

Performance of Doctoring: A Philosophical and Methodological Approach to Medical Conversation

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Abstract: This paper advocates a philosophical and methodological approach to the medical conversation between doctor and patient. It engages the issue of subjectivity in medicine, focusing on the dialogue between patient and physician regarding health choices and subjective experience. A performatory approach to training physicians to communicate with their patients (rather than a cognitive approach to doctor-patient communication) is described.

A working-class female patient tearfully and angrily lashes out at me and all physicians, saying, "I have had all these tests and they can't help me. They can't tell me what it is!"

What is the "it"? I ask her.

"I choke when I eat, and it hurts here."

Is that the "it" you are concerned about? I ask.

"They told me I had these enlarged glands in my neck and then say everything is all right."

Is the "it" the confusion? I ask.

"I hurt right here," she says.

I ask her if she was angry because she had all the tests and we still were not able to tell her what it was.

"Maybe," she responds.

Does she think we have to get to the "bottom of things" to help her? Do we have to have a name for her distress, or can we work on figuring out together what might be helpful even if we can't name it?

She gives me a small smile.

During a teaching session on the management of low back pain, I ask: "How do you talk to the patient who says, 'I am incapacitated, I have a slipped disc?' Can you ask him or her, 'What does that mean to you? How do you understand it? Is it possible that the disc found on the MRI might not have anything to do with your ongoing pain?'" A trainee/resident asks, "What about a specialty referral?"

"Well, how do you think about this?" I reply. "If you send your patient to Orthopedist X, an operative surgeon, your patient will probably come away with a different meaning and

understanding of the back problem than if you send him or her to the rehabilitation specialist? Does ‘meaning’ have anything to do with the patient getting better? What is your role in creating meaning with the patient? How do you help your patient, who just wants the pain to go away, to come to a new understanding of the back problem as process/activity?”

A colleague of mine developed chronic renal failure. In spite of our best efforts, he now requires regular hemodialysis. A number of people have offered to donate a kidney for him, so there is a likely possibility that one of them would be a match. In discussing the issue of a transplant, we spoke about the particulars of the procedure, and the post-transplant regimen, and reviewed the data on survival of transplant versus chronic dialysis. Our ongoing dialogue was about choice and method of choice. What are his values? What does he expect or want as a “quality of life”? A working-class man who has a deep appreciation for a day’s work, he said he does not want or desire perfection. He would like to be well enough to do his work. Dialysis allows him to do that. Aesthetically, the routinized, almost mechanical, dialysis treatments have more appeal for him than the medical regimen of a transplant, the effects of which are more idiosyncratic. He likes the social quality of the dialysis center, where others receive their treatment and congregate in the waiting room together. He enjoys the conversations he has with these other patients and with the staff. A deeply thoughtful man, he appreciates going through this philosophical process of choosing his treatment.

The above medical conversations are just a few of many that I have on a regular basis with patients and trainees in my general medical practice, which is based in a teaching hospital in Brooklyn. These conversations are qualitatively different than those I had with patients when I started in medicine 40 years ago. Today, my conversations are more philosophical and methodological than informational, and are much more likely to be about choice, method, value, truth and meaning than about what I know, or what I want to know from the patient, in an informational sense. Not only has the healthcare delivery system in the US undergone a substantial transformation in the last 20 years, but what doctors and patients do together has also been transformed. Although there is a relationship between changes in the healthcare delivery system and the transformations taking place in doctor-patient conversations, there are other significant forces at play as well.

Probably one of the most significant of these forces is the democratization of medical knowledge. Patients (medical consumers) have unlimited access – through the media, the Internet, consumer publications, and hotlines – to medical information and medical science. Independent of social class or educational background, most patients now come to their visits with opinions, judgments, and questions about things they have read, researched, seen on television, or heard on radio or from their friends. Although patients ask for my opinion, and most seem to give my opinion greater weight than many of these other sources of information, they do not look to me as the only source for their information. In fact, in my busy practice, I now often rely on patients to do much of the research involved in our collaborative endeavors.

