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Vitality of Patient Stories in Medical Practice

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ABSTRACT

BACKGROUND

Physicians and healthcare providers are essentially professional story-listeners, story-shapers, and story-responders. People have always related to each other and the world through telling, listening, and interpreting stories. However, increasingly complex health problems, compounded by social factors and other difficulties make for increasingly complex stories. Clinicians and healthcare professionals make decisions including the technology based on the patients' stories. Unfortunately, storytelling and listening are vital skills that are usually largely absent from the training of healthcare professionals and clinicians.

INTRODUCTION

Medicine prioritizes facts and data, objective evidence such as from drops of blood or imagining that takes us inside the body. However, technology cannot give the insights that doctors learn through a patient's stories. The healthcare team makes decisions based on the patient's stories. Often, poor outcomes are not the result of a bad physician but are a result of getting a story wrong. In this paper, what one might argue, is the most substantial and fundamental of technology, which is working with a patient's stories. Thinking more openly gives clinicians a more intimate relationship with language that may contain the very needed thing that doctors and clinicians need to hear. This paper hopes to appeal to patients, caregivers, or anyone who wants to think more differently and more creatively. The focus is on words that are spoken or unspoken.

OBJECTIVES

The purpose of this paper is to recognize the vitality of patient stories in medical practice. Additionally, the paper focuses on how to apply story anatomy to stories that patients tell in clinical medicine as well as tools for gaining traction in difficult stories and identifying ways in responding to them. Furthermore, this paper concentrates on the many ways in which stories can unconsciously influence decisions including appropriate diagnosis. Knowing how to embrace uncertainty in medicine as opportunities for deeper inquiry rather than risks such as a misdiagnosis. Lastly, the ways to use story-making skills to build empathy and gain insight into the experiences of others is an area that this paper pays attention to as well.

METHODS

The methodological approach uses to address the objectives is primarily through a series of evaluations of interactions between the doctor(s) and patient(s) as well as a review of each scenario from my point of view and various doctors who discuss the positives and negatives of each scenario. Each case scenario is based in the ER where each patient discusses their concerns with the doctor(s). On the basis of a mixture of the case scenarios, independent research by the faculty, and additional sources, this research was issued and explored.

RESULTS

A survey was conducted to the mass in which the majority of them were derived from healthcare professionals such as doctors, nurses, and so forth. The survey identified how many individuals feel comfortable with telling stories in a survey which was conducted by Brown University. Additionally, the results illustrate how many individuals feel comfortable with interpreting stories in a survey that was also conducted by Brown University. Furthermore, additional surveys were conducted by the same institute identifying how many individuals feel comfortable with ambiguity and identifying the most common role(s) in relation to caregiving.

CONCLUSION

The practice of medicine can be complicated because people are complicated. Clinicians shouldn’t be surprised that stories are challenging and neither should clinicians be frustrated when people defy easy solutions. In this paper, the vitality of patient stories is explored that is often taken for granted in medicine. One of the primary aims of this paper was to evaluate patients in the ER. An alternate means to explore predicaments through stories. The paper emphasizes on the importance of clinicians being story experts. The practice of medicine and listening to the stories patients tell doctors to demand similar humility. This means that patients and healthcare providers travel together.

METHODS

CLINICAL SCENARIO 1 DECONTRUCTION BY NON-MEDICAL DOCTOR

From the first clinical scenario, there were two doctors and a patient. This is my evaluation of the interaction between the patient and doctors from what I observed.

The first doctor, Dr. Andrews saw a patient at the ER and there were some major flaws in his skills regarding sympathy and his way and manner of communicating to the patient. Although, his medical knowledge was upright and respectable. His way of communication could have been better such as showing more sympathy and talking to the patient in a manner that will reassure her that she did the right thing by coming to the ER. Dr. Andrews was very blunt and did not take the patient's emotions into account. It is vital to calm the patient and reassure them that the doctors are here to help and provide them with as much care and support as they need. He did not build a rapport with the patient and he should have asked the patient's husband to be more polite and respectable rather than ignoring him. It was hard for the patient and her caretaker to not get frustrated and angry with poor sympathy and communication or interpersonal skills. Their interaction seems more like an argument or even interrogation than a consultation at the ER. However, as mentioned previously his knowledge was good. He was able to successfully communicate the patient's medical history and symptoms as well as concerns to the doctor in charge, who was Dr. Duncan. It is important to note that when Dr. Duncan consulted with the patient, there was a very minimal argument and frustration, as well as the patient, seemed calmer and more comfortable. This is due to her communication skills, she talked in a way that calmed the patient and lowered her frustration. This is why the way Doctors communicate and give sympathy is so substantial in medical practice. Additionally, she talked in a very slow pace and calm tone as well as told her that she cannot help her in providing her with a diagnosis and told her the cautions if she did. This is a good skill that Doctors should have which is honesty. However, the only thing I would point out is that she should have given her possible options to manage the patient's abdominal pain and refer to someone who may be able to help her with her concerns and symptoms.

