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TRANSCRIPT - GR 06 07 24 ***"Health Humanities for All: An Evidence-Based Approach to Education and Daily Practice"*** Ben Martin, MD from the University of Virginia

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Internal Medicine Grand Rounds

- Hi, everyone we're gonna go ahead and get started.
- So it's my pleasure to introduce today's grand round speaker, Dr. Ben Martin. He's 1 of our very own hospitals here at Uva, Assistant Professor and Assistant Director of Programs and Health Humanities and University of Virginia Center for Health Humanities and Ethics. He received his Bachelor of Arts with honors in English and American literature from Middlebury College, and was awarded the Donald E. Axon Prize for his creative thesis, and he has ongoing work today as an active writer with his most recent essay, Pu, published on Literary Hub.
- From a clinical standpoint, he attended Tufts University School of Medicine, and completed his residency here at Uva, receiving an Arthur P. Goldf foundation, humanism and excellence in teaching award and addition to serving as an academic hospitals, he's an active contributor to our undergraduate and graduate medical education and in addition to conducting traditional bedside teaching and question-based learning sessions on the hospital awards, he incorporates humanities, based discussions into his clinical teaching, using fiction, creative nonfiction, and other media and the medical humanities to expand our understanding of patients.
- His prior research has focused on differences in perception between healthcare professionals and patients with more current interest, focusing on how educators can assess educational outcomes in the humanities.
- So please join me in welcoming Dr. Ben Martin as he speaks with us about humanities for all.
- Thank you so much. Oh, this is a great turnout, thank you. Can everybody hear me. Okay.
- Alright. Well, thank you for that kind introduction. And I'm really happy to be here today talking to all of you about health humanities for all an evidence based approach to education and daily practice.
- I don't have any financial disclosures. It might not surprise some of you that there isn't a lot of money in the arts and the humanities. But I do wanna emphasize one of the things you were talking about in my bio, which is that I come to the health humanities really from a place of creative writing and literary criticism. And so today, we're gonna talk about a lot of different aspects of health humanities. But there's gonna be particular emphasis on creative writing and literature. And and that's in large part due to my background and my training.
- Gosh! This clicker thing is so awesome, alright great! I'll try not to wander around too much. So I think sometimes when we talk about art and humanities, we can start to feel a little squishy and a little amorphous. And so it's particularly important to me today to be really clear with our learning objectives. And I'm gonna keep circling back to these learning objectives throughout the talk.

- Learning objective. One is to just define what the health humanities are, we're gonna do that in the top context of global history, we're gonna do that in the context of local history. And we're gonna define health humanities in the context of broader educational goals by the double Amc. And Acme.
- By the time you leave here you're also going to be able to describe the evidence base that supports the use of health humanities both in undergraduate and graduate medical education. And we're going to see how the health humanities can not only help us be better teachers, but also might just help us be happier and be better doctors for our patients.
- Learning objective. 3 will then review examples of new and ongoing scholarly inquiry within the health humanities. And this might be my favorite learning objective, because I get to shout out certain people who might be here as doing some really exciting research in the field here at Uva.
- And then, lastly, learning objective 4. We're gonna learn discrete narrative medicine techniques for daily teaching and practice. And so by the time you leave here today, if you know nothing else, you're gonna walk away with 4 different discrete strategies to apply to your daily practice of teaching. You don't have to be particularly interested in reading. You don't have to be particularly interested necessarily in writing, but you're gonna walk out the door. Even
- Dr. Harris will leave this room and be able to do these practices. So just a little bit of foreshadowing. We're going to circle back to that at the end.
- I'm sorry, Drew. I couldn't resist
- So in order to do that, really it wouldn't be medicine grand round without a case. And and so we're going to get to learning objective, for through a fictional patient
- Rf. Might sound familiar to a lot of us in the room. He's a 32 year old male, with a history of alcohol, use, disorder, major depressive disorder and housing instability, and he presents to the emergency department with alcoholic hepatitis.
- I want you to keep Rf. In the back of your mind. We're going to circle back to them by the end.
- So let's start out now fully with learning objective one knowing where we're headed. And in order to to do that, we need to very quickly review the history of the relationship between critical medicine and the humanities.
- After we do that, we can in very discreet terms define what the health humanities are and distinguish that from medical humanities and narrative medicine.
- And then, finally, again, we're going to contextualize all of this within broader institutional goals of the double Amc. And Acme.
- So there isn't a lot of history. This is very brief, I promise. Don't get worried. But I did have to include Plato, because early early on with clinical medicine.
- Plato is attributed to, has said, the soul and body being 2, they have 2 arts corresponding to them. There's the art of politics attending on the soul. And there's another art attending on the body and the medical historian, Roy Porter, contextualizes this by writing Greek thinking emphasized the common ground between what would later become separate disciplines of philosophy, medicine, and ethics.
- And so, of course, we know that what Plato was doing is very different than what we do, and so over the sweep of history, with the enlightenment, with revolutionary advances in physiology, research in the 19th century, in Germany and France, and then possibly most relevant to us in the United States in the early 20th century, with

the influence of the Flexion Report and other efforts to codify the importance of science and biomedicine and medical education.

- Even as all that is happening there's persistent and vocal support of the the crucial role of the humanities. Perman, not my goal in 1,882 is the German physiologist who who wrote never forget that it is not a pneumonia, but a mnemonic man person who is your patient.
- More recently Rita Sharon, who will come back to again in 2,006, writes a scientifically competent medicine alone cannot help a patient grapple with the loss of health, and find meaning and illness and dying and possibly nowhere was more crucial in in these cries than University of Virginia. So here dr. Edward Hook, who a lot of us are familiar with, who is a groundbreaking Id. Researcher, the chair of Uva medicine for 21 years a founding member and president of Idsa, president of Acp's list of accomplishments, goes on and on, but some of you might not be as familiar with how much he cared about the humanities.
- He was a founding chair of the Hospital Ethics Committee. He created our medical schools, 1st faculty position and bioethics, and he actually founded the program of humanities and medicine that was the predecessor to what would become the center for health humanities and ethics, which is one of my academic homes.
- Dr. Hook cared so much about this that in 1997 he delivered the Jeremiah Metzger lecture, and this was at one of the many associations of which he was president, and I want to read his word because they're pertinent today. He he starts his lecture in a slightly dramatic fashion, and he says, humanities and medicine with an exclamation mark in the midst of the explosion in molecular biology and technology which characterizes modern medicine. It may seem a bit out of place and old-fashioned to discuss the broad, cultural and philosophical qualitative issues of doctering.
- These just don't seem to mesh well with the quantitative digitized medicine of today. He's writing this in 1 97. So before epic.
- And if that seems a little pessimistic, what he comes around to is ultimately again a rallying cry for the importance of the humanities. He writes the humanities, history, literature, ethics, and philosophy, religious studies, visual arts, and jurisprudence offer essential knowledge about people and teach skills which will enhance clinical competence, and therefore should be more firmly anchored than they are in education for the practice of medicine. So we really see echoes of Plato here in Dr. Hooks, words from 1997, and I think you'd be very pleased with the way we've seen this codified in the last 15 years. In medical education.
- 2,011, about half of accredited us. Medical schools required a course in the medical humanities 2,015. Many of us will remember that the Mcat was revised to include testing and psychological and social foundations of behavior and by (201) 720-1894% of medical schools reported, required, or elected courses in the humanities. So what we're seeing here again, is a modern, a codifying process of something that way back to Plato we've known is true, which is, the humanities and the practice of medicine are deeply intertwined so it would probably be helpful now to have a more practical definition of of what the health humanities are.
- I wanted to include this website from 1994 from Nyu, because I think it's just kind of a funky, 1990 S website. And it kind of cracks me up. But they have a really nice definition here, where they define the term medical humanities as a very broad interdisciplinary field that includes the humanities, the social sciences, and the arts. And if that's a little hard to read. What I did is I took that, and I I kind of plug this into

