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NARRATIVE MEDICINE: REIGNITING OUR SENSE OF PURPOSE AS CLINICIANS & PROTECTING AGAINST DEPERSONALIZATION AND BURNOUT

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Most western-trained medical students have encountered at least one PowerPoint slide early on in their training quoting Hippocrates, *Father of Medicine*, proclaiming that, “Where the art of medicine is loved, there is also love for humanity”.

Often met with a deep sense of awe and pride, this sentiment serves as inspiration to trainees worldwide as they embark on the life-long process of strengthening the knowledge, attitude and skills needed for this work: that of healing. Medical students, staff and resident physicians enter this field, one of implicit personal sacrifice made in favor of countless hours spent studying in libraries or at the bedside caring for ailing patients, with the hope that it will have been worthwhile. It is thus rarely primarily financial prosperity, rank, or status that drive prospective applicants to this discipline, but rather the desire to selflessly help our fellow humans in times of vulnerability and need.[1] In this way, the practice of medicine is widely regarded as beyond that of a career or a vocation, but one of *calling*.

THE ONSET OF BURNOUT

Fast-forward a few years into residency or independent practice, and far too often little is left of this initial love for the art of medicine, let alone that for humanity. Hundreds, if not thousands, of sleepless nights later —sprinkled with unrelenting and, at times grueling, constructive feedback all whilst juggling emotionally

charged, at times seemingly unappreciative patients struggling to navigate a complex and flawed healthcare system—and it is not unreasonable to see how the weight of these burdens can leave one feeling devalued and disconnected from their inciting motivating force.

The conditions in which medical learners have been conditioned to train and practice are wholly conducive to burnout, which the World Health Organization defines as an occupational phenomenon characterized by “feelings of energy depletion or exhaustion; increased mental distance [...] or feelings of negativism or cynicism related to one’s job; and reduced professional efficacy.”[2] Not only do those suffering from burnout bear the brunt of such effects, but so do those who are cared for by such affected individuals.

“Medicines cure diseases, but only doctors can cure patients,” said Carl Jung. But what happens to physicians who are plagued with their own illness experience of burnout? Who is left to care for them or their patients? The statistics on burnout are clear and yet inconspicuously personified by afflicted physicians. According to the CMA (Canadian Medical Association) National Physician Health Surveys conducted in 2017 and 2021, nearly 1 in 3 physicians and residents experienced depression and burnout in their lifetime, with burnout rates having since doubled to an alarming 53% since the onset of the COVID-19 pandemic.[3,4] Suicide is a longstanding and well-documented occupational hazard amongst physicians when compared to their non-physician counterparts, where there is nearly a 40% and 50% increased risk of completed suicides among male and female physicians, respectively.[5]

Not only are patients navigating a broken healthcare system, so too are their physicians. A system established with unhealthy working conditions that for too long have gone unopposed and unquestioned. These grueling conventions have paved the path to generations of depersonalization and burnout: over 100-hour, high-stake work weeks, chronic sleep deprivation, vicarious traumatization, and compassion fatigue. As such, themes like building wellness, self-care, and resilience have started making the rounds into medical education. Training programs across the world have dabbled in yoga, meditation, and other mindfulness practices. The danger here, as world-renowned physician suicide expert Dr Pamela Wible warns, is that such wellness practices, though well-intentioned, tend to frame wellbeing as the individual’s sole responsibility. This oversight adds another area of focus demanding the physician’s time and attention, and absolves the responsibility of the system in which they train and practice.[6] Furthermore, with the still-present stigma surrounding mental health, especially among healthcare providers, there exists an added barrier of timely access, superimposed on the implications surrounding attaining hospital privileges, disability insurance, and advancements in one’s career.[7]

NARRATIVE MEDICINE: HEALING OUR HEALERS

So, what of incorporating Narrative Medicine into our training programs? And what can be said about practices which encourage physicians to reconnect with their inciting passion and rekindle their purpose in service to others, notwithstanding the need for systemic reform?

