

Introduction

This paper is about creating a creative space in Family Medicine residency education for resident physicians to write and have conversations about their own “clinical” poetry. It is about an experiment in the process of teaching American Family Medicine resident physicians (that is, physicians who have already graduated from medical school) clinical behavioral medicine. Broadly speaking, behavioral medicine constitutes the “human” relational and experiential dimension of medical practice, in contrast with the more strictly “biomedical” or “biological” side. In this paper, I will first describe the unfolding of the experiment, then present some of the poems and some of our reflections on them.

I should say from the outset, that for the most part in medical curricula, the humanities are taught by using poems, stories, novels, paintings, film, and music created by others, that is, often great artists and physician-writers. (For an application of this approach to organizations, see Stein 2003a). The experiment I describe supplements this usual practice and literally brings the humanities home to the Family Medicine resident. For here, the poet is himself or herself.

Description of the Experiment

The “experiment” consists of (1) asking (not demanding or requiring) the residents during the course of a month-long behavioral medicine block to write one or two poems about a patient or a relationship with the patient, and then (2) discussing the poem(s) with me during a didactic session in a subsequent week. As a poet as well as

clinical social scientist, I have often found it helpful for me to write a poem about a “difficult patient” (more accurately, a difficult relationship) that we discuss at, say, grand rounds, give the poem to residents and faculty, and further reflect as a group on the case as mediated by the poem (Stein, 1996, 2003b, 2004, 2006). That is, we *play* with the poem as an external locus and focus of “the case” and our place in it. We discuss our personal involvement in a clinical case by first giving ourselves some distance from the case through the medium of the poem.

When, in 2005, I was asked by the residency director of one of the programs where I teach to supplement my longitudinal curriculum with one month-long intensive block for each individual resident, I thought: Why not invite each *resident* to write a poem, and see what happens? I was, in part, heartened to try this from work Dr. Johanna Shapiro and I had recently done in asking medical students to write poems in which they examined their relational systems (Shapiro and Stein, 2005).

Before I present some of the residents’ poems (all with their approval), let me describe the “mechanics” and “logistics” of the behavioral medicine block. The block consists of eight 1 ½ hour didactic meetings with a resident on the morning and afternoon of four consecutive Fridays (at the program where I direct the behavioral medicine curriculum). The discussion of each meeting is keyed to a sequence of topical readings on such subjects as physician self-awareness, clinical relationships (inclusive of, but not limited to, the physician-patient relationship), patients’ family dynamics, literature and medicine, the culture(s) of the patient, rural culture and the culture(s) of

biomedicine (since this particular residency program trains family physicians for rural practice).

The officially “didactic” sessions were in fact intense discussions of the topic in relation to the resident’s own life and clinical cases. Around the end of the first or beginning of the second day, I introduced the idea of the resident writing a poem or two for the following week. Each resident at first protested that she or he is not a poet. I tried to reassure the resident that I was not going to measure their work against some poetic standard, which is to say I would not judge their poetic efforts. Rather, I would “use” their poems, and our working relationship as a touchstone for better understanding them and helping them in their clinical work. What began as a protest ended with each resident making the project his or her own. They believed that I was truly interested in their world. I have thus far tried this experiment with four residents. Each person took the request seriously and at the same time played with the ideas in an idiom far different from the usual medically-focused clinical narrative. They were both pleased and surprised by the results.

I should add that the use of medical humanities (poetry, stories, visual art, music) was no stranger to them by the time we spent the month together. I will already have presented a Friday noon behavioral medicine conference on, say, medicine and literature, and they will be familiar with my style of occasionally introducing one of my own poems as a way of helping them to process a “difficult case.”

There is a further historical development or “twist” to this experiment. When I completed working with the fourth resident, I had the idea of building a Friday noon behavioral science conference around their poetry, which would mean that they would share with each other in a group what they had shared privately with me. I told them about the idea, and they agreed to it. They insisted, though, that I include some of my own poetry as part of the group processing! We proceeded by having one resident read a poem aloud, and then we discussed the poem. This process worked so well that it required two noon conferences rather than only one.