The last part of this evaluation is the behavior of the patient's husband. While it is typical for a patient as well as their family to be frustrated and angry, the repetitive way in which her husband expressed his feelings was rude and unacceptable. The resident, in this case, should have advised her husband to talk in a politer and respectable tone and way. However, it is also important to note that his behavior was less expressive when Dr. Duncan was consulting with his wife. Ultimately, the resident doctor's inability to sympathize worsened the interaction between the resident, himself, and his wife. As mentioned previously, rather than ignoring his behavior, the resident should have made it clear to communicate in a more respectable manner and if unable to do so, then he may not be able to help and provide the care his wife needs.

CLINICAL SCENARIO 1 DECONTRUCTION BY PROFESSIONAL DOCTORS

Dr. Jay Baruch talks with his colleague in emergency medicine, Dr. Michael Barthman, about the doctor-patient interaction in Scenario 1. Dr. Michael Barthman talks about the perspectives of each character in the scenario and is able to explain their perspective to Dr. Jay Baruch.

First, he explains it is common for patients like Mr. Richard, it is typical to feel frustrated after visiting so many doctors and having an unexplained illness. However, he does state that he seems “aggressive” in which it is important for the clinician to stay humble. Second, he explains that Mrs. Richards's point of view where she is embarrassed to answer some of the questions and frustrated as well to be answering the exact same questions that she had previously with other clinicians. He then moves onto the resident where he explains that he is a resident, a doctor in training which is important to take note of. He is trying his best to come up with the information needed to come up with a diagnosis for her unexplained illness and/or symptoms. He is able to communicate very effectively to the attending with all the necessary information needed. Lastly, he explains how the attending build that rapport with the patient by approaching her case differently, she validated her symptoms and communicated in a tone that led to a great consultation between the two. For example, when she asked if Mrs. Richards felt safe at home in which she initially replies “no” and then changes her answer to a “yes”, the attending takes into account social factors for her symptoms and not just medical.

In conclusion, Dr. Michael Barthman explains it is important to stay curious and humble in these types of situations. Also, he explains how clinicians can never know a patient’s full story which is also known as narrative humility and it elaborates its importance.

STRUGGLING TO TELL AND LISTEN TO STORIES (PART A)

Three colleagues join Dr. Jay Baruch to discuss the challenges patients face in telling their stories and the difficulties caregivers face in listening. The discussion with Doctors Cia Merin Panicker, Michael Barthman, and Nadine Himelfarb examines topics such as vulnerability, trust and connection, difficulties in connecting with patients, why listening to patient stories in a medical setting can be hard, and the constraints that may impact how we listen.

The Panel of Doctors discusses many things which will be covered. The first is how important it is for the patient to open up especially in the ER, taking into account time constraints and how having family can often help Doctors with getting the correct answers. The panel also talks about teamwork essentially, the resident comes with information from the patient and then the attending goes and confirms as well as gets additional information. In the end, the senior Doctor comes and tells what exactly needs to be done. Additionally, they talk about the importance of why not what or how in the patient’s story such as why is this happening instead of what can be done. For example, a patient came to the ER and talked about how he is tired and not eating anything and when taking into account his social factors that were affecting his health which was that he was newly homeless, it was a clear answer to why he felt hungry and tired. And thus, it is important to take into account medical symptoms such as physical pain as well as social factors into consideration when consulting with a patient.

STRUGGLING TO TELL AND LISTEN TO STORIES (PART B)

Doctors Cia Merin Panicker, Michael Barthman, and Nadine Himelfarb join Dr. Jay Baruch to discuss "narrative surrender," understanding the patient's story under time constraints, being present with patients, listening to stories of great suffering, and the importance of physician self-care.

