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Literary Narratives Examining Control, Loss of Control and Illness: Perspectives of Patient, Family and Physician

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This article examines how three literary narratives portraying the psychological effects of illness deal with issues of control in the doctor-patient-family relationship. Specifically explored are how patient, physician, and family members cope with the feelings of vulnerability and loss of control brought on by illness; and how each seeks to gain and maintain a sense of control in this coping process. Suggestions are offered for uses of these narratives in medical education. By exploring themes of control in the doctor-patient relationship, physicians develop greater insight and empathy that in turn can lead to improved outcomes for both patient and doctor.

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A perennial issue at all levels of medical education is how to instruct learners in what have been called "difficult-to-teach" clinical competencies (Hunter, Charon & Coulehan, 1995). No single comprehensive list of these competencies has been identified, but authors variously have included under this rubric aspects of the doctor-patient relationship such as empathy, compassion, genuineness, emotional engagement, and whole person understanding under this rubric. Such topics are considered "difficult-to-teach" because, in the minds of at least some scholars, they are not easily reducible to neat sets of behavioral skills or universally applicable principles and rules. Because of the incomplete accessibility of these competencies through social science's empirical and analytic methods, the search for viable teaching approaches has historically included the use of unorthodox pedagogical tools such as fictional literature i.e., poetry, short stories, essays, novels, and first person narratives (Squier, 1995; Downie, 1991).

Fictional literature has proven especially effective as an adjunct teaching modality in these domains because it is concrete and particular, and because it engages the imagination and the emotions (Coles, 1989; Stein, 1996), as well as the intellect, of the reader. The very fact that literature concerns itself not with general principles and theories, but with individual people,

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makes it easier for learners to see themselves through its words. Because its imaginative properties make literature "come alive" for learners, and because their emotions are aroused so that they "care" about the outcome of a particular piece of fiction, learners tend to wrestle with the questions literature raises in an involved, rather than a detached way. By simply illustrating situations and highlighting problems rather than offering models of solutions, literature provides an open-endedness that allows learners to explore a rich range of emotional and behavioral responses (Coles, 1989). The particularity of literature also makes it especially likely to trigger reflections on personal and professional experiences. The resulting insights tend to linger in the minds of learners, and they tend to recognize and remember their implications as they move through their own clinical experiences (Charon, Banks, Connelly et al., 1995).

As many authors have pointed out, (Charin, 1989; Donley, 1995; Pellegrino, 1995; Trautman, 1982) fictional literature speaks to medical student and physician learners because it is recognizable as part of what has been referred to as the narrative tradition in medicine (Epstein, 1993; Frank, 1998). While space precludes an exhaustive discussion of this concept, it is widely recognized that if two legs of the medical stool are the scientific tradition and the physical examination, then the third is its narrative component, i.e., the ineluctable need for patients to tell their stories, for physicians to receive and interpret those stories in the light of medical paradigms, and then for the stories to be returned to the patients in a way that, optimally, will improve their outcome, but at the least improves their sense of hopefulness (Brody, 1994). This narrative tradition expresses itself in identifiably literary terms, including character development, plot, themes, tone, climaxes, and denouement (Bouchard & Guerette, 1991). Therefore, the study of

fictional literature may well contribute to the ability to recognize and understand the stories of actual patients.

In this paper, we will first identify a specific "difficult-to-teach" clinical competency, i.e., the ability to recognize and manage control-related issues in the doctor-patient encounter. Next, we will proceed to a discussion of three well-known and frequently used works of fictional literature that illustrate different aspects of control problems among doctors, patients, and families. Finally, we will explore how such literary works can be used in various medical education settings to illuminate issues of control, recognizing that, in the clinical setting, these issues may interfere with communication and patient care.

Control in the Doctor-Patient Relationship

A casual reflection on doctor-patient interactions provides numerous examples of control struggles, out-of-control situations, actual loss of or fear of losing control, and compensatory overcontrolling strategies on the part of doctors, patients, and family members. Yet issues of control are rarely addressed directly in discussions of the doctor-patient relationship. Nevertheless, some researchers postulate that one of our greatest human fears is losing control; and one of our strongest human motivations and most basic needs is to have a sense of control over our own lives (Shapiro & Astin, 1998). Thus, it is not surprising that control (and its loss or threatened loss) is a dominant, although implicit, theme in medicine. Patients, family members, and physicians all struggle against loss of control, and employ psychological and behavioral strategies to help themselves regain and maintain control.