I was emboldened to conduct this experiment, in part due to a prior experiment during a presentation several years earlier at a professional conference. Among my many roles, I consult with organizations, including American biomedical educational and corporate organizations. In 2001, I was invited to present a talk at the February 2002 Midwinter Conference of the Society of Consulting Psychology, Division 13 of the American Psychological Association, in San Antonio, Texas. For nearly a decade at their annual Midwinter conferences, I had given anthropologically- and psychodynamically- oriented presentations about the process of consulting. As I became more involved in the Society, I became emboldened to introduce the “humanities” in consulting psychology much in the same way as I had been using it in my Family Medicine teaching and consulting. I viewed the use of literature, music, and visual art as a “window” to the inner life of organizations, that is, what it was like to

work in an organization. To my surprise, the reception was quite positive and the audience was “with me” throughout the presentation.

After finishing the formal talk, I invited the audience to take a few minutes and participate in a group exercise: to spontaneously write and then present to the large group brief poems or stories about some organizational situation in which they had consulted. I told them that I wanted to change the format from lecture-presentation to workshop. I wondered whether they would make this invitation into something “their own,” or dismiss it as so-much-irrelevant-humanities-fluff. To my delight and surprise, many members of the audience wrote something and then shared what they had written – personal and moving miniatures from their consulting work. I was heartened; here, in public, tough-minded corporate-world consultants leapt at the opportunity to incorporate something from the humanities into how they internally processed their own day-to-day work as organizational consultants. In the relative emotional *safety* that the setting offered, they allowed themselves to be emotionally vulnerable, that is, to share at least some of their inner life publicly. In the context of an actual workplace consultation, this type of experiment often opens up new mental space and previously unthought of modes of problem-solving (see Stein, 2003a). This experience gave me the confidence to conduct a similar exercise with medical professionals, also a group fond of control and fearful of vulnerability. After all, I imagined, this approach had succeeded among one group of tough-minded, not “touchy-feely,” professionals.

I will first present five poems and let them speak for themselves; I will provide only a few remarks to place the poems in context. Following the poems, I will discuss how we “used” the poems, and perhaps how they “used” us to reach more deeply into ourselves, and in turn to improve clinical relationships.

The Poems

"Powerlessness"

Margo Short, M.D.

Powerless
At home. At work. In society.

Against chronic pain,
against hypertension,
against prejudice.

I feel it also as I leave the room.
Frustrated. Taken advantage of. Powerless.

How do I empower him?
How do I empower me?
How do we treat dis-ease of body, mind and spirit?

Note: Many of the patients seen by residents and faculty at this clinic/residency program are poor, have few financial resources, hold low-paying jobs, and are members of minority ethnic groups. Dr. Short tells a dual story, not only about the patient, but also about herself in relation to the patient.

"Oklahoma Farmer"

Margo Short, M.D.

Frail, fragile, forgetful.
This proud Oklahoma farmer who was always strong.

Strong in his love for God, family and country.
Strong in his beliefs of hard work, right and wrong.

Now, his body and mind are fragile. They betray him.
They crack like the dry earth he once plowed.

But what of his spirit?
Is it not eternal, long-suffering?
At times, a glimmer of strength beneath the shell.

Note: Dr. Short surprised me with this poem, because it was not about a patient per se, but about her grandfather, a northwest Oklahoma wheat farmer. I accepted it (her offering). It could well have been about a patient – except here was a person whose life and afflictions she knew from the inside.

"frustrated"

Samantha Moery, D.O.

frustrated at...

- the family who refuses to accept any recommendations
- the parents who don't bring their child for immunizations
- the patient who keeps calling for narcotics
- the obstetrical patient who will not take the treatment for her STD
- the psychotic patient who refuses counseling
- and in a way, myself

Note: Dr. Moery's poem is about a list of "difficult patients" (which is also to say "emotionally demanding relationships") whom she saw all in *one* afternoon, between approximately 1:30 and 5 PM. Physicians prefer to see one or two such patients in a clinic session, sandwiched between less complex and less time-consuming clinical, personal, and social "cases," for instance, hypertension, upper respiratory infection, a broken bone to set. Dr. Moery felt overwhelmed by the cumulative demand her schedule required

"Doctor Pat continues to teach"

Jonathan Ek, M.D.

