

## **Creating a New Performance of Health**

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I am a practicing general internist, known as a primary care physician. This year I will be completing my 50th year of medical practice as a medical educator and clinician. My confession as a 'medical man' is that I have a passion for the medical conversation. I am always behind in my schedule, not because of the 15-minute allotment, but rather because I take such pleasure in talking with my patients.

Fifty years ago I went into medicine because I wanted to help people. Although I did, and still do have a great appreciation for medical science and the tools it has given to us to help people who are ill, the hook for me was the human dimension of health and healing. As a helping professional I wanted to interact/relate to other people and as a daughter of communists, a red diaper baby, health-care-for-all was my guiding force.

To me, the practice of medicine is and always will be a relational activity -- a subjective, cultural, historical activity that includes science and its methods, and the people who use them. In the early 20th century there was a strong movement to put medical practice on a firmer scientific footing. The Flexner Report was issued in the 1920s that mandated guidelines for the training of physicians that established the scientific basis of medical practice. This movement was spawned by a desire of the medical establishment to professionalize the practice of medicine and to differentiate --some would say exclude -- it from the myriad of healing practices and practitioners that were an integral part of healing in 19th century America. Entering medical school in the late 1950s, I was taught that there was pre-Flexner medicine (to be shunned) and scientific post-Flexner medicine (to be embraced). The highest calling for a physician was to go into research. On the low end of the hierarchy were the family doctor and/or the primary care specialist to whom we all referred to derisively as the LMD (local medical doctor).

The tenure of purely scientific medicine had a relatively short life, and many practicing physicians did not buy into it at all. Purged of the subjective, what many call the "art of medicine," medicine lost its humanity, its capacity to heal. Along with this turn, the

doctor/healer lost his/her revered position in society and millions of people, newly enfranchised health consumers, simply turned their backs on scientific, western medicine. There was recognition within the profession, and from the public, that somewhere in the drive to put medicine on a sound scientific footing the patient had gotten lost.

The 1960s and 70s was an exciting time for me. Both professionals and consumers were talking about, writing on, and experimenting with practices that addressed the question of how we could create a more humanistic practice of health and healing that was still grounded in science, but that also included the patient. Perhaps it wasn't articulated this way, but many were asking: How can we include the subjective side of medicine -- that is, the thoughts, concerns, sensibilities, cultural beliefs and practices, and the emotionality of our patients and ourselves as healers -- in the medical conversation.

Since this vibrant period known as the 1960s, there has been a vast rethinking of the medical endeavor, as well as a proliferation of critiques of the medical model, of scientific medicine, and of our model for health-care delivery in the US. These critiques have come from different perspectives and different disciplines:

A few that I have found particularly interesting come from bio-ethicists Alfred Tauber, Eric Cassell, and Carl Elliott. Their criticisms address, from a methodological/philosophical perspective, the inability of the medical model to address suffering. Their point being, while scientific medicine has brought enormous advances in medical knowledge, its method of abstracting, classifying, measuring, and diagnosing disease, has removed the person who is suffering the dis-ease from the process.

Atul Gawande and Jerome Groopman, both popularly known through their writings in *The New Yorker*, present their critiques from the vantage point of the clinician. They feel that our training in scientific medicine has taught us ways of seeing and being, for example, to always have "the right answer", the correct explanation, to not make any mistakes, to excel in the cognitive arena, which does not allow for the broadest range of observation and thinking, i.e., to really look. Our training shapes the medical gaze. It is very narrow and only sees limited possibilities for what is going on and what is possible in the way of health and healing. It excludes much from our view, including the patients' very own observations and assessments of themselves, as well as our own subjective experiences as providers.

One of the best commentaries on American medicine I have read is “The Emperor of All Maladies: A Biography of Cancer” by Dr. Siddhartha Mukherjee. In this compelling, yet-to-be-completed narrative, Mukherjee looks at cancer as a socio/political/ cultural/ scientific entity and shows how much extra-biological phenomena have shaped how we understand and relate to cancer in all its complexity here in the US.

Another important contribution to the growing body of literature critiquing contemporary medicine are the many hundreds of patient narratives of illness—from doctors as patients, therapists as patients, children as patients, patients with cancer, diabetes, chronic fatigue, etc. Many of the narratives that I have read address, some very passionately and eloquently, the dehumanizing experience of illness, including their interactions with those who are supposed to help them, as well as, the humiliation of being ill within an increasingly uncaring bureaucratized and fragmented health care system.

It seems important here to expand upon what I and most western-trained medical professionals mean when we talk about scientific medicine or the medical model. It is an understanding of disease as an objective entity -- a thing that can be abstracted, studied, generalized about and measured. The objectified disease can also be named and classified, and there is an assumption that it is the same in everyone. As Thomas Sydenham, an early proponent of scientific medicine, said, “disease is the same in Socrates and in a simpleton.”

Based on the above understandings of what disease is, there is an assumption that we can know what it is, and then, properly classified, we will be able to know what to do about it. The activity of doctors and healers is to appropriately and expertly identify, classify, and explain the illness/disease and then make recommendations as to how to fix people up. Patients and doctors share this understanding of the medical endeavor. If you have any doubts, just listen! The doctor: “I just want to find out what’s wrong, so I can help people get better.” The patient: “Hey, Doc! Just get rid of what’s ailing me; fix me up!”

