SPECIAL ARTICLE

Getting Started: A Call for Storytelling in Family Medicine Education

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BACKGROUND: In this article we introduce family medicine educators to storytelling as an important teaching tool. We describe how stories are a critical part of the work of family physicians. We review the rationales for family medicine educators to become skilled storytellers. We present the components of effective stories, proposing two different perspectives on how to imagine, construct, and present them. We provide a list of resources for getting started in storytelling and offer two personal vignettes that articulate the importance of storytelling in the authors' respective professional developments. We point the way forward for family medicine educators interested in integrating storytelling into their repertoire of teaching skills.

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Stories make differences in our care of patients. They help us think about our patients and their family members. They help us integrate our understandings of symptoms, laboratory tests, and disease. They help us translate those understandings into the way we care for other patients.

It would mean a lot if we could convince medical students and residents of the essential nature of stories and storytelling in the practice of family medicine. Expecting them to listen to, relate, and create stories isn't just wishful thinking: it is a learned skill, just as are all the other learned skills that go into the making of a family physician.

A Family Physician Educator, 2015

This opening comment tells us much about the importance of stories in the day-to-day practice of family medicine. It also reminds us just how challenging it is for family medicine educators to teach the skills of listening to and telling stories in current training environments. Unfortunately, as well, instruction about how to cultivate skills as storytellers in family medicine education is virtually nonexistent.

We admit there exist significant barriers to integrating stories, either as listeners or as tellers, in contemporary medical education. Accordingly, in this article we describe how stories play a critical part of the clinical work and the educational development of family physicians. We introduce family medicine educators to storytelling as a valuable teaching tool and review the rationales for them becoming skilled storytellers. In two vignettes we illustrate how storytelling has become part of our educational philosophies and repertoires of teaching habits. We conclude by presenting the basic components of effective stories and describing how to integrate the practice of storytelling into family medicine education.

Background and Rationale

Stories, Clinical Practice, and Professional Development

The practice of family medicine (and, in fact, all the generalist medical disciplines) is integrally involved with the telling of stories.[1] Numerous practitioners and scholars from psychology, narrative studies, the medical humanities, medical ethics, and medical education have discussed the crucial role that the telling, interpretation, and reconstruction of stories play in the process and outcome of clinical encounters: patients relate their illness experiences in terms familiar to them; clinicians listen to these presentations, draw out details through their questions, and reformat them as medical information by way of SOAP notes (having added objective data from physical examinations, laboratory tests, and diagnostic procedures).[2-7]

The net result is the creation of therapeutic strategies that attend

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to the traditional goals of curing and caring.[8] That stories contribute to this progression—they are the raw material from which practitioners and patients refine clinical paths—has consistently been considered a hallmark of high-quality generalist medical care.[9] Stories help family physicians and others understand the interplay of biomedical and social determinants of disease while they are attending to critical transitional moments in the course of patients' lives.[10]

As to professional identity development,[11] many physicians-in-training have used stories to tell of overcoming clinical challenges and managing steep learning curves.[12-14] Yet few narratives explore the intentional use of stories by educators of physicians or others involved in health care.[15] However, we suspect that many readers can recall when teachers' stories have helped shape their career development. We can personally attest to their substantial influence on our professional growths.

Storytelling as an Important Teaching Tool

Due to this recognition, we recommend that teachers of family medicine expand their skills at storytelling, regardless of whether or not they believe they currently possess the knack to tell stories effectively. By crafting and telling stories, they can model the many dimensions of patient care that form the basis for our discipline.[16] By including storytelling in their teaching repertoires, they can help their learners grow into thoughtful, capable, and confident generalist clinicians, adroit in embracing both the science and art of medicine as therapeutic tools.

Storytelling, whether oral, written, or by way of digital documentaries, is particularly useful in such family medicine educational settings as:

- when teaching biomedical information, and stories give the information a memorable human context
- when major adverse events traumatize members of a clinical team, and stories help them handle their grief, find solace in one another, and develop resiliency. (After the death of a patient, team members might share among themselves their connections with the deceased or how the patient's death has influenced them.)
- when faculty members want to model for learners how they have managed (with varying degrees of success) the same challenges that learners are struggling with, and stories are able to "show," rather than "tell," the way forward.

