

WELCOME TO THE HUMANITIES IN MEDICINE ISSUE

In this issue of *Forum* we celebrate the role of the Humanities in Medicine. Many thanks to Dr. Maria (Gaby) Frank, lead associate editor for the planning of this important topical issue. In addition, please view *Forum* online to read a special feature titled "Port*land" by Dr. Marjorie Rosenthal.

—Karen R. Horowitz, Forum Editor

FROM THE EDITOR

Learning from Larry

Karen R. Horowitz, MD

Last month, Lawrence Smith, MD, dean of the Hofstra North Shore-LIJ School of Medicine at Hofstra University, visited Cleveland as a guest of the Case Western Reserve University (CWRU) School of Medicine. Familiar to many at our institution, Dr. Smith is known as a dynamic speaker and champion of an innovative curriculum at this new medical school. As a Hofstra alum (chemistry, class of '79), I had been eager to meet this visionary leader. I awoke early that morning and arrived in time to share a few words with him before his 8 am presentation to clinician-educators at CWRU.

Reviewing the Hofstra website,¹ I was immediately struck by the prominent Values Statement of the school of medicine and its commitment to humanism and professionalism as follows:

Humanism: We recognize that only through a comprehensive understanding and appreciation of the human condition will we successfully develop and nurture a culture and community of physicians who will care for themselves, their patients, and their colleagues with compassion, tolerance, respect, and empathy. This commitment to a curriculum that recognizes, teaches, and rewards humanism enables us to support a culture and environment truly dedicated to healing and promoting health.

Professionalism: We are committed to fostering the personal transformation of our students into physicians through a thoughtful and appropriate admissions process, careful mentoring program, appropriate reward system, and a curriculum embedded in the student doctor-patient relationship. We believe that the virtues and behaviors that characterize a good doctor will redefine the personal identity of each student. We believe this transformation is a learned, continual process that must be thoughtfully designed, evaluated, and role-modeled to be successful.

To be sure, this lofty goal is in keeping with the Charter of Medical Professionalism in the New Millennium,² but how to translate this educational philosophy into practice is a challenge for any educator or curriculum. The essential element, according to Dr. Smith, lies in the process he refers to as "professional identity transformation" in the development of physicians. To explain this concept and its implementation, Dr. Smith described the design of the anatomy curriculum at Hofstra and the characteristics that differentiate it from a traditional anatomy course.

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Training or Education? A Reflection on the Role of Humanities in Medicine

Maria G. Frank, MD, FACP

Dr. Frank is associate chief of hospital medicine at the Denver Health Hospital Authority and assistant professor of medicine at the University of Colorado School of Medicine. Dr. Frank is also the lead associate editor for the SGIM Forum Humanities in Medicine theme issue.

Along with an understanding of the sciences they (medical humanities) constitute what it means to be 'educated' as distinct from simply 'trained.'

—RS Downie¹

Human relationships are essential to our role as physicians; however, with the development of new technologies and time restrictions, the study and cultivation of these relationships has become progressively limited. Medical students, residents, and faculty spend more time in front of a computer, iPad, or phone while at the hospital than they dedicate to direct patient care. This was well described by Tipping in his article "Where did the day go? A time-motion study of hospitalists."²

It is noteworthy that three of the 15 core competencies endorsed by the Association of American Medical Colleges (AAMC)³ for entering medical students focus on the ability of the provider to connect with the patient. This year 30% of a hospital's score for Centers for Medicare and Medicaid^{4,5} reimbursement will be based on how patients rate the way

they felt they were treated while in the hospital (i.e. whether the patient perceived that doctors and nurses communicated effectively). We obviously value the physician-patient relationship. How we maintain it in this era of change is worth consideration.

What does it mean to be a "Good Doctor"?

Jane Macnaughton, professor of medical humanities at Durham University in the United Kingdom and co-director of the University's Centre for Medical Humanities, describes a good doctor as someone who has a strong foundation in scientific medical knowledge and an appreciation and respect for the individual patient and his/her circumstances.⁶ She sees clinical judgment as the balance of humane judgment—including interpretation and awareness and "educatedness" gained through arts and humanities—and technical judgment, which encompasses scientific understanding and evidence.

What is the role of humanities in medical education?

Humanities curricula (i.e. literature, philosophy, drama, art, music, ethics) have been attributed with fulfilling two specific and interconnected purposes. The *instrumental* role of humanities rests on the opportunity to impart knowledge to students through the experience of "moral imagination" (e.g. reading about a character with depression

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Teaching, Professional Development, and Changing Behavior

Marshall H. Chin, MD, MPH

...I have transitioned from focusing on the immediate clinical problem to emphasizing the encompassing art of being a physician, including the technical, interpersonal, and life course skills.



Medical education is a major focus of SGIM members, and most of us have responsibility for the professional development of learners ranging from students to junior faculty. Moreover, those of us in research or administration who aim to improve quality of care and patient outcomes face the similar challenge of changing people's behavior in order to transform care.

I've been precepting medical students in the outpatient clinic for almost 25 years now and realized a few years ago that what I emphasize in my teaching has changed. Initially, I focused mainly on the clinical problem. What are the evidence-based guidelines for care of patients with diabetes and hyperlipidemia? What are the differential diagnosis and approach to this patient presenting with dizziness? While I still spend a lot of time teaching about these classic clinical issues, I've increasingly emphasized the whole picture and art of being a physician.

This year the University of Chicago switched to a three-month longitudinal approach in which the same third-year student works with the same faculty member in the outpatient clinic for a three-month stretch concomitant with his/her inpatient medicine rotation. Today a new student started with me, and I oriented him. I told him that this longitudinal outpatient rotation was one of his best opportunities to be a doctor in the full sense of the word. I told him that many students initially had difficulty with several major aspects of outpatient medicine. First, students need to develop their knowledge base and skills addressing the major common clinical problems general internists see.

Understandably this foundation takes time to develop as students increase their clinical experience.