I saw the mentor of my mentor today
Known only by affectionate fable
 And the portrait hanging in our clinic lounge
 A portrait I have pondered, with wandering mind
 Away from talks of bloody bowels and failing hearts
 A figure standing tall, three fingers touching the desktop
 As if keeping it stable, with a strong firm press
I saw him in the twilight of a nursing home
 Not unlike places he had been
 In his youth, perhaps like me
 Begrudging a woeful chore

His face was drawn and pale, and I smoothed his silver hair
He stirred and muttered, a flash of intelligent eyes
Then lost to a series of hacks draped in phlegm
I methodically went through my exam of his body, while my mind churned separately
 An odd mix of compassion for someone near the end,
 Someone who had lost part of himself along the way
 Some tiny particle had starved his brain of blood
 And part of him was dead now
 Yet there was a deep sense of longing, to do the best I was capable of
 As if a ghost from that portrait was looking over my shoulder
I felt as if the best was being pulled out of me
To honor this man whose vision I now occupied.

Note: Dr. Ek's patient, Dr. L. W. Patzkowsky ("Dr. Pat") had been the residency program director from 1980-1989; he was succeeded by the current medical director. This explains the introductory phrase, "the mentor of my mentor." Dr. Ek's poem is, among other things, a meditation on the fact that there is a person and a rich history behind the patient one sees near the end of life in a nursing home.

"Matriarch"

Jonathan Ek, M.D.

Large mountain of a woman.
Unkempt fronds of hair fall across her face.
Mother to the son of her daughter
 The daughter who had gotten pregnant at sixteen years old
 The dull doughy face of her youth who bore
 The two-year-old son who came in to the clinic with the funky rash
 A rash that made one think of bedbugs or mange
Mother to the tall quiet acne faced boy
 The boy who missed too many days of school due to a knee pain
 The sixteen year old who had flunked out of tenth grade

 The quiet boy who hadn't drawn much attention --
 other than a sense of sloth for the feigned knee --
 until he came in with Mother
 laced with cuts up and down his arms
Mother was told he must see a counselor
Or there could be consequences . . . unspoken she understood

But maintained her own ways. In the house imagined to smell as they did.
Mélange of unwashed sheets, stale ashtrays; faint acrid odors unrecognized

Months later she returned, humble, even petulant
The boy availed himself to help, climbing from the shadow of a mountain

Note: This poem has much in common with the first poem, “Powerless,” by Dr. Short. Dr. Ek paints a vivid portrait of a woman and her family, putting flesh on such wooden phrases as “single parent family,” “matriarchal family,” “teenage pregnancy,” and “physical complaint.” He tells a story that most clinical narratives omit because “they are not real medicine.”

At this point, I turn first to a discussion of methodological and theoretical considerations of what we “do” with the poetry (and what it does with us) after the poems are written, and then to a discussion of what has unfolded in relation to the five poems.

Some Methodological and Theoretical Considerations

I would be misleading the reader if I gave the impression that the experiment and exercise were primarily about writing and interpreting “clinical poems,” although they are certainly about this too. I do not treat the poems as final “things-in-themselves,” or *noumena*. It is not that I discount them, but, as a clinical teacher, I treat them, their creation, their creators, and clinical conversations about them as *ways of creating additional psychological space* simultaneously within each resident, between the residents and me, among the residents, and between the residents and their patients and families. The poems, and our conversations about them, are part of what Donald Winnicott referred to as “transitional space” (1953) and “potential space” (1967, 1971) between oneself and others, and oneself and the world. The process also expands one’s own inner space, so to speak, and facilitates inner conversations among the diverse parts of ourselves.

The experiment is one of engaging each of our imaginations in the service of deeper insight, and, in turn, in the service of improved patient care. There is, however, no immediate cause-and-effect relationship. There are no instant “results,” no definitive “answers” – an approach that can be frustrating to physicians who are expected to provide these throughout their education and careers. Instead, the resident and the group find that they are working within a broader and deeper universe of possibility. One of my chief purposes was to help the resident(s) reflect (Epstein, 1999) on the poem and on the case, and in turn to discover new possibilities not yet imagined. In short, in contrast with the intense focus on immediate outcomes in medicine, I sought to let outcomes emerge. Put in a different language, “The interpersonal conversation can prompt creative reflection through a process that could be called *assisted metacognition*” (Catterall, 2006: 1, emphasis in original).

