

## Narrating Our Selves: Eric Elder Lecture Presented at the annual conference of the Royal New Zealand College of General Practitioners, July 2016

Dr Lucy O'Hagan MBChB, DGM, DipGP(dist), FRNZCGP, Cert Narrative Practice



This paper is a wondering about us, doctors, and how we come to be who we are. I am not an academic. This is my lived experience of becoming and being a general practitioner (GP) for over 20 years.

I'm not even a very good GP. My patients wait, I get stressed and grumpy with my staff, I read hospital letters about 'CVKPDs' and even Google doesn't know what that is. But I do love general practice. I love the uncertainty of it, the great mix of humanity, how we seldom make a diagnosis that makes much difference, but still something happens.

This paper is about stories; how we make sense of the world, how we narrate our selves, by being in stories. Stories weave us to each other, to past and future. This woven nest of stories tells us who we are as doctors, how doctors ought and ought not to be. Some stories of being a doctor are spoken, many are not; some stories are honoured, others are not.

I could tell you stories of rural practice: rescuing an injured climber from a cliff top, in a farmer's helicopter with a haemorrhaging woman, a car accident in the dark where my neighbour lies broken. These stories have specific events, named characters and a plot that we recognise as part of a larger narrative, the Heroic Doctor narrative. These are stories about real doctors.

We come to medicine with our own stories - from our culture, our families, our lives, from the Bible, the Koran, Grimm's fairy tales, stories handed down from our ancestors. These stories showed us how to be human, how to be good, what was important. Before medical school we

had heard stories about doctors and sickness. We had been patients, we knew about miraculous scientific cures and we had absorbed the TV Doctor narrative. When I entered medical school doctors were like Dr Kildare. They were suited, white males, who had good teeth and looked like they were getting a lot of sex; rugged diagnosticians with a kindly edge.

The problem was that I didn't look like Dr Kildare at all. I was 19, had 3kg of wild hair, and large bone earrings. We were the 'girls can do anything' era.<sup>1</sup> My medical school class had more than half women, for the first time ever. But I don't think I saw a woman doctor until my 4th year of medical school. She was a GP, pragmatic and kind, she wondered rather than knew, she laughed. But she was rare. In my training women doctors were absent, not visible.

The profession was in a gentlemanly panic: 'How can women be surgeons and have babies?' 'Doctors can't work part time and be any good'. A 1983 magazine article about us, this strange phenomenon of the future, the female doctor, showed a very young female model dressed in surgical scrubs. The title of the article was 'Would you trust this woman with your life?'<sup>2</sup>

When I set up a rural practice with a friend in 1995, we were the first female doctors the town had seen. People rang and asked things like 'does your doctor write prescriptions?' and 'do you guys stitch people up?' Luckily the feminists wanted us. Female doctors would understand hot flushes, and provide hand mirrors for viewing one's cervix.

Back in medical school, it was hard to see how I could be me, and be a doctor, as if under my

J PRIM HEALTH CARE  
2017;9(2):100-104.  
doi:10.1071/HC15925  
Published online 30 June 2017

**CORRESPONDENCE TO:**  
Dr Lucy O'Hagan  
lucyohagan@gmail.com

white coat 'me' had to disappear. This Invisible Doctor narrative played out in many stories. At the end of every clinical attachment, we received our assessment on a single piece of A5 paper. I learned I was 'Satisfactory' because the options, 'Very Good', 'Good' and 'Unsatisfactory' were all crossed out. This was the total formative assessment. No other feedback at all.

What did I need to do for 'me' to be seen? Clearly my array of colourful outfits wasn't enough! The consultants who taught us often did not know our names or acknowledge us in the hospital corridor or cafeteria. It was as if we were not visible. Now I understand that the professor who could not see me was himself unseen. We were two disembodied white coats walking past each other.

The Biomedical Brainbox was the dominant narrative of medical training. These were stories of doctors who were highly competitive, cognitive, expert diagnosticians, who knew what to do, and got the dose right. The Biomedical Brainbox is still, I think, the most revered, the gold standard of how to be a doctor<sup>3</sup> which is problematic for GPs, because I recall that we make a diagnosis only ~40% of the time, most often the common cold. I also recall fine that the rest of the time we are doing something else, something really important.

