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Introduction

For the past 18 years, I have directed “Compassion and the Art of Medicine,” a lecture and performing arts series at Baylor College of Medicine. The program is open to the Texas Medical Center community and the general public, although most attendees are first- and second-year medical students. Each year we offer 7-8 programs, featuring patients who describe their experience of illness and physicians who describe their experiences of healing. Recurrent themes from the patient side include mental illness, chronic and terminal illness, disability, addiction, cancer, and AIDS. Recurrent themes from the physician side include care of underserved populations, medical activism, doctor-patient relationships, integrative medicine, the arts and healing, self care, and juggling career and family responsibilities. Some of our most popular speakers are physicians and other health care professionals who have themselves become seriously ill and describe what it is like to be on the other side of treatment. Several of our presenters are performing artists who use drama and music to tell their stories. We encourage all our speakers and performers to be concrete and personal, and not to shy away from the emotional and spiritual components of their experiences.

For most of these 18 years, I have taught an elective course, also called “Compassion and the Art of Medicine,” which piggybacks off the lecture and performing arts series. Our enrollment vacillates from year to year: over the past decade we’ve had as many as 180, and as few as 110. The vast majority of the students are MS1s, although each year 15-30 MS2s come back to take the course a second time. Repeating the course is possible because we rotate the speakers and topics. Baylor students are allowed to earn credit for a maximum of 8 elective hours during their pre-clinical training; our course is

one of dozens of electives offered. Students taking the “Compassion and the Art of Medicine” elective may earn 2 or 3 credits, depending on whether they write 1 or 2 papers.

The objectives of the course are to: (1) encourage students to be compassionate caregivers; (2) remind students that medicine is an art as well as a science; (3) introduce students to compassionate physician role-models; (4) expose students to the patient’s perspective on illness, suffering, and healing; (5) train students in the art of self-care: how to juggle career, family, and personal needs; and (6) recognize the ethical and emotional challenges facing those in the healing professions.

To meet these objectives, I have experimented with a number of formats, but in the past few years have settled on an integrative educational methodology: (lecture/performance), conversation, and reflection. Students attend the lectures and performances, then stay for an additional hour of workshops and small group discussions.^{1,2} They also attend additional lectures, panel discussions, and patient interviews. They are offered optional book discussion sessions and a poetry workshop. On their own they read a book, or two, and write a reflective essay.

Students select their book from a menu of several choices. Some books are by or about our speakers; others address the themes of the speakers’ presentations. Some students read their books and write their papers during the academic session; others prefer to read and write over the winter holiday break, at a more leisurely pace.

This year, students were offered the following choices: *Complications: A Surgeon’s Notes on an Imperfect Science*, by Atul Gawande; *The Spirit Catches You and You Fall Down: A Hmong Child, Her American Doctors, and the Collision of Two*

Cultures, by Anne Fadiman; *Mountains Beyond Mountains: The Quest of Dr. Paul Farmer, A Man Who Would Cure the World*, by Tracy Kidder; *Time on Fire: My Comedy of Terrors*, by Evan Handler; *Where is the Mango Princess?*, by Cathy Crimmins; *An Unquiet Mind; A Memoir of Moods and Madness*, by Kay Redfield Jamison; *My Own Country: A Doctor's Story of a Town and Its People in the Age of AIDS*, by Abraham Verghese; and *When Invisible Children Sing*, by Chi-Cheng Huang. One other option: to read 2 shorter works: *The Death of Ivan Ilych*, by Leo Tolstoy, and *A Very Easy Death*, by Simone de Beauvoir.

Student essays

Papers are 2 pages, single-spaced. The students are asked to offer their personal reflections on the book, not a summary. They may reflect critically on the book, if they wish. But the main purpose of the assignment is to wrestle with the themes of the book in terms of one's professional and personal development.

Students submit their papers by e-mail. As instructor, I read each paper, jot down some notes, and decide on a grade. Grading is easy these days, as electives at our institution are now "pass/fail." Each year I receive 2 or 3 papers that are not acceptable. I mark a paper unacceptable if: (1) I cannot tell whether the student actually read the book; (2) the essay contains little personal reflection; (3) the essay fails to incorporate the *themes of the course; or, (4) the content is superficial. In these cases I offer the students an opportunity to rewrite or to withdraw from the course.

Each year the remaining 200 or so papers are not merely acceptable; most are fabulous. I find myself amazed and grateful to be privy to the thoughts and fears, doubts and dreams of our beginning medical students. I can't just write "Pass" and record the

grade. So I don't. Instead, I do some things that are unconventional, at least in a medical school. I start a conversation. Actually, multiple conversations: student to professor; student to author; and student to student.