However, beyond this classic focus, and despite our students being kind socially adept people, many trainees initially have difficulty communicating clearly to patients and families. What will you say at the end of the appointment as you address the patient's problems and discuss the assessment and plan? What are the patient's concerns and fears? What is your practice style, and how will you build your rapport with this patient?

Where do today's visits and problems fit within the overall arc of patients' health and their lives, social circumstances, and relations with others? How well do you truly understand these patients? Regardless of what time of year it is, many students do not have a lot of experience addressing the full spectrum of these issues—the essence of being a physician.

Thinking back to my time as a medical student at UCSF, what I remember most vividly are these "art-of-being-a-physician" professional development moments. As a first-year student, I shadowed my research and career mentor Steven Schroeder, MD, once when he was inpatient attending. I remember when he had to give bad news, he sat down on the patient's bed as he talked to the patient. He later asked the residents and students what their approach to delivering bad news was. The last two weeks of medical school consisted of a review of key clinical pathophysiology and introduction to a variety of humanism and ethics topics. The session I remember most

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clearly was Molly Cooke, MD, discussing when you make a mistake. I don't remember a lot of the details from my third-year rotations, but I do remember the weekly required small-group sessions we had throughout that year with a wonderful psychiatrist named Loma Flowers, MD. She led extremely helpful discussions on whatever we wanted to talk about regarding our experiences as students.

During my research-oriented general internal medicine fellowship, we had roughly 12 sessions on becoming a better teacher. These were extremely helpful sessions on basic topics like developing a curriculum, small-group teaching, and giving feedback. In retrospect, similar to how a third-year student needs basic

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The Cadaver as My First Teacher: A Reflection

Meryl Colton, MS

Ms. Colton is a first-year medical student at the University of Colorado School of Medicine.

The first and only dead body I've ever seen was my mother's. I was 14 when she died of ovarian cancer, and for many years, I had nightmares about the night the doctor called my sister and me to come to the hospital, where she had died suddenly. Burned into my brain is the vision of walking down that hallway and turning the corner into her room to see her. A dead body.

Before this week, the week I started anatomy, I was afraid that those visions would be all I could think about during dissection of our cadaver. I was afraid I would be filled with emotion, cry, not be able to perform. But meeting my cadaver was a very different experience. The bodies were hard and cold. The faces covered. No wedding rings or favorite shirts to look at.

I'm not sure if I had talked myself up enough to compartmentalize

the experiences or if it was these stark differences, but I felt nothing. I could recognize the special opportunity of receiving a human body. I felt respect and gratitude for the life that lay before me. But here was my assignment. And in the induced mania of learning every bone, muscle, innervation, and blood flow in the body, I didn't have time to overthink it. Maybe that's the harsh first lesson I learned from my cadaver: Don't stop.

In the following three weeks, I've heard too many people to count offer the advice of efficiency. When panicked, we are instructed to "be efficient—it gets easier." We all made it to medical school listening to some utilitarian voice in our heads, and this advice is enticing. But does efficiency mean we cut the time to reflect? Process? Digest the gravity of what we're doing?

How is it possible that in the last two weeks I haven't thought once about the night my mom died? For someone, somewhere, my cadaver's death—rather, the death of the person who gave his life for my learning—caused the same pain that I experienced.

Working with the cadaver has been incredibly instructional, and I'm grateful for my ability to use my cadaver's body as a tool to learn. But every night, I can't stop myself from wondering if this was really the best way to start medical school.

I've recently thought about oncology as a specialty. I think my experiences could give me a deeper understanding of my patients' and their families' experiences. But if this week has taught me anything, it's that medicine doesn't give you the time to deeply reflect on your experiences. You are there to provide medical knowledge. You are there to be an expert and fight tooth and nail to provide the best care you can. And that is a beautiful and valiant endeavor. But does it fall flat of what drew us all to medicine? Does it fall flat of what medicine could be? I hope my cadaver has more lessons to share. *SGIM*

For someone, somewhere, my cadaver's death—rather, the death of the person who gave his life for my learning—caused the same pain that I experienced.

The Art of Listening

Suzanne Garfinkle, MD

Dr. Garfinkle is director of the Academy for Medicine and the Humanities at the Icahn School of Medicine at Mount Sinai in New York City.

On an afternoon in mid-August, between an introductory session on HIPAA compliance and the class picnic, 140 medical students gather for a mandatory musical concert. The program contains one simple message: In order to be a good doctor, it's important to care about how you listen.

When the Department of Medical Education at Icahn School of Medicine at Mount Sinai (ISMMS) established the Academy for Medicine and the Humanities in 2012, the Art of Listening—its inaugural event—instantly became an annual tradition. We are among the first to use music as a tool to cultivate listening skills in our medical students.

The event begins with a video clip from *Scrubs* demonstrating what happens when well-meaning doctors listen ineffectively to their patients. We provide some general information and statistics about the current state of listening in medicine: how we cut our patients off after only a few seconds, how we spend most of our time with patients looking at screens and keyboarding, how patient and physician satisfaction has dropped in this context, and how weak doctor-patient relationships produce poor clinical outcomes. I wonder, as the students are taking this in, if we are scaring them or boring them.

The mood brightens as the band sets up. The performers vary from year to year. They are professional jazz musicians as well as various physicians who play music on the side. We use the concert as a laboratory in which students are encouraged to observe, challenge, and improve their own abilities as listeners. Halfway through the program, we perform a skit in which standard-

ized patients play out clinical scenarios with our faculty, and we demonstrate the many ways we ordinary clinicians can fail at listening. The students build a mnemonic for good listening behaviors. The program concludes with an open discussion and reflections on the experience.