Storytelling may also be useful in opening learners' clinical imaginations, fostering reflective practice, and enhancing clinicians' abilities to understand the complexities of modern medical care.[17] Sharing stories, especially when framed in terms of crisis and resolution, is thought to encourage professional empathy in response to the vulnerability and loss that commonly accompany illness experiences.[18] In addition, stories are useful for purposes of persuasion.[19] As such, storytelling from a family medicine perspective is important in an era when tales of subsubspecialist- and technology-driven care dominate over those related to comprehensive, accessible, patient-oriented care.[20]

Implementation

Preliminary Considerations

Family medicine educators interested in cultivating their oral, written, or digital storytelling skills will be well served by keeping the following adages in mind. First, good presenters are good storytellers. There are many ways to share knowledge, but teachers of medicine are often guilty of pushing facts out to our audience. Pulling students and residents in with stories helps concepts stick more firmly and is more satisfying (or at least less boring) to both tellers and listeners alike.[21] Second, storytelling is about connecting to other people and helping people see what you see (a major task for any educator in any teaching endeavor).[22] Making a connection—exemplified by patient- and relationship-centered care—is foundational to generalist practice theory; bringing connection to teaching through storytelling reinforces its parallel power in clinical encounters.[23] Third, if you don't tell your story, someone else will—and they will set the priorities for how we define and accomplish the work we do.[24]

How to Tell Stories: First Steps

There are many recommendations for how to construct and relate stories, regardless of mode of presentation (oral, written, or audio-visual). Some are centuries old and drawn from traditional storytelling practices in existence prior to the written word.[25] Others, like the five-step plot line common in Shakespeare's works—exposition, rising action, turning point, falling action, and conclusion—got their start in theater.[26] Still others have come out of newer technologies, like movies, digital documentaries, and podcasts.[27] Additionally, there are a wide variety of ideas on building and telling stories that have philosophical foundations (though well beyond the scope of this introductory article): the hero's story, the heroine's story, and stories of collective memory and reconciliation are but a few illustrative examples.[27-29]

For family physicians interested in incorporating storytelling into their repertoires of teaching strategies, we suggest two possible introductory approaches for getting started, approaches that have served as our guides in our own growths as storytellers. The first, described in Table 1, follows several process- and outcome-oriented themes. These themes condense the fine art of storytelling into five manageable dimensions, each a series of three associated steps. The second approach, noted in Table 2, follows a sequence of questions to be used as prompts for considering how to construct and tell stories. These questions engage nascent and future storytellers in a repetitive process of inquiry and refinement, incorporating observations and reflections into

Table 1: Developing Storytelling Skills: A Process-Oriented Approach

Theme	Process and Action Steps
• We all have stories to tell	✓ Recognize them ✓ Reflect on them ✓ Refine them
• Stories have three foundational phases	✓ Beginnings ✓ Middles ✓ Ends
• Each phase has a purpose	✓ Set the stage—Who are the characters? ✓ Illuminate conflict—What is the predicament? ✓ Resolve the problem—How is the challenge overcome?
• Storytellers demonstrate	✓ Willingness to try and develop skills ✓ Courage to tell stories in creative and engaging ways ✓ Stick-to-itiveness to practice and improve delivery
• Practicing storytelling means	✓ Being responsive to audience members and their reactions ✓ Recruiting and attending to ongoing feedback ✓ Encouraging others to tell their stories

Table 2: Developing Storytelling Skills: A Question-Oriented Approach

• Why are you telling this story?
• What was going on for you when this story started to unfold?
• What was the first thing that grabbed your attention?
• Then what happened?
• How did you react?
• What else happened?
• What was going through your mind as this story was happening?
• How did the story end?
• As you look back now, what are your reflections about this story?
✓ Did you learn something?
✓ Did it change the way you see things?
✓ How have you changed?

a narrative mix that includes examination as well as resolution.

We present these approaches believing that those interested in improving their skills will take these themes, steps, and questions not as final answers on how to become expert storytellers but as initial stimuli to begin walking their own paths toward that goal. Other resources, listed in Table 3, can be helpful to those seeking greater storytelling facility. For those who are already well along in their abilities and want to take another step in their storytelling journey, Table 4 makes note of family medicine journals that accept written stories for publication.