a taxonomy and you can see these 3 major branches. This is just the humanities in general. But then I think it's worth noting even within these boundaries, as we try to have definitions, you're gonna see a little bit of cross pollination. So if you think of a work of literature, maybe this could be in the category of the humanities, especially if you're taking a critical interpretation of it. But then a novel is also literature, and that's really a work of art.

- So I think it's important, especially for all of us, as as kind of like, sometimes rigid and quantitative people to remind ourselves these boundaries are are inherently porous even though there are a lot of different definitions that circulate. And the more that you look into publications in academic medicine, you see, really, really overburdened, like tripartite definitions that honestly confuse me. I think the definition of medical humanities can be very simple. And for me, when I think about the medical humanities, it truly is just this, using the humanities which we just saw on the previous slide to understand medicine. And 1 point of distinction, you'll notice is that over the last 10 years there medical humanities, as a term has dropped off, and instead, people are using the term health humanities, including us at our center.
- And the reason for that, I think, is very nicely summarized here in this book by Crawford and his colleagues in 2,017, and I'll read you this quote.
- Not everyone aligns with medical visions of health care. There are multiple and often complimentary contributions to health and wellbeing which fall outside medicine per se.
- And so for that reason, instead of saying medical humanities, most of us now use the phrase health humanities. And again, a very basic definition, using the humanities to understand health.
- and I think that definition between met or that distinction between medical humanities and healthy mandates is worth sitting with for a moment, and I want to illustrate the importance of that distinction with this painting and this essay by Leanne Shaken.
- Leanne Shafton is the art editor for the New York Review of books, which is kind of considered in the art world to be the premier publication for any kind of scholarly work. She's also an incredible painter. She's an incredible writer. She was a competitive swimmer, and her memoir about competitive swimming won the national Book Critic Circle Award. So she is, in my eyes, an incredible artist and she wrote this essay that was published in Harpers a couple of years back, called Written Water, where she's reviewing a book about outdoor swimming, but in reviewing it, she incorporates her own experiences swimming outside, and I want to read you a passage she writes.
- We find a bend in the river where our friends have spread towels around a deep, pebble-bottomed pond. I turn off my phone.
- We swim and get out to dry in the sun and repeat this until we get hungry.
- On the way to the car my daughter stops to examine. Polly walks in a shallow stream so there's not a lot of medicine in here, is there? But I would argue there's a lot of health and so to do a little bit of textual analysis, to try to find some deeper meaning. If you look at word choice right away. You, you see pebble bottomed and poly logs, and already, mentally, I have these visceral associations from my own life of nature as a side of refreshment and potential and excitement.
- And then, if you look at her syntax, you have very simple declarative sentences that would be right at home in a short story by Ernest Hemingway. And so, in very

simple terms, she's getting at this idea that I think can be intuitive for a lot of us, which is, there's a dynamic relationship between exertion and appetite.

- And I think in a medical context, we think about hunger. A lot of the time, and a patient who's been nauseous and vomiting for 2 days, who comes in the hospital? Who's Npo. Who's getting an Egd. At 3 Pm. And feels a very specific type of hunger that to me is very different from this type of hunger that is much more related to a sense of health and wellbeing.
- And then, lastly, when we talk a lot about writing, we think about the mood, which is basically just what it sounds. What kind of feeling do I get when I read this? And for me it's a calm mood. There's almost a sense of Edenic innocence, and you start to think about yourself as a human being, a human body in relationship to non human bodies within this natural environment, it couldn't be more different from the environment we often work in day to day.
- And so I think for that reason health humanities, with an emphasis on health, is really useful in expanding the types of art and expanding the types of conversations we can have that are relevant to the people we take care of.
- Now I also mentioned that I was gonna distinguish that from narrative medicine. And so, if we think of the health humanities as this big umbrella narrative medicine is a much more specific term. It's almost like a legal term of art that refers to this specific practice, and it was coined by Rita Sharon, who is the god of narrative medicine, works out of Columbia, and in her book called Narrative Medicine, she writes, narrative medicine is medicine. Practice with a narrative competence, recognize, absorb, interpret, and be moved by the stories of illness.
- So here we're getting something much more specific, which is not only reading stories, but actually engaging with stories in a way that is going to advance your understanding of whatever you're engaging with.
- Okay, so we've got some definitions. Now, I want to contextualize those definitions within broader goals of double Amc and acgm. Me, and the question is, what does the double Amc. Think about to help humanities?
- We're very lucky that in 2,020 they issued a monograph their 3rd ever monograph at the time called the fundamental role of the arts and humanities and medical education, and and in this monograph they outlined a goal to improve the education, practice, and wellbeing of physicians through deeper integrated experiences with arts and humanities and in this 40 page monograph they issue 7 recommendations for how to do this.
- I'm not going to go over each one, but I just want to highlight number one. They they want to assert that the practice of medicine is an art as well as a science requiring a grounding and humanistic values, principles and skills, including a deep understanding of the human condition. So again we see echoes of Ed Hook. We see echoes of what we're seeing across the country, but it's being codified by double Amc. So this is something that on an organizational level is recognized as importance in the frame initiative. They also issue recommendations on how to advance scholarship in this field, and I'm not going to go through this bullet point by pullpoint now, but we're going to come back to this for learning. Objective 3.
- Now, if you compare the Double A and C to Acgme. You notice a big change. So acgm, Me has no explicit incorporation of health humanities and common program requirements. And if you're actually pull up that document and go through it like I did and search for control f humanities. The only thing you're gonna find is this,

which is is basically saying, whatever you started doing in medical school keep doing it.