Perhaps one of the reasons control has received little systematic attention is that it is a difficult subject to talk about. Everyone would agree with the abstraction

that it is better to be "in control" of a medical interview than to "lose control" of the interview. But we tend not to go beyond such generalizations. Further, it is uncomfortable to think of ourselves as engaging in "control battles" with patients. Finally, the experience of losing control is so fundamentally threatening that it makes it difficult to contemplate, much less explore such issues in any detail. Nevertheless, control issues abound for doctors, patients, and family members.

Illness-Related Control Issues. From the perspective of the patient, the sick role is often experienced as one of increased passivity, dependence, and helplessness (Parsons, 1958), a loss of control over one's own body, one's daily life, and even one's future (Sorum, 1994). Although this is usually a "state," not a "trait" phenomenon (i.e., once the individual is restored to health, the sense of loss of control, dependency, and helplessness disappears), it is nevertheless a disturbing, even frightening, experience. By definition, the experience of illness threatens the patient's sense of order and coherence, and encourages regression and infantilization. Cassell noted that loss of control is perhaps the most fundamental aspect of the illness experience, and how patients attempt to regain control is the defining moment in their relationship to their disease (Cassell, 1976).

Family members too may experience a loss of control in response to their loved one's medical condition. Illness in the patient inevitably places additional demands and burdens on family (McDaniel, Hepworth, & Doherty, 1992), interrupting the normal routines that provide a sense of control. In addition, the patient's illness can trigger intense feelings of fear and vulnerability in family members, both for the patient and for themselves (Rolland, 1987).

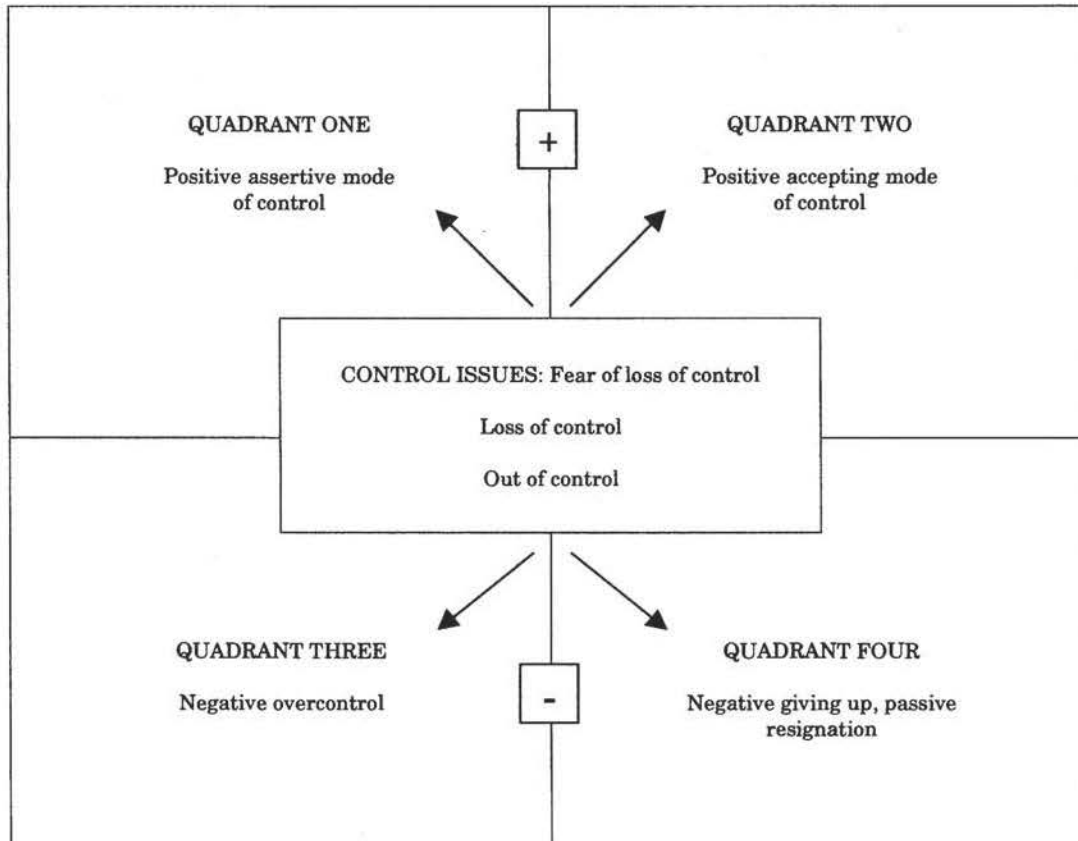
The physician usually is expected to restore as much control as possible

(Fleischman, 1999) to patient, family, and, indirectly, him or herself by providing diagnosis (control by naming [Randolph, 1992]), prognosis (control by prediction), and treatment (control by active intervention) (Wear, Jones, & Nixon, 1999). But physicians may also experience their own control-related issues. They may struggle with feelings of vulnerability and potential loss of control (Frank, 1998; Weissberg & Duffin, 1995). The work of Petrie, Booth & Pennebaker (1998) suggests that the physiological costs of being an attentive "listener" in high-stress situations such as physicians typically face with patients may contribute to their feelings of not having control, losing control, or being out of control.

