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Integrating Storytelling into a Communication Skills Teaching Program for Medical Oncology Fellows

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Abstract

Oncology training focuses primarily on biomedical content rather than psychosocial content, which is not surprising in light of the enormous volume of technical information that oncology fellows assimilate in a short time. Nonetheless, the human connection, and specifically communication skills, remains as important as ever in caring for highly vulnerable patients with cancer. We previously described a year-long communication skills curriculum for oncology fellows that consisted of monthly 1-hour seminars with role play as the predominant teaching method (Epner and Baile, Acad Med. 89:578–84, 2014). Over several years, we adapted the curriculum based on learner feedback and reflection by faculty and teaching assistants and consolidated sessions into quarterly 3–4-hour workshops. We now describe integrating stories into the curriculum as a way of building empathy and warming fellows to the arduous task of dealing with highly emotional content, such as conversations with young patients about transitioning off disease-directed therapy. Learners read and discussed published, medically themed stories; discussed their own patient care stories; and completed brief writing reflections and discussions. They then worked in small groups facilitated by faculty and upper level fellows who functioned as teaching assistants to work on applying specific skills and strategies to scenarios that they chose. Fellows completed anonymous surveys on which they rated the curriculum highly for relevance, value, organization, content, and teaching methods, including storytelling aspects. We conclude that sharing stories can help highly technical learners build reflective ability, mindfulness, and empathy, which are all critical ingredients of the art of medicine.

Keywords Patient provider relations · Narrative medicine · Adult education · Communication skills

Introduction

Molecular diagnostics and targeted therapies have improved cancer diagnosis and treatment dramatically in recent years. Yet, no matter how sophisticated our understanding of cancer becomes, the human connection will always be critical for understanding each patient's illness experience. Stories serve as the currency of human connection and understanding, a window into the patient's fears, hopes, and dreams. Stories are the primordial means by which we make sense of and convey the meaning of our lives [1]. According to Charon, meaning from stories is derived collaboratively by the teller and listener, reader and writer; the observer and the observed; and the patient and physician [2]. The effective practice of medicine requires narrative competence, which is the ability to acknowledge, absorb, interpret, and act on the stories and plights of others [3]. Narrative medicine, which is medicine practiced with narrative competence, improves the well-being of many physicians and their patients and strengthens bonds between them [4].

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Stories, unlike molecular diagnostics, are inherently ambiguous. So, interpreting the stories of gravely ill patients in a way that allows us to align with them and serve their needs requires many skills, such as using silence effectively, posing open-ended questions, listening mindfully, and responding empathically to strong emotions. These skills may seem conceptually simple, but in reality, they are highly nuanced and can be taught, learned, and refined over many years of practice and reflection [5].

Communication skills training, like any teaching, is most effective when adapted to the specific needs of the learner. Doctors at different stages of professional development face different communication challenges and occupy different places on the learning curve. Medical oncology fellows are in their last stage of training before becoming fully independent, so they have considerable experience engaging in challenging clinical conversations pertaining to life and death matters and have begun to establish their own styles for engaging in these conversations. In addition, medical oncology fellows are required to assimilate massive amounts of biomedical knowledge during their 2–3 years of training and engage in original research. They therefore focus more on technical and biomedical aspects of oncology than they do on psychosocial aspects. Any teaching, especially teaching that focuses on humanism, needs to respect the medical fellow's perspective, which is distinct from that of, say, medical students, medical residents, or health care providers in other disciplines.

We previously described a communication skills curriculum for first-year medical oncology fellows that focused primarily on skill acquisition through experiential rather than didactic learning in monthly 1-hour seminars [6]. We used several teaching methods, including enhanced role play, which involves spontaneous creation and enactment of difficult conversations from learners' own practices, rather than pre-established scripts with standardized patients [7, 8]. We recruited second- and third-year oncology fellows to serve as teaching assistants to help design, implement, and evaluate the curriculum. Each session focused on a communication or relational challenge commonly encountered in oncology practice, such as transitioning patients from disease-directed therapy to a purely palliative course, interacting with an angry patient or family member, or maladaptive coping. As the curriculum evolved in response to feedback from learners and reflection by faculty and teaching assistants over several years, we began to appreciate the importance of allowing fellows' time during each session to shift from a technical mind frame to a more humanistic one before practicing skills that are required during emotional encounters. One of us (DE) began to publish reflective essays in the medical literature that described several such encounters [9–13] and attended a workshop led by Rita Charon and her colleagues in the narrative medicine program at Columbia University. Over time, we began to appreciate the potential of stories to help fellows get into the right mind frame for working on emotional tasks and to become more skilled at interpreting their patients' stories. We now describe the process by which we integrated published, medically themed stories and other narrative methods into our communication skills curriculum and preliminary feedback from learners regarding relevance and perceived value of these adaptations.