When I “use” a poem (or story, or painting, etc.) in clinical teaching or organizational consulting, under the best circumstances what ensues is a playful, immensely creative dialogue between us. The poem is the external catalyst that stimulates a re-thinking and re-feeling of the case or problem. It is the initial “medium” between teacher and physician, and between consultant and client. During these times of intense work, I often have the fantasy that we have co-created a third living “entity” outside ourselves, neither quite an “it” or quite a part of “me” or the person (or group) with whom I am conversing. It is not reducible to the content of our discussion. It occurs in the transitional, “potential space” (Winnicott, 1967, 1971) between us, but it is

not synonymous with that space. It is personal rather than impersonal, more a “someone(s)” than a “something,” a kind of “us” outside of ourselves.

The closest I have come to understanding this experience in terms of theory is in Thomas Ogden’s fertile concept of “the intersubjective analytic third” (1994) that occurs between psychoanalyst and patient (analysand) during the course of therapy. Ogden uses “the analytic third” “to refer to a third subject, unconsciously co-created by analyst and analysand, which seems to take on a life of its own in the interpersonal field between analyst and patient” (1999/2006). Ogden views “the intersubjective analytic third as an ever-changing unconscious third subject (more verb than noun) which powerfully contributes to the structure of the analytic relationship” (1999/2006). “The task of the analyst is to create conditions in which the unconscious intersubjective analytic third (which is always multi-layered and multi-faceted and continually on the move) might be experienced, attached to words, and eventually spoken about with the analysand” (1999/2006).

Stated differently, the task of the analyst (or teacher, or consultant) is to create an emotionally safe environment that contains deep uncertainty and anxiety, processes these thoughts and feelings, and allows the analytic third to emerge. More broadly, as Michael Diamond writes, “The *analytic third* is what we create when we make genuine contact with one another at a deeper emotional level of experience whether in dyads, groups, communities, or organizations” (2006, ms).

In this context, I wish to underscore here that I did not “psychoanalyze” the poem and its meaning to the author and to the group. The understandings that emerged were not a one way, linear street. Rather, the analysis –i.e., the discovery of nuanced and textured meaning(s) – was the creation of the dyad and of the group – which is to say the intersubjective analytic third. I asked questions, offered speculative interpretations in the form of thinking aloud, and most importantly, was as emotionally accessible as possible to the resident(s).

In my life as clinical teacher and consultant, the “analytic third” has been a mode of relatedness in which “the subject” is contained and processed. I can tell for certain when it is taking place and when it is absent. When it is present, I feel a wonderful lightness about me. When it is absent, the relationship and its give-and-take feel mechanical; I feel weighted down, and the content seems routine, if not trite. When it is present, the relationship is alive, even spiritual. We are truly present to one another, and, at the same time, there is a “presence” between us. Martin Buber’s (1923/1970) ideas on the distinction between an “I/Thou” relationship and an “I/It” relationship would seem to be related to Ogden’s concept. The analyst, teacher, and consultant’s countertransference plays a crucial role in allowing the “analytic third” to happen, and to be made use of in the work of the relationship (see Diamond 2006). The generative analytic third eventually occurred in my individual discussion with all four residents, and in our group conversations as well. Often the beginning of the discussion of each poem was awkward, weighted, even mechanical (what Ogden terms a “subjugating”

analytic third), but soon the conversation virtually “took off” like a bird in flight. There was a playful “free association” quality to the process, with the thoughts of one person stimulating (via empathy and identification) the imagination of another.

Let me now describe how the process unfolded and what it yielded with these five poems. Whether with the individual resident or in the group, I would ask very broad questions about the poem, e.g., “What is the story the poem is telling? Where are you in the story you are telling? What was your relationship(s) like with the patient(s) in the story?” To the group, I would ask, “What does the poem ‘make’ you think or feel?” and “Does the poem ‘make’ you think about a clinical case?” During the discussion I would often ask a resident to say more about a word, phrase, or line that had emotionally affected me. In a sense, the response – and its conversation – was a story about the story (poem) about a relationship. The group, in turn, was made up of relationships from which emerged stories about the original story (poem). From the group, we learned more about the poem and its author than I had learned from one-on-one “didactic” meetings with the individual physician. The process, in sum, was recursive, circular, an outward expanding spiral, rather than a simple straight line