Ways to Establish a Sense of Control. Although there is a multiplicity of coping strategies that develop in response to control issues, theory and research have shown that they can be subsumed under two general categories (See Figure 1) (Shapiro & Astin, 1998; Shapiro, Schwartz, & Astin, 1996). One control strategy seeks to gain or regain a sense of control through active, instrumental means. This strategy can be either positive ("taking charge") or negative ("overcontrolling"). Negative instrumentality is typical of individuals who are excessively controlling and manipulative, especially in situations where such behavior is injurious to themselves or others, or is pointless.

A second control strategy involves acceptance and coming to peace with situations as they are. This acceptance strategy can also be either positive ("letting go") or negative ("giving up"). Whereas giving up refers to control-related behavior that is inappropriately or excessively passive, hopeless, and resigned, letting go implies a positive yielding to that which cannot or should not be changed. Research has concluded that a combination of positive instrumentality and positive acceptance is most strongly correlated with better health

FIGURE 1
A Theoretical Model of Control



and psychological outcomes (Astin, Anton-Culver, Schwartz et al., 1999).

Control-Related Coping in the Medical Context. Faced with a loss of control, patients, family members, and physicians will engage in some or all of the above strategies. For example, they may cope with appropriate instrumentality and problem-solving (Figure 1, Quadrant 1). In healthcare, positive instrumentality is often referred to as "fighting spirit" among cancer and AIDS patients (Classen, Koopman, Angell et al, 1996), and among their physicians is manifest in constructive problem-solving and active management of patient disease (Wear et al., 1999). Patients, family members, and physicians may also become domineering and aggressive in response to control issues (Figure 1,

Quadrant 3). Overcontrolling patients and their families are generally referred to as "difficult" (Hahn, Korenke, Spitzer et al, 1996; O'Dowd, 1988), uncooperative, belligerent, demanding, or noncompliant. Overcontrolling physicians, while usually not liked by their patients, are frequently encountered in medicine. The strong socialization physicians receive from their education and society in general that they must always be in charge (Hunter, 1991) results in an almost exclusive reliance on active, instrumental control strategies, both positive and negative.

Patients, family members, and physicians may also practice emotional and spiritual acceptance of circumstances beyond instrumental control (Figure 1, Quadrant 2). Such patients and families are

often described as wise teachers, from whom others can learn (Remen, 1994). Similarly, many physicians are able to integrate a positive acceptance of their limitations, and a tolerance of "negative patient outcomes," into their clinical practice (Loxterkamp, 1997). Sometimes, however, patients, families, and even physicians, become mired in hopeless withdrawal and passivity (Figure 1, Quadrant 4). Patients and families can be overwhelmed by depression and despair because of their medical circumstances (Frank, 1995). When physicians withdraw into a state of helplessness and hopelessness, it is usually because the patient is chronically ill or dying and their more active strategies to maintain control of the disease have failed (Garfinkle & Block, 1996).

Literary Narratives about Control

In the doctor-patient relationship, two short stories by Richard Selzer, "Fetishes" and "Mercy" (Selzer, 1998), and William Carlos Williams' "The Use of Force" (Williams, 1984) illustrate how themes of control operate in the clinical relationship from patient, family member, and physician perspectives. A brief synopsis of each story is provided below, followed by a discussion of control-related themes.

Story Synopses. In "Fetishes," a middle-aged woman, Audrey, faces a total hysterectomy. Her main concern, however, is whether her adoring anthropologist husband, Leonard, will discover post-op that she wears dentures, a secret she has successfully kept for fifteen years. Her surgeon and anesthesiologist are unsympathetic and dismissive about her concerns, as is her own sister Violet. However, a lame, careworn Indian resident, Dr. Bhimjee, feels compassion for Audrey and replaces her dentures after surgery, leaving her secret, and dignity, intact. At the close of the story, Leonard, to thank the resident for the "courtesy" he has shown

his wife, gives Dr. Bhimjee a healing good-luck fetish used by a tribal shaman.