Not being in the business of critiquing the critics, but wanting to learn why, it’s important to ask: Why -- with all of its reforms, as a woman dominated profession, and with communication skills a required part of every medical curriculum – has the practice of medicine been impermeable to change? After fifty years of reform, the medical model still prevails. It is a practice driven by diagnosis, problem- solving, measurement, and explanation. Clinicians search for causality and then reduce the

complex social, cultural, biological, emotive experience of illness to an explanation or diagnosis.

To begin to understand how this has happened, we have to look at the impact of the role that psychology has had on the medical profession. Almost all of the doctor-patient literature/interventions etc. are informed by psychology and psychology from its birth has been informed by science. It is an approach dominated by taxonomy, classification, naming, diagnosing, abstracting, and explanation. The Diagnostic and Statistical Manual of Mental Disorders (DSM) reflects this pseudoscience. In its efforts to establish itself as a science, psychology has all but purged itself of subjectivity.

Interestingly, as medicine turned to psychology for help in understanding the human organism, I looked for and discovered help in my quest to discover a humanistic practice of medicine from a postmodern, performance-based, cultural-historical-therapeutic approach to human development and learning called Social Therapy, which some have characterized as an anti-psychology.

Early in the 20th century, Lev Vygotsky, a young Soviet psychologist at the dawn of the Russian Revolution, was charged with creating a new psychology, an approach that could address the under-development of the masses of Russian people—illiterate, poor, and parochial. Vygotsky, in some sense, had to create a new psychology for the revolutionary tasks at hand. In his earliest writings, he declared that he would not abandon subjectivity in this quest. The appropriate material for study was human subjectivity and his method of study was one that could both look at and include subjectivity. Vygotsky's work was suppressed for many years by Stalin and rediscovered some 30 years ago in this country. His is an important voice in academic educational circles.

I would like to now fast-forward to when I first met the East Side Institute, Fred Newman, Lois Holzman and Social Therapy. I arrived in NYC in 1980, a veteran of the curricular wars to bring a more humanistic sensibility to medical education. I had quit a tenured position at University of California Medical School over a fight for more time for psycho-social teaching in our programs. In New York, I was hired by the Albert Einstein College of Medicine as director of a medical clinic at a large affiliated city hospital in the Bronx. There I met ESI faculty, not in a therapy office, but on a picket line. It was a cold January day, and many of the progressive health care professionals at the hospital were out on the line protesting the impact of cutbacks in services at the hospital initiated by the Koch administration. In meeting my future ESI colleagues this way, I

was drawn to them as activists, progressives and people who were serious about social change.

The ESI was founded in the early 1980s by Dr. Fred Newman, a Stanford-trained philosopher of language and science and Dr. Lois Holzman, a developmental psychologist. They, along with other NYC-based colleagues, developed a theory/practice of Social Therapy that engaged contemporary psychology/psychiatry's exclusion of the subjective. Social Therapy is a cultural, performatory, and philosophical clinical approach within the postmodern, radical therapy tradition. Social Therapy's task, as articulated by Newman and Holzman, was not to explain, get to the bottom of things, create insight, diagnosis, or problem-solving, but rather to help people grow, develop, and become better at creating their lives.

Newman and Holzman are Vygotskians. Holzman as a developmental psychologist brought Vygotsky into their relationship -- both were strongly influenced by Vygotsky's work on thought and language. It was through Vygotsky and the work of Viennese philosopher Ludwig Wittgenstein that they began to explore the social-performatory nature of language and discovered performance as central to the process of human development. 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. Just as children go beyond themselves when they perform as language speakers ("perform a head taller than who they are"), people of all ages can do this. When we are creating conversation, that is, performing, we can transcend our limitations, go beyond ourselves, explore new ways of being, and create new things. We can be both who we are and who we are not -- that is, we can perform who we are becoming. According to Newman and Holzman, this innate human capacity to perform and to go beyond ourselves is what allows people to grow.

We are all performers, and yet in life most of us do not perform. Performance is relegated to the professionals. Young children perform/play all the time and make enormous leaps in learning/development. At some point in our lives, children go to school and are told that it is time to grow up, to stop playing around, stop performing/pretending/creating their world and to get down to the serious adult activity of learning. We are not supported to go beyond ourselves, but rather to behave. Social Therapy is a practice that supports people to perform new emotions, new ways of being, new conversations and to grow our atrophied performance muscles. Performance cannot be done alone. It is a social activity. Creating the ensemble, the environment, the

production, the group is (in Vygotsky's words) both "tool and result" in human growth and development.

I could speak for hours about the many ways that the work of Newman and Holzman has shaped my work as a physician--from what I do in my day-to-day work, how I think about and approach the medical endeavor, and where I locate health and healing. Relocating health and healing in the broader world has brought me into entirely new arenas of work outside of my office--producer of a senior theatre group, workshops on healthy aging, and as a development officer (fundraiser) for the ESI, being just a few examples.