This part of the panel discussion focuses on the challenges faced by Doctors. They begin to talk about how they put an emphasis on documenting the correct and relevant information in order for it to be useful for the next doctor so that they are able to help the patient as much as possible and provide them with the proper care they need. It is hard for Doctors in the ER to work with constraints such as time, interruptions, and how the story is going to be documented which can be pressurizing. There are definitely time limits as a medical student and if the patient spends 2mins talking about their children then that is useful as well in building a rapport with the patient which can help build trust and for them to open up to the Doctors. It is frustrating for the ER Doctors when they know what is going on with the patient but then realize that it is actually something else because it builds a level of uncertainty. It is important for Doctors to be able to sympathize with their patients and let them know that they can't relate or empathize but they are here for the patient and that they are not alone which builds a Doctor-patient relationship that is useful if they are going to see the Doctor again, for example dealing with families whose child is suffering from cancer.

FRAMES FOR STORIES

There is an anatomy to the story's patients tell. All stories are made up of character, conflict, and desire. It is constructed in a way where a complex character wants something badly and that something is often at the heart of the story. Then the character encounters obstacles where we raise questions such as: will they give up, will they fight and if so then why, what is their motivation, what is at stake, how will they change along the way, and more importantly, what do they learn about themselves. What patients may want may not be aligned to what the clinician wants such as often, it is thought that providing a diagnosis and treatment is what they are looking for. Clinicians then must then face these challenges and can include navigating a cold health care system, the impact of their illness at their job or in relationships, and even their identity. Patients in conflict face what they expect to happen and that is the reality.

Illness is a stressful experience and will test patients in many ways. But physicians are tested as well such as by fixating on medical explanations for symptoms and finding no diagnosis. Clinicians are expected to answer all the patients' questions and to offer solutions to their concerns but what the clinician's response when they are challenged.

CLINICAL SCENARIO 2 DECONTRUCTION BY NON-MEDICAL DOCTOR

In this particular scenario, there is a female doctor – Dr. Sax, and a nurse present at the ER room. The patient is a male named Jerry who was found collapsed in the lobby and does not recall any of this. He has a history of medical drug usage. In comparison with Scenario 1, this is a way better situation where a Doctor is able to practice medicine. Dr. Sax has a very good manner of communicating and handling patient who seems very aggressive and agitated. The Doctor informs him in a very professional manner that they cannot help unless he is willing to communicate and be upfront. Her knowledge seems also advanced and appears to be very friendly, especially after her interaction with the nurse present in the room while Jerry is on a call with his mother. Both professionals seem to have a good relationship with each other which helps with providing better care as a result of good teamwork. Dr. Sax also asks for permission to talk to his brother rather than telling him that she needs to talk to him and maintains her professionalism with his brother as well. Through effective communication and rapport, she is able to come up with a possible diagnosis and get a medical history. She also does a good job informing Jerry that all information that he tells them will remain confidential which is a big aspect for many patients. However, Dr. Sax's repetitive questions on his usage of drugs were agitating for Jerry and would be for the vast majority of patients.

Her knowledge seems to be questionable as she misdiagnosis Jerry's brain cancer for a seizure. In this case, she should have gotten the relevant information from the patient which was hard as the patient kept getting agitated which was primarily due to her repetitive questions on his usage of drugs that came across as possibly accusative. Her method of communication was better than the resident in scenario 1 but not as good as the Senior Doctor in Scenario 1 whose communication and practice were better than Dr. Sax. If she would have communicated in a more effective way then she would most likely have come up with the correct diagnosis for Jerry.

CLINICAL SCENARIO 2 DECONTRUCTION BY MEDICAL DOCTORS

Dr. Jay and his colleague discuss how Dr. Sax was rigid in her mind with the story and looking at other ways to look at a situation. They believe that Dr. Sax starts off by taking off a very narrow history. The doctor asks whether the patient is on drugs or has gotten into a fight giving the patient options. This is not really an open question but more of an inquiry in Dr. Jay and his colleague's perspective. They believe that Dr. Sax almost gives her patient a multiple-choice test. They believe she has a failure of imagination by asking those narrow questions i.e., who gets into a fight in the middle of the night or takes drugs in the middle of the night. They believe that Dr. Sax should have found out about the brain tumor that the patient had as it is not the patient's job to deliver all the information to the doctor. She should have asked about other things that could be causing other medical causes. Dr. Jay and his colleague state that you can trust people but verify everything. When the clinician does not have the story, they can go into two directions – lack of story and not doing anything and probably conducting many testing if the patient's brother had not shown up. The doctor has the wrong information prior to meeting the brother and came to conclusion too early. Dr. Sax should have seen the patient and have not lumped the patient into a category during her consultation could have been a more productive narrative, this would open up to various possibilities from there onwards.