"The Use of Force" evokes a different mood. Set in the earlier part of the twentieth century, before the discovery of the diphtheria vaccine, poor immigrant parents, the Olsons, have asked a local doctor to examine their ill daughter, Mathilde. With other cases of diphtheria already confirmed in the neighborhood, the doctor suspects she has contracted the dreaded disease, and asks to examine her throat. The little girl refuses to open her mouth, and the parents seem too overwhelmed to be anything other than passive bystanders. A battle of wills ensues, in which the doctor feels morally and medically obligated to pry open the child's mouth, so that he can perhaps save her life.

"Mercy" is a meditation on the responsibilities of the physician to his patient in the dying process. In this story, a terminally ill man with pancreatic cancer suffers excruciating, uncontrollable pain. Patient and family members plead with the physician to end his suffering, and the patient's mother explicitly consents to the doctor's administering a lethal dose of morphine, which he does. The physician then remains at his patient's bedside, waiting for death. But the patient does not die. In his helplessness, the physician contemplates asphyxiating his patient, but cannot bring himself to do so. When he rejoins the wife and mother, he claims that the patient is not yet ready to die, but the mother insists it is the doctor who is not ready.

Patient Control: Issues and Strategies. In "Fetishes," the patient Audrey attempts to retain her sense of control in the face of major surgery, the loss of her "womanhood," and possible malignancy by "controlling" Leonard's discovery of her false teeth. Fifteen years earlier, when she allowed an arrogant dentist to remove all her teeth, she voluntarily relinquished control in a passive, resigned manner, and she is

determined not to let this happen again. Keeping the secret of her false teeth therefore becomes a kind of “control anchor,” and its loss threatens her fundamental well-being.

Audrey’s encounters with control are all win-lose situations that vacillate between futile positive instrumental strategies (Quadrant 1) and negative giving-up (Quadrant 4). With her dentist, surgeon, and anesthesiologist, she tries assertive, active coping approaches by making her wishes known and attempting to influence the outcome of events, only to revert to passive helplessness when these efforts fail. Only with the help of the compassionate physician Dr. Bhimjee is she able to accept and trust her situation (Quadrant 2).

In “Force,” the patient attempts to retain control by pitting her will against that of the doctor. Mathilde has only one control strategy at her disposal—increasingly frantic assertion of her resistance (Quadrant 3)—and she clings to it fiercely. Yet whereas in “Fetishes” Audrey is helped to keep her harmless, yet symbolically potent secret (the existence of her dentures), in “Force” it is evident that Mathilde’s secret (the infection in her throat) will kill her. Her control strategy is dysfunctional, and must be challenged to save her life.

In the final selection “Mercy,” the author presents a dying patient who has lost control of the dying process and become a victim of his own demise. He makes barely any utterances, his only words a cry for help. Although he pleads for release, the patient seems to have given up hope (Quadrant 4) that he can control his dying.

These stories variously illustrate the great importance of control in the experience of patienthood. All of the patient characters feel they have lost control or are out of control, and attempt to exert some control over their situation, whether by asking for or resisting help. They provide examples of Quadrant 1 positive instrumentality (Audrey at certain points in the

narrative), Quadrant 2 positive acceptance (Audrey at the end of the story), Quadrant 3 overcontrolling resistance (Mathilde), and Quadrant 4 passive resignation (Audrey at various points; the patient in “Mercy”). From these stories we can learn much about how patients struggle with control issues.

Family Control: Issues and Strategies. In “Fetishes,” Audrey’s sister Violet attempts to maintain a sense of control by ridiculing Audrey’s secret and by refusing to help her communicate her wishes to her doctors. Violet’s behavior is a typical overcontrolling response (Quadrant 3)—she is simultaneously domineering and withholding. Her actions give her a sense of being in control, but at Audrey’s expense.

Leonard, on the other hand, is an accepting, tolerant man who normally does not need to exert control over his wife (Quadrant 2). Nevertheless, because he does not listen carefully when Audrey begs him to stay away from the hospital, a positive Quadrant 1 instrumental action (visiting his hospitalized wife) becomes overcontrolling (Quadrant 3) as it reduces Audrey’s sense of control still further and exerts his will over hers.

In “Force,” the child’s mother and father are portrayed as ineffectual, passive, and helpless in the face of their daughter’s powerful will. The Olsons appear unable to control Mathilde’s tantrums or assist the physician in any way to conduct the necessary examination of their child. Their single positive assertive act (Quadrant 1) to keep control of the situation was summoning the doctor. They seem to feel they have no control over what happens from this point onward. Their subsequent behavior, apologizing to the doctor while failing to restrain Mathilde, illustrates the demoralizing nature of passive resignation (Quadrant 4).