Another contributing factor to this shift in the medical dialogue is the flourishing practice of complementary and alternative medicine. Patients have sought relief from health problems that mainstream medicine has been unable to cure, particularly chronic illnesses such as cancer and arthritis, and multifactorial conditions that fall outside the medical paradigm (illnesses such as chronic fatigue syndrome and fibromyalgia). Patients with these conditions, often assisted by

loved ones, have taken to doing their own research and have become knowledgeable and skilled consumers of non-western medical practices. (It is estimated that in the US, consumers now spend a greater portion of their healthcare dollars on alternative medicine than on mainstream western medicine.) Patients now often insist that discussions about alternative approaches be included in the dialogue with their physicians. For example, when a patient asked me about what I thought about the value of acupuncture for a particular problem, a discussion of what it meant to have a holistic approach versus a particularistic approach ensued.

As patients gain greater exposure to medical information, they are also exposed to the controversies now surrounding medical research and medical opinion. Witness the recent mammogram controversy. For years women had been told that, without a doubt, yearly mammograms were of great value in the early detection, treatment, and cure of breast cancer, and that if a woman neglected this important screening procedure she was not taking good care of herself. Today there is major critique of the mammogram literature, with both patients and physicians exposed to the ongoing debate about study design, data collection, and analysis. What is the professional's advice, in the face of all this controversy? "Let the patient choose."

Indeed, "patient choice" has become a mantra. Science and technology have given medicine a dazzling array of treatment approaches and a seemingly unending supply of new pharmaceuticals, which has resulted in much more effective treatments, as well as much more uncertainty. In the face of many different technologies, treatment approaches, and clinical trials that often contradict each other – evidence-based medicine notwithstanding – medical decision-making comes down to patient choice more often than not. Two years ago, I would have advised my 50-year old female patients to have mammograms. Today, I discuss the various pros and cons of having the procedure, and then leave it up to the patient to decide. To me, and to many others who espouse a humanistic practice of medicine, it is right for the patient to be choosing. But what does that really mean?

Choice is a complex issue and, I believe, a methodological and philosophical activity. Given the array of choices, in terms of treatment and diagnostic approaches, and the uncertainty that accompanies these approaches, they cannot be decided upon by simply looking at the data (the scientific facts, that is). My conversations with patients about these issues are as much about who they are, what values are important to them, how they think about the concept of "getting cured" and getting better, and other subjective issues, as they are about cognitive issues (what is "known" scientifically about these issues). For example, it is not an exaggeration to say that I spend at least 20% of my time with patients exploring their understanding of "cure" and looking at how that understanding impacts their health-seeking activity. The patient who goes from physician to physician and submits to test after test that provides neither certainty nor assistance can be helped a great deal by a philosophical/methodological discussion of the term "cure."

If choice is a methodological and philosophical activity as I believe it is, what do patients and doctors need to create answers and solutions to the complex issues being presented by medicine today? As a long-time teacher of medical trainees in medical schools and residency programs, a question that arises for me is: What do we, as professional healers, need in order to conduct such methodological/philosophical conversations with our patients? Western medical training does not prepare us to have such dialogues. Modern medical history-taking, the basic form of which has not fundamentally changed since its establishment in 1880, places great emphasis on

information exchange, quality of information, cognitive content, and accuracy. Characteristically, physicians, particularly young physicians, look to the medical interview, or conversation, to provide them with information that can be put into an orderly, systematized scientific hypothesis, which then can be objectified into a diagnosis, or a discovery of pathology. This formulation is, in turn, returned to the patient in the form of an explanation and treatment recommendation. In the last 20 years, many critiques of this method of medical communication have been written in both popular and academic literature.¹⁻⁶ Many researchers and educators have advocated and implemented new practices in an effort to reform the mechanistic, reductionistic activity of medical history-taking. Some of them teach medical professionals to broaden the informational sweep to include data about emotionality, psychosocial information, and patient understanding, thereby creating broader working hypotheses. Others focus on training patients to intervene in the history-taking process.⁷ Some medical educators such as Robert Smith emphasize a “patient-centered” care approach, while others, inspired by the Pew Fetzner Task Force, focus on “relationship-centered” care.⁸

In spite of these reforms – which have contributed greatly to focusing much needed attention on the art of medicine – the dominant view of the medical encounter is that of a goal-directed activity, the point of which is to get to “the bottom of things,” medically/diagnostically speaking. John Launer, in *Primary Care in Narrative Based Medicine* captures this dilemma very well:

“... there is a tension between the complex narrative that the patient brings into the consulting room and an apparent understanding by the doctor of what is really going on, as formulated in a diagnosis or an idea about pathology.”⁹

Conversations about choice, value, meaning, and method do not fit into our scientific processes. These conversations are about subjective issues, and subjectivity is characteristically seen as imprecise, nonlinear, disorganized, and inaccurate. In short, it cannot be objectified or generalized about to fit neatly into a diagnostic category. This subjective approach often makes physicians uncomfortable. Subjectivity is considered outside our realm of expertise. Thus, we often limit our conversations to a discussion of the medical data or evidence. However, we then turn to our patients and say “you choose” and leave it up to them to engage in this complex philosophical/methodological activity called the decision-making process, with no assistance from us.