Methods

We used one or more narrative methods for each 3–4-hour workshop. First, we read published, medically themed reflective pieces aloud or viewed selected scenes from a medically themed motion picture and, then, discussed key themes. Second, fellows shared their own clinical and non-clinical stories in small groups or with the entire group of 12 or more learners. Third, fellows engaged in brief writing reflections.

How We Chose Stories

Our first foray into narrative medicine was reading and discussing "First Love," by Richard Weinberg [14], a nonfiction account of a physician's love for his patients:

> Not as one loves a parent or a brother, or a friend or a lover. But with a physician's love. Neither brazen, nor careless, nor wanton, nor abandoned. But gentle and caring and deliberate, carefully measured, each according to his need.

One of us (DE) first read this reflective essay while facilitating the Healers Art course [15] at two neighboring medical schools. We then chose two additional stories recommended by one of us (BN) based on his extensive experience teaching writing seminars on fiction, medicine, and the practice of empathy at the Rice University. Those stories included "Water Child," by Edwidge Danticat, published in *The New Yorker* in 2000, and "I Want to Live," by Thom Jones, published in *Harper's Magazine* in 1992. "Water Child" is the story of a nurse who has an abortion and suffers the emotional effects of terminating the pregnancy. It portrays her interactions with a cancer patient who lost her voice after a laryngectomy and the profound effect that the nurse's abortion had on her relationships with her parents, the baby's father, and her coworkers. "I Want to Live" is the story of a woman dying of advanced cancer and her strained relationship with her daughter, her distant relationship with her physician, and the healing relationship with her son-in-law. We also showed selected scenes from the well-known motion picture "Wit," which was adapted from the Pulitzer Prize–winning play by Margaret Edson and starred Emma Thompson as a woman who dies of ovarian cancer while receiving experimental chemotherapy.

One of the above three stories was read or viewed and discussed at each of three workshops.

We chose these stories for a few reasons. First, they are ambiguous enough to stimulate reflection and lively discussion while still being accessible to highly technical learners. Second, all these stories are clinically relevant, beautifully written, and focused on humanistic and psychosocial themes. Finally, these stories are short enough to read aloud in their entirety and discuss in about an hour. Fellows did not need to prepare ahead of time. Time efficiency was important, since only 12 hours were devoted to the entire year-long communication skills curriculum, which competes for time with a didactic schedule packed with biomedical content.

Our Goals for Incorporating Stories into the Curriculum

Our primary goal was to help fellows build "empathic muscle." A core component of narrative medicine education is close reading, or learning how to thoughtfully and critically analyze a text. This reflective process helps students develop empathic listening skills to better understand and connect with patients [16–18]. Narrative competence is the ability to absorb, interpret, and respond to stories that enable providers to practice with empathy, reflection, professionalism, and trustworthiness [3]. According to Irvine and Charon, inhabiting another's narrative world, or imagining what it might be like to be within another's story, requires feats of imagination and empathy [1]. So, reflecting on and discussing any form of art or literature, particularly fiction, to prepare for future emotional patient encounters are analogous to a pianist practicing a concerto before preforming at Carnegie Hall.

We also used stories with the intention of helping fellows get into the right mind frame to work on emotion-laden topics. For instance, when asked what conversations they found most challenging, fellows often cited goals of care conversations with young patients dying of cancer, such as a young mother of three children dying of triple negative breast cancer. Discussing end of life issues with such a patient not only resonates with fellows, all of whom are young adults, but also elicits strong emotions, such as sadness and helplessness. We used stories to help warm fellows to the task of focusing on such heart-wrenching conversations.

Sharing of Fellows' Stories

Besides reflecting on the stories of others, fellows also had the opportunity to share their own stories with each other, either in small groups or with the entire group of 12 or more. Shared narratives encourage an environment of disclosure and support, help normalize the emotions experienced in difficult situations, and allow for self-reflection and learning from shared experiences. Sharing stories also gives physicians an outlet for their emotions [17, 19]. In short, sharing creates camaraderie, which benefits those who undergo trauma and suffer long-term consequences of trauma [20], including patients with advanced cancer [21], and those who care for them. Giving learners time to share their own stories also fosters a collegial environment, which can help alleviate fear of being embarrassed or judged, such as in participatory exercises [7]. Camaraderie increases collaboration, which in turn increases cohesiveness.