Some years, the best part of the afternoon has been hearing the professional musicians talk about their own experiences learning to listen. One drummer spoke especially well about the necessity of listening in jazz: In order to improvise, you need to understand what's going on in the music to know what to play next. When your solo is over, you join the background, continuing to play by "comping"—or providing a supportive background to—the next soloist. He described the difficulty of listening to a solo when you don't like what the person is playing and how you can't really listen unless you can find a way to respect the person speaking. We get into body language, facial expressions, and the use of silence. Doctors do not typically examine communication in this way, so it's useful to let the musicians guide us.

One of the surprising "take home" points is that listening is more important and more challenging than speaking. While we may believe that better communication equals more sharing of information, through this program we come to understand how much we emphasize our own speech above all else. While we strive to establish "rapport" through friendly banter, this does not necessarily produce a therapeutic relationship. Many doctors seem to forget that listening to what the patient says is often more important than most anything we have to say.

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The afternoon is almost over and the violist, a third-year medical student, stands up to tell a story. During his medicine rotation, a "frequent flyer" patient complained of recurrent stomach pain. Upon review of the clinical facts, the team had decided it was psychosomatic. The medical student, however, described hearing "something in the quality of her voice" that told him "her pain was real." Building on his attention to the nonverbal, he lobbied for an endoscopy that identified severe gastritis. His musical ear had saved the day.

No one involved in this program naively assumes that good listening can replace medical science. However, in the 21st century, where clinical encounters are impinged upon by charting and other legal requirements that compete for our attention, the importance of a return to a fundamental healing skill—listening—cannot be overstated. We hope that our Art of Listening program will inspire further efforts at our hospital and elsewhere to restore this fine instrument of "doctoring" to the doctor.

SGIM

John McCrae's Message to Us

Salvatore Mangione, MD

Dr. Mangione is associate professor of medicine and coordinator of medical humanities at Sidney Kimmel Medical College of Thomas Jefferson University.

**"If ye break faith with us who die
We shall not sleep, though poppies grow
In Flanders fields."**

December 8, 2015, marked the 100th anniversary of the publication of "In Flanders Fields," the most famous poem of World War I. Printed anonymously in *Punch* magazine, it told in three stanzas the story of the carnage of war through the voice of its silent victims: the fallen soldiers. It was a poetic attempt to provide meaning to what appeared so utterly meaningless, and it immediately resonated. In just a few years it transformed the poppy—the beautiful image of its opening lines—into an enduring symbol for both remembrance and oblivion. It was, in fact, an ode to death by a Canadian poet, physician, and soldier so accustomed to loss to be almost in love with the night.

John McCrae first experienced mortality when only 20 years old. Taking a break from college because of medical problems, he fell in love with a young girl of 18 before soon losing her to typhoid fever. He was never to marry, and death was to become the protagonist of 24 of his 29 published poems.¹ As he wrote to his mother, "Perhaps it is because I was brought into nearer connection with death that I have ever been before, that I think so much about it."²

Outwardly McCrae appeared gregarious, social, and even prone to humor, yet he harbored a sadness rooted in the awareness of how fleeting—at times even meaningless—life can be. In fact, only two of his poems make clear reference to an afterlife,³ which is odd since he had been raised in a strong Presbyterian tradition and his grandfather was a minister. Hence, "In Flanders Fields" can be read not as much as a call to arms—as many first interpreted it, to the point of using it for Canadian War

Bonds—but as a plea by the dead to the living to not let them die in vain. That thought must have been on the minds of so many Great War soldiers, perhaps explaining why this poem became so popular. After all, in Steven Spielberg's *Saving Private Ryan*, the dying captain Miller makes the same plea, "Earn this...earn it."⁴ In this regard, "In Flanders Fields" is not about those who suffered—it is about those who were spared suffering.

McCrae wrote the poem after seeing his brigade almost wiped out by gas at Ypres. Then, ten days later, a German shell killed a beloved Canadian officer. Alexis Helmer was only 22 at the time, had just graduated from McGill University, was engaged to be married, and was literally blown to pieces. Just before the bombing, his last words had been, "It has quieted a little and I shall try to get a good sleep."³ Afterwards, the only intact thing his comrades found was the picture of the sweetheart he was to marry. McCrae, also a McGill man, had befriended the lad and thus was touched by the absurdity of his death. He asked to perform his friend's burial service and that evening went back to his dressing station, tending the many wounded and dying. The following morning, May 3, 1915, he was seen walking at dawn to a field ambulance near the small cemetery where Lieutenant Helmer had been laid to rest. There, sitting on the ambulance back steps, he produced in less than 20 minutes his famous poem.⁵ He was 42 years old and soon fell into a dark despair from which he never recovered.

As Harvey Cushing noted years later, "Since those frightful days he had never been his old gay and companionable self."⁶ He started taking

long rides on his horse, all alone except for the company of his dog. Then in January 1918, just after being promoted consulting physician to the First British Army, Colonel McCrae entered the military hospital of Wimereux with pneumococcal pneumonia. To friends who tried to encourage him, he replied that he "knew it was the end." Meningitis developed two days later, then coma, and on January 28, 1918, he was dead.

Cushing, who attended the funeral, wrote in his diary, "Some of the older members of the McGill Unit who still remain were scouring the fields this afternoon to try and find some chance winter poppies to put on his grave—to remind him of Flanders where he would have preferred to lie."⁶

Although McCrae was gone, his poem lived on. It's on the Canadian \$10 bill and a Canadian stamp, and it even earned its author induction into the Canadian Medical Hall of Fame.⁷ In fact, it still resonates 100 years later because we all hope not to have lived in vain, we all desire to make a difference, and we all wish to be remembered.

Physicians have the privilege of touching so many lives that it's no surprise the poem came from a fellow doctor. McCrae was in fact the kind of doctor who makes us proud of being physicians, which brings us to why "In Flanders Fields" still matters to medicine—especially a medicine that wants to be humanistic.

Before 1910, medical education was inspired by the Franco-British model, wherein medicine was a spin-off of the humanities and solid humanistic schooling was considered essential for all students. McCrae's

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The Surgical History

Avital Y. O'Glasser, MD, FACP

Dr. O'Glasser is an assistant professor of medicine and assistant medical director of the pre-operative medicine clinic in the Division of Hospital Medicine at Oregon Health & Science University in Portland, OR.