Discussion: Clinical Learning via Residents’ Own Poetry

Dr. Short’s first poem, “Powerlessness,” is at once a unique, personal statement, and one of the core issues in medical practice shared by most physicians. Physicians are trained to have at their disposal an enormous “armamentarium” of tests, technologies, and procedures that leads them to expect to control diseases and patients. This is

especially true for care of patients in hospitals, which physicians often construe as a “controlled environment.” By contrast, patients have ideas, priorities, feelings, and family and cultural environments of their own that often conflict with physicians’ hopes, ambitions, and expectations. The contrast between doctors’ and patients’ worlds seems greatest when patients are poor and are of non-Anglo-American cultures.

Dr. Short’s poem shows the enormity of her task and her sense of being overwhelmed by both the patient’s worlds and by the patient’s neediness. I hasten to add that her poem, and its mood, have much in common with Dr. Moery’s poem, “frustrated,” which I shall discuss later in the paper. Both in individual conversation and in group discussion, Dr. Moery avoided attacking and blaming the patient – a response that many physicians have to their thwarted ambition and the inability to control either disease or patient. Physicians often ask themselves and me in exasperation: “Why do patients come to the doctor if they’re not going to do what the doctor requests or prescribes?” In fact, patients’ lives are mostly beyond either physician or patient’s assertion of will.

Dr. Short has the grace to “sit” with the feeling of powerlessness rather than to try to feel temporarily “good” by judging and scapegoating the patient. Dr. Short equally has the grace to “sit” with the complexity of human suffering. She does not focus exclusively on the biomedical, biological dimension of dis-ease, a kind of intellectual safety net in which many physicians fall. She poignantly concludes the poem by asking how both doctor and patient can be empowered so as to treat “dis-ease of body, mind,

and spirit.” However she or we define these three domains, together they constitute the wholeness of the experiencing person, what family physicians speak of as their ideal of treating “the whole person.” She struggles with empowerment as part of treatment. She struggles with the gulf between what the relationship between physician and patient might be and what it is. In the poem, and in her discussion of the poem, she holds onto the frustration, but does not give up on the patient or on herself. Put differently, she does not rush into resolving the conflict once and for all in order to feel “good.”

Dr. Short’s second poem, “Oklahoma Farmer,” contrasts markedly with the first poem. Yet, beneath the surface, it has much in common with “Powerlessness.” “Oklahoma Farmer” is about a member of northwest Oklahoma’s mainstream, if not dominant, white American culture. It is about a man who once was in control of his body and of the considerable technology and organizational skill it took to run a successful farm. It is also, and poignantly, about the loss of that control. “Always strong” does not last always. The “body” and “mind” that once obeyed him now “betray” him. What and who were once strong are now “cracked” and “fragile.” What and who are left is mostly a “shell.” Dr. Short has decades of memory with which she compares and contrasts the grandfather she knows today. We discussed her grandfather not as her patient, but as a person (a close relative) who *could* be her patient.

As we discussed Dr. Short’s grandfather, and her relationship with him, we realized that his loss was not only of many social roles, but of his very identity. Put in a formula, he not only farmed (verb), but he was a farmer (noun). What happens when a

person who is a farmer can no longer farm? What and who does he become when he loses himself? To himself? To others in his family and community? More broadly, the poem is about the importance of one's work in a person's life story and identity. It is further about the question of the continuity and discontinuity of the self over the life cycle.

In a sense, "Oklahoma Farmer" is about a man's loss of the enormous power he once wielded, and the hanging question of what and who remains after that loss. Dr. Short answers that question: her grandfather's "eternal, long-suffering" "spirit" is what remains. It gives "at times, a glimmer of strength beneath the shell." It is something both she and her grandfather can hold onto. Somewhere in this conversation I observed that many other people don't have that "glimmer" to keep them going, and I wondered how it was different to work with them as patients. I sensed in the "Oklahoma Farmer" poem the moods of both sadness and determination. By contrast, the poem "Powerlessness" is about a patient who never had much power, and about a physician who is uncertain of her power, including her capacity to empower her patient.

