

Cardiologist's Education Based on Culture and Humanities. A Practical Proposal

BACKGROUND

Medicine has as purpose the relief of human suffering. The dimension of the medical task happens in simultaneous and complex levels and it confronts us daily with fellow being in difficult times of disease, loss and grief. From this complex dimension inevitably arise two questions:

Firstly, we ask in what extent we are humanly and technically trained to build a doctor-patient relationship that allows us to hear the real history of the problem that we face and to resolve it with the possible widest view.

The second question, more intimate, is in what extent we can handle the emotional turbulence that is caused by the daily contact with suffering, also facing the constant risk of taking decisions that they may help but also hurt.

The phenomenon of burn-out, a serious consequence of poor preparation of conflicts and dissatisfaction in professional practice, may occur even in early stages of medical residency. (1)

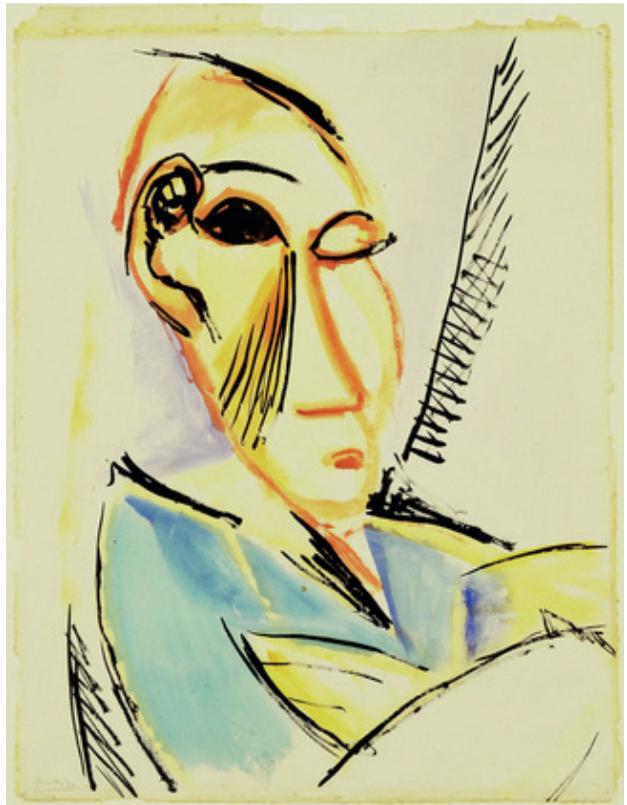
Most of the post-graduate training programs in residencies, real stage of care activity of our specialty, they have not contemplated the exploration of the doctor-patient relationship or methodologies for his training, much less a reflection on emotional conflicts of the career.

This Director's Letter, in an article devoted to medical education, will aim to explore some proposals to overcome the shortcomings identified in residency programs. I will take as trigger a recent article in The Lancet journal.

HUMANISTIC EDUCATION: ARTHUR KLEINMAN'S VISION

Arthur Kleinman published an article in the The Lancet journal, (2) in section The art of medicine, with a provocative title: 'El yo dividido, los valores ocultos y la sensibilidad moral en medicina'. The article was accompanied by a Picasso's painting, 'Retrato de un estudiante de Medicina' (Figure).

The medical student is drawn into two layers: the background, which we guess a simple sketch of a neutral face, and in the foreground, with black lines, a disturbing mask. They are the two dimensions that Kleinman addresses to speak of the divided self and hidden values, that is to say, the dissociation between the passing of a medical practice that is orientated to solution of problems with systematics and guides, technical level, and on the other hand, moral values and conflicting emotional experiences that are generated in massive way before the link with patients.



Portrait of a medical student. Pablo Picasso. 1907

The lack of recognition of these values and emotions, the author tells us, can lead to weaken the personal life and clinical interaction. Although many years have passed, I remember vividly how in the early years of residence we developed very dehumanizing attitudes in treatment and even a strange language, a slang that the 'pipes' fit (patients with severe general impairment), and barracks jokes and even cruel irony.

Kleinman puts it as 'the transition from the early 'pre-cynic' years of the medical school to the 'cynic' years of the guards and clinics, the first years of residence and professional practice'. 'Before the absence of a moral sensibility about what should be the clinical work in a world of hidden and divided values, idealistic students are remade as cynical, likeness residents and practicing physicians that they emulate'.

Kleinman's response to this impairment is a proposal initially simple: we should reflect critically on our human values, our experiences, what happens to us when we face the professional work and, in turn,

what happens to patients and their families.