In plain terms, Narrative Medicine is a relatively new model of practice, spearheaded by Harvard-trained general internist Dr Rita Charon, in which stories are recognized to be at the forefront of healing for both patients and practitioners alike. In *Narrative Medicine: Honoring the Stories of Illness*, Dr Charon describes it as “medicine practiced with [the] narrative skills of recognizing, absorbing, interpreting, and being moved by the stories of illness.”[8] As such, this novel framework is posited to be able to transcend the inherently flawed system in which practitioners provide care, thereby being able to treat sick patients more holistically and with fiercer intent. Moreover, this framework allows for those, physicians or otherwise, who provide care to the sick to be themselves, in turn, continually nourished.

The utility of narrative competence is not a new concept to centuries-old disciplines such as law, government, sociology, and education. These fields inherently recognize that stories are of vital importance in the search for truth and justice, understanding and appreciating human behaviour and relationships, as well as societal progress.[9] Moreover, these narratives provide a foundation in which to ground the worker in their daily undertakings.

Research has shown that it is often the element of emotional exhaustion that lends itself to adverse effects on one’s work, relationships, mental and physical health.[10] Humans have the capacity to experience a myriad of emotions in a single day, at times multiple emotions at once, all from a single stimulus. Without interference, these emotional responses typically have a beginning, middle and end.[10] One might hear a crunching sound in the woods, feel a gush of fear, respond with fight, flight or freeze, and then realize that there was in fact no threat, or that it was successfully evaded. Eventually the surge of adrenaline subsides. And in such a situation, the response to the threat (either running away from or staying to fend off the threat) was the very one used to bring an end to the natural course of the inciting emotion. The danger of an otherwise adaptive fight-or-flight response lies in repeated exposure, in patterns that do not naturally include an end point, where the emotion lingers.[10] In psychology, this is often referred to as the “stress response cycle,” which when unchecked, can contribute to burnout.[10] In medicine, physicians run from one threat to another, often without sufficient time to process their emotions, or to recharge.[11,12] Therein lies a unique occupational hazard for physicians in the helping profession, who are constantly surrounded by patients in need, and are without the knowledge, training, insight, time, or systemic support to find a way to end their cycles of stress.

“A scientifically competent medicine alone,” Dr Charon proclaims, “cannot help a patient grapple with the loss of health and find meaning in illness and dying.”[9] The argument can likewise be made that a strictly scientifically-minded and competent physician alone cannot grapple with the emotionally taxing demands of clinical and academic medicine. Instead, they are left to struggle to find meaning in the barrage of never-ending patient care seamlessly lending itself to provider burnout. Narrative Medicine offers a remedy to, and protection from provider burnout, as well as an outlet to rekindle a collective sense of purpose as

disillusioned physicians strive to provide ailing patients with the best possible care with limited resources at their disposal.

REFLECTION AS A CORE COMPETENCY

Just as is taught the skills of interviewing, history taking and formulating differential diagnoses, so too must the skills of reflection be taught in the lifelong training of present and future physicians. Through reflection, and active creative expression —literary, visual, performance and sound— can physicians start to recognize and turn towards their emotions in order to gain the strength needed to reconnect with their calling, be present with their patients, and find the wellness from which is needed to tackle the unsustainable systemic perpetrators of moral injury.[13] The distinction between the stressor and the stress cannot be overstated. As Drs Nagoski plainly state in their publication on Burnout, “generally the strategies that deal with stressors have almost no relationship to the strategies that deal with the physiological reaction our bodies have to those stressors.”[10]

For Dr Laura Vater, a practicing gastrointestinal oncologist, this turn towards narrative medicine, specifically in her practice as a writer, was almost instinctual. “I don’t think that medical school prepared me for the emotions that I was going to experience in medical training,” she starts in an interview with The Work Room podcast, “there’s a lot of things that we witness: severe illness, death, grief, loss [...] but we don’t talk about that.”[14] She describes the experience which ultimately sparked her putting pen to paper. As a third-year medical student, pregnant and on an obstetrics and gynecology rotation, she had witnessed a woman — whose baby was at the same gestational age as hers— experience a stillbirth. “I remember [...] walking in the middle of the night [...] like I was no longer this student that was supposed to just stand there quietly with my arms behind my back and I just had this release of emotions. [...] that’s when I really started journaling about my experiences in medical school. [...] That’s what led me to writing. Taking those [journal entries] and shaping them into essays and sharing them with other people.”[14] This narrative experience would go on to transform into her essay, *Papaya*, published in the *Intima Journal of Narrative Medicine*, which ends in the following:

“I had found myself in a place, in a career, where life gets upheaved, where death comes unannounced. It was an unnatural pattern of being. I was just learning how to weave such upheaval into the fabric of my life, and to go on living. I didn’t know that learning how to navigate this landscape—to feel, to care, to grieve, and then restore myself again—was a skill as important as interpreting a blood count or stitching a suture.

When July came, with its sweltering days, so too did my daughter. She emerged with a piercing scream, with writhing limbs, with eyes wide open. The nurse placed her into my arms and said, “She’s beautiful. Congratulations.”

I would forever contrast the cries that night, and the coos, wails, and laughs in the months to come, with that silent room. That still-as-stone face. Those tiny feet. The ritual of loss. His death, and her fragile, flourishing life.”[15]

Alongside her large social media presence, Dr Vater has since gone on to become a member of the Pegasus Physician Writers at Stanford and publish a number of other narrative medicine essays which can be found in the *Journal of General Internal Medicine* as well as *Blood and Thunder: Musing on the Art of Medicine*.

OPERATING IN AN EVIDENCE BASED WORLD

The evidence-based benefits of Narrative Medicine —though this area of research is still in its infancy— can be found among literature published in the wake of the COVID-19 pandemic. In fact, just a few short months after WHO declared a Public Health Emergency, a perspective piece titled, *Storytelling and poetry in the time of coronavirus* by Barrett et al., was published. This piece explored various narrative medicine approaches in their pursuit to uncover how such avenues may provide solace and an outlet to healthcare providers during such a particularly tenuous time in healthcare. In reviewing various practical strategies utilizing poetry and storytelling, the practice of narrative medicine in such iterations as Schwartz Rounds and Balint groups are stressed to go beyond mere reflective practices and extracurricular pursuits. Rather, they have the potential to remind one of the strangeness of the human condition and lends itself to a sort of distance which, “invites space to recognize the shock of deviation from the norm as experienced in burnout.”[16] In this way, it provides an “opportunity to stand back from [the] world, to contemplate it, before once again immersing ourselves in it, for better or for worse.”[17]

One systematic review found that poetry, as a form of narrative medicine, may increase empathy.[18] However, the current body of evidence remains limited on whether there is a discernable reduction in professional burnout amongst physicians and other healthcare providers.[18] Of 401 screened abstracts, only 2 quantitative, 3 qualitative studies and 1 research letter addressed the relationship between narrative medicine and professional burnout. Only one quantitative study showed moderately reduced burnout post-intervention among high attendance participants, and one qualitative study noted limited reductions in burnout. As such, the integration of the humanities within medicine is currently lacking rigorous research and there is much uncharted territory.[18]

RECLAIMING OUR HUMANITY THROUGH STORIES

It is no coincidence that many published physician accounts, be they autobiographical or fictional in nature, often center around the loss and recovery of the physician’s own humanity. Among such releases include Dr Paul Kalanithi’s memoir, *When Breath Becomes Air*, published posthumously after succumbing to terminal cancer, as well as Dr Stephen Bergman’s (pseudonym: Samuel Shem) world renowned satirical fiction, *The House of God*, detailing the dehumanizing experience of residency training. In fact, in a short

JAMA Network documentary, *The Making of the House of God*, it becomes clear that the author's primary intention in writing was to reclaim his sense of identity and process his own medical training. "Steve is a brilliant writer [...] and a lot of the humor comes from his recounting of the episodes," Dr Richard Anderson says of his colleague and former co-resident during the documentary, "But it is also true that gallows humour was the currency of our relationships, and it was the way that we coped. And we did need to cope to deal with our impotence in the face of human suffering." [19]