A Postmodern View of the Medical Conversation

In helping medical professionals to have conversations with their patients that are more dialogic, that are more inclusive and responsive to patient and physician subjectivity, that are non-linear, non-goal directed or truth referential (in this sense pointless), I believe the work of various postmodern movements (narrative therapy, social therapy, social constructionism, social poetics) has something to teach: namely, how to have philosophical and methodological conversations with our patients. As a non-philosopher, non-linguist, and non-therapist, I would like to briefly attempt to say what these postmodernists have contributed to my understanding of the medical conversation.

What I have found most relevant and valuable is their writing on language/communication. In medicine, as in many fields, communication/speaking is viewed as primarily a cognitive and

interpretative activity in which language use is understood as representative and/or denotative, and always *about something*. The postmodernists have liberated us from a conception of conversation as simply information exchange and have helped to shape an awareness of conversation as a continuous, creative building activity that goes on between two or more people. It is this relational activity that shapes what is talked about, how it is understood, and what gets built.

Kenneth Gergen, a leading postmodern social constructionist, provides us with a way of viewing knowledge outside of the logical positivist/scientific box. Social constructionism, in demonstrating the social-linguistic, rhetorical, ideological, cultural, and historical forces responsible for generating the world of knowledge, challenges all claims to authority, truth, rationality, and moral superiority. To the social constructionist, we live under conditions in which we are in a state of continuous construction and reconstruction. Gergen states that we gain substantially if we consider the world-structuring process as linguistic, rather than cognitive. In *Therapy as Social Construction*,¹⁰ Gergen challenges the concept of therapist – here we might substitute health professional – as a knower or distant scientist who accurately and systematically applies rational procedures in evaluating and synthesizing information.

According to John Shotter, a postmodern communication theorist, language is primarily responsive and rhetorical rather than representational. Shotter rejects the understanding that conversation is primarily communicative and/or rule-governed. In his article “Hearing the Patients ‘Voice’: Toward a Social Poetics in Diagnostic Interviews,” he and co-author Arlene Katz describe how they use social poetics in training medical residents to creatively understand and hear the patient’s voice, and to move between the different languages – medical, professional, and ordinary language – of doctor-patient discourse so as to expand the relational possibilities.¹¹

Launer and other narrative therapists provide us with an appreciation for the rich and complex, often disorderly, patient-generated stories of illness, and show us how the inclusion of the patient’s subjective experience of illness contributes to the therapeutic process.

Social Therapy, a cultural, performatory, and philosophical clinical-practice approach within the postmodern tradition, focuses on human growth and development, as opposed to explanation, insight diagnosis, and/or problem-solving. Social therapy was founded by Fred Newman, Ph.D., a Stanford-trained philosopher of language and science, and his colleagues at the East Side Institute for Short Term Psychotherapy, a New York City-based training institute. Newman and his chief collaborator, Lois Holzman, PhD, a developmental psychologist, have challenged the epistemological bias of 20th century philosophy and have focused their attention on activity as the relevant ontological unit of human study. Newman and Holzman have been strongly influenced by the work of the late Viennese philosopher of language, Ludwig Wittgenstein and the late Soviet psychologist, Lev Vygotsky.¹²⁻¹⁶

Wittgenstein, in his later work, challenged the conception of words, and the conversation we make with them, as representational and denotative (that is, always having to be “about” something). In his work on language games, he sought to show that the use of language (speaking) is a social activity, a creative process that people engage in – perform – together. Vygotsky’s writings on language as a completion of thought contribute to our understanding of

the social/performatory nature of language. In writing about children's acquisition of language, Vygotsky posits that thinking/speaking is a dialectical unity in which speaking completes thinking: the structure of speech is not a simple mirror image of the structure of thought as it is conceived of in a representational model, nor does speech serve as the expression of developed thought as is put forth in a denotative model. Thought, according to Vygotsky, is restructured as it is transformed into speech through a social process that takes place among individuals. As a theatre director and therapist, Newman found that the activity of creating conversation, in the Wittgensteinian and Vygotskian sense, was similar to the act of people creating a play together – performance. In Newman and Holzman's view, we are all born performers. Children acquire language through performing as speakers long before they learn the rules of language and grammar. In Vygotsky's words, "they perform a head taller than who they are." Much like children who go beyond themselves when they perform as language speakers, people of all ages, when they are creating conversation, that is, performing, can transcend their limitations. They can be both who they are and who they are not (that is, who they are becoming). According to this view, this innate human capacity to perform and to go beyond ourselves is what allows people to grow and develop.