MEDICAL WORSHIP AND REQUIRED LEVELS OF ALPHABETIZATION

According to Kleinman, 'the postgraduate medical curriculum should be enriched with attention to humanities: anthropology, history, literature, arts, movies, biography, novel, everything that contributes to improve human sensitivity to the clinic. Also music, art museums and humanistic psychotherapy'.

In interviews with candidates to the residence, nowadays it is remarkable the very little cultural training in "humanities" in the sense of the developments above referred. The new cultures related to the virtual, the Internet and a different dynamic of access and knowledge management are still little explored for medical training.

I have clear that knowledge of medieval art, the recitation of the Divine Comedy in Italian, the history of the battles of the First World War or the reading of Joyce's Ulysses in any way guarantee a better job or make your medical wearer more human in the sense of a greater sensitivity and empathy for the suffering. I know that film scholars are unable to perceive the conflict to a cinematic story offers us, distracted by the background of the actors, directors and details of jet-set. To make matters worse, erudite physicians in everything (and who try to make this situation noted) are in practice little empathetic or warm, consumed in defending their bronze levels. (3)

As Kleinman expresses very well, we should not try to use humanities to be humanistic physicians, ethicists, sociologists and anthropologists, 'but to cultivate and develop a richer and deeper receptive sensitivity: critical, warning aesthetically and morally responsible'.

Iona Heath (4) expressed in similar terms a proposal of medical alphabetization in four domains: professional alphabetization (classical education), corporal (learn from the experiences of pain and disease that we live to understand the experiences of our patients, cultural (sensitivity to the manifestations of human experience in their different fields) and emotional (ability of empathy and understanding of the life history, values and disease of our patients in every sense).

A REFLECTION ON THE YOUNG PHYSICIANS AND PATIENTS' DEATH

A few years ago, I was assembled by Guillermo Fábregues, I participated with Hernán Doval, Jorge Thierer and other colleagues at a table in the SAC Congress dedicated to physicians and patients' death. The experience was very moving, experiential predominates on academics, with an intimate communication with the audience. This material has remained unpublished and I will summarize a part to this letter.

In the early years of residence we have the

opportunity to witness the first deaths of patients in our care. In this way, inevitable questions arise: Has he died because of my fault?, Could I prevent this death with another therapeutic strategy? We have for first time to report that someone is going to die, the repeated phrase of 'do you think that I am talking with the family?' When we take a long time to resuscitation, in order to 'get ready' and then report the death.

To what point are we prepared to assist the patient's death and support the family? Do we have medical facilities where we develop our activity in an environment of support for these emotional storms, commotion that we all live when we start working? Fortunately there are many colleagues who have been encouraged to write and investigate these issues.

In a study about evocations of the medical activity of the early years, (5) residents clearly remember the harsh experiences of giving bad news. The author of this research suggests some practical recommendations for the ideal context in these situations:

'In the first instance, you should observe a physician with more experience, be assisted during the first few times and have a space for further assessment. This space should allow you the possibility of reviving the situation, communicating feelings, reviewing what he said and maybe what he should have said'.

One way to start this preparation is the 'emotional training', which allows us to perceive what is happening to the other. Empathy is a shared, involuntary, essentially instinctive emotion, which we all have, that part of the look in the mirror. In fact, we perceive the pain of others playing that circuit in our own body. (6)

However, our medical training is anti empathic. Perhaps to protect us, the medical practice keeps us from this empathic perception, in the early years. It is so massive the suffering that we are witnessing, death, pain, mutilation, physical disability, anti empathy allows us to go ahead with our practice and training, but at a cost. To recover our empathic capacity, over the years, we should do another workout, sometimes through psychotherapy, a slow, careful, but crucial way so we can know to inform, consult, share, commiserate with patients.

What are the defensive reactions against this massive flood of painful sensations?

One way is called toxic intern syndrome, which leads to cynicism, insensibility. (7)

We imagine (or remember) a dialogue during the residency:

- How did you do in the yesterday guard?
- And, three to zero.

Translation: they were died the three patients who we tried to resurrect. Or three to one, we got one, we lost three.

That is, we start to use a sort of disaffected slang, to tolerate and accept these extreme situations. This can lead us even to take insensitive or cruel decisions

to the patients' needs.

Did she die because of my fault?