Student-professor conversations

I write a brief letter back to the student, telling her what I like about the paper, how the paper challenged my thinking, and asking questions to clarify, extend, or deepen the reflection process. If she writes about personal experiences of suffering or illness, I acknowledge her situation and offer empathy or encouragement. If the paper shows artistic promise, I offer to help her rework it for publication. If the paper addresses family health issues, I might encourage her to share the paper with her husband, partner, parents, grandparents, or siblings.

I would enjoy sitting down and speaking directly with each student, but this type of conversation is seldom possible. The class is large, and I teach it solo, on a small fraction of my FTE. Talking by e-mail has its advantages, though. Sometimes the conversation continues for weeks, beyond the formal duration of the course. Spreading out the conversation over time allows time for thoughts to percolate and to get used to new ideas. If I challenge a student, she feels less pressure and offers less resistance.

I am amazed at how connected many of the students feel after one or two brief, but thoughtful, e-mail exchanges. I will pass students in the hallway, or see them in the grocery store or gym, and their eyes tell me that we are already in deep conversation. Having grown up in the pre-electronic era, this unnerves me to some extent. To me, the medium still feels impersonal. To them, though, who grew up "chatting," e-mail is where

they feel most comfortable developing their thoughts, trying out new ways of being, and incorporating new information into their old worldviews.

Perhaps we should start a chat room among the students—or do they already have one? I don't know. What I do know is that in their papers and in their email exchanges many are more vulnerable than they are in the classroom. If I assign a book or we have a speaker on some delicate topic, like sexual orientation or mental illness, they tell me things that I know they are not telling their classmates, with whom they feel an obligation to maintain their “medical macho.” E-mailing papers and e-mailing follow-up conversations about papers provide a way for students to develop their professional—and personal—character. All it takes is someone with professional training to read their papers, listen to their musings, take them seriously, and take the conversation to the next level.

Student-author conversations

I also connect students to the authors of the books they write about. Each year, the first day of class, I tell the students that, with their permission, I will send a few dozen papers to the books' authors. The students look a little surprised at first, but studying their faces from the front of the auditorium, I'd call it a pleasant surprise. For some, it may even be a challenge—a challenge to write something worth reading.

After the course is over, I send papers to the books' authors. Some have been speakers in the class and are easy to reach. Others must be located through agents, publishers, or websites. I never hear back from some of the authors, but many respond, expressing appreciation for the opportunity to see the impact of their books on medical students and to see the richness of the students' reflections. One author, whom I have

never met, sent a hand-written note, saying she was “delighted to receive and read them.” Another said that he was moved to think that he was influencing a generation of future physicians. I enjoy sharing these responses with the student-authors.

Students tell me they feel flattered to have *their* words read by a famous author, and they appreciate the opportunity to connect with the author. I sense that in addition to being flattered, they feel personally validated in some way, as though they are being “promoted” to a new level of adult and professional conversation. Whereas in college their papers were mere “student” papers, written for credit and a grade, here in their professional training their papers are written to articulate their professional formation, to engender serious conversations. The rehearsals are over. They are becoming colleagues. They are being taken seriously.

Each year a few students decide not to give permission to share their papers with anyone but me. These students have generally written on deeply personal issues. I commend them for placing clear boundaries around intimate details of their lives, or for protecting the confidentiality of family, friends, or classmates. Some of these students write back, asking for referrals for professional help, or asking for advice on addressing sensitive issues while maintaining privacy. So this becomes an extended conversation as well: student to professor.

Student-student and student-faculty conversations

The third type of conversation is student-to-student and, to some extent, student-to-the-medical-community. Each year, as I read their papers, I cull some of the more insightful or representative statements about the major themes in medical humanities. (I omit any identifiers or information that could be linked to a particular student.) I compile

the statements into a single document, organizing them under topics and subtopics. I call the document “Chicken Soup for the Soul—Wisdom from Medical Student Papers.” I then email the “wisdom” back to the class, to other medical students, and to selected faculty, administration, and staff. And more conversations begin.