In medical school we had the Biomedical Brainbox drilled into us in a strange form of education called 'bedside teaching'. The method was simple: publicly interrogate the student to the extent of their knowledge, then one more question, just to humiliate them. We were learning to avoid the Shamed Doctor narrative, the shame of getting it wrong, not knowing. I still have an internal audience of my professors accompanying me in my head. Sometimes they are useful and kind but more often they shame me. *'Look at you now, doctors don't swear in front of patients or crack jokes. You should know what the CVKPD is Dr O'Hagan. You are winging it aren't you?'*

The Reflective Patient Centred Doctor narrative was unheard of in medical school. We rarely saw kindness. Empathy was talked of but we often took part in stories of appalling brutality.

The patient who was not in his bed for the ward round, was simply humiliated, examined publicly, in the hospital corridor, gown up, testicles evaluated. The delirious old woman wailing from her bed *'help me doctor, help me doctor'* as the ward round turned, grandly abandoning her for the next room. The man who boldly asked the professor *'Excuse me doctor, I was just wondering what was wrong with me?'* The white coat momentarily paused, switched back and barked *'You've got cancer. Are you happy now?'*

A white coat without a person inside? A culture that excused brutality so long as you met the Biomedical Brainbox gold standard. There were only one or two teachers who were different - gracious gentlemen who quietly looked me in the eye and saw me. And smiled.

Fortunately, we medical students stuck together, supported each other, laughed, resisted. My friend Paddy and I spent a lot of the time crying in the toilets. We knew we could not cry anywhere else. Doctors didn't cry.

Except recently I met a patient who carried the most unbearable suffering I have ever witnessed. Decades of physical and mental anguish. The patient was grieving the loss of a previous GP, who had left the practice. I asked *'What was it that he did that helped you?'* After a long pause: *'When he did not know what to do, had nothing to offer me, I could see a tear in his eye.'* I doubt he learned this in medical school. We learned the Deeply Detached Doctor narrative. We learned to ignore suffering, to box up our emotions, to detach from our intuitions and our bodies, pushing on, working harder and longer, without a chink of vulnerability.

I had osmosed the Deeply Detached Doctor narrative way back in 3rd Year. Six weeks after my brother, Sean, was drowned crossing a river I walked into my first ever post mortem. The dead body of a drowned man lay on the table. I felt the violent roar of the circular saw cut through his sternum, the blade open his trachea, and finally the pathologist excitedly exposing the critical evidence of drowning, froth in the trachea, the man's final struggle. I knew only that my story should stay invisible under my coat.

I also kept my story hidden in 4th year at the psychiatric hospital where I had visited my own sister, Mary. She had been there many times with recurring mania. The ward had an assessment room where the whole team gathered on one side of a pane of one-way glass, watching the registrar

interview the new admissions. Many years later I wrote a poem about it (Box 1). Looking back I felt discomfort at the professionals hiding behind glass, keeping ourselves safe, our behaviours unchallenged, our assumptions unexamined. I was learning that in the Suited Professional Doctor narrative, we decide who is sick and who is not, who is entitled and who is not. We have privileges, a special relationship with society, we are trusted with public money. To belong in the group, the Suited Professional Doctor must practice at an acceptable biomedical standard, observe professional boundaries and follow particular legal and ethical mores. We were taught the Suited Professional narrative in a series of cautionary tales. Stories of doctors outside the group; mentally unwell doctors, doctors who made mistakes, got it wrong, had addictions, burnout, who transgressed boundaries, fell from grace, became outsiders. The Shamed Doctor narrative.

Yes, being professional is important. Sometimes we need to be heroic, invincible and detached, and sometimes, even in general practice, we need to be terribly clever Biomedical Brainboxes. But in general practice we find ourselves in very different stories to our hospital colleagues. Stories of un-diagnose-able suffering, stories without obvious answers, stories where we need to take off our metaphorical white coats, and feel, and be, us.

It was GPs who showed me how I might be a doctor. They were warm, enthusiastic, teachers; challenging, thinking differently. Patient Centred Medicine was a revelation: someone was willing to imagine a different way of being a doctor. I read McWhinney's Textbook of Family Medicine<sup>4</sup> in one sitting. Patient centred medicine did challenge the old narratives, but according to Gothill '*created a strange paradox ....a person centred doctor who was not yet themselves a person.... a Dr No Body*'.<sup>5</sup>

Working in a small rural community as a very young GP, this tension between Dr No Body and my own person became absurd. To start with I thought I had to look like a doctor when I was not at work. I caught myself not going to the supermarket in my gardening clothes, not dancing

## Box 1.

At 8.30 every morning

We gathered

On the sunny side

Of the one-way mirror.

We were us

Professional kin

Dressed for dispassionate observation of them

Us, them, the glass, all untouchable.

