The use of stories in medicine and medical education

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What I will talk about

• How we teach medical students and doctors to pay close attention to patients’ stories
  (and how NHS systems could help)

• How we use stories to teach students and doctors
Ethical and moral dimensions

Integration of the two frameworks to produce a working diagnosis and a shared management plan.

Information-gathering:
the “golden minute” and focused history-taking
Rapport-building

Patient presents symptoms

Patient’s agenda:
- Ideas
- Concerns
- Expectations
- Feelings
- Thoughts
- Previous experiences

Understanding patient’s own experience of health and illness.

Doctor’s agenda:
- Signs
- Symptoms
- Investigations
- Underlying pathology
- Differential diagnosis
- Ideas on management.

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Traditional case history

- Presenting complaint
- History of presenting complaint
- Past Medical History
- Review of Systems
- Social History
- Family History
- Drug History
- Examination
- Differential Diagnosis
- Management Plan – Investigations, procedures, treatments, referrals, etc
But...

“The case history negates pain, distances the physician from the patient and thus sanitizes suffering. It is a highly useful, necessary tool, but it is a reductionist, “minimalist” reconstruction of a person's illness narrative.”

Patient’s stories

William Labov

1. Abstract
[What’s the story all about?]

2. Orientation
[Who and what does it involve. When and Where?]

3. Complicating action
[Then what happened?]

4. Resolution
How does it end?

5. Evaluation/Coda
[So what, and what does it all mean?]
Attending to patients’ stories

• Compare 2 clinical encounters – in one successful storytelling; in the other patient is interrupted
• Illuminates the exercise of authority in clinical encounters
• Negotiating topic; setting scene; clarifying action and consequences

How long before doctor interrupts?

20 seconds?

30 seconds?

45 seconds?

1 minute?

>1 minute?


Active listening

Focused attention
Noticing “cues” – internal search
Para-language – “mm, uh-huh, I see, go on..”
Body language – nodding, mirroring
Echo-ing
Demonstrating empathy
“ICE”

Ideas

Concerns

Expectations
Could do better...

• Small part of the curriculum
• Not always integrated
• Role modelling far from perfect
• Patient voice still muffled
• “Assessment drives learning”
Using stories in teaching
Potential benefits of stories in medical education

- **Meaning-making** (eg Bruner, 1990)
- **Enhancing memory** (eg Fernald, 1987)
- **Promoting empathy** (eg Greenhalgh, T 2001, Charon 2006)
- **Reflection on practice** (eg L. Hunter & Hunter, 2006)
- **Development of illness scripts** (eg Schmidt et al., 1990)

Greenhalgh, T. (2001). Storytelling should be targeted where it is known to have greatest added value. *Medical Education, 35*(9), 818-819.
Stories in medical education

Case histories [clinical anecdotes, formal presentations]

Medical humanities [literary texts, film, poetry, drama, drawing, art]

Significant event analysis

Reflective diaries [eg digital storytelling]

Role play [consultation skills]

Problem-based learning

Patient experiences
[expert patients, patient accounts, patient journey, healthtalk]

Longitudinal attachments
How do medical teachers use stories in basic science lectures?

- Researcher observation of teaching sessions
- Student focus groups
- Teacher 1-1 interviews
The first bit is Stage I and Stage I sleep is that drowsy stage which you can observe in a practical laboratory called the tube. So if you watch somebody on the tube, you'll see them start to lose that postural muscle activity as they fall asleep. And their head goes (lecturer pretends to nod off to sleep) and you'll also see them lose their ocular eye muscle activity and their eyes will start to roll – they'll do this (lecturer rolls eyes). But in Stage I sleep you're still responsive to sound, so when he gets to South Kensington you'll see them do this as they sit up and then as you go through the different stages of sleep and you become less responsive to sensory stimuli so when you get down here into deep sleep you're less responsive. So this is the one that you see slumped in the corner of the circle line then dribbling and all bets are off (audience laughter). And that's deep sleep and that’s the stuff that makes you feel better – it is the deep sleep that makes you feel restored and vital and healthy.
Example – the Tube Story

STUDENTS

• Memory
• Engagement
• Meaning – understanding of sleep stages
• Becoming an expert
• Humour

LECTURER

• Memory
• Engagement
• Meaning – understanding of sleep stages
• Relevance to exams
• The scientific approach
• Credibility
Results – in a nutshell

- Lecturers are telling many narratives, and several stories, even when they don’t think they are (some deliberate)

- 20 or more in 45 minutes lecture

- Less antipathy towards use of stories/narratives than I anticipated – in both students and lecturers.

- Lots of different types of story for different purposes: eg sleep on tube; bacteria and phagocyte

- Narratives- particularly stories - often used to convey messages about:
  - patient experience
  - professional identity
  - becoming an expert
  - life as a scientist/doctor
  - clinical experiences/warnings
  - tips about key skills for working as a doctor [eg empathy]

- A few students find them a distraction from their task – exams!

- The word “story” is problematic for both students and lecturers
Conclusions

- Patient stories at heart of modern patient-centred care -> key to humanising healthcare.

- Could do more to help healthcare professionals pay full attention to patient stories – training, time, continuity of care, patient voice in case histories?
The End
Why bother listening?

• Accurate diagnosis
• More satisfied patients
• More engaged and cooperative patients
• Better outcomes
• Reduced repeat consultations for the same problem
• Lower risk of litigation
• Better use of resources