I want to talk today about how performance has changed my relationship to the medical conversation. Fred Newman was my patient for 30 years, and until he died 6 months ago we would have ongoing conversations about the practice and method of medicine. In one of our early conversations, I told him proudly that I had been successful in introducing a course on doctor-patient communication into the curriculum for resident training at my small hospital in Brooklyn. (My pride being that I got them to pay for it.) Fred congratulated me, and then said he did not get it. What did he not get? When I looked bewildered he said, "Susan, that is what medicine is; healing resides in the conversations between doctors and patients. What else is there? How can it be separated?" I thought to myself, "Perhaps this is where medicine had made its wrong turn."

Interpersonal skills (IPS) training, after many years of being relegated to the periphery of the medical school curriculum as being "too soft," is now an integral part of medical education and every academic internal medicine training program in the country. Curricula in IPS are designed with the same approach as any other academic endeavor in the school of medicine. The assumption being that there is a body of knowledge to be imparted along with specific skills that can be taught behaviorally, through role-playing and case presentations with discussion. A formalized set of items specific to doctor-communication were developed called the OSKI's and the presumption was/is that skills such as using open-ended questions, personalized introductions, eye contact, and accessible language were something that can be measured, quantified, and taught behaviorally.

I, like many of my fellow IPS trainers, used these methods. Though as I developed as a conversationalist, my listening skills, my performance skills seemed distant from what I actually was doing with my patients in the office. One day while listening to a very

deadly and un-intimate role-played conversation between two of my resident trainees, out of sheer frustration I said: "Why don't you guys pretend you are friends at a dinner party and just talk to each other." This direction was literally transformative. The young people actually began to talk to each other. Being doctors, they had a somewhat health-oriented conversation, as I imagine they do in real life, but they talked to each other like human beings.

With this move, my work with the ESI and my work as a clinician-educator began to come together. In October 1997, I proposed that my hospital contract with Performance of a Lifetime (POAL), a performance school and training center that used principles of social therapy to teach skills of improvisation to corporations, social service agencies, and to provide IPS training to our medical residents. They accepted my proposal and the POAL team came to the hospital for weekly trainings where they taught medical residents the skills and practice of improvisation. For one hour a week, the residents were allowed to play with each other, through improv games, warm-up exercises and scenes, ridiculous and strange. Most, of the trainees, I was surprised to see, were fairly game, even those from the most conservative cultures. They participated fully. As the project progressed, we added videotaping of resident/patient conversations and looked at them through a performance lens.

The Performance of Doctoring project ended after five years as budget cuts removed the support we needed to make it work. Like much of what we have learned at the ESI, what we discovered with this small project was inseparable from the process of discovery. It was a developmental process where practice and theory emerged in a nonlinear, random process. Newman and Holzman would describe this as a practice of method, and I am still learning/developing with this project that formally concluded over ten years ago.

Did the performance of doctoring and training transform the resident trainees' interactions? This would be difficult to say. The program was disorganized, and attendance varied and I am not trained as researcher, so there were no formal evaluation tools. What I do feel confident in saying is that the trainees got a glimpse of a different approach. In our video tape reviews, they could see that there were more conversational options available to them than they had supposed. And I hope they felt more relaxed in their interactions as they moved on to become practicing physicians. A few of the things I discovered in the Performance of Doctoring project:

The opportunity to play and perform with young becoming-physicians gave me some insight into how our medical training shapes our activity as healers. The doctor as knower is an authoritarian model. It leaves out the patients' concerns, understandings, self-knowledge, i.e., their subjective experiences of illness and disease. Our concern with "getting to the bottom of things" dampens our appreciation for the relational activity that is taking place, i.e., the subjective aspect of healing.

Another was an appreciation of how methodological dualism -- mind-body, inside-outside, etc. -- permeates our doctoring activity. In introducing a performance-based approach into the pedagogy of IPS training, we were challenging this dualism of medical practice. The "performance of doctoring" approach is radically monistic in that it makes no separation between scientific doctoring and relational activity. As a performance, the medical encounter is a continuously creative activity in which the doctor and the patient create the visit together.

Time is a constraining construct for physicians. In presenting this work to them, I am often told by physicians, "I can't spend all this time talking to the patient about personal things/subjective issues—things that I don't think are important-- because I don't have enough 'time' to do that. Don't you know this is the age of managed care and the 15-minute encounter?" These questions of time become irrelevant when the focus is on performing the conversation. What we do in the time we have is create a conversation with our fellow travelers, where we might or might not get to the "bottom of things." We might come up with a way of doing something, health-wise, that is transformative, or it might be of no use at all. What we are doing is a health activity that has something to do with the development of our health -- discovering new ways of being, of relating to our health issues, and identifying new possibilities for relating to our bodies and ourselves. This, I might add, is not a traditional model for the relationship between healer and the person healing.

For me, personally, performing conversations with my patients is a great deal more fun. Physician burn-out is real. Creating a performance with my patients, each one a unique "show," has brought a great deal of joy into my work and into my life. When the five-thousandth patient with a cold or respiratory infection comes into my office, it is transformative to say, "What are we going to create today?"