As we discussed the poem and what it elicited from us, we focused also on Dr. Short's loss and her experience of her grandfather's loss. We came to see the poem as about a *double* loss. We later moved to consider actual medical cases – patients – with whom the physicians had developed relationships and subsequently became terminally ill and died. This process becomes emotionally more demanding the longer a physician has known a patient. One of the ideals of the discipline of Family Medicine is

“continuity of care,” that is, long-term relationships with people through many years, if not decades. A veteran family physician who has thus far practiced nearly thirty years once told me of his emotional vulnerability: “There’s a downside to taking care of people for decades. You see them decline.” The physician goes through loss and grief just as does the patient. And here is where the protective barrier between doctor and patient is most threatened (Stein, 1990).

There is a price to letting one’s professional shield down and allowing oneself the vulnerability of caring for a person rather than “fixing” a “machine” (a common metaphor of the human body in medicine). The price of intimacy is loss – and painful grief. On the other hand, one avoids the possibility of feeling loss if one never permits oneself to become emotionally close to a patient. This theme will come up again in the discussion of Dr. Ek’s poem, “Dr. Pat Continues to Teach.”

Dr. Moery’s poem, “frustrated,” immediately brings to mind Dr. Short’s first poem, “Powerlessness.” Dr. Short’s poem distills her frustration at being able to help a single patient. Dr. Moery’s poem distills her sense of powerlessness accrued over a single afternoon of encountering patient after patient who does not follow her medical advice. The types or categories of “difficult” patients and relationships Dr. Moery describes are classics in the lexicon of American biomedicine (demanding, noncompliant, seemingly uncaring about their own health), but she ends with a twist, a glimmer of awareness of her own powerlessness, perhaps in part over her intense wish to help others. Until the last line, the frustration is toward people outside the self; in the

last line, the frustration looks inward. It is as if to say, “Maybe the issue is not entirely *them*; maybe it’s partially *me*.” Thus Dr. Moery is feeling frustrated not only by the overwhelming task, but also by the eruption of her own cynical tone at the end of a long clinic session. The door is opened to introspection.

Physicians today are increasingly trained to practice “patient-centered medicine,” rather than exclusively “disease-centered medicine,” a doctrine that emphasizes eliciting the patient’s perspective, agenda, expectations, priorities, story, and feelings. This is a necessary corrective to the earlier hierarchical, physician-dominated practice. Yet this approach can become just as skewed as the earlier model. Physicians often find themselves discounted and overwhelmed by the demands of the patient, the patient’s family, the clinic or hospital, the insurance company, and the ever-present threat of lawsuit. Dr. Moery wanted to tell her story, her deep desire to help, and her feelings of frustration. In a word, she wanted to be heard, understood. People can listen to others only if they are themselves listened to (Stein 1994).

As Dr. Moery and I talked, and as we all discussed her poem in the group, it became obvious that she is the opposite of a callous, judgmental physician. She goes “the extra mile” in behalf of her patients. She is generous with herself and with her time. She genuinely cares about her patients. She is a good listener. The emotional generosity is sorely taxed, and the emotional reserve drained, however, when an entire afternoon (or morning) clinic is composed of some of the most complex patients and

their social situations. Dr. Ek's second poem, "Matriarch," echoes some of these same themes.

Dr. Ek's first poem, "Dr. Pat Continues to Teach," juxtaposes the dying patient in the nursing home with the large color photo-portrait of Dr. Patzkowsky twenty-five years earlier. Dr. Ek is caring for "the same" person who once presided over the residency program, yet his patient is far from "the same." This double-portrait is not all that different from the one Dr. Short painted of her grandfather: the person as he was then, and as he is now. Dr. Ek wrests continuity of function from the discontinuity of ability. Dr. Pat continues to teach, not in the usual role of clinical teacher and supervisor of a resident, but as a patient who teaches. Dr. Ek transposes himself via identification into the young Dr. Patzkowsky as a resident, rounding on nursing home patients: "Not unlike places he had been/ In his youth, perhaps like me...." There is the implicit, unvoiced, identification that he, too, someday may be in Dr. Pat's current condition as a dying patient in relation to yet another young resident. At the end of the poem, he summons the image of the younger Dr. Pat to represent his ideal as a doctor to the older Dr. Pat.