One of the tough questions facing the death of our patients is whether we made a mistake, if we have 'the' guilt. I think everyone working on the ledge of intensive care or emergency have felt guilts. We know that medical error is an important cause of death. In the United States is estimated to be the eighth leading cause of death, and although we all recognize its importance it is a difficult issue to discuss in hospital life. Barriers to the discussion of error are manifold, and the medical staff seems to deny the effects of stress or fatigue on job performance. Another problem mentioned is the refusal of the most experienced staffs to accept the opinions or concerns of the young members in this regard. At the residence, the error is related to insufficient training, with the extreme demands, with inadequate work conditions. Many times we have tried to bury these alleged errors or faults together with patients, but as in a Poe's story, their echoes follow torturing us for years. (8)

In a recent survey in Spanish physicians, within the major sources of psychological stress are referred to in daily contact with suffering and death, responsibility for human life, uncertainty over the diagnosis, the possibility of being sued and communicating bad news. (9)

One risk of the 'steel man', from this depersonalized man, concealment of these affective commotions is the burn-out. The burn-out is a well-studied syndrome, which consists of being emotionally exhausted, which often leads to abandonment of the specialty, medicine or the motivation to practice it, to addiction and even suicide. What is the prevention to this phenomenon of destruction?

First, realize that one is subjected to this kind of tension and try to create a good working environment and a good academic environment. Intellectual exchange, everyday discussion guides to the better understanding of medicine and patients, it is an exceptional protective mechanism. Also, the feeling of belonging to a group with far-reaching goals avoids entering into this dissolution.

How can we deal with this protection with practical strategies?

RESPONSE FROM THE MEDICAL HUMANITIES AND NARRATIVE MEDICINE

In the last fifteen years in diverse university contexts, proposals of humanistic education that take different denominations have emerged: 'Medical Humanities', predominantly in Great Britain, (10) or 'Narrative Medicine', with its origin in the United States, as well as periodical publications covering the subject. (11)

Both terms indicate an intention but they are not self-explanatory and well worth stopping to specify what we really mean. I will focus on Narrative Medicine, because of the perspectives for its practical

application that I will discuss in the final section.

Columbia University has developed a Master in Narrative Medicine and it is guided to 'teach narrative theory, reading skills, reflective writing, interpretation of the narratives of disease and the philosophical basis for the development of an empathic relationship between clinicians and patients'.

Rita Charon is the leader of this project and in an editorial in the *Lancet* (12), she outlines the three levels of conceptual exploitation in narrative training: understanding before every medical circumstance which is known / knowable and differentiate it from the unknown / unknowable, the universal and particular aspects of each experience of disease, and body focus and the self of the patient. Interestingly, she associates these three dimensions with the pattern of circles of medicine based in evidence: the evidences (what is known), the general context (universal and particular) and preferences (the values and the patient's ego in making decision).

It is about to listen to the patients's histories, to interpret and engage with them, and in turn to understand what happens to us with these histories. To understand the histories, they are applied the tools well known in letters but unknown by physicians: analysis of the narrative, metaphors and language of the story, the recognition of signs and meanings.

As theoretical discuss, training in narrative with techniques that I will discuss later, is guided to obtain 'attention, representation and affiliation'.

Attention: to be present with the patient.

Representation: the act of representing with language or any other means what I perceive. Part of the statement that one fully understands what is experienced only when represents it. The training in narrative consists of writing and telling the patients' histories and ours as physicians.

Affiliation: development of affective bonds with the patient and his family and environment, between physicians in groups, among physicians and culture.

It is noteworthy that the author is a clinical medical care, aware of all the evidence and pathophysiologic knowledge, with responsibilities to residents in the specialty and, of course, on par with a doctorate in Letters and other personal developments. She has numerous publications, a classic book not yet translated into Spanish, (13) and this year it was published a report on the network Intramed carried out by Dr. Mauro Tortolo during a rotation in his training as resident, which was very rich in concepts and in order to meet the author in her more personal level. (14)

I take some interesting paragraphs:

"If I were the Rector, I would insist that all my students were in psychoanalytic treatment, I think that it is necessary that doctors get a serious and deep psychotherapy, preferably psychoanalytical therapy."

(Quoting to Psychoanalyst Hans Loewald): 'Writing

is a sensorimotor act whereby I transform the immaterial into the material, so I can communicate it to myself and to communicate it to others. Until I do not write about something I have seen, I have not seen it.”

‘We think that medicine was wrong to separate the issues of life from the issues of disease’.

“The fruits of narrative medicine will be a lower glycosylated hemoglobin, an improved blood pressure control, fewer cigarettes smoked, more loss of weight, and so on. Patients will feel heard, and physicians will be happy.”

Although narrative teaching is experiential and groupal, it is not a structure of psychotherapy in the style of Balint’s groups of several decades ago. What is it about, then?

Narrative Medicine in practice. The Group’s expertise in pediatrics at the Hospital Italiano de Buenos Aires.

A few months ago I attended the first conference of Narrative Medicine organized by Working Group on this issue of Hospital Italiano de Buenos Aires in the context of the International Symposium of an Argentine Congress of Pediatrics Dr. Carlos Gianantonio, experience I could reinforce sharing with Lic. Ignacio Usandivaras and Pediatrician Cristina Catsicaris, a narrative workshop in Argentine Conference on Medical Education.