Conversation is understood as performed activity, as a journey that two or more people take together that does not have to go anywhere, represent anything, nor have a relationship to some overriding truth in either how it is conducted or its content. I have found this understanding to be most helpful in learning to have philosophical and methodological conversations with my patients.

The following is an excerpt from a recent philosophical medical conversation that I had with JW, a good friend and patient. JW is a very talented teacher who periodically consults with me about the ongoing management of what has been diagnosed over the years as chronic fatigue syndrome. Although she consults many physicians and alternative practitioners – too many from my perspective – I am her primary physician. One of the doctors she sees is a holistic physician who recently told her that, in addition to her multiple allergies, she has developed asthma.

JW: As you know, Dr X told me that I have asthma. That frightens me. He gave me a pump to use, but I don't like to use it because it makes me feel more frightened. I don't know what to do.

SM: First of all, do you think it is helpful for you to have this name, "asthma," for what is going on with you?

JW: What do you mean?

SM: I know you pretty well, and it seems that you often get very reactive to the "names" of things. One of the forms that this preoccupation takes is your asking the question, "If I use the pump, does it mean I have asthma?" You might be able to learn to use the pump more effectively if you simply paid attention to how you were feeling; and then you would be able to determine whether using the pump helps your symptoms.

JW: I am very resistant to using my pumps, even though they help when I am feeling tight. I am afraid that if I use the pump all the time, I will become dependent.

SM: What is dependent? Our good friend Bill takes pills every day. Is he dependent? What do

you mean when you say that? Bill takes pills every day so he won't get so sick that he can't do his work. In that sense he is dependent, and it is a choice he makes. Do you want to make that choice?

JW: I don't know how much of my problem is emotional. I get very panicked when my breathing gets worse, but I also know when I am stressed, which I've been a lot lately. I feel my chest tightening up and my breathing getting bad.

SM: Why do you think it is valuable to separate emotional causes and components from physical ones? A more useful way to look at the problem might be to see your lungs and breathing activity as a vulnerable area of your physiology that is reactive to a lot of stresses in your environment. If you are always focused on trying to decide whether it's emotional or physical, getting caught up in dualism, you are probably less attentive to what your lungs and breathing need and what you need to do in the way of prevention and prophylaxis. What are you doing positively and pro actively around your health?

JW: I go to an acupuncturist who is helping to open up my restricted lungs. I use the pumps when I can't do anything else. I go to a chiropractor, which helps my back. I am pulling up all the rugs, getting the air conditioner fixed, putting an air purifier in my office, and I'm back on my diet, so I'm not eating foods that provoke my allergies. Oh, and I have also started to see a therapist every other week.

SM: You are doing a lot, and it seems to me that most of these health practices are reactive to the particularities of what is going on with you. For example, when the lungs are tight, you use the pump or have an acupuncture treatment. What seems lacking here in your health regimen is an activity that would build your overall strength and energy...that would help you to move forward.

JW: I do yoga sometimes and I like that.

SM: I think that's a good practice in that it focuses on breathing more effectively and could help build up your core strength. Why don't you practice yoga more often?

JW: I get bogged down by the number and variety of health practices that I have to do, and then I just stop.

SM: I think that taking a look at your understanding of what's going on might help you in deciding which practitioners to see. You have a tendency to become anxious by the naming activity of western medicine and to become overly focused on the particularistic, "what is going on in my windpipes," for example. Consequently, a nonwestern holistic approach, with its understanding of the interconnectedness of your biological, social, emotive self – as opposed to a western one that is very particularistic, specific, and disease-oriented – might be a more useful framework in which to work on your health. There is no quick fix here. As you know from experience, creating your health is an ongoing process.