- And that's it. So what we see really functionally is that we've codified this, there's a lot of time and effort thought about it, and then it kind of drops off once you start residency, and you're on your own but that doesn't matter. That A/C me, it doesn't mean that they're not doing really cool and important things. And so this equity matters website that I found seems like, it would be an opportunity to have some humanities oriented stuff.
- If you look at the way that they're incorporating perspectives from different populations on their website. Or if you look at the effort that they're making to think about mental health and wellbeing and questions of suicide.
- All of this seems deeply related in my mind to the humanities. But if you spend a little bit of time on this website, and I encourage everyone watching these, videos, the video. The second from left is like a 3 min video, and if you watch it, it's exactly what it looks like, which is a group of people standing directly addressing a camera, saying, If you're thinking about suicide, or if you know someone who's considering suicide, you should talk to a mental health professional and I would say rhetorically for me, that leaves a little bit a little bit to be desired. And I wonder if there's space on an institutional level to incorporate something like this. Donald Antram, who's widely considered one of the best working writers in our country, personally experienced horrible suicidal depression, was hospitalized for months underwent ect. He actually had psychotic depression and came out of it on the other side, and then wrote a personal essay about it in New Yorker, and so to have someone who is already established as one of the best artists in our country undergo this ill mix experience, come out of it and write about. It seems like an incredible, valuable opportunity to engage with it. So I wonder if there's a way for Acg. Me to work that in much the same way double Amc. Has.
- Alright.
- So we're we're doing good on time. We're going to pick up the pace here learning objective 2. Let's talk about the evidence base. So that's great that we've seen this trend. But when you study this, what do the studies actually show?
- And in 3 main categories here?
- there's just people wondering what happens if you look at what happens to people when they're exposed to the humanities.
- The second group is what happens to people when they do nonmedical reading.
- And lastly, is what happens to people of different training levels when they engage in reflective and creative writing.
- So in that 1st group. This is a study from 2,018, and it's 1 of the most commonly cited studies in the health humanities, literature, and the investigators wanted to see if there's any relationship between exposure to the humanities and certain personal positive qualities and burnout.
- And so what they did is they sent out a survey. It was a 3 part survey to 5 different Us. Medical schools, and had an impressive response rate of 30,
- 739 students, and all of those students filled out these 3 different parts of the survey. One was just basic demographic information.
- One section is they answer 10 questions about their relationship with the humanities. And these questions were super basic, like, how often do you go to museums and galleries? And there was a numerical scale 0 never for daily, and then they they the investigators compiled those scores as a composite score of

humanity's exposure and then, lastly, the survey respondents filled out previously validated scales, looking at specific personal qualities, wisdom, empathy, tolerance or ambiguity, emotional intelligence, self-efficacy, burnout and spatial skills.

- And then they performed an incredibly fancy and impressive statistical analysis that I'm not gonna get into the weeds of but I wanted to include this table, basically to show that they ended up grouping together these in these variables, based on a moderate relationship and conducted a multivariate regression analysis. And what they found was that human as humanities. Exposure went up.
- It significantly predicted all of the positive personal qualities. It also there's a statistically significant correlation with ambiguity, tolerance, and empathy interestingly, spatial skills as well, and that humanity's exposure just by going to the museum or doing these really basic things was a significant negative predictor of burnout.
- There's so much in this study that we could talk about. But one thing that I want to highlight is, I really like that. They included tolerance or ambiguity, and they used a validated scale because this is something. That I know. People in this room are interested in studying. When we think about how are medical students who spend the 1st 2 years in a classroom going to adjust to the real world of clinical medicine, when all of a sudden you're sitting down with someone, and you don't have tissue biopsy yet, and they're asking you, well, do you think it's cancer? These moments are rooted in ambiguity and uncertainty? And so if there were a way to determine before you're in that situation, how are you gonna fare that could be really useful data to know?
- The second category of evidence is nonmedical reading, and the question in general terms is, what happens to doctors and medical students when they read things that aren't related to medicine.
- I love this study partially because Daniel Marshall, who I was introduced via Marsha Childress. He's based out of Georgetown, and and he's a huge proponent of nonmedical reading, and he and his team conducted the study, looking at the impact of nonmedical reading specifically on clinician burnout. And this was in the population of palliative care providers.
- They sent out a 16 question electronic survey and the primary outcome that they were assessing was burnout as defined in the validated 2 item, Maslow burnout inventory, which was again a previously validated tool, and this was defined as the presence of high emotional exhaustion, high depersonalization for both that a present pretty decent response rate of 15.2% and 129 of 709 respondents met criteria for burnout.
- Then they also asked the participants, how much do you read? And this is all non-medical reading. They didn't distinguish fiction nonfiction. They just said, Do you read? And they they divided everyone into 3 groups. One was an inconsistent reader, so you didn't read anything, or you maybe would read part of a book.
- One group was defined as consistent reading. If you read one to 3 books per month, and then the last group they defined as avid readers who read 4 plus books per month, which might be like impossible to even imagine for a lot of the residents in the room and what they found was that there was a statistically significant correlation between a decreased, decreased, or a burnout in the consistent reading group, but not in the average reader group and that, or was driven by a decreased or specifically in depersonalization. So there are all sorts of ways to speculate

about this. But what they found essentially was that decreased depersonalization in consistent readers.

- What the study did not look at was what types of books are being read? Are people reading Charles Dickens, or people reading, you know, pulp mysteries. They didn't talk about method of reading, so they didn't look at. If you're listening to an audio book while you're folding laundry, or are you sitting down with the text and highlighting and annotating. And so these are nuances that I do think are are pertinent, especially when we think about something like depersonalization alright. And lastly, the category of reflective and creative writing is particularly important to me, because I like to write, but I also think it's something that is often talked about a lot within an educational setting as useful and narrative medicine can help you do XY. And Z. And my mind always goes to. Well, how how true is that so? Investigators asked this question back in in 2,008 and I thought this study was was bold because they asked interns at 9 different IM residency programs to volunteer to write nonmedical narratives every 8 weeks, and they successfully enrolled 32 interns who agreed to do this, and you'll notice that by the end of the study there are only 20 interns remaining. So I'm actually kind of impressed that 20 interns stuck it out after intern, year. I remember what it was like.
- But at the end of the year what what the investigators did was they? They had the participants sit down and say, All right. Well, what did you think? How did this change you as a person, as a medical? So as an intern. 19 out of 20 participants reported that the exercise prompted deeper reflection which to me is intuitive right? Because that's really what you're doing is you're sitting down on, you have to reflect on something in order to write about it.
- A really interesting number to me is 7 out of 20 participants reported enhanced self-awareness and emotional healing.
- And to me, I feel ambivalent about that number. I think you're gonna look at it 2 ways. One is, if you think about a very low cost, low time, intensive intervention to help you emotionally heal. 7 out of 20 is pretty good, that it's a very, very low risk potentially high reward.
- I also think he could look at it and wonder what happened to those other 13 interns where you're sitting down every 8 weeks, and no part of you was emotionally affected by that. So I was just a little surprised by that number. I find it interesting.
- Last study I want to talk about is a study back from 2,009, published in academic medicine. And this was looking at faculty. And again, this is a really interesting study design.
- 29 participants were enrolled in an 18 month faculty development course. And what that faculty development course was a little heterogeneous. It included different philosophical aspects of teaching, but it also focused heavily on writing and discussing critical incidents and or appreciative inquiry narratives. So this was 18 months of a dedicated routine narrative medicine at the end of the, at the end of the study period. They then took a control group of 47 faculty from the same schools who had been identified by medical students as exceptional teachers.
- And then they talked to the medical students who have been taught by faculty in both the experimental and the control groups and they used a novel, 10 item questionnaire assessing, teaching effectiveness. And what the investigators found is that participants in the Faculty development course, who are routinely doing narrative writing had significantly higher scores than their peer controls.