I'm spoiled. For all my physician friends who scurry between 15- and 20-minute appointment slots, and for all the concerns about safe inpatient provider censuses, I'm spoiled. I am a hospitalist who staffs our dedicated pre-operative medicine clinic. My patients are scheduled for 60-minute consults. I utilize the time performing a detailed review of known comorbid conditions, updating charts on patients who are often receiving their second episode of care ever at our institution, and including a very detailed cardiopulmonary review of systems to decide who meets the criteria for additional pre-op testing. I also provide pre-op patient education and instructions. Sometimes I need more time for tasks such as arranging an urgent ECHO after hours for a frail immobile patient who lives six hours away in rural Oregon. Sometimes I need less time, and I fill a few minutes with pleasantries or get a patient on the road a few minutes early before rush hour hits. And sometimes having the full hour reaffirms why I need to slow down, ask, and listen.

On a particular Friday, my last patient of the day was a 96-year-old gentleman who was scheduled for TAVR (transcatheter aortic valve replacement). He had received the bulk of his care, including his primary care, at our institution. His electronic chart, so to speak, looked very complete—notes, EKG, imaging, and laboratories already all on file. There was even mention of a gunshot wound to his left thigh buried in the past medical history. However, one section of the chart was notably blank: the past surgical history tab.

He arrived with his two sons. We chatted. His last name led me

to learn that he was originally from Poland. We confirmed that he was aware of the indications for his surgery and that he was indeed symptomatic from his previously documented severe aortic stenosis. We reviewed his recent upper respiratory infection as well as his allergies and medication list.

And then it was on to the past surgical history.

"Have you ever had surgery before?"

"Oh sure, I had my tonsils taken out in the 1960s," he replied.

"Have you ever had any other surgeries?"

"Oh yes, I had surgery on my left leg."

I was listening. And with that, and without me asking, he hiked up his left pants leg practically to the inguinal fold. His skinny leg showed signs of multiple deep scars on both sides of his thigh, medially and laterally.

"That's right! I saw in your chart that you were shot in the leg!"

"Gunshot wound doesn't quite describe it," he said.

Now I was really listening.

What had been recorded, transmitted, automatically imported into template notes, and established as a permanent part of his medical record as a "gunshot wound" was actually artillery fire from an airplane.

He was being transported from one concentration camp to another as part of a large German convoy that appeared to include military equipment. The Allies fired on it, and he was hit.

The wheels in my head started turning quickly, then furiously, then at a breakneck speed as I was sat next to him with my jaw slack in stunned silence. All the teaching in elementary school about the Nazis and the

Holocaust came rushing back, and I tried to fill in the gaps in the timeline from his injury to his recovery. Who? What? Where? How?

"Wait.... A Nazi surgeon didn't perform your surgery, or did he?" I asked.

"No. Another prisoner in the camp, who had been a doctor, performed the surgery."

"You didn't have anesthesia for this surgery, did you...?"

"No, no I didn't. I had ether for one of my follow-up surgeries, and I did fine with it!"

Now, not only was I listening, but my jaw had hit the floor floor. Every teaching point I make to my students and residents about the importance of "pertinent positives" and "pertinent negatives" was swirling around my head. This detail was seemingly unrelated but at the same time was immeasurably and critically vital to why this man was sitting next to me in an exam room awaiting heart surgery in a week.

I was in the presence of a true survivor.

I quickly gathered my thoughts and explained to his sons why I was asking these details, lest it appear that I was just being nosy. I explained that I ask every patient how he/she has fared with past surgery—and more specifically anesthesia—to gauge how he/she will do with the upcoming surgery. Without missing a beat, his son replied to me, "So he'll do fine with his heart surgery, right?"

Faith Fitzgerald, MD, writes eloquently on curiosity and acknowledges that it requires time. I am a full supporter of promoting curiosity in all medical providers, though I am also realistic that curiosity does indeed take *time*—time to talk, time to inquire, time to actively listen,

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Journal Venues for Clinician-Educators

Robert Smola, MD; Carlos A. Estrada, MD, MS; and Ryan Kraemer, MD

Dr. Smola is a PGY-2 resident at the Tinsley Harrison Internal Medicine Residency Program, Dr. Kraemer is assistant professor of medicine and assistant program director, and Dr. Estrada is division director at the University of Alabama at Birmingham and the senior scholar at the Birmingham VAMC Quality Scholars Program.

“Someone should write that up!”

This phrase is frequently heard at the end of a case conference or morning report. Not only is publication in peer-reviewed journals an important step in the training of medical students and resident physicians, but it also remains an important criterion for advancement and promotion for clinician-educators at most academic institutions.

“Where should I publish my medical education project?” You may hear this question repeated at faculty or national meetings. Every day, clinician-educators innovate teaching and evaluation methods, implement new curricula, and conduct original educational research.

Choosing the right journal venue for publication can become a challenging roadblock for many trainees and junior faculty. Below we list our answers to commonly asked questions about journal selection.

At what point in the writing process should I select a journal?

We suggest selecting several target journals early in the writing process since the format, length requirements, and style of the journal will have a significant impact on the writing process.

Which journals publish case reports and medical education projects?

In order to facilitate the submission of case reports and medical education projects, we have updated the list of journal venues published in a 2011 issue of *SGIM Forum*. (<http://www.sgim.org/publications/sgim-forum>). Journals are listed according to their most recent impact factor. Medline-indexed status was determined by inclusion in the National Library of Medicine catalogue. We also included

relevant journals from recent reviews and an annotated bibliography.^{1,3} Additionally, Dr. Peña et al. provided a list of venues for quality and safety work in the August 2011 *SGIM Forum*.⁴

What factors should I consider when selecting a journal?