Rationale for a Performance-Based Approach to Teaching Medical Communication Training

For many years, in the US at least, the dialogue over teaching communication and interpersonal skills (C/IPS) to medical students and residents centered on whether this area of medicine contributed in any significant way to the training of physicians. Those who favored IPS training devoted their efforts to convincing the academic decision-makers that the “soft” skills of medicine, namely, speaking and relating to patients, should be given the same priority in medical training as the more scientifically oriented skills, such as the physical examination, medical procedures, and clinical problem-solving. Fortunately, the advocates of IPS training won the day. Today, virtually every medical school and primary care residency training program in the country have mandated courses in medical interviewing and IPS training.

The terrain of the dialogue has now shifted to the more interesting question of how to teach these critical doctoring skills. It is here that I think the work of the above cited post-modernists, particularly the performance-based approach developed by Newman and Holzman, has a great deal to offer the medical profession. As C/IPS training has been introduced into medical school and residency-training curriculums, it has not surprisingly attempted to conform to the cognitive-behavioral model of the rest of medical training. That is, there is a discrete body of knowledge being developed that is known as behavioral/psychosocial medicine, specific measurable skills that are identified as being essential to a good patient-doctor interaction, and a body of research that attempts to abstract and quantify elements of a successful transaction. Examples of this is the effort by the American Board of Internal Medicine to use a computer simulation model to develop an evaluative tool for psychosocial skills of newly graduating residents and efforts to develop standardized tests for grading medical students in the area of C/IPS. The claim of many of the medical educators working in the field of C/IPS is that all or most, of the medical transaction is knowable, measurable, and teachable like a science.

Although the acceptance of C/IPS as a legitimate component of medical training has been gratifying for those, like myself, who went through the curricular wars of the 1970s and 1980s, the tendency to develop a discrete curriculum on communication and relationship-building that can be learned, known scientifically, and taught cognitively and behaviorally, is problematic. For one, it leads to a separation between those elements of the transaction that can be rationalized – activities of doctoring such as accumulating data, ordering data, making diagnostic hypotheses and formulating scientifically-based treatment plans – from the relationship-building activity of medicine that is not so easily rationalized in spite of the best efforts of medical educators. I find this expression of dualism problematic in that it does not occur in life. Ian McWhinney, in the Pew-Fetzer Task Force Report, notes that “...in describing an integrated approach to health care as merely attending to psychosocial concerns, in addition to biomedical concerns, is both misleading and perpetuates the reduction of complex problems and situations to abstractions... even the term *bio-psychosocial* could be taken to imply that human experience consists of three separate realms.”

This dualistic way of viewing our medical interactions is understandable. The pedagogy of scientific medical practice is about acquiring and interpreting evidence, using it to develop a hypothesis about disease, and testing to validate the hypothesis. On the treatment end, the patient is educated on the nature of the disease and given instructions based on a scientifically derived

treatment plan. In contrast, the pedagogy of relationship-building involves learning about subjectivity, which is idiosyncratic and personalistic and does not fit into the scientifically informed, rationalized scheme of information exchange that physicians learn throughout their medical training.

Although lawfully arrived at, given that physicians spend the bulk of their training in scientific medicine, this separation of realms of activity holds back our endeavor to teach physicians C/IPS and, I would contend, profoundly impacts their ability to perform as competent healers. It is not that physicians reject the importance of relating to the patient as a person and getting to know patients in all their particularity, but rather that physicians simply do not feel they have enough time to devote to this kind of activity. Whenever I speak to a medical gathering on the doctor-patient relationship, practicing physicians, residents, and even students who know almost nothing about practice say to me, “What you are saying is valid, important, and true, but we simply don’t have the time to do this.” In deconstructing the “this” of their statement, one finds that the “this” is everything involved in getting-to-know-the-patient, including what the patient thinks and feels about things, medical and otherwise; that is, their subjectivity. The assumption is that patients really come to physicians for their scientific knowledge and approach. Because physicians, for the most part, control scientific knowledge, there is also an implication that it is the doctor who should determine what the visit is about. This assumption has been called into question on many levels. For example, medical communication researchers such as Roter, Greenfield, and others have shown that greater patient involvement in the medical interaction results in better outcomes and greater patient satisfaction.