Because I am not a party to these conversations, I cannot say where they go or what they accomplish. I do know a few things, based on what students, faculty, and staff tell me. I know that students are pleased to discover that they are not the only ones harboring doubts and fears, or ideals or sentiments. I know that students are pleased to discover that talking about these issues helps them “work out their salvation,” as Kierkegaard would say, albeit with “fear and trembling.” I know that getting their “soft” feelings out in the open has a liberating effect, just like letting go of a family secret or coming out of the closet. Medical students, residents, and faculty are notorious for harboring and expressing “hard” feelings, such as anger, cynicism, confidence, contempt, even hatred. Just watch “ER” or “House,” or read *The House of God*. But “soft” feelings, such as sadness, fear, discouragement, uncertainty, or loneliness are often taboo in the competitive, macho world of medicine. Our conversations are designed to violate that taboo.

I also know that faculty and staff are encouraged to see how badly students want to be good doctors and good people. They are encouraged to see that students are wrestling, at the outset of their careers, with issues that their generation often put off until too much damage was done: competing tensions of vocational idealism and career practicality, of saving the world and being happy, of juggling personal and professional priorities.

Occasionally, a cynic will tell me that the students are pulling the wool over my eyes by telling me only what I want to hear. I don't think so. I think the students are telling me what *they* want to hear. More precisely, they tell me what they want to hear themselves saying, because this is what they want to become. I can see in their papers that they have cynical thoughts as well as idealistic ones, hard feelings as well as soft ones. It's all there. However, in their papers, I believe they are trying to figure out a way for the idealism to trump the cynicism, and to feel comfortable with softness and tenderness in a world of "hard" sciences. They have just accomplished an incredible feat—being accepted into medical school, and a highly competitive one at that. They did it by bracing themselves, being "hard," being nearly perfect during their college careers. Now, what they really want is to recover: to get back in touch with the rest of their being, to be healthy *themselves*. Reading this book, writing this essay, and talking about the essay are ways to achieve their goals.³

Face-to-face conversations

Orchestrating conversations in a large medical school course requires creativity. We have no budget to hire faculty as small group facilitators. Yet, in a medical humanities course, conversations are essential.⁴ You can't teach medical humanities with Powerpoint. The medium really is the message.

Having students read books and write essays has proved an effective way to start conversations. Each year I meet with a focus group from the class and ask for their feedback. Each year they tell me that the papers are an essential ingredient of the course. Reading the same books as their classmates, wrestling with the themes of the book, and

sharing ideas and feelings help them to process the high speed learning at this stage of their training.

This past year the focus group came up with another suggestion. For years I have wrestled with the problem of how to structure student-to-student conversations about the content of the lectures and performances in the hour following the lectures and performances. This time is ripe for such conversations. Students have just been riveted by a moving presentation, which they want and need to discuss. If ever there was a teachable moment for the moral, emotional, and spiritual components of clinical medicine, this is it. In the past I facilitated conversations with the entire class, but in a group of 100-150, such conversations lacked intimacy.

This past year the focus group suggested that second-year students who took the course the previous year serve as facilitators for small-group discussions. "Is this permissible?" I asked. They explained that second-year students serve as teaching assistants for anatomy lab and other courses.⁵ The upper-level students receive the benefit of the teaching experience and something good to add to their resumes when applying for residency. I asked if I would have trouble recruiting 10-15 facilitators from their class, and they all volunteered on the spot. We put our heads together and worked out the following deal: they would facilitate discussions in exchange for course credit, teaching and leadership experience, and teaching skills training.

I would conduct a teaching skills workshop with them at the outset of the course and a focus group course evaluation at the conclusion of the course. In between, I would be available to them during class to float from group to group, and after class to answer questions and troubleshoot problems. From now on, students would submit their papers

directly to their small-group facilitator, who would read the paper, write comments, forward to me. I would add my comments, then forward it back to the student and the facilitator. And we would have yet another conversation.

We are now half-way through this year's course. The teaching skills workshop went well, and the small group discussions have far exceeded my expectations. Student facilitators have embraced their leadership responsibilities, and their classmates are responding. The hour after the guest presentation is proving to be a most teachable moment.

Over the past 5 years students rated the course highly on their annual evaluation forms. When ask if they thought the course was worthwhile, and whether they would recommend the course to next year's students, they gave mean scores of 4.5 and 4.6 on a 5-point Likert scale. (A "4" indicated "agree," and a "5" indicated "strongly agree.") Facilitators now tell me that, as much as they liked the class last year, in-class small-group conversations have proven to be the missing piece of the puzzle. This year's approach has the feel of completeness. This year's students leave the classroom having already processed the themes of the presentation with their peers in an open, respectful atmosphere.