REVIEW OF THE PANNEL DISCUSSION

Doctors Cia Merin Panicker, Michael Barthman, and Nadine Himelfarb join Dr. Jay Baruch to discuss how we make sense of difficult stories, thinking of patients as protagonists in their own stories, the concept of chaos narratives, and how we can respond more creatively and compassionately to patients whose problems might not point to a neat answer.

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The panel discuss how a story can lead us in certain directions and perhaps we did not anticipate as clinicians. Research shows our mind will take any bits of information and create a story out of it. It is vital to be aware that there is other information out there. In A&E there are people waiting along with the time pressure as a result of this which ends up sometimes getting clinicians into trouble as someone ends up dissatisfied. Either the patient is dissatisfied or the clinician. This is usually the case when a story is not properly and accurately made and can be problematic for both the clinician and the patient. The clinician also feels dissatisfied when they think of a possible diagnosis and it turns out to be wrong because the story was not put out the right way. Clinicians should know how to ask different types of questions when trying

to make a possible diagnosis. Clinicians can provide care. For the physical but no other factors such as the patient's state of mind such as a teenage boy came to the A&E who was in a very bad state and it turned out that he just had a breakup and was very depressed. This could have been easily missed without having a proper story. It is important to dive deeper into the stories that patients tell you such as not what are the symptoms but what do the symptoms mean to the patient along with how is your life being impacted due to these experiences and what are the patients fears. By asking the patient what you envision for tomorrow, clinicians are not giving a prescription to get you there tomorrow but helping you to get there in other ways than just prescribing a drug. Beginning a career as a clinician, responding to having provisional diagnoses and stories that don't fit in neatly makes the clinicians have a rough time. Some of the clinicians in the panel discussed that success does not always mean a cure but provides hope such as being able to see fireworks on the 4th of July or being able to run at this baseball game. This is why asking the patient what they value is vital and how we can make a treatment plan as a clinician if we cannot get to a cure. As clinicians, if patients are pushed to a certain narrative that they are not experiencing, clinicians are doing some damage and some harm to the patients by not acknowledging the experiences that they are.

RESULTS

From the results shown below, it can be said that most people in this survey feel along the lines of comfortable in telling their stories to the clinician or doctor. Additionally, it can also be said that they are very good at interpreting stories. It is good to note that most individuals who participated in this survey derive from professional care such as doctors, nurses, and so forth. However, most of these healthcare professions struggle with ambiguity and there is the vast majority of healthcare professionals who are on the less comfortable end of ambiguity, which is a substantial part of the medical encounter with the patient.

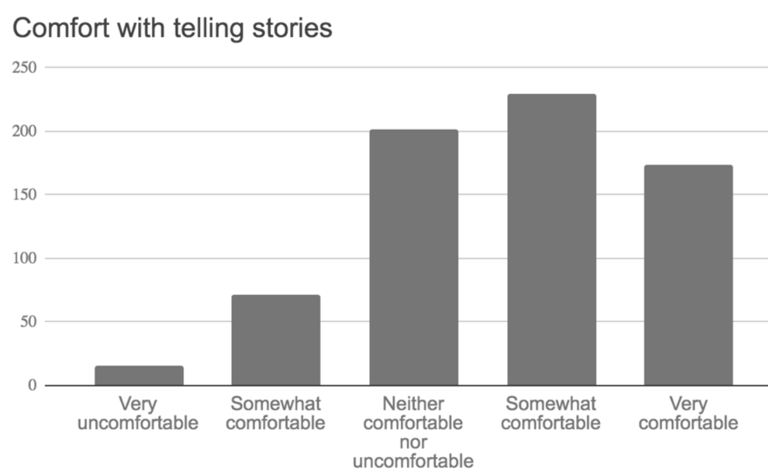

Figure 1.0
The chart above illustrates how many individuals feel comfortable with telling stories in a survey conducted by Brown University

Figure 1.0 demonstrates that the majority of the people feel comfortable with telling stories. Over 200+ people who participated in the survey felt somewhat comfortable. While only less than 15 people felt very uncomfortable.