- This table illustrates some of the questions that were being asked. So if you see here, question, one listens carefully to connect with others.
- There was a statistically significant association in this faculty development course but to me there were. There were serious methodological flaws with this study. And and to begin with, I think if you invent your own scoring system, but you're also the person coming up with the course. That seems like a very strong source of bias. And then I didn't talk about the enrollment practice. But another problem with selection bias in this study is that the faculty who were enrolled in the education development group. They had been identified by the investigators talking with people at the home institutions as exceptional and promising educators. So my question for this study is one of external validity, and if you were to take this intervention and apply it to all teachers at all medical schools across the country really strong ones. Once you were struggling, would you say, see the same results, and my suspicion is you would not.
- So if you're starting to feel like some of this evidence isn't the strongest evidence. You're not alone and in 2,021 there was a scoping review that was performed looking at health, humanities, curriculum and evaluation and health professions, education if that identified 24 studies that included a broad swath in the health humanities. So this was everything, from visual art to film, to literature, to ethics and what they found was just that outcomes, being assessed were highly heterogeneous. So some of these studies were looking at. How does this practice in the health humanities help you learn something.
- Some of these studies were looking at. How does this practice in the health humanities make you feel? Does it increase your wellness?
- And, in fact, the studies were so heterogeneous that what the the authors of the scoping trial write is the primary finding of this review is that there is an absence at present of a consistent framework for health, humanities, learning, teaching, and assessment, and hence little capacity for systematic evaluation within or across curricula.
- It's a little disappointing. So I want to come back to the ponds.
- Take a deep breath, think about the poly logs and I think another way to look at this study in a slightly more positive way, is we're still at a pretty new place in medical education when it comes to figuring out how to effectively measure the benefits of the health humanities. And so there are also a lot of opportunities for new research and new innovation and teaching which conveniently takes me to learning. Objective number 3.
- What are new studies going on in the health humanities right now? And and what are they up to?
- And now I wanna come back to the double Amc's recommendations for advancing scholarship. Now, these bullet points are really helpful. They're really concise. And this will serve as a framework for thinking about ongoing research. The bullet point one double Amc. Recommends that we engage more diverse perspectives and voices in the literature by including those of learners, patience and arts and humanities, scholars so just expanding the field of who is actually contributing to the literature.
- I think it's worth noting. Shout out to Uva and aspire values equity. This lines up very nicely with our aspire value.
- And so I wanna highlight fair contractors here today. A superstar 4th year medical student who embarked on a research project this summer between her 1st and

second years of medical school. I also want a full disclosure that I'm I'm her research supervisor, and I have permission from her in advance to to talk about this and she came up with a really good idea. She just wanted to know. What is it like to be a healthcare, professional or a healthcare professional student who also has a chronic illness, or also has some kind of self identified disability and she wanted to get the experiences directly from the people having them. And so she developed a structured interview or a set of interview questions that she then applied in a semi structured interview process, and some of those questions included questions like, How has health been at odds with your professional advancement?

- How has your experience with illness and disability shaped your care of patients?
- And because Farah has an exceptionally strong record of qualitative research, even before starting medical school. Initially, she was approaching this, thinking, I'm gonna aggregate all the data and then conduct conventional qualitative research, assign codes and go on but as she was talking to people, she started to think a little bit more about the goals of narrative medicine as being exploratory. And she thought, maybe I can. I can convey this information in a different way. Maybe I can integrate these interviews into an essay to explore in subtle and nuanced ways, intersectional aspects of a patient and healthcare professional identities. And so this is an ongoing manuscript in progress. But I'm convinced this is either gonna be published in the New England Journal, or the Parish Review, or some fancy literary journal. So keep your eyes peeled for this exciting work.
- 1, one of the recommendations. Double Amc. Has is to increase evaluation of and research on integrative curricular approaches.
- And so I get again to highlight another student. I'm supervising here. This is another star student, Kate Lou. I'm a 4th year medical student, and the summer between her 1st year and second year Medical School. We were talking about all this, and she started wondering. Well, it seems like there's a lot of overlap in arts and humanities and ethics, and a lot of ethical issues have a lot of gray zones that don't have easy answers. And so how has art been leveraged to explore those ethical issues?
- She then conducted an absolutely exhaustive literature search of almost 3,000 articles, and there were only 25 studies. She identified that used examples of how specifically fiction is used to teach about bioethics and all of those 25 articles she actually found 0 that looked at. How is fiction used to teach bioethical dilemmas? So when we think about the hardest ethical issues. When we think about someone who's encephalopathic and screaming every time they go to dialysis. But family saying, No, she has to go to dialysis.
- What do you do then?
- This seems like the territory territory of art, and yet no one has actually studied. How do you use art to explore that.
- Well, Kate being the enterprising student, she is wanted to figure out one way to do it. And so what she did is she devised an experimental seminar for 1st year. Medical students who are currently enrolled in the ethics thread.
- and she used Alice Monroe's incredible short story comfort about physician assisted suicide as a way to discuss and complicate ethical aspects of physician, assisted suicide.
- After the seminar which he led was completed. She then issued post seminar surveys, asking specific questions about what the medical students thought about post textual analysis of fiction and how they felt. It helped them understand the

goals of bioethics instruction. And this is something that we're still sifting through in the data. But it's pretty exciting. And so hopefully, again, in a major journal near you, in about a year you'll be able to read about it