Conclusion

It is difficult to create constructive humanities conversations in the medical school setting. Time limitations, large classes, clinical and research-oriented faculty, and cynical attitudes all contribute to the problem. One solution is to facilitate conversations about medical humanities themes through e-mail correspondence about personal

reflective essays. Another is to train students to serve as small-group facilitators. Such approaches help structure positive conversations in the medical school setting.

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Appendix

Chicken Soup for the Soul – Wisdom from Medical Student Papers

Compassion and the Art of Medicine 2005 - Baylor College of Medicine

Compiled by Warren Holleman, Ph.D.

I. MEDICAL EDUCATION

Feeling the Pressure

Upon starting medical school, I've found no half-hearted, weak-minded individuals in my medical school class. In fact, I rather miss the lazy individuals which seemed ample

during my undergraduate years. They served a useful purpose in making me feel better particularly during days before a difficult upcoming exam.

Learning on Real Patients

It made me absolutely quiver to think that for the sake of my learning, a patient may receive sub-quality care, suffer physical damage, or even death.

As I read the first few pages of *Complications*, it occurred to me that learning how to practice medicine may be like the half an hour frenzy and chaos before a show that you are organizing is about to go on. Your heart races with the pace of doubts sprinting in your mind because you're not quite sure what the outcome will be, but any experienced showman will easily tell you that but somehow, inexplicably, everything smoothly falls together as the curtain opens. Amazingly, though, no one, not even the organizer, can really put a finger on how exactly order came out of chaos. It just does.

At times I am struck by the realization that students themselves create most of their perceived pressure and performance anxiety – patients are often happy to help us learn and offer understanding and forgiveness for our initial inadequacies and deficiencies. Despite all this kindness, students like me still feel uncomfortable learning such a skilled and potentially hazardous trade via real-time experimentation on very real patients.

In the past, if I was going to give half effort in school, the consequences were poor grades, unrealized honors, or even just a lack of personal satisfaction. Never did the life of another person enter the picture.

The Not-So-Hidden Curriculum

My medical school application essay described my experiences volunteering for a local physician. In the essay I spoke tenderly of the desire to help people, save lives, find cures, and bring the art of compassion back to medicine. Several days later, when my mentor called me into his office to go over his suggestions and editing, he floored me with the first words that came out of his mouth: “Bullshit...you know this is all bullshit right?” My heart sank. My mouth, dry as cotton balls, stammered while I tripped over my thoughts, unsure of what to say.

II. SELF CARE

The Perils of Perfectionism

We are selected for having personality traits that are not necessarily positive. We are perfectionists. We often do not work well with others because if we want it done right, we must do it ourselves. We must not make a mistake. We sacrifice all else in the pursuit of learning more than humanly possible. We must know everything. We spend hours taking care of patients, [but] we refuse to take care of ourselves. We are medical students.

Instead of reducing one's career to a competition to be the top of the class, the best of the best, why not relish that which brings joy and meaning in day-to-day professional activities? That is, take joy in what ideally drew me to medicine in the first place.

Juggling professional and personal priorities

When I first started medical school, I could not wait to start having stories. Great ER stories, great OR stories, great stories about characters I had met, treated, and helped. But from reading Dr. Gawande's book, I was reminded how these great stories come with serious footnotes. How tempting it is to leave the uncertainty of diagnosis and treatment out of the tale. How harsh the consequences when good doctors continue to hold those feelings inside and, at variable rates, eventually burn out.

Staying connected

We must not forget that there is life beyond our medical walls and that we were each once part of that non-medical world. I try to remind myself of this by visiting my family and friends on a regular basis, by studying at a local library or coffee-shop rather than just on the medical school campus, by continuing to socialize in circles outside of medical school, by talking to the security guard about how his weekend went, by coaching a team at a local middle school, and by tutoring young people twice a week.

III. COMPASSION

One Size Does Not Fit All

This book helped me understand that we have to treat people, not diseases. It is very easy to see the symptoms, go back to the text book, and do exactly what has been proven successful in the past. If we do this, then we might as well have chosen cooking as our profession.

Twenty-first century medicine may completely explain the pathophysiology of a disease, but frequently, as demonstrated in Dr. Watt's stories, successful treatment of the patient requires the physician tailor their own actions to the particular knowledge, fears, and expectations of the individual patient.

Caring vs. Curing

The vast majority of physicians probably enter the profession for philanthropic reasons, but as Gawande implies, the deification of science, the characterization of patients as unreliable witnesses to their own bodies, and the insistence upon only fighting winning battles against disease will ultimately compromise the good we can provide our patients and the pride we can take in our vocation.

