

The art of medicine

How do we tell the stories of medicine?

In the beginning, with each new group, I thought: this time it won't work. Then I watched as the people around me—usually physicians or medical students, but sometimes nurses, pharmacists, social workers, or residents—girded themselves. We would be in either a classroom with institutional chairs pulled into a circle beneath whiteboard walls or a windowless hotel meeting room with faux-fancy drapery and garish carpeting. Although the occasions were classes or workshops in what my collaborators and I call public medical writing, many participants balked at sharing their work. As is always the case, when at last someone volunteered, relief was evident among those who had earned a temporary reprieve, while the person who agreed to go first showed eager anticipation. He or she had something important to say—often a story to tell—and, finally, a solid beginning on paper or screen and an attentive audience.

Public medical writing is a form of public medical communication, an emerging field focused on writing, talks, blogs, and social media posts by health professionals about medicine and health care. It allows engagement and dissemination both beyond the individual patient-provider relationship to the public at large and outside traditional professional circles to colleagues across specialties and health professions. My collaborators and I generally divide such trainings into three parts: discussion of exemplars to highlight writing techniques and strategies; writing time; and discussion of works-in-progress by the participants. It was on the precipice of the participants reading their drafts aloud that I used to become anxious. With only 20–30 minutes to write, I feared no one would have produced anything of value. Yet it always turned out that I need not have worried. It isn't that we routinely encounter the next Anton Chekhov or Atul Gawande during these meetings. Rather, the sessions succeed because what is read always offers insights and communion between the participants within the room and addresses something important about medical care or practice.

I have held versions of these classes and workshops at meetings and medical centres across the USA. Each time, I am impressed by how the participating health professionals think, what they care about, and what they have to say. The writings themselves vary widely in content and form. Some pieces are fairly journalistic, part story and part fact-based advocacy aimed at improving health and health care. Other works are reflections, largely of use to the writer. A fair number are personal essays about a patient, family member, or the author's own dealings with the medical system. Most participants

strive to use a particular experience in the form of a story to say something with wider resonance. Some are literary in the beauty of their sentences or in their structure or imaginativeness; most are not. Many, however, are compelling—well enough written with at least the beginnings of a good story, a persuasive argument, and professional authority. Rarely, they are none of these things. Always, these classes remind me why I became a physician and give me hope for the future of medicine.

Hearing such accolades, anyone with a scientific mind will think sampling bias, and they are right. These activities are usually elective. As such, they select for those who want to write or have something to say. But that isn't always the case. The first time I and colleagues taught a workshop to residents, the assembled young doctors had signed up for advocacy training, not for a writing class. When told of the writing, many protested. One woman in particular felt duped and unprepared. "I'm a doctor", she argued. "And I was a science major. I can't write." We made them do it anyway. After all, our goals were modest. We didn't expect anyone to write anything of note after just three brief sessions. Moreover, we argued, while doctors are not expected to write beautifully, they must be competent writers in order to produce useful progress and consultation notes.

To say the outcome of these workshops surprised us would be an understatement. The protesting young woman's first piece, an op-ed, appeared in *The New York Times* 2 months after her impassioned objection to the exercise. It turned out she'd had a patient whose situation infuriated and nagged at her. And she wasn't the only one; others in that group of 19 residents published in *Annals of Internal Medicine*, *Health Affairs*, and *The Huffington Post*. When we repeated the curriculum the next year, publications in other newspapers followed, and former participants have subsequently published in newspapers, journals, health blogs, and also broadcast on the radio.

I don't mean to imply that most people who come to the workshops get published, or even that the publications prove the worth of the curriculum. For most of us most of the time, a piece worthy of publication won't emerge in near-perfect form in a single sitting. It will require multiple drafts, input from thoughtful readers, and possibly an investment in skill development. So it is this that matters most: many of the participants in these workshops, including those who never publish, learn new ways to think about, discuss, and communicate to others their clinical experiences and thoughts about health and health care. They link disturbing or inspiring events to issues of medical or social import, share and explore experiences

that might otherwise have simply festered internally, discover alternative perspectives on events, learn new skills for communication and meaning-making, and become aware of another arena in which their expertise might benefit their careers, profession, and society.

I like to tell the story of the protesting resident for several reasons, not least because she didn't want to write, felt writing was not among her strengths, and had no training in it. But all she needed to do was get her story and message across, and she succeeded because she had the writing skills of an educated person, sought honest feedback, and devoted time to revision. Her patient's situation had moved her. Through her op-ed, it also moved many others by doing what public writing must do: it distilled complex abstractions of medicine and policy into the actual experiences of a real person in circumstances that invoked compassion for the patient and outrage at a failing of our health-care system. It's easy enough to write off an idea or theory and much harder not to care about the unnecessary suffering of a specific fellow human being.

I believe that this is one way that we must tell the stories of medicine: one patient and one provider at a time, in plain language, and with passion about a cause that matters. Politicians, journalists, business people, public relations firms, and fund raisers have known this for centuries. Tell people about a suffering nation and few are interested. Tell them about a town or village in dire straits and you don't do much better. Tell them about a family and you start to get some traction. Reduce that family further to one individual, a person you bring to life in all their idiosyncratic uniqueness, and now you have people's attention. Now things begin to change.

We in medicine are fortunate. Stories abound in our work, and we have unique perspectives from which to tell them. We regularly see and do existentially significant and deeply intimate things that most other people rarely see or do. And we have such experiences in numbers that allow for a vision that is both individual and societal. Not that our experiences as professionals are equivalent to those of patients, unless we or a family member is the patient. Critically, we may use real stories only with permission or after making changes to protect patient privacy. Yet while each encounter with a patient is unique and their own, patterns also tell important stories. Using the story of a particular patient to illustrate a pattern of social, economic, political, or medical import can lead to changes that improve health and lives.

In medicine, we often call such stories anecdotal evidence and write them off as lacking significance. While this may be true when it comes to making treatment decisions, we disregard such stories and writing at our professional peril. It is well known that many people don't understand statistics, yet too often that is the



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means by which we try to sway them, both at the bedside and in public discourse. By contrast, everyone responds to stories. For millennia stories have been a universal and universally effective mode of communication and persuasion. We are introduced to them in childhood. They transcend time, culture, and geography. We use them to derive meaning from experience and to pass along knowledge, values, and wisdom. Health professionals might need training in how to most effectively tell stories to a particular audience but we, like our fellow citizens, require no tutoring to understand them.

The primary reason to tell the stories of medicine is to increase understanding of the facts and complexities of health and health care. If on an individual level, it is widely accepted that good professional communication improves patient care and outcomes, then by extrapolation, it seems plausible that better public medical communication could similarly affect positive change on a systems level. And who knows, it may be that if we can communicate effectively with the public and colleagues we can't see and don't know, we might also communicate more effectively with our patients, their families, and the health professionals we do know.

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