The patient’s wife in “Mercy,” by contrast, is not accepting, but passive and desperate (Quadrant 4). She pleads for help from the physician, but in vague terms, and focuses

on her own despair. The patient's mother, on the other hand, combines active instrumentality with acceptance (Quadrants 1 and 2). She clearly instructs the physician to administer a lethal injection of morphine to her son. She also explicitly tells her son to "go home." In both these cases, the mother takes a positive action to resolve a painful situation. But her words also convey an acceptance that contains "neither gratitude nor reproach" for what is about to occur.

The family perspectives presented in the three stories help us understand family members' efforts to retain or regain control. Audrey's sister tries to keep control by mocking and distancing from her (Quadrant 3), whereas her husband attempts to be in control by pursuing his supportive, loving role (Quadrant 2), even when this is not what his wife desires (Quadrant 3). The parents in "Force" are examples of what can happen when family members feel they have no control and essentially give up (Quadrant 4). In "Mercy," we have an example of positive instrumental control (Quadrant 1), where a family member is willing to make difficult life-and-death decisions for her son, combined with positive acceptance (Quadrant 2).

Physician Control: Issues and Strategies. In "Fetishes," dentist, surgeon, and anesthesiologist, when confronted with their patient's hesitation to relinquish control, respond with harsh, overcontrolling strategies (Quadrant 3). Instead of listening to Audrey's concerns, they intimidate her and force her to accept courses of action that are repugnant to her. They use their greater power and authority to override her wishes, under the guise of a pseudo-benevolent paternalism. By structuring these medical situations to their convenience, they maintain a sense of control, but destroy Audrey's in the process.

Dr. Bhimjee, by contrast, uses a strategy of positive acceptance (Quadrant 2) through acknowledgment of his patient's needs and

concerns. "There was a peacefulness about him... not resignation so much as acceptance." Dr. Bhimjee is nonjudgmental and seeks common ground with Audrey. He is the prototype of the wounded healer (Gagnon, 1994; Glaz, 1995). His physical disability serves to link him to his patient, and establishes their shared, and vulnerable, humanity. His own physical limitations and suffering, Selzer implies, have taught him that to maintain control in this world requires sharing control with others, including patients. Out of this atmosphere of forbearance and unconditional regard comes a Quadrant 1 instrumental strategy (the replacement of the dentures) that simultaneously supports his sense of control while restoring a sense of control to his patient.

The physician in "Force," as the title suggests, meets force with force. In his view, Mathilde's control strategy requires him to oppose it with his own strategy of dominating assertion (Quadrant 1). No other strategies occur to him. The doctor in "Force" makes no apologies for his behavior, although he admits that he "had got beyond reason" and at various points in the narrative is operating in an out-of-control fashion (Quadrant 3). The narrator appears to view this situation as an elemental struggle of good versus evil, in which justification for the assault on his patient paradoxically is the welfare of this self-same patient.

Finally, in "Mercy," the doctor struggles between Quadrant 1 positive instrumentality (administering the lethal injection), Quadrant 3 overcontrolling strategies (contemplating strangling his own patient to achieve the goal of death), and Quadrant 4 withdrawal ("fleeing" from the patient). As the mother astutely observes, the physician is "not ready" for his patient to die. When he cannot solve the problem with active tactics, he leaves the patient to battle on alone with death.

These stories also help us understand

control issues from the perspectives of physicians. We learn from them that physicians, like patients, struggle against loss of control and, at times, may actually lose control. They appear most comfortable with active control strategies, whether positive or negative. Physicians may have a tendency to exercise "too tight" control with patients, ignoring their wishes and communications (Quadrant 3) and imposing their will in the name of beneficence. Occasionally, they may give way to despair and withdrawal (Quadrant 4). However, as the portrait of Dr. Bhimjee suggests, we can also find a model of a physician who knows how to maintain a sense of control by taking both active and yielding steps to support the patient's need for control (Quadrants 1 and 2).