Brief Writing Reflections

We also introduced brief reflective writing exercises to engage each learner individually. Reflective writing about personal experiences gives trainees the opportunity to evaluate and understand their own narratives, whereas sharing those narratives and learning about others' stories improves empathy through better appreciation of common experiences [22–24]. An example of a prompt for a writing reflection is:

> Take a few minutes to consider a time when you brought something to your relationship with your patient that was healing, other than chemotherapy or a referral to a phase I clinical trial. It may have been something you said, such as words of encouragement or wisdom, or something you did, such as acknowledging the patient's loss, that you thought was embraced by the patient. Discuss how this may have affected your relationship with your patients.

Fellows then had the opportunity to share their writing with the group if they so desired.

Integrating Stories into Workshops

All 3- to 3.5-hour workshops started with brief introductions and reiteration of ground rules, such as maintaining confidentiality and avoiding distractions. We then spent over an hour reading and discussing one of the stories mentioned above or selected scenes from the motion picture Wit to warm fellows to the task of focusing on emotional content. After reading the story or viewing film clips, we encouraged reflection and discussion with prompts such as:

- "Which character resonated most with you?"
- "How does this story inform your clinical practice?"
- "How did [the main character] connect with her patient?"

We often ask fellows to discuss their general impressions of the story or film in small groups of three or four before opening the discussion to the whole group and, then, let the conversation proceed naturally, gently redirecting only rarely to keep on task.

We devote the second half or more of each 3- to 4-hour workshop to skill-building. Faculty members often model key skills in front of the entire group and get feedback from learners regarding what they like about the portrayal and what they think could have gone better. We then often divide into small groups focused on specific clinical scenarios that fellows choose.

A faculty member or teaching assistant facilitates each small group of two or three fellows. Our approach to small-group facilitation is consistent with best practices described in the literature [25, 26]. In general, we encourage fellows to reflect on possible strategies and key phrases rather than simply telling them how we do it, although we balance reflection with modeling. We practice skills in the least threatening way possible. For instance, we allow for "time outs," which let group members reflect on and discuss possible solutions to the predicament at hand, try key phrases, watch the leader model briefly, reverse roles, consider the thoughts and feelings of one or more characters, and, then, get back in role. Working through the challenge is a team effort. The key principle is that mastering complex skills requires reflection, nonjudgmental feedback adapted to each learner's specific needs, and practice.

Skill-building in small groups also gives teaching assistants the opportunity to practice small-group facilitation and to demonstrate the communication skills themselves. Thus, participation by teaching assistants gives them the opportunity to prepare for their future role as faculty members. After working in small groups for an hour or more, everyone reassembles and debriefs for a few minutes, which entails one or more representatives from each small group describing what they took away from the process.

Feedback from Learners

We surveyed fellows anonymously at the end of each academic year to assess whether they valued the skills we taught. Responses showed that the overwhelming consensus among fellows was that they found the skills to be helpful or very helpful in their practices, both before and after implementation of narrative techniques. We also solicited feedback from fellows regarding the curriculum's organization, content, and teaching methods. The consensus was similarly favorable, with all fellows either agreeing or strongly agreeing that objectives were clearly defined and that content was relevant and reflected real clinical challenges. We included survey items that specifically asked fellows whether they believed that close reading and discussion of medically themed stories was relevant and educational. We used a four-point scale, with one being most favorable. The average score for "First Love" was 1.4, for "I Want to Live" was 1.4, and for "Water Child" was 1.5, indicating that fellows viewed the process favorably.

Discussion

Oncology training focuses primarily on biomedical and technical content, with relatively little attention devoted to communication skills training and other humanistic pursuits. So, few if any oncology fellowship programs integrate year-long, structured communication skills training into the didactic schedule, as ours does. In addition, our curriculum is the first that we know of that integrates medically themed stories into communication skills training for oncology fellows, although an Iranian group recently reported on integration of art-based teaching strategies, such as reading poetry or viewing paintings, on oncology fellows' performance in a breaking bad news scenario [27]. By encouraging reflection and human connection, our program has the potential to greatly mitigate physician burnout, which is a serious problem begging for solutions.

One of the limitations of our curriculum is that it involves primarily first-year oncology fellows, with involvement by second- and third-year fellows limited to those selected as teaching assistants. Fellows in our program work under the close supervision of senior clinicians during year 1 and start their own continuity clinics at the beginning of year 2. Our curriculum may have greater impact if it were offered during the second or third year, or ideally, if it were continued throughout all 3 years, adapting to the evolving needs of the learners. However, as it currently stands, there is insufficient time in fellows' didactic schedules to accommodate a more comprehensive and longitudinal program. Even for first-year fellows, the curriculum consists of only 12 hours, which is a tiny fraction of their total didactic schedule. Humanism and communication are arguably the most important aspects of oncology practice, so we hope to devote more time to them in the future.