Physicians, by virtue of their lengthy training in scientific medicine, are always going to place greater value on scientific doctoring over patient-centered, relational activities. As a consequence of approaching these two activities separately, physicians, particularly those without experience, become overly reliant on information qua information as a therapeutic tool. “I did my job. I told the patient what was wrong and what they should do.” By the same token, there is an undervaluing or unresponsiveness to what is going on between patient and physician qua the relationship-building process (and how that process contributes to outcomes). Trainees are often insensitive to or unselfconscious about elements of the interaction that impact subjectivity, that is, the relational activity that generates trust, friendship, empathy, fear, anxiety, dislike, or anger.

In an information-based system, it is difficult for them to see that the process by which information is obtained is as important, or perhaps more important, than the information itself.

An additional problem of dualism, with its hegemony of scientific doctoring, is that it fosters an understanding that there is an objective truth to be learned about the patient’s illness. There is an assumption that if enough data are collected and the right questions are asked, a “true” rendition of what is going on can be determined. This is an assumption that requires the patient to provide the physician with an account of his or her problems that fits into the physician’s conception of how an illness or disease should behave. This search for the truthful or accurate account often excludes the patient’s subjective experience because it cannot be objectively verified. Thus, the wealth of patient experience – their personal knowledge about the working of their bodies, their emotionality, their capabilities – and their capacities is not available for use in the service of healing.

In introducing a performance-based approach into the pedagogy of C/IPS training, we wanted to challenge the dualism of medical practice. The “performance of doctoring” approach is radically monistic in that it makes no separation between scientific doctoring and relational activity. This approach views the medical encounter as a continuously creative activity in which the doctor and the patient create the visit together. The material for this doctor-patient play is provided mostly by the patient. The scene that evolves is one which can be created by two or more very different people who bring to the encounter all the complexity and richness of their varying perspectives, areas of knowledge, cultural beliefs, expectations, and so on. The process of production is continuous from one visit to the next and is shaped by the ongoing dramas of the participants’ lives. Within the space that doctor and patient create together, information is given, meaning is created, diagnosis and decisions are made, and support, empathy, and treatment are given as a seamless ongoing activity.

In creating a performance-based approach to C/IPS, we asked the following questions: How do we teach young physicians and students who are completely immersed in the scientific method to appreciate, in a practical and critical sense, that the activity they are engaged in with patients is a continuously creative process that does not distinguish between the subjective and objective? How can we help residents come to understand the relationship-building process as a vital and inseparable part of their doctoring as scientist activity, as opposed to the current view that it is something to be attended to or added on when they “have enough time.”

Through collaborations with practitioners of social therapy, I have developed an appreciation for performance as a therapeutic/developmental approach that is not grounded in the scientific method. In searching for a non-reductionistic method for teaching the unscientific skills of relationship-building as something continuous and inseparable from the scientific activity of medicine, the performance-based approach was appealing. It allows young physicians to discover that in performance, they can go beyond themselves to develop as skilled relationship-builders, while at the same time being who they are, doctor-scientists.

Description of the Performance Training Project

In October 1997, my hospital contracted with Performance of a Lifetime (POAL) , a performance school and training center based on social therapy principles, that teaches the skills of improvisation to corporations, social service agencies and, increasingly, medical professionals, to provide C/IPS training to our medical residents. The POAL training team that has come to the hospital over the past five years is led by a professionally trained and highly accomplished actor and director.

Training for the first-year residents consists of eight weekly hour and a half sessions for 10 to 12 residents. The classes start with a relaxation exercise and movement warm-up. The orientation session is a group interview in which residents share their performance history. Did they play the violin in the second grade? Do they sing in the shower? In subsequent sessions, the POAL directing team guides the ensemble in a series of improvisational exercises and games. In each session, time is devoted to reviewing videotapes of resident-patient encounters. Residents are encouraged to approach these encounters as scene studies and to use the language and concepts of improvisation to talk about the interactions. Residents are also asked to re-perform certain aspects of the scene with direction from their POAL director.

Based on our experience, Performance of Doctoring, as this training program is called, addresses the subjective-objective, mind-body, inside-outside divisions of medicine in a way that cognitive-behavioral approaches currently being used to teach C/IPS do not.