Control battles. When the various pieces of each story are put together, they illustrate a common, but rarely discussed, phenomenon in the medical encounter: the battle for control between doctors and patients. Rarely do these control struggles have the physicality portrayed in "Force." More often they transpire as in "Fetishes"—the physician urges one course of action, the patient, who wants another, first uselessly protests, then gives in, as Audrey does, or withdraws from treatment, as she contemplates in fantasy. *How can we control disease?*—surely a legitimate question in the practice of medicine—is subtly transmuted into *Who will be in control of the patient?* as patient and disease become confounded (Shafer, 1995). In the first two stories, both patients sense the terrible, irreversible violation that will occur once control of self is completely surrendered to the powerful physician other, and struggle furiously, although ultimately ineffectually, to resist. They cling to such shreds of their dignity as are left them, since the alternative, symbolized by the helpless capitulation of the Olsons or the despair of the nameless patient in "Mercy," is an infinitely greater and more devastating loss

of control. For most of the physicians portrayed, however, the perspective and desires of their patients are a threat and a complication to their own view of the world, and must be overcome at any cost. The result is a control battle.

Win-Lose vs. Interdependent Models of Control. Such doctor-patient encounters easily become defined in win-lose terms. They assume a power-over model (Miller, 1993), in which one person must establish dominance over the other. Generally, the patients (who already belong to relatively powerless groups—women, children, the dying), are the ones who lose. The physicians, variously self-satisfied (surgeon and anesthesiologist of "Fetishes") or self-accepting ("Force"), all win. Despite the patients' protestations and resistance, these physicians render to their patients the help they were trained to give. The only doctor who might be considered to "lose" is the physician-narrator in "Mercy." By giving up and abandoning his patient, he becomes, in the eyes of both reader and patient's mother, contemptible. Yet his "loss" is much less significant than that of his patient's, who continues to struggle alone toward an agonizing death.

Is there another way? In "Fetishes," Selzer answers in the affirmative. In the relationship between Audrey, Leonard, and Dr. Bhimjee, Selzer portrays a model of interdependent, reciprocal control among patient, family member, and doctor that relies on a combination of positive instrumental and accepting control strategies. In this paradigm, control is not a zero-sum, win-lose game. Although the patient must cede a fair amount of control to her physician, the physician is willing to listen to and learn from the patient. Because the patient trusts the physician (a result of his displaying his own humanity and vulnerability to her), and trusts that he has understood her interest, she is willing to accept a certain degree of dependency on him. In this model of mutuality, control is

fluid, moving among doctor, patient and family as the situation demands, with a common, shared goal of healing for all parties involved.

How does the physician achieve this level of positive interdependent control? Paradoxically, one of the most interesting aspects of the kind of interdependent control described by Selzer in "Fetishes" is that it requires tremendous empathy on the part of the physician for the plight of the patient. Awareness of the patient's perspective and sensitivity to the patient's feared loss of control encourage the physician in modulating an appropriate balance of positive assertive and positive yielding strategies.

Implications for Teaching

These three stories raise difficult but fascinating questions about the role of control whenever doctors, patients, and family members interact. Using these or similar texts (Appendix 1) to elucidate how to recognize and deal with control-related dilemmas can be an important teaching tool in medical education settings. But how specifically can such stories be used most successfully? Below we briefly discuss possible educational goals and teaching methods for a variety of learners from preclinical students to experienced physicians.

Goals and Objectives. We postulate that a change in physician attitude toward control issues ultimately can generate positive behavior changes toward the patient. Therefore, the overall goals of a

*We have had experience using all or some of the above-referenced stories with preclinical medical students, clerkship students, family practice residents, and experienced family physician faculty. On a human level, issues of control speak to all levels of learners; however, from a strictly clinical point of view, they become most relevant for learners with enough clinical experiences to have encountered similar scenarios.

teaching exercise using the above stories include the following:

1. Recognition of the unstated "meta-issue" of control as it operates in medicine. As was discussed earlier, it is difficult to identify control issues in medicine. Seeing them elucidated in the particularistic form of literature, with subsequent discussion and examination, makes awareness and understanding of such issues more accessible.

2. Ability to identify multiple perspectives and points of view about how control operates in the doctor-patient relationship. Because these stories incorporate viewpoints from patient, doctor, and family, it is easy to see how control issues of various players can clash and come into conflict. By realizing that not only patient, but physician, and family, struggle with maintaining control and fear losing control, learners are more likely to see control issues as processes to be negotiated, rather than absolutes to be imposed.

3. Recognition of over-control as a response to perceived threat: In patients and physicians alike, overcontrol is frequently triggered by feelings of loss of control or fear of loss of control. Physicians' overcontrolling responses have the effect of distancing from and objectifying patients.

4. Ability to construct and use "win-win," interdependent control approaches that honor the dignity and suffering of the patient, and the expertise and obligation of the physician.

