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Abstract:
Writing workshops and narrative experiences for medical trainees can be a useful way to approach certain issues in their education. This article describes a brief writing exercise that can be used for physicians in training to help them recognize issues of countertransference in the doctor-patient relationship. While these issues are generally covered as part of residents' behavioral science curriculum, this exercise allows trainees to use a creative method in order to uncover them. To date, this exercise has been used in two residency programs with residents informally expressing improved understanding of their own experience with patients.

Background

In recent years, many medical schools have incorporated narrative medicine experiences into the curriculum for both students and residents. These experiences have ranged from having a once-weekly group reading/discussion (1), to a single afternoon dedicated to narrative medicine and writing once a year (2). While the appeal of narrative medicine has been well documented as a way to enhance our understanding of patients' histories (3), residency programs and medical schools have only begun to explore the use of narrative or writing to highlight specific educational components or competencies. For example, cultural competency is a topic easily approached through narrative and writing (4), since the illness narrative by definition contains many important themes about the patient's culture. However, for many faculty members, while narrative medicine and writing can be appealing alternatives to didactic sessions, it is important to find a niche for this approach that transcends "mak[ing] clinicians or students feel better"(5).

The exercise described below is a technique using narrative medicine and writing that can enhance residents' understanding of their own feelings and unconscious biases toward their patients. These feelings are often explored in Balint groups, though not every resident has access to one during their training.* The focus of Balint groups is to better understand the patient's experience; a secondary goal is to help physicians recognize issues of countertransference in the doctor-patient relationship (6,7). While these issues are obviously complex,

and the focus of research and writing in psychiatry, family medicine residents should be exposed to the topic as part of their behavioral medicine training. An exercise such as this one can serve as an adjunct to traditional Balint groups, or as a separate assignment designed to spark discussion and awareness among residents.

The learners (residents or medical students) are asked to write for a prearranged period of time (usually ten to fifteen minutes) about a recent patient experience that was difficult or challenging in some way. They are not told that the exercise has a particular focus other as an aid to better understanding of the event. If learners are unable to think of something to write, we usually prompt

[*] Balint groups are used in many primary care educational settings as a venue to discuss and process troublesome issues in the doctor-patient relationship. Begun by Dr. Michael Balint (The Doctor, His Patient, and the Illness, 1957), they are used in many family medicine residencies as an adjunct to the usual behavioral medicine curriculum that specifically explore the issues above. While not every resident will experience a Balint group during their training, most will be exposed to the issue of countertransference as part of their general behavioral medicine curriculum.

them by saying, “Write about an experience that has stuck with you, that you thought about after you went home, that bothered you somehow, even though you may not know why it did.” The learners then take turns reading these writings aloud, sometimes prefaced by a one-liner such as, “This is a patient with chest pain whom I saw in clinic last Friday.” The group listens to the writing as it is read aloud and gives supportive feedback usually focused around naming and describing whatever interpersonal or medical issue made the experience challenging. After everyone has read, we tell the group that in the second part of the exercise they will write for a similar period of time (usually ten to fifteen

minutes again) and tell the same story, now from the patient's or family member's perspective. Learners are usually either dismayed by this part of the exercise or say that they can't imagine what the patient was thinking. They are encouraged to be as creative as possible in order to imagine what might have been happening for their patient. (These "imaginings," of course, may not correspond to the patient's reality, but they can offer important insight into what the resident is feeling about the patient. Residents should not assume that they "know" something about the patient based on the results of this exercise, but they may discover something about their own point of view that can be helpful in the encounter.)

In the second part of the exercise, when learners are asked to speak in the voices of their patients, we see the impact of the learners' expectations and their ideas about their patients reflected in what they imagine the patients to be thinking. Listening to these pieces read aloud often illuminates the source of the interactional difficulty and helps the learner (and their peers) identify important issues that are present in the relationship. For example, at one workshop, several residents read aloud pieces about infant patients who had subtle presentations of problems that could indicate developmental delay. The residents' versions clearly indicated that they felt guilty for not having discovered the problem sooner, and questioned their judgment in noticing it at a later time (despite reassurance from the entire group that they would have approached these patients in the same way). When these trainees wrote their stories again, this time from the parents' perspective, they imagined the parents feeling similar

guilt about not noticing the problem earlier, thus leading them to doubt themselves as good parents. It was moving and helpful for these physicians to appreciate the themes of guilt and remorse that permeated both stories, and to reflect on whether that feeling was a valid assessment of that patient's care, or a more universal emotional reaction. In these cases, the realization that it was the latter allowed these residents to put aside their own feelings of guilt and attend to the guilty feelings of the parents by reassuring them that they were doing a good job. The transformation brought about by the writing exercise helped them to be more effective family physicians.