The Language of Improvisation

One of the major elements that differentiates a performatory approach to training C/IPS skills from a cognitive-behavioral approach is the introduction of the language of performance and a view of the medical encounter as a performance. For example, a key concept in the lexicon of improvisation is the offer. In improvisation/performance, the performer makes an active move – a statement, gesture, sound, facial expression, even silence – to which the other performer(s) responds. The responses, in turn, become new offers through which the performers collaboratively create and build the performance. In responding to an offer, there is no separation between objective information and subjective material. The offer is simply what your fellow performer gives you to build with. In Performance of Doctoring, residents learn not only the language of improvisation, but also the skills of observation, listening for, accepting, and building on what another performer offers. Offers, responses to offers, and responses to responses to offers, create the medical performance. They can take all forms, including an offer of or response to medical information. In Performance of Doctoring, improvisational games and exercises are used to help residents develop listening and building skills. For example, in the “*yes-and*” game, a basic improvisational exercise, each participant adds one line to a collective story that was begun by one person in the group. Each person responds, “Yes, and...,” making his or her own contribution to the story without negating anything that has come before it. The rules of the *yes-and* game require that each person accept the preceding person’s contribution, the yes, and build with it, the and. One may not negate the other person’s contribution, and everything that is offered must be responded to as if it were true. Physicians, by virtue of their training, are very good at listening for selective information that they can then interpret and fit into their diagnostic or disease-referential framework. They are not so good at attending to and building upon, the totality of what the patient is offering. Practicing a *yes-and* methodology helps physicians-in-training to develop the skills of active listening and an appreciation for the medical encounter as a building activity that they are doing with another person. After playing this game for a short while, residents can identify, in an improvised scene or videotaped encounter, when a *yes-and* activity could be helpful.

Videotaped doctor-patient encounters are also used to help residents view their interactions with patients as performances or improvisations. Looking for different offers, different ways of responding, and different performances helps them to see that there is a wide range, in fact, an endless range, of conversational possibilities. Additionally, they discover that if a scene is not going well, it can be redirected and played again. In their training as scientists, physicians are taught to value objective evidence, that is, to evaluate their methods against scientifically correct ways of doing things. Much of their academic lives are devoted to finding and giving information that is scientifically correct – the right answer on the test, the right diagnosis, the right treatment, the right response to board questions. There is little room in this model for creativity, or even for uncertainty or ambiguity. The script that medical students and trainees receive to guide them through their interviews with patients is given to them as a scientific tool – the right way to collect evidence. Although the “medical history” may be the best way, for practical and scientific reasons, to order data, it is an error to assume that the conversation and

interaction that produces the information can be reduced to a “right” way or method. The medical conversation, like most conversations, is unpredictable, non-rational, and idiosyncratic. The conversation is between two people who bring vastly different perspectives, knowledge, understandings, belief systems and emotionality to the interaction. Given that the medical conversation is a co-construction, there is no formulaic method that can be imposed from outside. The possibilities for conversation are limitless. The only correctness in this process is that it be co-created by the participants.

Our performance approach is grounded in an understanding that creating a conversation (relationship building) is a social-cultural phenomenon and that it is best studied and taught using cultural approaches. The problem with cognitive-behavioral approaches to teaching C/IPS is that they are taught like a science, that is, as content that can be abstracted, studied, and applied as generalizations. To apply the scientific method to something that is fundamentally interactive and relational supports it being a doctor-directed show that excludes patient subjectivity and inter-subjectivity. By teaching improvisation and performance we are attempting to give our trainees a method through which they can make use of all that is known, in a cognitive sense, about patient behavior, physiology, anatomy, and therapeutics, while simultaneously responding to subjectivity as a vital part of the health-producing activity.

Science and technology have given, and continue to give, medicine a dazzling array of tools that are invaluable to physicians’ healing activities. The task of clinicians is both to know these tools in a cognitive and knowledge-based sense and to engage in a process with patients – in the broadest sense, family, friends, and community – to determine how these tools are to be used in the service of healing. It is the doctor and patient together, within the context of their relationship, who create the illness, its meaning, and the solutions.

This process of meaning-making, we contend, is a cultural and subjective process that cannot be taught or learned as a science. As a process, it is constantly changing and developing, and, in spite of efforts to do so, it cannot be reduced to reified elements.

Summary

Physicians speak to patients in the way that they have been trained – as scientists. This mode of medical conversation is coming under scrutiny from the public, the insurers, and, increasingly, from the profession itself. Performance of Doctoring provides an environment in which residents can experience the cultural dimension of medicine, where they can go beyond their role as scientists, and self-consciously engage in a relational activity and performance with their fellow residents and their patients. Given the shift in the medical conversation to more philosophical and methodological concerns, we feel it is critical to physicians’ development as healers to be sensuously engaged in this cultural dimension of medicine as an integral part of their doctoring activity.

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