But I found I wanted to scream,

To reach through

That impenetrable safety glass

For had not my own disheveled sister

Sat in that observation box

Naked

Except for a green hospital gown

Gaping at the back

Revealing her soft pale skin

Exposed for dissection

Her unconsenting story

To be surgically excised

Creating a wound

They would kindly dress

Twice daily

With stellazine

But I did not scream I wept for my lost innocence

And they saw my tears and they wanted to undress them

Kindly examine and excise them

Categorize and pathologize them

But I did not trust their methods

I would not disrobe my story

For I saw how easy it would be

To graduate

On the wrong side of the one-way mirror.

at the pub: I wouldn't look professional. I once had 12 friends for dinner - 10 of them had consulted me as a doctor. Patients in small towns are not 'other', they are 'us'. Doctors in small towns are not 'other', they are 'us'. There is no glass wall. I was 'me' inside and outside of work.

Later I studied medical anthropology and the philosophical basis of general practice. We read American oncologist Eric Cassel who rather boldly asserted that *'the fundamental goal of medicine is the relief of suffering'*.<sup>6</sup> We have powerful biomedical tools that can and do relieve suffering but sometimes the CVKPD doesn't work or wasn't the right thing or the technician was so rude to the patient that even though their affliction was cured, the experience itself created more suffering. Sometimes there is no CVKPD to offer and we are marooned, alone with a suffering patient. What if our computer software had a new question to answer in every consultation: *'What is this person's suffering and how might it be relieved?'*

A worried GP told me a story about a patient who failed to attend investigations for suspected bowel cancer. He described him as a lone ranger, a traumatised beneficiary, living on the street, estranged from his family. Curious, he asked the patient *'What is important to you in your life?'* The man replied *'I want to be able to give something to my kids that I never had. Perhaps some sport after school.'* Sometimes the biomedicine distracts us from what else is important.

The Patient Centred narrative went with the Reflective Doctor narrative. We were taught to be GPs by being aware of self, *'reflecting on and in our experiences'*<sup>7</sup> by taking part in stories that take us to the edge of what we thought was possible for a doctor, trying things out, failing, reflecting, succeeding, reflecting, trying new approaches.

But curiously, we don't share our stories nearly enough. We can tell each other stories of failure, but only 'near misses' where nothing bad happened. We can tell each other about complaints, but only if the patient was obviously bonkers. We might whisper about a human's suffering and our capable colleagues cite medications they would

try. The reflective doctor in us is alone in our room.

The situation is intensified by a new medical narrative - the Performance Measured doctor narrative. We are measured on our productivity and outcomes. Good doctors are very busy alone in their rooms, ticking a lot of boxes, measuring their diabetics, the EBM on CVKPD at their fingertips. In a grand collective delusion we assume the things that are measurable are the most important. Suffering and healing, though, cannot be reduced to countable tick boxes. They are deeply mysterious.

In the last year I have visited my own two GPs many times. I didn't have anything easily diagnosable, there was no pill to give me, no guideline. But those GPs were wonderful. They were kind, curious, imaginative, and funny. They accepted and held me in the mystery. What they did cannot be measured. They will not be rewarded for reaching a performance target, or achieving required quality outcomes. Encounters like those are the essence of general practice, the work GPs do every day. Why do we not speak of it, value it? Why do we feel slightly ashamed that we are not 'proper' doctors, measurable, detached, biomedical brainboxes?

According to Arthur Frank *'new narratives arise out of untold stories being spoken'*.<sup>8</sup> What stories do we need to speak, even stutteringly, to create a new narrative for general practice? How about I hear about you and you me? How about we embrace the diversity of doctors' stories in this room; different personalities, cultures, styles, quirks, failings. How about you get to know the doctor working beside you? How about we have some compassion for ourselves, for each other? Doctors need kindness too. What might real peer support with other doctors feel like? How about we just be ourselves? How about we speak of shame?

Perhaps then, I would be able to stand here and tell you about my burnout, how I failed in the Invincible Doctor narrative, how my great big brain box just gave up and wouldn't work, until I stopped. How I burned with the shame of failing; that first call to my insurance case manager confessing I was sick; what it was like to tick that box

on the medical council registration form; the box that made me 'outsider', needing to be checked to ensure I was safe to practice.

I can tell you that now because I recognise the value of that place - the view from the outside. I do not want to be 'othered', invisible or shamed. I want to look you in the eye, and see you, and you see me. Only then, will we be able to imagine the unknown possibilities for General Practice.

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