Perhaps the most important criterion in journal selection is making sure the journal has a manuscript category that fits your article. Visit the “instructions for authors” page on the journal’s website to see what manuscript categories are available for publication. Here you will find guidance for the structure of each type of manuscript submission along with word, author, and table/figure limits. To find a category that fits your article, take a moment to think about the strengths of your submission. For instance, if a major strength of your case report is an interesting image, then perhaps an “images” category would fit best. On the other hand, if you have a case with a poignant teaching point, then a full case report with discussion may fit better. For a brand new innovative medical education topic, a brief report such as *Medical Education’s* “Really Good Stuff” may fit well,⁵ whereas a more developed curriculum with several rounds of evaluation data would likely need a full manuscript category. Other important considerations are listed below:

- **Impact Factor.** This is a measure of the frequency with which the average article in a journal is cited. Journals with high impact factors usually have lower acceptance rates. A highly innovative single-center study or a multi-center well-designed educational research study have better chances of being considered for publication in

more prominent journals. At a minimum, we look for journals indexed in PubMed.

- **Publication Cost.** Cost varies from none to \$2,000 to \$3,000. Setting aside the debate of the professional value of journals that charge publication fees,⁶ we avoid expensive journals. We reserve paying publication costs for certain journals that require a small fee per page published or when a grant can cover the cost of a worthwhile project and we have an interest in wide dissemination. Additionally, some figures for case reports and clinical vignettes are just better displayed in color. Finally, a small publication fee is worth spending to empower the novice writer.
- **Journal Audience.** The readership of a journal will vary based on its intended target audience. Most journals will list their mission statement or aims on their website. Review this information to see if your manuscript is a good potential fit for the journal.
- **Journal Style.** Once you have identified a preliminary list of target journals, review the table of contents of a few issues as well as a few publications. It will give you an idea of the type of articles published and writing style.

How do I know if a journal publishes in this area?

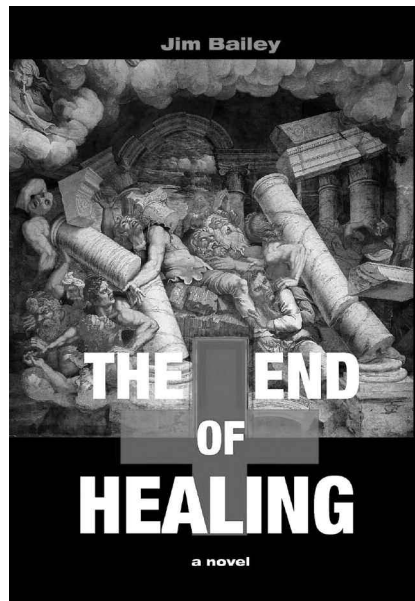
Perform a focused literature search by restricting only to the journal. In PubMed, one can search a specific journal by selecting “Advanced” search and changing “All Fields” to “Journal.” A journal that just published a very similar study is less likely to consider yours. At the same time, a journal that regularly publishes on the topic may be interested

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Why We Should Share Our Stories: Confessions of a Physician-Novelist

Jim Bailey, MD, MPH

*Dr. Bailey is chair of the Practice Management Subcommittee of the Clinical Practice Committee and author of the recently released novel *The End of Healing*.*



By day I am a professor, researcher, physician, and author of journal articles. By night I write fiction. It took more than 10 years to complete my first novel and to gather the courage to announce its publication. For those of you who have closeted your own creative writing, perhaps my story will encourage you to come out as well.

My own awakening to the need for general internal medicine physicians to tell their stories happened at the beginning of the new millennium in early 2000. That year, the prestigious Institute of Medicine released its famous report titled *To Err is Human*. It documented that 100,000 Americans are killed by medical errors in hospitals every year, making medical errors the number-one cause of accidental death in America. It came as no surprise to those in my scientific discipline—health systems research—that our system was badly broken. Even so, solutions were available. We knew how to prevent these needless medical mistakes, but we weren't doing it. To us it was a relief that the word was finally out. I fully expected an outraged American public to demand immediate action.

To my dismay, nothing happened. The few people who heard about the report didn't believe it. After all, every American knew that the United States had "the best health care in the world." Americans were truly in the dark. I realized that I could pub-

lish hundreds of journal articles in prestigious journals every year and still it wouldn't wake the American people up to the truth about modern medicine. Statistics wouldn't do it. People needed a story.

So in 2004 I began to write my first novel, *The End of Healing*, to let Americans see their own stories through the eyes of a young doctor who reveals the tragic reality they have been hiding from. On 9-11 it dawns on my protagonist Dr. Don Newman that more than enough people to fill a jumbo jet are killed every day by medical missteps in America, that hospitals are more than five times more dangerous than our most deadly roadways, and that Americans are shelling out extraordinary sums for low quality healthcare—amounts that have now grown to more than \$25,000 a year for the average family of four and \$50,000 dollars a year for the average Medicare-age family of two. He and his fellow students in an Ivy League graduate school program for health system science are stunned when they realize that although Americans think they are getting the best

care available for their money, more than a third of their health care spending goes for scams to pay middlemen and proceduralists for dangerous care they don't even need.

The End of Healing tells the stories of our patients and loved ones who have struggled to get the care they need most, who have seen things go terribly wrong after entering the hospital, and who assumed their bad experiences were rare aberrations—not business as usual. These are the difficult stories that our patients need to hear from us: stories of patients who've been misled to think their lives were saved by dangerous care—like radiation or coronary artery stents—that actually did more harm than good; stories of medical errors like Dennis Quaid's newborn twins who almost died because the hospital confused adult and pediatric blood thinner bottles and gave 10,000 times the recommended dose; and stories of industry injustice and greed like the husband who loses his beloved wife because his insurance company canceled their policy in the middle of her potentially life-saving chemotherapy treatments and who realizes that his years of health insurance policy payments went for caviar and five-hundred-dollar-a-bottle champagne for executives who got fat bonuses to reject claims and prevent payouts.