- alright.
- Going back to the 1st bullet point from double Amc. Engaging more diverse perspectives and voices in the literature. I want to turn to theory again very briefly. And this theory is the critical health humanities. So we've defined health humanities. And now we want to think about, how can we move towards that 1st educational goal via the critical health humanities and critical consciousness?
- So I'm going to redo this quote. And this is a quote from Sharma et Al. Back in 2,018. In academic medicine critical consciousness involves reflecting on power, privilege, and the inequities embedded in social relationships with an active commitment to social justice.
- If social determinants of health are human-made, then they can also be dismantled through human efforts.
- And so how can we use that idea and then apply it to the health humanities. Well, I think that's where we get critical health humanities. And I wanna highlight the work of my close friend and co-editor here, Dr. Mattu. For those of you who who don't know her you will. In 5 years, when she's a nationally known name. She's a pediatrician here. She's a poet. She's a public health researcher. She's just kind of a superstar in every way, and she's a great human being and we we collaborated on this theoretical paper together, and we wanted to try to more clearly articulate what we mean by critical health humanities. And so I'm gonna read you this quote as well. Close reading of literary text can train future clinicians to closely read their patients, social and political context, and can also generate what we call structural compassion in ways that quantitative pedagogy on health disparities alone cannot do.
- We're in theory. It's a little abstract. And so let's pull back to reality. Here, let's see, what does it actually look like to practice the critical health humanities? And I'm gonna go out on a limb here and do something. I I promise myself I wouldn't do, which is read a poem here, medicine, grand rounds. Because I'm guessing that no one else wants to do it. So this is a poem that Dr. Mcku and I use when we're teaching critical health humanities in our literature and medicine elective for 4th year medical students owed to small towns by Tyree day.
- Let me, I'm gonna move over here where I can really see it. Well, okay this where all the roadside memorials are pink wreath and dirty. Teddy bears this where a man walked when he wanted to fly.
- This is where he lay down and later died. This where the train tracks folded the town in half this, where the man who died loved a woman that's his, are you here? Not the train this where I ran the dreamcolored woods, and did not know why.
- This, where I believe a dog is buried this where I danced in the long moonlight of a field, this where a woman planted ghost peppers, this where she thin her blood with root water, this where you can see the whole town, this where the moon never goes, this where my grandmother hid some dreams, this where my dad may have met, this, where they'll bury me, this where I shot a bird from smoke smelling sky, this where it fluttered, fell.
- Think after you listen to a palm. It's always nice to just let it sink in a little bit.
- Poetry really bothers us, I think, because the question is always, what does it mean? And document 2 is the 1st to say it doesn't have to mean anything.

- But when we're thinking about the critical health humanities, what we really are trying to do is to extract some kind of meaning as it pertains to social determinants of health. And so, again, very briefly, thinking about theory. If unlike me, you did not study theory as an undergrad when we think about literary theory. What we're really trying to do is take a pre-existing framework of philosophy and apply it to a work of art in order to extract some higher meaning. So if you think about Freudian literary theory, you put on your Freudian glasses and you read a work of art, and you're looking for clues of something like the edible complex.
- Or you think about applying feminist theory. You put on your feminist glasses, and you read a work of art or a text, and you try to look for clues about the patriarchy.
- And so in much the same way, when we think about critical health, humanity's theory, what we're doing is we're thinking about social determines of health. We're putting on those glasses. And then we're going to look at this poem much more critically and much more thoughtfully and starting out, I think all of us noticed the clause this where it's repetitive and very different from what we're used to hearing, and instantly, as doctors as medical students, we're in a flipped hierarchy. So instead of going into someone's room and pulling out information and leading them to exactly the diagnosis we want to bring them to.
- We are now following
- Tyre. The speaker in Tyree Day's poem is giving us a tour of a small town, and leading us along, and so we have no choice but to follow the speaker.
- A lot of the time when we teach this in literature and medicine. The medical students use words like desolation and hopelessness. And there's this overall sense of discomfort. And I think, of course, a lot of that comes with the the recurrent use of the word death and death imagery, and this claustrophobic sense that even if you wanted to escape a place where death is all around you. You couldn't. This is all you know.
- But the more times I read this, and the more time you spend in Tyree Small town, the more I think you begin to question
- the norms we have surrounding death and wondering, you know, is proximity to death necessarily bad?
- Could there be something comforting about day speaker, knowing exactly where he's going to be buried.
- And furthermore, what exactly does death even mean in this town? This line here, this where my dead may have met and makes you realize that this is a very different environment than our biomedical world. In the hospital, where someone expires and their body is removed in 2 h, and then it's out of sight, out of mind. Here death lingers, but the dead are still moving around. They're convening. They're up to something. There's something supernatural going on here, and we get that in other parts of the poem, too, where we hear heartbeats instead of the train we see dream colored woods.
- And so there's a high degree of uncertainty for me when I read this poem, because I don't know what all this supernatural stuff means. And I think for me, from a critical health, humanities, perspective. That's the point is that I am challenged. My doctorly urge to make narrative and material sense of this is not going to be satisfied.
- After we do this with our medical students, then we ask them to write an autobiography from the perspective of the land you consider home thinking about. I grew up in a small town, but other people might have grown up in cities.

- And when we we? This is a very deliberate prompt, because we're pushing our students. We're almost forcing them to use anthropomorphizing metaphors a very weird way to use language to describe a place you're very used to talking about. So anyone who's talking about their hometown probably has a set of 3 or 4 terms that they use habitually.
- You can't. You can't do that anymore if you're actually speaking from the perspective of an old house. And so it becomes a little bit of a cognitive, forcing technique, where, when you have to sit and reframe all of a sudden, you're confronted with cultural, environmental and political histories, both local and more widespread of your home and your hometown and it's an opportunity for students and all of us to begin thinking about. How have those histories impacted their own lives. How have those histories impacted other people with whom they routinely interact?
- And the more time you spend with Pirie Da's poem, the more you realize how different it feels to the language we routinely use unthinkingly and reflexively as healthcare professionals. So when you think about a small town, some of the words up here on the right hand column might come to mind.
- A lot of these terms are are pretty pejorative, or can be in the wrong context, and and some of these terms might still bubble up, and you need to wrestle with those. But what I love about this exercise in this poem is that you're confronted just with how different those 2 columns are, where you think about some of those words, and they really wouldn't have a meaningful role within this world that Tyree Day has created.
- So again, critical consciousness involves reflecting on power, privilege, and the inequities embedded in social relationships. And the way to do that in art this is quoting from Arno Magai, who's a wonderful scholar in the world of health humanities. He says that art disturbs and disrupts one's assumptions, perspectives and ways of acting, so that one sees the self, others and the world anew. And so you're taking something familiar and making it strange, and then hoping to move away with some kind of new meaning.
- So a lot of theory. We've been going at a fast pace. And so let's pause here.
- Come back to Leanne Shapton's ponds. Think about clear water, it's so deep, but it's clear you could see to the bottom of the surface.
- Take a deep breath all right. So we're on learning objective 4.
- And I promise you that you're gonna walk away with some discrete narrative medicine techniques for your own daily teaching and practice. So what exactly does that look like when you're on the wards? You know I'm a hospice. I know what it's like, and you're getting hammer paged. And how are you actually going to make that happen?
- And the most time I want to spend is with parallel one-liners. I think this is a really easy and realistic way to do it.
- So parallel one-liners is is a term that I've come up with in response to the parallel chart. The little historical background is helpful. The parallel chart was invented by Rita Sharon in 90 93, and really what it means is, there's a space to write down all the stuff that we think about, and feel about our patience, that we would never write an epic.
- She 1st did this with a group of medical students, in which she asked medical students in ordinary language, who at least once weekly write in their parallel chart and the goal, as she described it, is to recognize more fully what patients go

through, and then also to explicitly examine the students' own journeys through medicine.