Dr James V. Lucey, professor of Psychiatry at Trinity College Dublin, at the MindReading Conference of 2017, speaks to the importance of finding a home in the written word for the countless patient stories encountered by physicians. In his keynote address, *Listening to Patients, Telling Their Stories*, he asserts that, despite vitally important confidentiality clauses, the "stories we hear are not secrets. They need to be told and sometimes the very thing patients want us to do is to retell them." [20] He reminds the audience of the cornerstones of medicine: inspection, palpation, percussion, and auscultation – or "to look, to feel, to tap, and to listen." He emphasizes the importance of listening to the history instead of relying solely on one's stethoscope, because "if you haven't got the story, before you even look at the biochemistry, you're really not going to get the answer." [20] He goes on to say that these stories need re-telling and that as physicians, this "storytelling is part of our being." [20]

In truth, the act of storytelling is not only an act of advocacy on behalf of the story's teller to increase visibility toward unique patient suffering, but also serves as an act of healing on behalf of the story's recipient. Penning out these stories, internalizing, engaging with and meditating on them — out loud, on paper; in music, movement, poetry or in prose connects us with who we are as physicians and as otherwise spiritual beings having a material experience. Likewise, Pediatrician Dr Rachel Naomi Remen warns her colleagues against relying solely on scientific objectivity in their practice, whilst attempting to protect themselves from the difficulties of this work. In her New York Times Bestseller, *Kitchen Table Wisdom: Stories that Heal*, she goes on to say that, "Objectivity is not whole. In the objective stance no one can draw on their own human strengths, no one can cry, or accept comfort, or find meaning, or pray. No one who is untouched by it can really understand the life around them either." [21]

CONCLUSION

Despite the years of extensive training undertaken by medical students and residents, or the decades of devoted clinical practice that follows, there remains much of human suffering that has yet to be fully understood or appreciated. Through the active practice of reflection and connection —of turning *to*, rather than turning *from*— can physicians begin to grapple with the unknown, that which cannot be explained of the patient or physician's lived experiences by the current body of evidence-based medicine. Such reflective skills must be fostered early on in training, encouraged in practice, and studied with the same level of devotion bestowed upon other facets of clinical teaching and learning. Narrative Medicine, as a nascent practice and practical tool in healthcare, offers tremendous promise in allowing the culture of medicine to

slowly transform into one that allows for objectivity and subjectivity to exist in harmony rather than in opposition. It creates space for the experiences and stories of patients and physicians to lend colour to the at times dreary concrete numbers, routine physical exam findings, and depersonalized radiographic reports in the path toward healing. In this way, Narrative Medicine provides a framework by which physicians can reconnect with their sense of purpose, process their emotions, and complete their cycles of stress, ultimately protecting themselves from the perils of emotional exhaustion and burnout.

For in the words of John Keating, portrayed by the late Robin Williams of *Dead Poets Society*:

“We don’t read and write poetry because it’s cute. We read and write poetry because we are members of the human race. And the human race is filled with passion. Medicine, law, business, engineering, these are noble pursuits, and necessary to sustain life. But poetry, beauty, romance, love, these are what we stay alive for. To quote from Whitman: 'O me, o life of the questions of these recurring, of the endless trains of the faithless, of cities filled with the foolish. What good amid these, O me, O life?' Answer: that you are here. That life exists, and identity. That the powerful play goes on, and you may contribute a verse. What will your verse be?”[22]■

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Biographical note

Charlene Habibi, M.D., CCFP, is a Queen's University-trained Family Physician currently completing an enhanced skills year of training at Dalhousie University in Palliative Care. She has a passion for medical education, physician mental health, and narrative medicine. Central to her practice is a belief in the power of storytelling — that everyone has an emerging story, with compelling and influential characters, which she hopes to influence positively in her work as a palliative and primary care physician. A writer and poet, she can be followed on Twitter @charlenehabibi or Instagram @writtenbychar_md.