The End of Healing tells many of these dark stories—ones we have
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SIGN OF THE TIMES: PART I

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in innovative approaches to examine the same problem. If a journal venue has never published a related topic, contacting the editors with a short summary of the purpose of your work may help clarify fit. Such communications are not “binding,” and we have found them useful.

How many journals should I select?

We usually pick several journals with similar requirements of varying impact factors. If our article is rejected by the first journal, we will take the suggestions/feedback to see if it can be improved for subsequent submission. This improves the overall chance of successful publication.

What is the MedEdPortal?

The American Association of Medical Colleges (AAMC) provides a peer-reviewed publication venue for medical teaching materials, assessment tools, and faculty development resources on MedEdPortal.⁷ In addition to a description of the medical education initiative, MedEdPortal allows uploading of educational materials for dissemination.

How else can I get advice on journal selection?

Ask your co-authors and colleagues about journals that have published

their work. Additionally, ask if they will share from which journals they have had submissions rejected. This information can be valuable as you gain experience with different journals in your area.

Additional tips and suggestions for identifying and moving case reports from concept to publication are available from Drs. Mookherjee and Berger in the June 2015 *SGIM Forum*.⁸ Also, Dr. Rebecca Blanchard et al. recently published strategies for submitting educational innovations for publication in *JGME*.⁹

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SGIM

SIGN OF THE TIMES: PART II

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all experienced and hidden from view through the years. For the good of our patients, it is time to bring these stories out. We should share our darkest stories because they expose America's greatest injustices entrenched where we least expect them—in our hallowed halls of healing. We need young heroes like Dr. Don Newman for our patients to follow through the darkness of the modern health care industry so they can understand how and where they are being scammed. We need our patients to understand the ills of our health care system with a clarity that the best

ad men from the insurance companies and hospitals of Wall Street cannot shake. If we muster the courage to tell our difficult stories, it will embolden our patients to tell their own stories. Perhaps they will finally begin to demand the kinds of high-value primary and preventive care they need most.

This is my call to action for SGIM members. Share your stories of modern medicine's greatest harms and its greatest heroes. Encourage your patients to wake up, open their eyes to the truth, and follow our greatest heroes of health system transformation. Encourage your patients to join

in partnership with us—their primary care physicians—and follow Dr. Newman through the dark underworld of the health care industry to look and find something better for themselves, their families, and America.

To share your story of the dark side of American medicine and of the healing heroes you have witnessed leading the path to improving care, go to www.EndofHealing.com/share-your-story. Or if you want to talk with a recently “out-of-the-closet” writer to help you gather your courage to tell your story, contact me at jim@thehealthycity.org.

SGIM

PRESIDENT'S COLUMN

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didactic background on the approach to common clinical topics, these 12 education sessions gave us technical building blocks for our teaching.

Many of us, including clinician-educators, do not get formal training on how to best help students with their overall professional development as clinicians. A typical student evaluation form will ask us to comment on the student's knowledge, diagnostic and therapeutic reasoning skills, communication, interpersonal qualities, and professionalism, but training for teachers in how to help students progress in each of these core areas and put it all together is uncommon.

When I discuss teaching with my colleagues at the University of Chicago in the Dean for Medical Education Office who are responsible for the overall four-year undergraduate medical curriculum, it's clear that different parts of the curriculum address these different aspects and that a longitudinal developmental perspective is taken. Similarly, masters in medical education programs will typically cover these developmental learning perspectives.

Still, how best to develop, promote, integrate, and sustain these medical and professional skills is unclear. One of the controversies around the American Board of Internal Medicine's (ABIM's) Maintenance of Certification program revolves around the mission creep of the board's scope. Most physicians

would agree that strong doctor-patient communication and ability to improve quality of care are desirable. Whether it is possible or appropriate for ABIM to be the organization measuring and certifying those skills is controversial. Current proposals to reform the ABIM Maintenance of Certification program will likely focus on measuring and improving medical knowledge as its core function.

One of the most gifted medical educators I know is Monica Vela, MD, who has led or co-led the University of Chicago's required health disparities course for first-year students for many years. One of the things that makes Monica so impressive is that she has the comprehensive professional development of medical students as one of her explicit goals and thus carefully designs and revamps the course to meet this goal. Like other medical topics, health disparities has a technical component ranging from how to work with a medical interpreter to understanding Medicare and Medicaid reimbursement policy and the social determinants of health. An equally important component is helping students develop insight into themselves and their attitudes and solidifying their commitment to reduce health disparities. Monica and course co-director Valerie Press, MD, spend a lot of time thinking about where the students are coming from; what their ideological and social contexts are; and what types of educa-

tional sessions, discussions, exercises, and assignments will be most valuable for enhancing their professional development as a diverse set of students.

Returning to my evolution as a preceptor in the outpatient clinic, I have transitioned from focusing on the immediate clinical problem to emphasizing the encompassing art of being a physician, including the technical, interpersonal, and life course skills. For years I possessed the different pieces necessary for teaching students this holistic approach, but it took me a while to put them all together. In part, it took me time to mature in my own personal approach as a physician, and partly it was a focus—perhaps justified—we have in medical education to emphasize the immediate clinical problem. However, I believe we can do a better job training medical educators to help students in their comprehensive development as physicians. This is not just the responsibility of the medical education leadership of academic institutions or professional societies and medical boards. Students are most influenced by their immediate teachers and peers. Improving the comprehensive skills and professionalism of our trainees is an evolving and exciting area in medical education and scholarship and is an area that SGIM can continue to emphasize in its burgeoning faculty career development programs.

SGIM

COMMENTARY

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and time to provide the patient a chance to share. These are the things that I agree are difficult to achieve in this time-crunched 21st century practice of medicine. I think we have to nurture the time-curiosity relationship—to use our existing time with a patient to have our eyes, our ears, our full senses open to the humanity and human story of each of our patients. Sometimes a

small fill-in-the-box “best practice” detail is small—but sometimes it opens the doorway to enriching the art of medicine and creates lasting patient connections.

