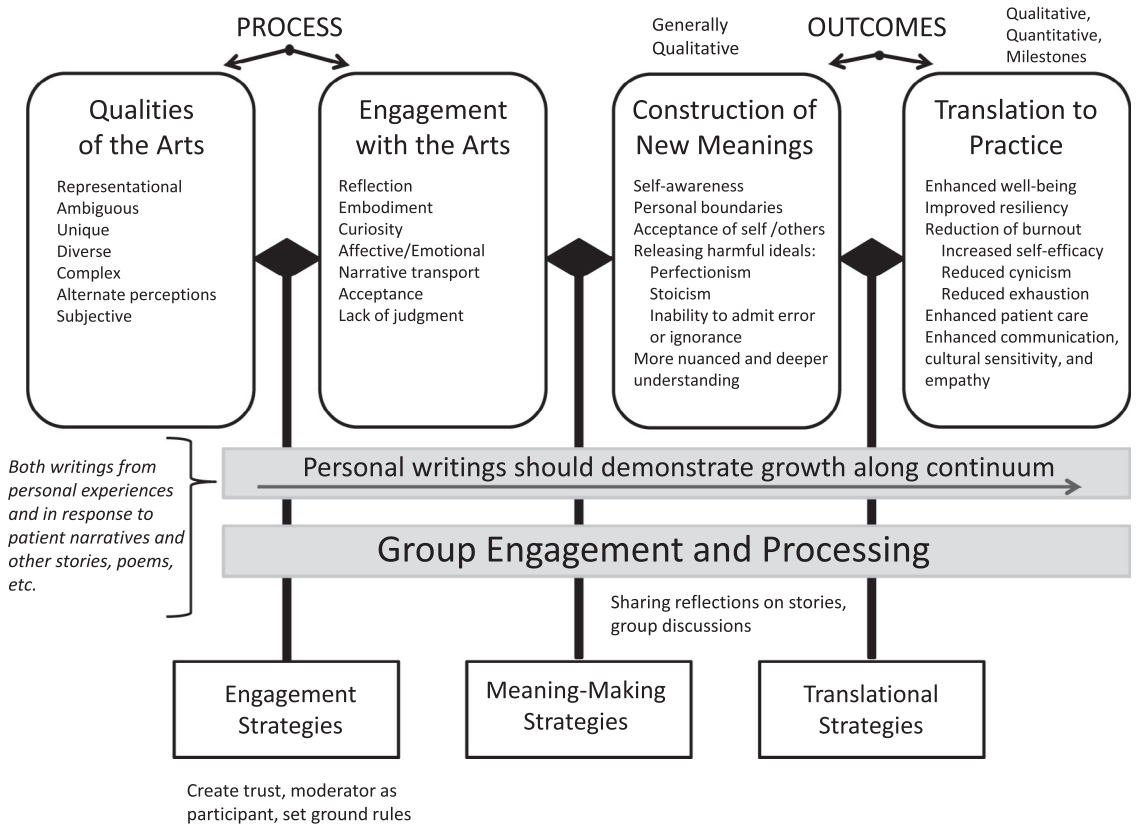

Figure. *Progression from understanding qualities of the arts to translation to practice: interactions among engagement, meaning making, and translational strategies guide the learner from experiencing the arts to exhibiting meaningful behavior change. (Adapted with permission from Haidet et al,* Med Educ*. 2016;50:328.)*

through qualitative synthesis of 49 humanities-based medical education studies: 1) unique qualities of the arts that can promote learning, 2) particular methods in which learners can engage with the arts, 3) short- and long-term documented outcomes arising from arts-based teaching, and 4) specific pedagogical considerations for using the arts to teach in professional education contexts (Figure). The degree of movement from one step to another is dependent on the degree of group engagement, time for reflection and processing, and presence of an environment of trust that is free of judgment and shame.

Implementation and Outcomes

Measuring outcomes qualitatively and quantitatively will aid both the momentum and credibility of the humanities in the medical education movement. While validated empathy, burnout, depression, and anxiety scales may be utilized for wellness outcomes, methods to track clinical outcomes, patient satisfaction, and provider communication may be used to investigate the quality of the patient–physician relationship and the quality of care. The ACGME competency domains—particularly Professionalism, Practice-Based Learning & Improvement, and Interpersonal & Communication Skills—would also be useful tools to examine the efficacy of humanities programming. Finally, an additional excellent resource to consider as an evaluation tool would be the domain of competence offered by Hicks et al,[25] which focuses on coping, resiliency, and help-seeking behaviors. One must also consider the limitations of NM, particularly supporting those students and trainees who have difficulty with reading assignments or may feel less comfortable with writing. Further, assigned readings will be emotionally triggering for some individuals. While an emotional response to readings is in general a desirable outcome, care must be taken to ensure participants have safe and effective processing and coping strategies for dealing with untoward effects the readings may have on their mental health or overall well-being. Ultimately, any successful NM curriculum will require supportive mentorship, thoughtful peer interactions, and modeling of effective resiliency practices.

Curriculum Design

Below we provide some specific considerations for those considering a NM curriculum.