During the group discussion of this poem, I noted that many of the very sick elderly patients whom they now see and treat in nursing homes, in the hospital, and in the clinic, all have rich histories just like Dr. Pat, except that, for the most part, the physician will not have access to that history. The physician will only see the "shell" (to borrow from Dr. Short's poem) of the patient whose memory and communication

skills are impaired. I wondered aloud: “Do you ever try to imagine who the person was that is now your patient?” or something like that. As a group, they politely erupted in protest, insisting that if they did so with every patient, they would be completely drained emotionally and would be unable to continue treating all the patients they needed to treat. “You need a wall,” they said, “To protect you from being overwhelmed. You focus on what you can do biologically, and go on to the next patient.” I suddenly felt a poignant paradox taking place, which I shared with the group. I said something like: “I respect your need for these walls, yet you are the very same people who so often lower your walls in order to help your patients.” I think I noticed tears in one resident’s eyes. I admired their struggle to keep their patient human under circumstances that could easily lead them to see their patients as merely a heap of failing biology.

Dr. Ek’s second poem, “Matriarch,” is a broad canvas of a single parent and her family. While the “case” is unique – as is every one – the poem portrays many themes of single mothers, their often chaotic families, and their erratic relationships with the health care system. In a way, the poem could be a metaphor for countless types of patients seen in the clinic, and in clinics throughout America. One by one, we meet the cast of characters and their plight, their symptoms, and their stories. We begin and end with the “large mountain of a woman” who dominates the family she cannot control. The grandmother is “mother” to her son and grandson. The poem ends, though, with a twist, on a note of development and separation, and maybe even hope. The sixteen

year-old boy, her grandson, accepts help from a counselor. The shadow cast by the mountain is not as all-consuming as it had been.

Dr. Ek is an astute observer of the people he is trying to help. Part of his relationship with patients is carefully studying them. He knows their lives, not only their diseases. In doing so, he upholds one of the core ideals of Family Medicine. He also practices another of its ideals, continuity of care, that is, care of family members over the long haul, sometimes even two and three generations. As we discussed this poem, Dr. Ek made clear to me that one factor that diminished his sense of urgency with this family was his knowledge that he would see them again. Maybe she or her son or grandson would be open to some change the next time they came to his office. He would be “there” for them. He can wait.

I said something to the effect that the story in his poem was far broader than most clinical narratives that focus strictly on the diseased tissue or broken bone and its treatment. Dr. Ek tells us the story behind the two year-old boy’s “funky rash.” We learn in vivid detail of the woman’s squalor. We learn about people’s lives, because Dr. Ek takes lives seriously as a part of his medical practice. He cares about them in their lived worlds. His clinical narratives go beyond the boundary of what is often called “real medicine” (that is, human biology). He tells me that he has a background in behavioral science. He is also curious and compassionate. The poem is not only about the woman and her family, but also about his relationship with them.

To summarize: at one level of understanding, each of these poems – and their poets – is unique; at another level, each symbolically “stands for,” or represents, a large cadre of patients, patient-situations, and physician relationships with patients and their families. If these poems, and what we learned from discussing them, are not statistically generalizable, they are nevertheless *thematically representative* of a large part of these physicians’ practices. The exercise of writing and discussing these poems consists of a process of reflecting “aloud” about the experience of patient care. It is a process of articulating old thoughts and feelings (thoughts and feelings that are already known) and those that emerged from the writing and discussing. There can be no (linear) prescription of how to “apply” these poems and their discussion to patient care, apart from the process of discovery and articulation itself. This is contrary to the swift current of outcome-oriented biomedical education whose logic is cause-and-effect. The way the poems and the processing of the poems “work” is that they create more mental space for new ways of clinical thinking, feeling, decision-making, and behavior. They also affirm the worth of the physicians writing and processing the poems

When the residents and I have finished with the exercise, they often thank me. They are often surprised with what they and we have done together. In a way, the process has been the opposite of the rote memorization that has characterized most of their medical education. A large part of what has been learned is the process of gaining access to parts of oneself that had been to some degree closed out from the practice of “real medicine.” In the exercise, they learn that they knew more than they thought they

knew. My hope is that some of this process of discovery and curiosity will be transposable to the world of clinical practice.