This patient did indeed make it through his TAVR and was discharged home three days after surgery. His surgical history has been updated in the electronic health record and is now being imported

into templated notes by others. I hope it sparks future conversations. I already know it triggered at least one more meaningful patient-provider connection. Two days after his surgery, his anesthesiologist sent me this message: “He is an amazing man, and he did great! I felt honored to be able to care for him; we were all hoping he would do great.”

SGIM

FROM THE EDITOR

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The preclinical curriculum includes two years(!) of integrated anatomy, physiology, and pathology study. In addition, students are led in reflection and narrative writing, which enables them to process the myriad emotions triggered by the study of anatomy (and inherently this extended exposure to death) and enables them to build psychological connections to life in their future careers as physicians. In addition, students are encouraged to learn about the person who donated his/her body for study and to understand the motivation and core beliefs of the individual who made the gift. The course begins with a combined orientation and memorial service for the donors and ends with another program devoted to expressing gratitude and appreciation for the anatomical gift of the cadaver. In this way, each life is celebrated by medical students together with family members of the deceased.

As the writings of students demonstrate, this program engenders a sense of humility, respect, and appreciation in learners that is rarely seen in medical training. They are brought to a new understanding of the gift of life and their relation-

ship with death. Dr. Smith read excerpts from student reflections on this curriculum that demonstrated the transformative nature of this experience. Learning about this curriculum was transformative for me as well—I was left with a sense of lightness, of burden lifted, and of optimism for our students and their futures yet to be realized.

This week, while assembling this edition of *Forum*, I read the reflection of a medical student on the cadaver as her first teacher. As I read her description of “the induced mania of learning...” and visualized the covered faces of the anonymous cadavers in her lab, I was flooded with memories of my own experience in gross anatomy in Buffalo in 1979. In stark contrast to the contextualized and meaningful experience going on in Hempstead, NY, here was the disappointment of a student immersed in the experience of a traditional anatomy program. Despite the addition of an elective on narrative medicine to the curriculum, the unspoken agenda of the curriculum was the same as 30 years ago.

My lesson from reflecting on these two disparate yet formative experiences is that humanistic val-

ues cannot be taught solely by adding a narrative medicine experience to the curriculum. Professional identity is not attained through exposure to more lectures, discussion groups, or nights on service. To engender humanistic qualities in our learners, we must model these qualities in ourselves and imbed these lessons in the curriculum—right from the beginning. Humanism in medicine is not the course we add, the poem we write, or the drama we analyze, although these are the tools that we employ toward this endeavor. It is the actions we take every day in our discourse with our students, our colleagues, and our patients that matter.

And *that* is what I have learned from Larry!

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HUMANITIES IN MEDICINE

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education was indeed rooted in the liberal arts, and as a draftsman, poet, storyteller, member of the Shakespeare and Pen & Pencil clubs, singer in the choir, and traveler extraordinaire, he was exactly the kind of multifaceted physician the profession once produced in droves: passionately curious of everything human. Then the 1910 Flexner Report moved the curriculum to a German model, with an emphasis on the lab, the white coat, and the supremacy of science. As a result, doctors like McCrae have become increasingly rare. Medicine now holds the record for the profession with the highest suicide rate,⁸ a close to 50% burnout rate,⁹ dwindling empathy,¹⁰ and a disturbing tendency

for physicians to quit.¹¹ What went so wrong in 100 years of medical triumphs? What did we lose along the way? Can McCrae teach us how to best extract meaning from pain, protect ourselves in the process, and comfort and relieve others even when we cannot fully cure them? If so, what were the traits that made him such a wonderful healer?

The first was undoubtedly competence. Trained by Osler in Baltimore and later at McGill, McCrae was the most “talented” Canadian doctor of his generation.¹² His appointment as consulting physician to the British Army—the first Canadian to ever receive that honor—is a tribute to his outstanding capacities.

He was also compassionate and kind. As a friend later put it, “...through all his life...dogs and children followed him as shadows follow men. To walk in the streets with him was a slow procession. Every dog and every child one met must be spoken to, and each made answer.”³

Lastly, he was an educated man. Hence, the third ingredient of that unique mix called “a well-rounded healer” was—and still should be—culture. Curiously, culture is not as strongly emphasized today as compassion and competence, and yet it is the one ingredient whose presence was considered fundamental until the Flexner Report of 1910.

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HUMANITIES IN MEDICINE

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Writing in 1902 about the “four great features of [our] guild,”¹³ Osler pointed out how medicine had to be the profession of a “cultivated gentleman.” And even Flexner included in his 346-page report an often-forgotten passage where he mentions the “varied and enlarging cultural experience” that he considered so important to the education of physicians:

“...the practitioner deals with facts of two categories. Chemistry, physics, biology enable him to apprehend one set; yet, he needs a different apperceptive and appreciative apparatus to deal with other, more subtle elements. Specific preparation is in this direction much more difficult; one must rely for the requisite insight and sympathy on a varied and enlarging cultural experience. Such enlargement of the physician’s horizon is otherwise important, for scientific progress has greatly modified his ethical responsibility.... It goes without saying that this type of doctor is first of all an educated man.”¹⁴

Yet somehow being “cultivated” is no longer a tenet of the profession. Medical schools have become technical schools. The humanistic aspects haven’t been fully shed—we are still caring for human beings—but are now secondary in both undergraduate and postgraduate curricula.^{15,16}

Hence, John McCrae reminds us of what has been lost (and forgotten) in the well-justified rush to implement Flexner’s recommendations. He reminds us that being physicians ought to be something larger than being mere technicians. If this premise is accepted, then the next step is to recognize those personal traits that made people like him possible so that we can start recruiting for them and then nurturing them during training. If this premise is instead rejected, McCrae may still serve as an inspiring reminder to the younger generation of the kind of men and women that medicine was able to produce—and hopefully will produce again. After all, without the past there is no future.