The Bottom Line: Why We Tell Stories

In environments constrained by fear and anxiety (not uncommon in medical settings), stories can be used to share common experiences, to break down damaging barriers, and to explore ways of becoming more whole. In Vignettes 1 and 2, we share our own experiences with these evocative issues and how we came to see storytelling as an integral part of our professional lives as teachers of family medicine.

Further Reflections

Some educators may argue that listening to patients' stories and retelling them in ways that include our presence in their lives are forgotten competences of a bygone era in family medicine, and that using stories to help socialize students and residents into the work of family medicine is an impossible task given competing academic interests. Some may say that the purpose of formal preparation for family physicians-in-training

Table 3: Key Resources for Beginning Storytellers in Family Medicine

Radio and Online Programs Featuring Storytelling • The Moth: True Stories Told Live. www.themoth.org • This American Life. http://www.thisamericanlife.org/ • Radio Storycorps. www.storycorps.org
Distance Learning Courses • The Center for Digital Storytelling. http://storycenter.org/ • CreativeLive. Power Your Podcast With Storytelling. https://www.creativelive.com/courses/power-your-podcast-storytelling-alex-blumberg
Health Care-Based Digital and Video Storytelling Resources • Patient Voices. www.patientvoices.co.uk • RealTime Health. https://www.youtube.com/channel/UCoF7BM98ZeZLHjPuFEbx2Lw • Silence Speaks. http://silencespeaks.org/ethics/

Table 4: Family Medicine Journals That Publish Written Stories

• *Annals of Family Medicine*. http://www.annfammed.org/site/misc/ifora.xhtml
• *Families, Systems, & Health*. http://www.apa.org/pubs/journals/fsh/?tab=4
• *Family Medicine*. http://www.stfm.org/NewsJournals/FamilyMedicine/AuthorInformation
• *Journal of the American Board of Family Medicine*. http://www.jabfm.org/site/misc/ifora.xhtml
• *Pulse—voices from the heart of medicine*. http://pulsevoices.org/index.php/submissions

is to become up-to-date with the ever expanding biomedical base of knowledge related to diagnosis and treatment. While we agree that concerns of diagnosis and treatment are critical for any learner or practitioner in family medicine, we respond by noting that there exists extensive evidence demonstrating the clinical efficacy of approaches that enhance affinity, intimacy, reciprocity, and continuity.[34,35] In family medicine education we often tell stories to convey principles key to the practice of family medicine, principles that distinguish family medicine from other medical disciplines.

Although many will agree with us that stories have long been used to explore illness, healing, life, and death, others may point out that very little evidence supports the use of stories as a teaching modality in medicine. They are correct: there is limited quantitative proof that they improve educational outcomes. We hold, however, that stories are already assumed to be an effective teaching tool, as when individual cases are used to teach about disease management and treatment options. In addition, we argue that stories can open our eyes to different ways for understanding truth and are useful tools for opening hearts and minds, as well—ours and those of our learners.

Still others may argue that it is principally through reflection that we really learn, and that it is the skill of reflection we should be teaching our students and residents. We have no qualms with this point of view. We see storytelling and reflection as two sides of the same coin that explores the many facets of any clinical situation. Whether sharing observations or reflections (or moving seamlessly from one to another), the medium is the same: we are telling or retelling our stories.

Conclusions

Storytelling encourages educators to bring humanity to the teaching of medicine. It encourages teachers of family medicine to identify important events from their personal and professional histories, to refine the key elements of these events, and to build repertoires of narratives for communicating important lessons to nascent practitioners in the art and science of the discipline. Storytelling can foster a nurturing atmosphere where knowledge, experience, honesty, and vulnerability bring teachers and learners closer to shared wisdom.

The insights offered by storytelling have the capacity to lead to new understandings, fresh approaches, and more stories. As one practiced storyteller has noted, "Great stories happen to those who can tell them."[35] Let us all work to tell our stories better, so that we may fuel more great stories from teachers and learners of family medicine.

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Vignette 1: Exploring Professional Self-Awareness/William Ventres

The 4 years of medical school was the longest decade of my life. Then came my second longest decade: residency. I spent much of these periods of time in a kind of emotional and intellectual fog, moving from one class or one rotation to another, trying to put the biomedical pieces of the medical pie together as a whole.