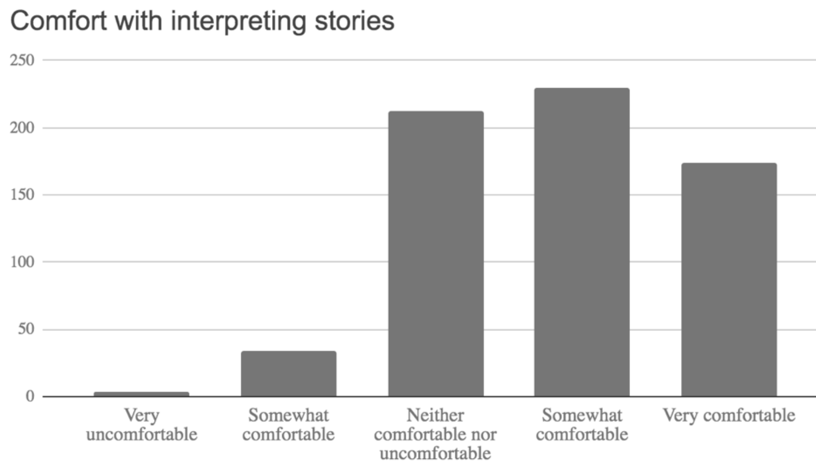

Figure 2.0
The chart above illustrates how many individuals feel comfortable with interpreting stories in a survey conducted by Brown University

Figure 2.0 demonstrates how many individuals feel comfortable with interpreting stories. Over 230 participants feel somewhat comfortable with the second highest being 215 who neither feel comfortable nor uncomfortable.

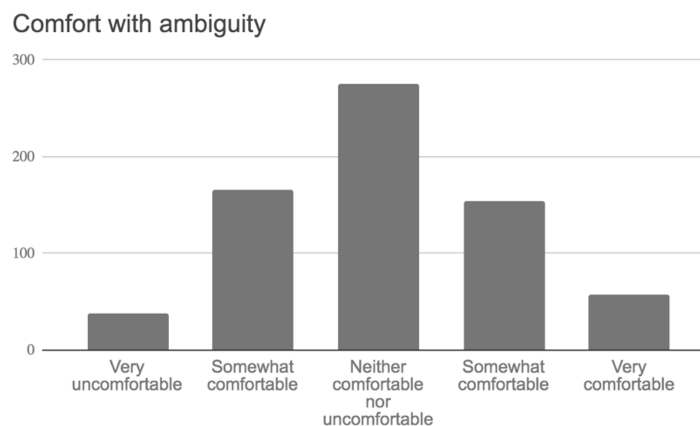

Figure 3.0
The chart above illustrates how many individuals feel comfortable with ambiguity in a survey conducted by Brown University

Figure 3.0 shows how many participants feel comfortable with ambiguity. The outcome was over 270 participants felt neither comfortable nor uncomfortable. Additionally, around 150 participants felt somewhat uncomfortable and somewhat uncomfortable. Notably, only 50 participants out of all the participants felt comfortable.

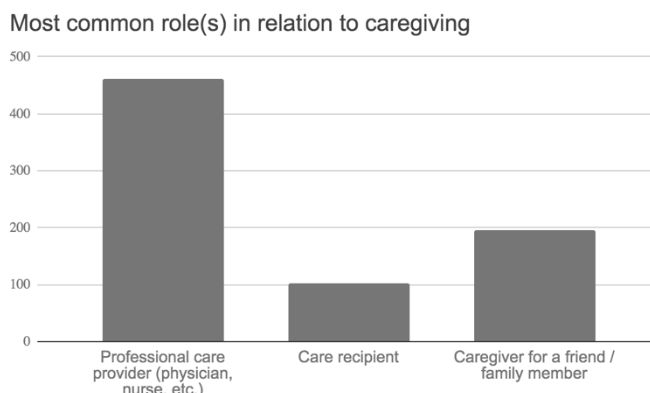

Figure 4.0
The chart above illustrates the most common role(s) in relation to caregiving who answered this survey that is conducted by Brown University

Figure 4.0 demonstrated the most common roles that participated in this survey conducted by Brown University. Over 470 of the participants derived from a professional healthcare provider such as a physician, nurse, and so forth. Care recipient was at its lowest with only 100 participants. Caregivers for a friend or family member scored second highest in participating in this survey with nearly 200 participants.

DISCUSSION

Besides time there are many obstacles faced in meaningful communication. But they do not worry the patients who are sick, worried, or afraid from coming to the Emergency Room (ER) and telling their stories. The constraints are the reasons why doctors need to be excellent communicators and listeners. It is the doctor's duty to understand the patient's stories, interpret their meaning and respond with clinical acumen and a touch of empathy. The stories that patients tell can be troublesome and difficult in ways doctors can appreciate. Diagnosis and treatment are often considered the toughest part of the medical encounter however, the story is what is essential. The patient's story can be more complicated and nuanced than can be believed.

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Literature Cited

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