- What that looks like is some pretty heavy stuff. And so this is one of in the study Sharon published. This is one of the medical students. Reflections on a patient he cared for with heart failure, and I just want to read the 1st part of it the student writes, she's the kind of person I want to be when I'm facing my own frailty and decay. I want to be like her. When I'm dying.
- I find myself frequently daydreaming about how this woman cops with the debilitation and despair.
- So these are words that I would guess a lot of us have felt something like at some point when we're caring for someone. But again it it.
- No one's going to write that in epic or a medical chart.
- Well, that's a lot to ask of people who are not used to writing, and I think the parallel chart is kind of tall order, and so what I propose is to do something we're very used to doing, which is to write a 1 liner. So there's a medical one liner that we saw with our fictional patient. Rf. I introduced at the beginning of the talk, and then we're gonna see? What would it look like to write a parallel one liner for him?
- So I'm just going to review Rf, he's a 32 year old male with a history of alcohol, use disorder, major, depressive disorder and housing instability, who presents with alcohol and hepatitis very familiar. One liner parallel. One liner might look like this.
- Robert started drinking when he was 10, and although he used to drink while fishing, he hasn't gone in a while.
- He tells us he doesn't like doing anything now, he tells us. Now it's all dust.
- And so the parallel one-liner is an opportunity to try to encapsulate a momentary interaction with another human being using a shared lexicon. So we're no longer trying to diagnose or treat. What we're trying to do is understand what's going on for Robert in this moment and I think I really like this exercise because it retains the importance of specificity and detail that we know is so crucial in a medical one liner it's also an opportunity to borrow patient language. So if a patient tells you, does not say I'm depressed, but says it's all dust that's your one liner right there. And so you're identifying and using a shared lexicon. You no longer have to translate between you and the patient.
- And then there's also this really strict emphasis on narrative construction. So when you just have one or 2 or 3 sentences, I cheated in my example you have to be really honest, with what do I need to include, and what would be better if I left it out?
- What am I going to take and compress into a single two-word synopsis. And what am I going to spend a little bit more time and attention on expanding?
- And that's true for writing in general. And so if you're thinking, hey, I came to this talk today with an interest in the health humanities. And I want to maybe start writing a little bit more. The next step for you might be 55 word stories.
- And that retains the same sense of the importance of editing. So 55 word story is basically exactly what it sounds like. It's a short story about something you experience in the medical world or not. and you limit it to 55 words, and this was 1st started in 2,000 when Sheets and Fry published their approach. The 55 word story in Jama, and in 2,010. There was an updated table with instructions on how to write a 55 word story, which part of me thinks is a little bit funny, because it's like what you just write it. But I also think it can be useful if you do sit down in front of the paper, and you get a little nervous about well, I don't really know what to do.

- I like that. Their instructions start with. Just write. You just write whatever is in your head, and then you put it away in a drawer, and you don't think about it. And after enough time has passed you come back to it, and then you ruthlessly edit it down.
- And I like that, because this is very much a. At this point a cliche in the world of writing which is, kill your darling. So if you've written something and you love it so much, and you think this is going to blow everyone away. That's the sentence that you have to take out, because chances are someone's already done it before so ruthless editing.
- But the great thing about that is, it's still pretty short. And so 55 word stories has been widely accepted across the United States. And if you Google University, Washington, what you'll see is they really ran with this during Covid. And so throughout the worst of the pandemic people were submitting their 55 word stories. And for me it was working through Covid. It's it's a really intense experience to go back now and look at these stories and to see the shared experience that you do as compiled. So the other nice thing about 55 word stories is you can read different stories by different people and kind of get this patchwork of meaning from it now, maybe you're thinking. No, I definitely never want to write. That's not me. But I still have this desire to do a little something with the healthy Manneys, and that's where I think the shapes of stories could be really useful.
- So this image is from a book from 2,016, looking at storytelling in medicine, and it's inspired by Kurt Vonnegut who developed a lecture series over the years in which he used an X and Y axis to plot out the major plot points of fairytales, and if you just Google it, if you've never seen it before, it's super funny. Kirvan is is very charming, and is eccentric, old man way. But the authors of this book took that idea and wanted to apply it to illness, narratives, and so they asked, well, if our X-axis is time and our y-axis is well being what do different diseases, or what do different illness experiences look like? And if we were to use the top example right there sporting injury and recovery, we see that we might be able to relate to this personally if things are going along pretty well, and then, all of a sudden, you have some kind of mechanical trauma, and wellbeing drops off a cliff slowly over time. You're going to build back up to that recovery through physical therapy.
- We know that progressive neurological diseases like dementia have a very different shape to their story, and I think this one to me is really helpful, because it's a very easy transition from clinical medicine to narrative medicine, where I'm sure a lot of us have seen cardiologists or heptologists plot out rehospitalization and heart failure or cirrhosis, and using this idea of the experience of people over time to get at something more about what their life is like.
- So we think about our fictional case. Patient? Rf what would his story shape look like? Well for those of us who take care of people with alcohol use disorder. We know that there are a lot of ups and downs. And again, I think this can be useful to where initially, you might think, oh, yeah, I know. Rf, I know his shape right out of the gates, and then you draw it out, and you might pause and say, Oh, well, what was going on for him when he had that local maximum? How much was he drinking, then? Is he fishing again? What? What did life look like? And so, in addition to being something that's quick and easy, it can also be a gateway to just more curiosity.
- Alright.
- This last practical health humanities. Bullet point is, I think, the one that's most robustly supported by evidence. And that's just simply reading things that aren't

related to medicine, and I know for a fact that there are a lot of avid readers in this room here, and so I challenge you to take it to the next level and start nonmedical reading 2.0.