Needs Assessment and Existing Resources

The first step involves an assessment of needs and existing resources: people (local expertise or interest), facilities, content, buy-in, and time. Identifying an hour or two of face-to-face time is sufficient to begin the program, particularly if participants read the narrative outside of the group meeting time or short stories or poems at the beginning of the session. Alternatives include evening or weekend sessions away from the clinical setting. This approach has the added benefit of

a less hierarchical environment, and it may invoke enhanced reflection and engagement.

IDENTIFYING MENTORS

It is helpful to identify individuals who can lend expertise or assist in other ways. Ultimately the formation of scholarly working groups within our academic organizations would be invaluable to centralizing and advancing the humanities movement within pediatrics. Until then, humanities efforts may continue to be isolated at distinct stops along the medical education continuum, with instructors at the premedical, undergraduate medical education, and graduate medical education levels unaware of each other's efforts. To locate effective mentorship, it may be necessary to reach across humanities genres (art, music, and literature) as well as varying university levels. Faculty who teach in established medical humanities curricula are passionate believers in its effectiveness and are willing to mentor, collaborate, and help others get started. Unlike most physician mentors, however, a humanities mentor does not necessarily need to be a physician. Rather, the opposite may be true: the physician with an interest in literature may benefit the most from mentorship by a professor of literature who similarly has an interest in medicine.

IDENTIFYING AIMS

We suggest referring back to the model of Haidet et al for session design. What does the NM curriculum hope to accomplish? Which step in the model will be the initial focus? Session leaders may begin with just simple infusion of NM into the curriculum, focusing on feasibility and acceptance. Specific curriculum objectives could include the following: learning to use both reading and writing to achieve resiliency and self-care, enhanced patient care, improved patient communication, and increased engagement in the community. As learners and moderators become more narratively competent, evidenced by progression through the model from engagement to meaning making and translational strategies, session leaders should consider how this competence may be translating to clinical practice and wellness outcomes. As curriculum goals and objectives develop, session leaders must consider how they will measure outcomes qualitatively and quantitatively. Using validated tools and scales (eg, Jefferson Scale of Physician Empathy,[26] Toronto Empathy Questionaire,[27] Maslach Burnout Inventory[1]) will increase the impact of the work.

GETTING STARTED

STARTING SIMPLE

Initial efforts can be simple, starting with a short didactic session for students or residents. This could include reading a poem or a short story, for example, at the beginning of the session. Medical Readers' Theater is a collection of emotionally charged, medically based short stories that have been adapted to play format, and can be utilized with little preparation. Important considerations include whether discussion should be focused on a particular topic or simply an open discussion. We have utilized Richard Selzer's 1996 short story "Imelda" to investigate physician behaviors with a focus on the ACGME Professionalism competency. Reflection should be encouraged during the session and also when the story comes to mind in a future patient encounter.

TAKING IT UP A NOTCH

A book club can be a strategy to introduce longer narratives into the curriculum. Participants are assigned a book to read with monthly meetings for facilitated discussion. This format is excellent for interdisciplinary participation. Imagine the richness of social workers, nurses, chaplains, medical students, and physicians all coming together to process and reflect on thought-provoking works such as Anne Fadiman's 1997 pathography *The Spirit Catches You and You Fall Down: A Hmong Child, Her American Doctors, and the Collision of Two Cultures*, or Roddy Doyle's 1996 novel *The Woman Who Walked Into Doors*.

ALL IN

Programs that already have a growing NM curriculum could consider starting a formal humanities track for medical students and/or residents. Such a track would incorporate elements of NM on multiple rotations, building in reflection, reading, and writing as a core component of both experiential learning and didactic curricula.

TAILOR TO THE LEARNER

Goals and objectives may vary according to the target audience. Premedical students, some of whom have an inflated, outdated notion of what it means to be a doctor, may benefit from a NM curriculum focusing on empathy and expectations. For medical students, when burnout first appears, a focus on resiliency may be appropriate. When medical students reach residency and fellowship, they assume the ultimate responsibility of patient care. Here narrative can be utilized to help the learner focus on self-care in order to provide better care to patients. Finally, once physicians are in independent practice, all of the above should be reinforced through workshops and other faculty development programs with a particular focus on modeling professionalism, resiliency, and self-care.

CONCLUSIONS

Many factors in the medical education process threaten empathy and well-being, including outdated, unrealistic standards for physicians, emotional and physical exhaustion, and the pressure for clinical efficiency and academic productivity in an era of limited time with patients. It is now our explicit task as educators to pick up the mantle of both excellent patient care and self-care to pass on to our trainees. As in the case of clinical care, we must lead not just by direction but by example. Engaging deeply in NM and the humanities offers an important path to both the prevention of burnout and the growth of empathy, resiliency, humanism,

humility, and help-seeking behaviors. While slowly evolving, our medical education process as currently conceived still threatens each of these, nearly every day, and does not discriminate among years of experience. We must do our part as medical educators to preserve the calling of medicine by incorporating the humanities along the entire length of the medical education continuum, including throughout a lifetime of practice. It is our sincere hope this article may serve as both inspiration and road map.

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