Emboldened by the extent to which the four residents made this exercise their own, I am continuing this approach with subsequent residents during their month-long behavioral medicine block. I first invite each to write a poem or two, and then engage in a thematic analysis of the poem *with* the resident. We discover meanings, emotions, and relationships together. The exercise is not limited to one-time or two-times. Rather, like a tributary to a river, it flows into a longitudinal behavioral medicine curriculum that is in turn integrated into the rest of their medical training.

Conclusions

In this paper I have described the ebb and flow of a medical humanities teaching experiment with Family Medicine residents. I have included five poems of three Family Medicine residents, described both the methodological and theoretical underpinnings of this experiment, and illustrated how this process unfolded.

What can be extrapolated or generalized from this experiment for teaching and learning through the arts, in medical education and beyond? First, the teacher or instructor must be fully emotionally present to the student or group of students. Second, the task (suggested or required) must be conducted in an atmosphere of emotional safety, which is the *sine qua non* for allowing the vulnerability to be experienced, shared, and processed. Third, the poem (or, for that matter, any art form) is less analyzed, strictly speaking, than becomes the point of departure for the exploration of

thoughts, feelings, fantasies, relationships, and other experiences that the poem triggers. Fourth, the teacher must be comfortable with not-knowing, with losing himself or herself in the flow of the conversation, and with freely offering his or her own imagination to the process. Finally – as an ideal outcome of this process – some of the curiosity, imaginativeness, and playfulness are transposed from the seminar setting to the physician-patient relationship and to other work relationships and problem-solving tasks. With these lessons in mind, it is my hope that the reader's own imagination will be stimulated to create experiments of his or her own in the use of the humanities in all forms of teaching.

References

- Buber, M. *I and Thou*. Walter Kaufmann, trans. New York: Scribner's, 1970 (orig. 1923).
- Catterall, JS. Conversation and silence: Transfer of learning through arts. *Journal for Learning through the Arts* 1(1); 2005:1-12.
- Diamond, MA. Organizational change and the analytic third: Locating and attending to unconscious organizational psychodynamics. Paper presented at the Colloquium of the Center for the Study of Organizational Change, University of Missouri-Columbia, October 6, 2006.
- Epstein, R. Mindful practice. *Journal of the American Medical Association*, 282; 1999: 833-839.
- Ogden, TH. The analytic third: Working with intersubjective clinical facts.” *International Journal of Psycho-Analysis* 75; 1994:3-20.
- Ogden, TH. The analytic third: An overview. <http://psychematters.com/papers/ogden.htm> Accessed May 17, 2006. Originally published in *fort da* 5(1); 1999

- Shapiro, J. and Stein, HF. Poetic license: Writing poetry as a way medical students examine their professional relational systems. *Families, Systems and Health*, 23(3); 2005:278-292.
- Stein, HF. *American medicine as culture*. Boulder, CO: Westview Press, 1990.
- Stein, HF. *Listening deeply: An approach to understanding and consulting in organizational culture*. Boulder, CO: Westview Press, 1994.
- Stein, HF. *Prairie voices: Process anthropology in Family Medicine*. Westport, CT: Bergin and Garvey (Greenwood Publishing Group), 1996.
- Stein, HF. The inner world of workplaces: Accessing this world through poetry, narrative literature, music, and art. *Consulting Psychology Journal: Practice and Research*, 55(2); 2003a:84-93.
- Stein, HF. Ways of knowing in medicine: Seeing and beyond. *Families, Systems and Health*, 21(1); 2003b:29-35.
- Stein, HF. Countertransference and organizational knowing: New frontiers and old truths. *Free Associations* (United Kingdom), 11(Part 3)(No. 59); 2004:325-337.
- Stein, HF. 'The centre and circumference of knowledge': The use of poetry as a tool of countertransference in organizational knowing and consulting. *Free Associations* (United Kingdom), http://human-nature.com/free-associations/Centre_and_Circumference_stein_H.html Published March 31, 2006. Accessed November 28, 2006.
- Winnicott, DW. Transitional objects and transitional phenomena: A study of the first not-me possession. *International Journal of Psychoanalysis*, 34; 1953:89-97.
- Winnicott, DW. The location of cultural experience. *International Journal of Psychoanalysis*, 48; 1967: 368-372.
- Winnicott, DW. *Playing and reality*. New York: Basic Books, 1971.