- And in order to do that it's pretty easy. But I think we can. We can use again Rita Sharon's help here, and she published this table in this paper, and this is a reading guide, and so I I won't go through every bullet point. But essentially, she's using a lot of language that's very common in the world of writing and literate criticism as a way of developing a more granular approach to textual analysis.
- And so the next time, if you were to pick up a book and read it for the story, what you could do instead is, you could choose item number 3 form.
- And you could ask yourself, what's happening with time here? Why is Faulkner deciding to go from different points in time from different perspectives, and leaving me so confused when he could just start from the beginning.
- And in doing so you're going to notice that the more you dig in, the more questions you have that are going to generate more meaning and more questions.
- The good thing about the health humanities is, you're definitely not alone. Here at Uva we have a whole center for health humanities and ethics. That's 1 of my academic homes. We do a lot of teaching in the undergraduate Medical education space. So, like I mentioned, I co-teach literature and medicine, the co-teach and other humanities. Course.
- We teach a lot of courses also in undergraduate space and graduate medical education. And we have a small but mighty group of dedicated core faculty.
- And so I wanna take this time to pause and and note that we talked a lot about Ed Hook, but no conversation about health. Humanities at Uva would could be complete without acknowledging how much Martha Childress, who's here in the room with the beating heartbeat of health humanities at Uva for decades, and continues to be so by training as an expert in Virginia Woolf with the Phd. But has done so much thoughtful work in the space of how health humanities can help message medical professionals. And then, of course, also I need to give a shout out to Danny Becker, who a lot of us know in the room as well, and Danny Becker, who's now retired. But he was an internist at Uma, and an incredibly talented poet who got his Mfa. He taught me so much about the importance of just sitting down and listening to a patient, and he's maybe the only person I've ever met still, who actually takes his parallel chart and puts it into epic. So if you read his progress notes they look different than other progress notes in the best way possible.
- So all of us at the center would love. If anyone is curious about all this stuff we'd love to collaborate. We'd love to talk more. Nothing is too small or trivial to email me and going back to our learning objectives. What we see is, I promise you we define the health humanities. We talk about the evidence base and some of the faults therein. We talk about examples of ongoing scholarly inquiry here at Uva, and we would end with some discrete narrative medicine practices you can take away today.
- These are my many sources, and I'm gonna end with my 2 favorite readers and my life, my 2 daughters. So welcome any questions and comments. Thank you.
- Cool. Thanks, Ben. Yeah, good talk. Thank you a comment. And then a question. I guess my comment would be, my big pay home. Is that the feedback I should give learners is read more which a everyone's shocking, because ironically, that's like the most lampooned feedback to give. But and that's contextualized within medical knowledge. And I agree that but with like AI coming into this, whereby maybe we're

offloading medical knowledge. Where do you see AI moving towards humanities and things like that?

- Oh, that's a great question. I I have a lot of friends who got their Mfas. And creative writing here, and so AI is like is A is a sore spot for a lot of creative types. I don't know about you. I've looked at a lot of AI art and
- I'm not sure that I found anything so far that has compared to what Leanne Chapin can do. So I think if you're really serious about art, and if you're regularly reading the New York Review books, and you care about high art on the highest level. AI seems completely irrelevant. I wonder about people who generate revenue and money from art that appeals to a broader audience. So if you think about how is AI gonna impact writers for like Netflix shows that they're gonna turn out every 3 months. That's a that's a great question for me, it's less relevant to the health humanities. Because I think ultimately, this is just a tool for us to sit down with our patients and get more meaning out of that human interaction. And so I would be interested to know how AI can augment that. But I'm I'm an AI skeptic at this point when it comes to the health humanities.
- One thing I feel like has would help us better understand, like the narratives of our patients as we practice medicine, is something that we don't. We've moved away from nowadays, which is home visits. Obviously very logistically challenging. But I was just curious. If you've found or heard of any medical schools or residency programs that try and incorporate that somehow into their formalized teaching. That's a great question. Totally agree. Actually. So, the Director of health and managed programs is Justin Mutter. He has a whole own visit program. So he's a geriatrician and his. The majority of his clinical work right now is a home program, and he's compiling a lot of really compelling data trying to look at, how can home visits specifically be useful in a preventative medicine role? But when it comes to the health humanities. I couldn't agree more. I mean, I think if you walk into someone's home you're instantly gonna learn more about them in 30 seconds than you will maybe talking to them in a sterile clinical room for for 2 years.
- So Uva is absolutely doing really exciting stuff with that. If you're personally interested in that I would absolutely reach out to Dr. Mutter, he has medical students join him on home visits.
- And then actually going back to Danny Becker. Danny, one of my probably my favorite poem, Danny Becker ever wrote, is about a home visit, and so I'll try to see if I can dig, dig that up, but I think it plays a huge role in the health. Humanities totally agree.
- Thank you for the wonderful talk one of my former colleagues. Gate and scroll is also medical humanities. Person he used to talk about for medical students how important it would be if, before we sent them onto the wards for the 1st time, telling me, do a physical exam and take their 1st history. We had them have some reps and just taking people's stories and talking to them about their background. I know we do a lot of that within fcm, and Psp, and we have different forms of that. I'm curious within the hospital. How do you feel about the state of that today? Uva, do you think there's ways we could expand things like that where we're actually with our curriculum, telling learners how to incorporate the person story in background.
- Tough send. When we started our patient interviewing unit, we just started by going very beginning of 1st year medical. So we just went to the hospital and talked to people and and I. I love that idea, and I think that A lot of that is actually driven here. Ubi on the student interest side of things. So there's a i don't know if this is

still going on. But there's a medical student. You really wanted to do something that's happening at other institutions, which is meeting up with a patient and getting a a 1 page story of their life, and then actually, physically embedding that into epic. So that way, it's like a more expanded social history.

- You can click on a tab in epic and see a complete story from the patient's mouth as interpreted by the student.
- I love that idea. I mean, I think it's like so many things in the health humanities where it seems so intuitive and so easy. And then you start to dig a little bit into the mechanics of okay, well, what kind of are we gonna need? And and it gets a little trickier. But I think that particularly with new students, especially on the internal medicine, inpatient wars. There could be huge value of that where you walk into a room, and you look at the alpha, that soup laundry list of the one line or anything. I don't even know what to do. And then you walk in the room, and the person starts yelling at you. So instead, if you just walked in the room and had them yell at you and nothing else, then then I think there'd be true value top.
- I have a question from the chat from Dr. Evan. Heel, says dr. Ed. Hook was my attending as an intern. Some of us were easily convinced, or practice teaching and lives would be nourished by humanities. Some are not convinced, maybe they are right. Often those who would seem to benefit most or hardest to reach. If Uva emphasized a narrative medicine curriculum, would we reach some who didn't think it would help? Would we attract a different pool of applicants.
- Such a great point. I've come to think of the health humanities as like quitting smoking, so I think you can just be straight up pre contemplative, and you can say I'm not interested. You know I'm a skilled, some of my closest, dearest friends. I'm a skilled surgeon. Why would I want to read a book like I'm going to the Uva basketball game. Forget it.
- I agree. I mean, I'm not sure that this is gonna be something that you're gonna be able to sit down and force feed Leanne Chapton down their gullets. But I think there are a lot of people who are in that pre-contemplative phase, or that contemplative phase where they're thinking you know, I I've never been an artistic person, but I keep seeing stuff that doesn't make sense to me from a medical textbook, and wondering how I can get to some higher level of meeting. And so when I think about like a formal curriculum that's required. The question to me is always like, What margin are you gonna be okay with, like, what percentage of student feedback are you gonna say.
- I'm okay. That 20 said this was useless to me. And I'm not sure that I have a magic answer for that. But I haven't healed. I you know I I totally agree. I think it's a great question.
- Since I I think Dr. Harris had to slip out. I'll I'll speak to the home visit. Question a little bit. So that that's something we've been trying to wrestle with incorporating in our the community partner and medicine rotation proper levels and the logistics of the supervision of the home visit. And I think the the increased sense of awareness of safety going out in the community are are things we're trying to problem solve. But but hopefully, I'll have a better model for for this year. I have distinct wonderful memories of doing home visits with some of my Uma patients as a resident was fed lunch by one of my patients and provided a piece of art that that grateful patient had had given to me. I think some of the where some of the programs or schools that have had robust home visit. Programs are in, yeah, especially urban centers where there's just a a higher and more compact populations. And say, I think that's 1 of