When science is incapable of revealing a cure, compassion can still bring healing.

The Road Less Traveled

I envisioned myself forging deep, meaningful relationships with patients, sharing in their lives. I have had the opportunity to walk alongside patients during the darkness of illness, yet had the privilege of knowing them outside of the label of disease and

treatment, seeing them in their natural habitats and sharing in their joy. However, that has not been possible with as many people as I thought. Also, I understand it involves taking time to step out of the pressure to be efficient, to impress attendings and residents. It is an endeavor that is not always rewarded, at least, not in the manner we learn to appreciate being rewarded as students. Verghese's feelings of estrangement from his family, friends, and colleagues [sounds] familiar, as I now know that not everyone will understand your sense of compassion and may actually consider it detrimental.

Cultural Competency

What Fadiman's book teaches us, though, is simply to question the assumptions Western culture constantly makes in its pursuit of bodily health; Fadiman [reminds us] that "health" is a term that can be applied not only to a biological reality, but to a social, familial, and spiritual one as well.

How to Change the World

Dr. Farmer's sacrifice has given my own personal passion to help people through medicine a direction. He has shown me that I don't have to be anyone important to make an impact on [the lives of those who hurt]. All I have to do is be willing and determined.

What I found most encouraging, however, was the simple truth that one person really can change his or her corner of the world. This past semester left me slightly overwhelmed and bogged down in details, and *Mountains Beyond Mountains* helped me remember why I wanted to be a doctor in the first place. It was a much needed reminder.

IV. THE ART OF MEDICINE

Healing Lives as Well as Diseases

In his book, *Bedside Manners*, Dr. Watts . . . does not simply view patient time as an opportunity to extract needed information in order to construct a thorough history. He actually tries to interact with the patient and make them feel comfortable and safe. The constant throughout his stories is his goal of attempting to make patients feel better emotionally while still attempting to figure out what is physically ailing them.

The importance of getting to know one's patients and learning about the human struggle at the core of every illness and recovery is, after all, the reason we all want to become physicians.

While I may be able to prescribe drugs, medications, and advice, I cannot heal the patient. The healing comes from within, from the patient, and all I can hope for is to be there to support the process.

Hope

We have to give hope but when does it become false hope or hope with an ulterior motive? I do not have the answers to these questions but I hope that asking them now will help me in clinics to be aware of the consequences of selling a treatment plan without making sure it will really fix the problem first.

Communication Requires as Much Skill as Brain Surgery

[There is a] tendency to assume that one understands another without actually taking the time to confirm whether this is truly the case. For instance, I have often watched my parents accompany my grandparents to an appointment, only to listen to each person present offer a different account of what the doctor said. From discussions with family, friends, and acquaintances, as well as personal observations of medical interactions, this is not a unique experience.

V. MISTAKES

Admitting Our Mistakes

Gawande astutely notes that fear of legal action has spawned a tight-lipped, don't-ask-don't-tell attitude regarding medical mistakes. This is a lose-lose scenario for doctor and patient alike, especially because we humans often learn the most valuable lessons from our mistakes.

It is hard for anyone to admit that they are wrong, but it is ten times harder to admit you are wrong when you are supposed to be an expert or when you can easily get away without admitting it. That is why I felt it was very admirable for Dr. Watts to admit his shortcomings in this particular case. It made me realize that not only is it all right for a physician to say "I don't know", but it is also all right to say "I was wrong."

Accepting Our Limitations

Learning to accept that even our best efforts are not always sufficient is one of the most difficult challenges a doctor must face.

If there is one misconception about the medical field, it is that there is an answer to everything. A doctor is expected to know the problem, cause, and solution to any illness that befalls a patient that comes walking through the door.

Dealing with Uncertainty

Although perhaps apparent, the fact that so many gray zones exist is difficult to grasp for someone first entering the field of medicine-- That *I*, with all probability, will make a medical mistake, that *I* will someday decide on a treatment option on pure whim, that *I* might have to look into a patient's desperate eyes and tell them that "I do not know."

One of the great draws of medicine to me as a child was the sense of comfort and certainty that physicians were able to instill in me. I always felt as if they knew exactly what was going on and were able to solve every problem they encountered. This was, of course, far from the truth.

Doctors must face the uncertainties of medicine, while accepting their own fallibility as humans. However, they must view these limitations with practicality and continue to make educated decisions to aim to achieve the best possible care for their patients.