The narrative techniques we used in our program differ substantially from established narrative medicine techniques developed by Charon and her colleagues at Columbia. Close reading of great works of nonfiction literature or poetry is one of the key elements of narrative medicine. Close reading involves painstakingly reading the work line by line and reflecting on and discussing potential meanings of ambiguous passages. The basic premise is that once clinicians learn to be close readers, they have the capacity to become close listeners of their patients' stories. Close reading helps people discover things they would not have otherwise noticed and is an inspiration for respectful and effective healthcare [28]. In the case of a great novel, close reading can take many hours over weeks or months. In contrast, we read and discussed medically themed short reflective essays and selected scenes from the motion picture Wit, which were accessible even to learners with little or no literary background. The narrative aspects of our workshops took only about an hour at the beginning and were designed primarily to help fellows transition from a

biomedical mind frame to an emotional one, thereby promoting empathy. We spent the remaining 2 hours or so teaching specific communication skills applicable to real-life clinical scenarios chosen by the fellows. So, our reading and discussion of stories did not qualify as close reading in the conventional sense. Rather, we read and discussed stories in a focused, time-efficient manner in order to adapt to the unique needs and circumstances of our learners. We considered reading and discussing at least one non-medically themed story, but the consensus among faculty and teaching assistants was that learners would not see the relevance of such stories. In the future, we plan to determine whether in-depth close reading of poetry and non-medical literary fiction can be integrated into the curriculum, at least for selected learners.

In addition to reading and discussing stories, we also occasionally completed writing reflections based on specific prompts. According to Hermann [29], the art of the writing prompt is a fine one, very much dependent on the setting, context, goals, and the group of people you are working with. The goal of every writing should be discovery and expansion of the mind. The prompt should never provoke a search for a specific answer or encourage narrow thinking. Shorter is almost always better. Often good prompts can be lines taken directly from a piece of writing. Our prompts, like the one noted above ("…consider a time when you brought something to your relationship with your patient that was healing…"), were adapted to the needs of our learners. However, some were longer than those described by Hermann. Nonetheless, we chose writing prompts that allowed sufficient freedom of thought and expression, regardless of length.

Previous randomized controlled studies have shown that training can significantly improve communication skills, usually after a workshop that lasts for several hours to a few days. Nonetheless, the question remains whether our year-long curriculum improves communication skills, attitudes, or clinical decision-making, and if so, whether integration of stories specifically enhances those improvements. These questions will be difficult if not impossible to answer for a number of reasons. First, even if we were to unequivocally demonstrate that fellows' skills improve significantly over the course of the year, it would be impossible to parse out how much of that improvement was attributable to the curriculum and how much was attributable to many other potential confounding factors, such as teaching and modeling by other faculty members, or fellows' own maturation and reflection over time. One way to address this issue would be to randomize fellows in our training program to either the curriculum (intervention) or a control intervention lacking key pedagogic elements. However, dividing the group in this way or comparing our fellowship to other similar large fellowship programs that lack similar training or have other types of training [30, 31] would not be logistically or methodologically feasible. Whether or not our curriculum ultimately proves to build specific skills, we know from anonymous surveys that oncology fellows believed it to be relevant and useful.

Another important question is whether the benefits of communication skills training crystallize gradually over the many years of an oncologist's career rather than increasing over the short time around a specific training program, whether that training occurs over hours, days, or months. The same question applies to any skill. Are pianists and tennis players better for having received expert coaching as opposed to honing their crafts in isolation? Intuitively, it seems that a motivated tennis player or pianist who receives excellent coaching will be more skilled than they would be without it, but there are no controlled trials to confirm this hypothesis. Perhaps the power of communication skills training lies not in whether a physician learns specific skills, such as posing more open-ended questions or offering empathic phrases during an encounter with a standardized patient. Rather, the power of such training may lie in its ability to stimulate reflection and mindfulness over a physician's long career. Developing outstanding relational skills is a lifelong learning process achieved through constant practice, reflection, feedback, and astute observation. The truth is that great doctors create their own unique art form, just as great musicians and athletes do. The best ones learn to listen carefully to their patients' stories.

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Compliance with Ethical Standards

Conflict of Interest The authors declare that they have no conflict of interest.

Ethical Approval Not required.

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