Specific learning objectives for each story can also be generated, depending on the level of the learner, as indicated in Figure 2. Following Squier, objectives can be tailored to the learner's developmental needs.* For example, preclinical students with little patient experience may reflect on how control issues have presented in other aspects of their lives. Residents may want to discuss the temptation to keep tight control of interviews in the interests of time efficiency. More experienced physicians may

FIGURE 2

*Examples of Learning Objectives for Stories***FETISHES: Learners will be able to**

1. Identify instances of how dentist, surgeon, and anesthesiologist act in an overcontrolling manner (**preclinical medical student objective**).
2. List alternative ways in which these three professionals could have responded to their patient's control-related needs (**resident objective**).
3. Describe approaches that Dr. Bhimjee uses to create an interdependent model of control between him and his patient (**experienced physician objective**).
4. Discuss instances in their own clinical experience where they have acted in an overcontrolling manner; and instances where they have been able to establish an interdependent model of control (**resident/experienced physician objective**).

FORCE: Learners will be able to

1. Distinguish between situations in which controlling action is or is not warranted on the part of the physician (**resident/experienced physician objective**).
2. List examples of emotions evoked in the physician, based on their own experience, as a result of the patient's loss of control (**clerkship student, resident, experienced physician objective**).
3. Identify specific methods they have used in their own practice or clinical encounters for managing an out-of-control patient without losing one's self-control (**resident/experienced physician objective**).

MERCY: Learners will be able to

1. Formulate strategies for encouraging desperate or hopeless patients to stay engaged in the patient-doctor relationship that have been successful in their own professional lives (**resident/experienced physician objective**).
2. Identify oscillations between overcontrolling and giving up behavior in both patient and physician in the story (**preclinical medical student objective**).
3. Discuss whether they have experienced similar occurrences in their own interactions with patients (**resident/experienced physician objective**).

enjoy sharing their own perceptions of how control operates in the clinical setting, and what strategies they have developed in response.

Setting and Methods. The optimal teaching environment for this type of educational activity is a small, informal group of learners, facilitated by a physician-non-physician (e.g., psychologist, nurse, medical ethicist) team (for the value of incorporating different professional points of view), that emphasizes emotional engagement, reflection, and self-disclosure. The role of group leaders is to ensure that all participants have a basic understanding

of the reading, to facilitate group discussion, and to model a personal approach to analysis. Study questions (see Figure 3) are designed to help learners make connections between the stories and their personal experience.

An important issue is where and how such a topic can be introduced into the medical education curriculum. Such a complex question cannot be fully resolved within the limitations of this paper. We have had the opportunity to teach literature-based approaches to control themes in the doctor-patient relationship in these venues: 1) as part of a preclinical first year

FIGURE 3

Study Questions for Learners

-
1. List the pros and cons of
 - a. Active, instrumental control
 - b. Yielding, letting-go control
 in a patient-doctor encounter. Use two examples from your clinical or personal experience.
 2. How do you recognize when you feel vulnerable, or fear a loss of control with a patient (i.e., thoughts, bodily sensations)? Are certain patient "styles" or situations more likely to bring out these feelings in you?
 3. How do you recognize when you are exerting too much control with a patient? Are certain patient "styles" or situations more likely to bring out these feelings in you? Think of specific, real encounters with patients.
 4. How might you deal with a situation in which you feel you are in a control battle with a patient? Give either a real-life or a hypothetical example.
 5. How do you imagine a wise, compassionate physician might relate to the patients in each of the three stories? Have you seen this behavior modeled by peers, colleagues, or mentors? Describe what it looks like.
-

elective course on literature and medicine; 2) in a second year elective attached thematically to a required Patient-Doctor course; 3) in a required three hour internal medicine clerkship humanities session; 4) as part of a larger required family practice residency behavioral science lecture series; and 5) during an informal evening get-together for faculty. Thus we have experience with both informal/optional and structured/mandatory curricular environments, each with advantages and disadvantages. The primary benefits of an optional, elective format are the enthusiasm and interest of self-selected participants; while the advantages of requirement are the added legitimacy and opportunity to reach a wider audience. A disadvantage of the optional format is its limitation of preaching to the choir; while the most significant drawback of a required format is the difficulty of finding sufficiently accessible and relevant readings to convince skeptical participants that reading fictional literature can help them become better doctors.

Achievement of Specific Learner Skills (Outcomes). One of the most useful aspects of these stories is that they present

fascinating control-related clinical situations for which there are no clear right answers and that can be considered from many different and legitimate perspectives. They encourage the exploration of questions such as: "What might have been another way Audrey's doctor could have handled the interview?" "How would you have dealt with the screaming Mathilde?" "How could you have behaved if you were the physician in 'Mercy'?" This exploratory aspect allows for multiple solution-generating approaches that give learners practice in developing a varied response repertoire to control-related situations.