the challenges that we have is the the the broader geographic scope of where some of our patients come from. So it's a little bit more complicated to get out to certain homes, but working, working, working on that for sure. And yeah, I've just a kind of augment glenn's comment around AI was the 1 question I was thinking about is, there's such a push for efficiency and offloading tasks that are often, you know, felt to be not value. Add, and some of even the more banal creative work that we do of. You know, writing the personal statement, the letter of recommendation, this, that or the other. I think there's a i'll be interesting to see what the pendulum swing is just keeps going or starts to come back. A little bit. in terms of do you know, are we? Are we using AI to offload the the less beneficial writing? Or do you know are we gonna find we start to miss a little bit more of that micro creative output of, you know, again writing and talking about other people or for ourselves. So yeah, thank you. That's such a great point. Yeah. And I was thinking of AI generated art. But I think that's such a good point, as if you were to leverage AI have everything integrated, so that AI was writing your epic note and then communicating with AI that was also doing billing and coding. And meanwhile you're just sitting and talking to the patient, and maybe you write a couple of things down on a piece of paper that could be the future. AI, if you're a techno optimist, so I love it not to jump back in. But that's sort of what I was getting at.

- I went through this talk and that a a Futurist was there and said, the knowledge industry is what we should be getting out of, because AI is gonna do that better. But it means you should be in humanistic things. And like medicine, humanist is a service industry. And it might mean that we could do more of this, if that is a tool that we could use. That was maybe what I was thinking of. But I love I love it. i i i hope that's the future.
- Yeah. So thanks for your talk. Maybe kind of related. I notice you know the near absence of this kind of emphasis. And, Jimmy, what do you think that looks like in terms of starting to maybe change that institutionally or not necessarily here, but at at a national level. And is there anything that you think would would fit well in in terms of emphasizing? Not just medicine programs, but Jimmy programs all over the country. Yeah, it's a great question. I mean, I think, about that a lot where it's like, why, why does the Acme default to like a 3 min video speaking into a camera instead of just posting an essay. And I I don't know. I I wonder if, like, it's 1 of those things. I always think about a tool. Gawande's article, the cost conundrum where he I I it was such an interesting investigation of how single individuals in power can drive huge cultural change. And so I wonder if it's the type of thing where you need someone like an Ed hook, or you need someone within a higher title role at Acgm. Me to just believe in it. And to say, instead of doing this video, instead of hiring these actors and spending $10,000. We're gonna post a Donald Antrim essay and then trust the adult learners that if they care about this topic they're gonna take the 30 min to actually read it.
- So from my perspective, having been in the space for a little bit of time, I I do wonder if it just, you need leaders in those key roles to to believe in it. Yeah, but that's not like a particular satisfying answer. So it's a great question, and if you have ideas to, you know, want to continue that dialogue.
- Okay, so I was very struck by your conversation on parallel one liners. Especially you mentioned a quote in which I believe is with physician right? That was saying that they wanted to die like their patient. I was very struck by that. I got emotional, actually, because I just thought that that was so beautiful, especially when you put

that against the medical note that goes in there that's striking. And so with this is more of a comment than a question with the implementation of the health humanities into medical education. I think that death is central, you know that is such an area of feeling and of experience and grief. And I think that in the you know coursework as they're working that out like death, you know, confronting that like it is not just.

- The patient has expired. You know that euphemism it is.
- I will die, and I want to care for this patient and understand them. And and it is that I think that might be one of the difficulties with implementing the health humanities is that that is so. Challenging is that this is not just perspective. This is not just you. This is me. And opening oneself up to understanding is also opening oneself up to empathy and to be empathetic. We have to stand in the shoes of and say, What if? What if this were me, and so I don't know. I just thought that that quote was incredible, and I would love to hear more about that afterwards from you. I'm glad. I'm glad that, that resonated. I think it's a good point where I think I I do think that there's a lot of attention on death and dying in the healthy Mandy's world, and I think that's driven by the function of uncertainty. Where talk about like the most the highest degree of uncertainty is, what what do you do as a doctor? When your patient you can't take care of your patient, you can't make them better anymore. And that's where our our palliative care team, I think, are just like wonderful leaders in terms of like reconfecturalizing that. But I'm glad that that connected and that was a medical student, and Rita Sharing's class. So if you go to Columbia and you come across Rita share, and what you'll do is you'll actually write a parallel chart with her leading you.
- So we have one last question. So this comes from Dr. Peggy. Please, Logan, who says the story we get depends in part on the questions we ask. We don't often ask patients and families about strengths and growth.
- How can we help to expand the things we ask about. Yeah, that is such a great point. Gosh, Dr. Please, Logan, you're the best and and always teaching me, even when I'm giving grand rounds. I?
- I think it's a great point, I think. And and again, first, st I just wanna say that that gets to this question of the potential for bias. So let us not forget that anytime we're casting judgment or tried to construct a narrative about a patient that is fraught with the risk of bias, too. So it's 1 of the reasons I think narrative medicine is so great is it's inherently iterative. So you could talk with your patient, Rf. And come up with your parallel one liner, and then talk to them the next day and say, Oh, I have a totally different parallel one-liner today, based on this moment of this interaction. So I think, being really thoughtful about, how are we even framing that conversation, in the 1st place, to get to that one-liner?
- So. What? What can we do? I think, like I come back to what I heard at Uma when I was a resident, which is something Danny Becker said where he was. He said the the residents need to enjoy their patience more. They need to think they're funnier. They need to joke around with them. And and so I think, like especially in a lot of the interactions I have in the hospital, humor can be one of the easiest conduits to just getting a better sense of who this person is when they're feeling good. And you can kind of learn about what matters to someone when they're not sick and tired, but when they're really feeling their best self it just comes down to asking that question and trying to connect in that way.

- Dr. Blue Zogen, I'm speaking in the ether, but I think you probably have a a lot better and more seasoned ideas about this than I do but I think probably the most important thing when I think about teaching medical students is just having that in the front of your mind. So I don't wanna cast this person in front of me as this person who only lives in in a sick place. I wanna also all the time have in the front of my mind what makes them feel healthy? What makes them feel good in the true sense of who they are, so just having that thought in the front of your mind. I think it could maybe be helpful.
- It's a great point. Thank you so much. Everyone. I appreciate it.