Here is a composite example written about a mock patient (with similar issues to stories written during past resident conferences) for the purpose of illustrating the exercise:

Physician Version

She is dumpy and dour, wearing a sleeveless floral dress like the ones my grandmother used to call her "housedress." I think it is this patient's only dress. "I don't like to go to doctors," she tells me in Spanish, "because I am healthy. I'm only here because my knee hurts. I need some medicine for my knee."

I ask her about the last time she had a physical. "Oh, I had one," she says, nodding vehemently, and I am relieved. But then I ask when. "Oh, not long ago," she says evasively. "Four, five years. In my country."

Mammogram? "No, I don't need one," she says. No Pap either. I manage to talk her into some blood work, at least, since we can do it right here before she escapes. "We'll check you for cholesterol, and diabetes," I tell her. She nods in recognition; she has had that test before. "And everything was okay?" I ask. "Oh, yes," she tells me. Her blood sugar was high, but it was just from eating too much rice. When she stopped eating rice, it went down again. This sounds like a weird story to me, so I ask her again. "It got better?" "Yes, better,"she says. "How did they know it was better – did you have another blood test?" I ask. She looks puzzled. "No," she tells me. She knows it got better, because she felt fine. She is healthy, she tells me. Healthy.

Patient Version

When I was ready to go to America, they told me I might be sick. "Diabetes," they said, naming the disease that killed my mother, and I looked straight ahead, toward the door, the road,

the airport, and I thought about the healthy food in America, the fields of lettuce and tomatoes and grains under the blue skies, and television shows where everyone is thin and healthy, and I knew I was getting out just in time. “Medication,” they said, and I clutched my purse handles in my hand thinking about the plane, the carry-on bag, the bottled water with pictures of clean green trees, and I knew that when I got there, I would be better because I could exercise in the gyms, I could lose weight eating the diet foods they show on TV, I could walk outside in places where it’s not so hot and dusty all the time. I was leaving this place, humid and smelly and poor, the place where my family had lived and died with the dirt still stuck under their fingernails, where the hospitals are crowded and noisy and the fresh vegetables are all taken away to be sold. I was leaving this place and going to America, to be thin and healthy and wear black shiny shoes with pointy toes like on TV. America, where I will be a new person, stylish and wealthy, leaving these old problems behind.

This exercise tells us something about the patient, but perhaps more about the physician: the physician’s awareness of the wide gap between the medical model understood by the patient and the one used by the doctor is expressed as an imagination of a different culture, an entirely different understanding of the problem. We realize from listening to this exercise that the physician feels sympathetic toward the patient, but very distant from her world-view. Faculty members offering feedback on this exercise might observe that the physician seems curious about the context in which the previous testing occurred and clearly wants to know more about the patient’s emotional understanding of chronic disease. The physician also has imagined a certain set of circumstances which led to the patient’s immigration to the U.S. Faculty members might point out that the physician’s description of this patient may reflect the way this physician thinks or feels about people who have left their country of birth to come to the United States.

The exercise can be used as a one-time experience for residents or as a recurring experience in the context of a behavioral science discussion group. It can also be used with medical students or anyone involved in a provider-patient

encounter. We have implemented this exercise in a group setting and found that the experience of listening to one another's writing has been useful for residents. Many times, learners are quick to identify transference or countertransference issues in the writing of their colleagues, but have more difficulty identifying these issues in their own writing. This feedback from the group increases everyone's awareness and fosters discussion of what the narratives mean in the larger picture of the doctor-patient relationship.

To date, this exercise has been used only once a year in two separate residency programs, so resident feedback has been limited. Most learners describe the exercise as helpful and illuminating, though many express frustration at trying to imagine their patient's point of view. As noted above, they can gain more understanding from listening to others' narratives than from their own. However, several residents have left the workshop with new insights into their own role in the most frustrating doctor-patient interactions, and have said that these insights will help them in future visits with those patients.

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