The specific skills learners develop through such dialogue are two-fold. First, they are able to develop an increased awareness of the role of control in clinical interaction. Learners begin to see the presence of control issues in critical aspects of patient care, e.g., the language of the doctor and the patient, or how the interview is structured and by whom. They recognize how statements such as "You have no choice except to have the operation" might be considered an overcontrolling response to force the patient in a direction the

physician finds most desirable; while saying to a terminally ill patient, "There's nothing more I can do for you" reflects the passive giving up of Quadrant 4. Interaction patterns that "interrogate" the patient and leave little opportunity for exchange are another example of an overcontrolling style, as is having a nurse knock on the door to interrupt the encounter. Similarly, learners can think about how they use silence in the encounter, whether in a controlling way (Quadrant 3) that ignores patient concerns; or a supportive, yielding way (Quadrant 2) that allows space for patients to ask questions and express worries. Finally, such discussions can help learners identify their own "control styles," for example, whether they tend toward overcontrol or passive resignation in difficult situations, as well as the control styles of particular patients. This understanding produces an anticipatory awareness that is useful in heading off likely problematic control-related interactions between doctor and patient.

Secondly, learners can also begin to illuminate behavioral and communication strategies to help them work with control issues in the clinical setting. Learners' discussions generally involve a combination of cognitive rehearsal, self-instruction, and role-playing that helps them construct more appropriate control responses. When considering "The Use of Force," for example, learners often suggest that the physician could have waited a few moments, calmed himself and reoriented to the task at hand, then conversed gently with the child, until she felt safer (a Quadrant 2 positive yielding strategy). In discussing "Fetishes," learners role-play Audrey's encounter with the physician when she learns she must have a hysterectomy. They may take a positive assertive stand (Quadrant 1) as the physician (actively recommending the hysterectomy on medical grounds), but are careful to pay attention to their patient's fears and concerns (Quadrant 2). By

integrating a more mindful (Epstein, 1999), empathic stance with positive assertion, they begin to see that collaboration with the patient produces the kind of interdependent control achieved by Dr. Bhimjee. Recognizing when patients are out of control, are behaving in an overcontrolling manner out of a fear of threat, or have slipped into passive "giving up," and have become disengaged from their own healthcare, helps learners to develop more appropriate assertive and/or accepting strategies.

Conclusion

The particularity of fictional stories provides an accessible bridge to learners' real-life experiences. Learners begin by talking about Dr. Bhimjee, or the doctor in "Force" or "Mercy" and end up telling their own clinical stories. Sometimes in these stories they are the heroes, and sometimes they are flawed protagonists who make mistakes in their management of patients. But the struggles of the fictional characters seem to give learners courage to acknowledge not only their successes and wisdom gained, but their weaknesses and failures as well.

The very raising of a "hidden" issue such as control in the doctor-patient relationship, and experiencing its dramatic illustration in works written by physicians, acknowledges the "normalcy" and universality of its occurrence. Learners can explore their own feelings about issues of control and vulnerability, begin to see that patients are experiencing similar control issues, and then use the stories as starting points to discuss how they might ideally learn to act in those or similar situations. Ultimately, such discussion has the potential to teach that it is the "good doctor" (Loxterkamp, 1997) who knows how to integrate positive take-charge instrumentality of healing intervention with an acceptance of the patient's story, point of view and illness trajectory.

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APPENDIX

ADDITIONAL LITERARY SOURCES WITH CONTROL-RELATED THEMES

- Alden, Paulette Bates: *A Journey Through Infertility* (first person account—infertility)
- Dubus, Andre: The Fat Girl (short story—obesity)
- Gilman, Charlotte Perkins: The Yellow Wallpaper (short story—depression)
- Hawthorne, Nathaniel: The Birthmark (short story—scientist wants perfect wife)
- Huxley, Aldous: Brave New World (science controls every aspect of life in the future)
- Jones, Alice: The Biopsy (short story—breast biopsy)
- Mates, Susan Onthank: Ambulance (short story—medical student/death of patient)
- Parkman, Kathy M: Everything That Falls Has Wings (short story—eating disorder)
- Skloot, Floyd: The Virus (poem—chronic fatigue syndrome)
- Vonnegut, Kurt: Fortitude (short story—scientist keeps head of woman alive)
- Warren, Rosalind: Outpatient (short story—encounter between patient and physician)
- Watts, David: Starting the IV (poem—Anesthesia)
- Yglesias, Helen: Semi-Private (short story—breast cancer)

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