This group of Hospital Italiano gets over a project oriented to improve aspects of doctor-patient communication and reflect on the ethics of everyday practice, working with students, medical residents and staff of the Department of Pediatrics.

Through the use of narrative as a tool, they search to improve aspects of doctor-patient communication and reflect on the ethics of everyday practice.

They work with students, residents and physicians of the Department of Pediatrics of Hospital Italiano de Buenos Aires.

I have asked them to summarize the types of activities that they perform in the weekly meetings with the physicians during an hour and a half.

1. *Rewriting of a history*: based on the information contained in clinical histories, participants are trained to rewrite or tell these histories in their context, in everyday language (not in the technical language of the records) and compare their perceptions and experiences.
2. *Critical reading of literary texts or film materials*: it is to generate imaginative skills that help to cross the gap between knowing about a patient’s disease and understand his experience. For example, texts such as ‘Elena sabe’ by Claudia Piñeiro, ‘El hombre lento’ by J. M. Coetzee, ‘The man who mistook his wife with a hat’ by Oliver Sacks, ‘Ivan Ilyic’s death’ by Leo Tolstoy.
3. *Evocation and writing*: dream techniques aimed to evoke personal experiences related to the subject

matter and later writing of them.

4. *Spontaneous Theater*: theatrical technique that works with the public accounts dramatized by a group of actors of Cosmos Company.
5. *Audiovisual triggers* (comics and cartoons, paintings, graphic humor) published by the team for further processing through writing.
6. *Plan of periodical writing* about life experiences during the relationship with patients.
7. *Narrative of disease*: to promote narratives of the of patients’ experiences in the hospital during the inpatient monitored by medical residents.

I participated in several of these workshops, some with slogans to write, and it is essential that at the end you get awareness that something important has happened. There has not been a class or a psychotherapy session, but we have learned. An example: during the mentioned working day, we read with Professor Craig Irvine at Columbia University a Neruda’s poetry, ‘El rol del poeta’.

After discussing plot, metaphors and intention, he invited us to write in poetic tenor how we saw the role of our profession. There were physicians, nurses, social scientists and a philosopher, and the experience was important, not only I heard reflections of colleagues and different views of life projects, but also I was motivated (in a provided environment) to think about my current view of my role as a physician and thus make explicit thoughts and feelings I live but they do not have common areas or channels of expression.

As lesser experiences in the Cardiology Department of Hospital El Cruce we have invited residents and physicians to write histories of life of hospitalized patients, with very poignant outcomes. We also do, though with some discontinuity, the analysis of a sculpture or painting in some way related to medicine, the body, disease, a segment of the central atheneum of the hospital that we affectionately call ‘A piece of culture’. The effects have been quite interesting: many physicians have been encouraged to seek works of art and comment them, and in general, it has been generated a new level of conversation and interest. In some physicians for the first time, and in all, there is a possibility of enrichment through knowledge of other planes of co-workers, their concepts and values.

FINALLY. WHAT WE CAN AND SHOULD DO WITH THE NARRATIVE

In a discussion of the new field of medical humanities, two English authors exchanged ideas in a very creative way and the addressed problems are applied to the possibility and limitations of these programs.

One of them, Pattison, (15) expressed concern that these projects conclude in a formal education. He cited as example the field of medical ethics, where after a boom in the sixties and seventies, became in many cases formal programs with made phrases and the absence of frames of daily reflections in the hospital

about the real problems at the patient's bedside. He proposes as a means of preventing the development of a humanities-narrative movement: 'inclusive, lax, porous and wrong-defined', composed of individuals and groups, clinicians, psychologists and theorists with different backgrounds, skills and perspectives. The only binding motif would be the concernment in all aspects that have to do with human being and healthy being.

In response, R. S. Downie, (16) one of the leaders in the development of this subject in Great Britain, agrees on the need for the medical humanities and arts-related issues and health remain as special modules, always voluntary, and not ongoing programs with compulsory attendance. The modules should be determined by a professional trained in

humanities and a physician or health professional interested in these subjects. Both agree, as well as Rita Charon, in the difficulty of measuring the outcomes of these pedagogical-experiential interventions, with quantitative methodologies and short periods, and they also oppose that monthly results are sought. It is reasonable but probably not viable in the long term.

I think the possibility of testing such programs in cardiology services with academic activity and residents is perfectly feasible, low cost, and could be a solid contribution to the training of more empathetic, 'educated' physicians, and with a better doctor-patient relationship and with his own professional career. Be aware that we are doing nothing to improve the complex reality of the emotional and humanistic training of junior physicians, it must place us in the starting point of a change that is entirely in our hands.

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