Only I don't think I succeeded very well. I kept getting caught up in trying to master the minutiae for fear of demonstrating my ignorance in front of teachers and peers. I also don't think it helped that I felt alienated from the very patients I was supposed to be doctoring. They were lost to me amid the exigencies of learning all that I could, though much of the time my knowledge seemed pitifully less than adequate.

By rough estimation, it took me about 5 years after finishing my residency training to understand what being a family physician was all about. It took me that long to come to construct the qualities that I believe are at the core of my work,[30] including the ability to seamlessly weave in the truly biomedical parts of medicine with the psycho-social-existential components so important to developing therapeutic relationships with patients.

It took me many more years of practice to refine my skills, and it has taken me many more still to feel comfortable telling my story: to tell of the richness of the work I do, to tell of the failures I have endured and the successes I have accomplished, and to tell of frustrations and satisfactions along the way.[31-33] Yet these stories, my stories, are important to tell. Not that they will solve all the challenges that exist in my day-to-day practice—I wouldn't bet on that happening anytime soon—but because they put my work life in perspective.

They put my early attempts at information mastery to good use so as to frame my training not as an end in itself but as the leveled dirt upon which I built my professional home. They put the challenges I have had along the way—my "home remodeling" never seems to stop—not as blunders but as opportunities to explore more deeply my own resilience. They put my current work as a clinician and educator—by unanticipated circumstance outside the United States—not as an impediment to professional advancement but as an opportunity to look at my life with new eyes, to use new lenses of perception so as to try to make sense of it all and engage with others at the same time.

Perhaps if I had the confidence to share my story earlier on, in those early training years, I could have better managed the longing I had for connection with patients and colleagues. Perhaps I could have been less frustrated and less lonely at the time, and perhaps I could have looked ahead with more optimism as to how my future professional life would turn out. Regardless, it has—somehow, incredibly—turned out well, and for that I am profoundly grateful. And, yes, for that I feel compelled to tell this story of my professional self-awareness and encourage other people to tell theirs.

Vignette 2: Finding Truths/Paul Gross

For me, the practice of medicine involves a quest for truth. And storytelling is one way of capturing the truth of medicine.

Let me tell you a story.

I'm a third-year medical student, and it's the first day of my first clinical rotation—surgery. The team—a chief resident, senior residents, interns, and medical students—gathers in the surgical ICU. It's painfully early; I didn't think it was possible to wake up at this hour, yet here I am, dressed in my stiff white coat. After brief introductions we enter a room to examine our first patient, a pale, bloated 60-ish man who is lying comatose, half-draped in a hospital gown, looking barely alive.

The intern grabs a clipboard from the foot of the bed and rattles off vital signs, recent labs results, and a dismal list of medical issues. As I listen, thoughts swirl through my head: This patient is terribly ill—he may, in fact, be dying. The human aspect of this situation does not seem to concern our team. I'm a bit lost with these numbers and terms. I've got to project a confidence I do not feel.

Entering the next patient's room, the chief resident barks at us: "Don't just stand there! Examine her lungs!" Two of us leap to the bedside, fumbling with our stethoscopes (being careful to point the earpieces in the right direction), and place the chest pieces on the woman's back. We scrunch our faces to hear something, anything, above the residents' chatter. Suddenly, the room is quiet. We look up.

The team has vanished. It's just the patient and us.

"Excuse us," we mumble, and dash after them.

Medical education focused my attention on slivers of the truth—measurements of bodily functioning, assessments of disease progression, studies of therapeutic efficacy. But over time I realized that if I wanted to be an astute clinician and compassionate healer, I needed to pull the camera back and look at the many other truths that informed illness, health, and health care.

That first day on the wards, what truths were at play besides our patient's high white count and deteriorating renal function?

What was his truth? If he had a lucid moment, did our patient realize how sick he was?

What was this family's truth? What was the impact of his illness on them? What was my truth? How overwhelmed and uncertain did I feel?

And today, how can I convey to someone my medical world: my patients' heroic struggles with chronic illnesses and challenging lives, the affection I feel for them, the untidiness of our health care system, the lunacy of our electronic medical record?

A patient's chart only skims the surface. To convey the whole truth, I need to look deeper and fashion a glorious and messy story, one that acts as my most perceptive observer and honest messenger.

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