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DONATION

Prone on a table, lifeless and cold
Is this what happens when we become old?
Only to some, the brave and the few
Who donate themselves as the last thing they do.

We donate our clothes, spare change, and old shoes
We give away things that we don’t care to lose.
But to donate yourself, for the good of another
Is a donation so special, it’s unlike any other.

Your body complete, from head to toe
Taught more people than you could possibly know.
You gave the very last thing you could give
And because of your gift, others will live.

It’s an incredible thing, to do what you’ve done.
I wish I could thank you, and meet the one
Who was so giving, so thoughtful, so great
Whose last request, was to donate.

—Travis Barlock
University of Colorado School of Medicine

EDUCATORS' CORNER

continued from page 2

and hence learning about “what the character feels like”), to improve communication skills (e.g. written through literature, verbal and non-verbal through drama and visual arts), to conceptualize an argument (e.g. utilizing the constructs of philosophy), or to gain perspective from historical events.⁶

On the other hand, the *non-instrumental* function of humanities education resides in knowledge gained, personal growth, and the experience of “counter-culture.” This “social” education refers to broadening students’ perspective; personal growth denotes the development of students’ professional selves; and “counter-culture” provides students with the ability to understand different points of view. Altogether, the role of humanities education is to develop students’ cultural competence.⁶

What is the difference between being educated and being trained?

The *Merriam-Webster Dictionary* defines *to educate* as: 1) to provide with schooling; 2) to develop mentally and morally, also to provide with information, to discipline, to instruct. The same dictionary defines *to train* as: 1) to cause to grow as desired; 2) to form by instruction, discipline, or drill; 3) to make or become prepared for a test or skill. We frequently consider these words interchangeable and have become comfortable with the term “medical training.” The disparities between the verbs are important, and yet they are not exclusive. In fact, I feel that they should be complementary,

as both are necessary for good medical practice.

Macnaughton provides a clarifying statement: “Education is not just concerned with what someone can do, but about what kind of people they become as a result of their education. Developing as a certain kind of person is important for the good doctor because medical practice is not just concerned with knowledge and skills but is also concerned with a humane and sympathetic approach to people.”⁶

How do medical students respond to the incorporation of medical humanities curricula during medical school?

We are not to expect unanimous acceptance of humanities curricula during medical school. Three kinds of responses have been identified in the literature.⁶ The first includes those students who are immediately delighted by it and will seize all opportunities for learning and personal growth. The second group of students realizes the utility of the curricula in a delayed manner, likely when confronted with a challenging case. The third set will never understand the utility of this training in a broader educational experience but may still benefit from subconscious “personal growth.” Nevertheless, providing students with the opportunity to experience humanities education during medical school has become the path to follow in the 21st century.

Summary

The routine study of the arts heightens our senses. Appreciation of

graphic art is known to improve observational skills while music enhances our ability to listen. The performing arts and literature help us understand and give social context to many medical events. Enhancement of these skills may prove essential in our ability to improve our performance in bedside diagnosis and in interactions with patients and their families.

Art, in all of its forms, allows for the expression of truth and beliefs. While some works of art challenge our fundamental beliefs, others affirm our faith. Art is an important tool in prompting us to examine our own views and has the ability to transport us to a different time and place while gaining historical perspective and understanding. More importantly, art has the power to evoke distinct and unique emotional responses in both artists and patrons. As physicians, art has the potential to enable us to better understand and express our emotions and those of our patients.⁷⁻⁹ Several medical schools in the United States have introduced art observation courses to their curricula, and currently many US medical schools offer a “medical humanities track.”

The addition of medical humanities curricula to medical school education highlights the importance of respect for patients’ values, preferences, and expressed needs. It is hoped that such curricula will enhance the development of effective and empathetic communication and listening skills through improvement of cultural competence. Under the same premise, understanding a patient’s perspective, needs, and cultural background will engender trust and confidence, improve patient-provider interactions, highlight community concerns, and hence result in delivery of exceptional health care. This curriculum may also address professionalism as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to diverse patient populations.

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The addition of medical humanities curricula to medical school education highlights the importance of respect for patients’ values, preferences, and expressed needs. It is hoped that such curricula will enhance the development of effective and empathetic communication and listening skills through improvement of cultural competence.

EDUCATORS' CORNER

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tions, which is a key Accreditation Council for Graduate Medical Education competency.¹⁰ Giving students the opportunity to develop their cultural competence may lead to optimizing the patient's experience and foster patient-centered care (Always Events®).¹¹ As medical educators our goal should be to educate and not to solely train.

To be educated is not to have arrived; it is to travel with a different view.

—RS Peters¹²

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THE VIEW FROM AMBULATORY CLINIC

I. Referral

I knew that he was scared
I knew that he was sick
I sent him to the ER
So he would get help quick

I followed all the notes
And read up on the tests
I spoke to the attending
Who I knew was the best

He had the "big C"—cancer
We knew it at a glance
We admitted him for testing
So he would have a chance

And that's where my part ended
I knew he'd get good care
But inside me a question
Why wouldn't I be there?

I'm really very busy
With alerts, abstracts and home
My family is waiting and I really want to go
I'm tired and I'm stressed and it's easier to say no

I wish that it were different
That I could do it all
I wish that it were different
Maybe I'll give him a call...

II. Fragments

Oncology

Chemical pain
Infusing hope
Crystal ball longing

Cardiology

CPR
AICD
Life...electrifying!

Hospitalist

Treating
Till you say, "stop!"
Hospice consult

Follow up

Frail...smiling
BIG HUG!
Diminished...grateful

—KRH

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SGIM Forum is a monthly publication that offers articles, essays, thought-pieces and editorials that reflect on health care trends, report on Society activities, and air important issues in general internal medicine and the health care system at large.

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Forum is currently seeking case reports for our Morning Report column.

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