

■ OCCASIONAL PAPERS

A study of storytelling, humour and learning in medicine

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ABSTRACT – Story telling is a fundamental part of clinical practice. It provides the mechanism by which doctors and patients communicate and understand the meaning of illness and possible ways of dealing with it. Humour is a particular aspect of story telling and, while there are some negative aspects, generally does have a therapeutic benefit. The physiological effects of laughter are considerable. Both story telling and humour are important for learning and are complementary to the more formal learning from text books and lectures. Stories assist in the development of emotional knowledge. The hypothesis of the contagious theory of behaviour change is presented as a way in which ideas are transmitted from one person to another

One may ask whether, in an age of scientific medicine, measurement and rational thinking, an article on storytelling, humour and medicine has any place at all. This essay tries to answer this question; the award of a Queen Mother Fellowship from the Nuffield Trust made it possible to expand it into a monograph¹.

Narrative is important in all our lives: we live and learn by stories and much of what we do relates to how we listen and understand stories. Doctors are no exception to this: they also need to tell stories and listen and learn from them. Stories, particularly those of patients, are at the heart of clinical practice – the clinical history is central to diagnosis and prognosis. Humour improves wellbeing and quality of life and may even have a therapeutic benefit; laughter is universal and specific to the human species. How can one use stories to improve the way in which we learn? This is not to challenge conventional learning methods but to support and extend the effectiveness of the process. The three themes of storytelling, humour and learning come together in what might be called ‘the contagious theory of behaviour change’. It suggests that learning and behaviour are caught and not taught, and that the transmitted idea, the ‘transmid’, is at the heart of this. The objectives of this essay are to explore the relationships between these three issues, to consider how behaviour might change as a result and what

benefits come from the three themes, and to identify some research issues.

The purpose of stories

Stories have many different purposes: they are part of our experience. While the following are general statements, it is possible to see how they fit into clinical practice. They provide a framework for life, and help us deal with major life events. They may have a therapeutic effect, in that telling one’s story to someone else can often help. Stories also record events and, taken together, form a history. Stories assist communication and bridge generations to provide continuity in thought, ideas, values and culture. Listening to stories is a way to build up trust between patient and doctor. Stories set standards and values, and the goodies and baddies in stories tell us how we should behave. Stories are also important from the point of view of leadership: good leaders tell good stories, and that is why people follow them. The medical analogy here is clear in the way in which some clinical leaders have changed practice and influenced generations. We also learn through stories, and stories are repositories of knowledge. Put two doctors together and they will inevitably start telling stories and sharing experiences. Stories are also there to amuse and entertain. They involve both the storyteller and the listener, a key point in the recognition of their value.

Understanding stories

Stories are not simply lists but also illustrate how patterns of human life and action come together. They have meaning and purpose. From the doctor’s point of view one of the key things is the interpretation of the story. This is sometimes called exegesis. It involves actively listening to the patient’s story, trying to understand it, and not trying to second guess the problem. It helps in dealing with uncertainty. Uncertainty and the never-ending story represent the most difficult aspect of clinical practice. Patients and their families may want to know the end of the story, what will happen, even if the end is the loss of a loved one. The difficulties of prognosis, of uncertainties,

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of completing the story, are very real. Stories can transform, and as we understand the deeper meaning of some stories, they can affect us profoundly. A further important part of this is the creation of a new story: something different, something not told before, based on curiosity and a wish to learn more. To discover new things, and to go where no other storyteller has gone before, must be an important part of the clinical task.

Humour

There is a real problem in trying to study humour. As soon as one dissects a joke, it is left lifeless and without form. Analysis can end up with a dry academic report that is anything but funny. Yet humour is such an important part of life that it is essential that we at least try. If we only knew why people laughed, then it might be possible to make it happen more often. The physiology of laughter is now well documented, and the complex muscle movements in the face, neck and diaphragm have all been recorded. The purpose of laughter, and how an incident or a form of words results in the physiological changes, remain a mystery.

Over the last few millennia, from Aristotle to the present day, a great deal has been written about humour, much of it relating to the psychological and social aspects of humour and attempting to understand its purpose. Freud, for example, wrote a book on the analysis of humour and, not surprisingly, considered that it was related to repression and to the subconscious. Few biological mechanisms for the action of humour have been suggested, and this is an area that deserves further thought. Perhaps the MRC should review the area?

The key question is: what are the benefits of humour? We know that considerable physiological changes occur after laughter. The blood flows more freely, the immune response is stimulated, muscles pump, endorphin production is increased and there is some relaxation. All of these, not surprisingly, make one feel better. The end point is thus of real significance to us all.

I looked at more than eighty publications on humour in medicine for this study. Few gave clear indications as to its benefit, most being anecdotal. There were some negative aspects to humour, mainly in those with mental health problems. However, there are a couple of publications which suggest that the pain threshold is raised following laughter and thus patients require fewer analgesics. Perhaps there is a need for a laughter clinic in all hospitals.

There is a great deal of humour in medicine, and in medical practice. Medicine is full of in-jokes and specialty jokes. Medical humour occurs in films and on television and in stories about doctors, many of which ridicule doctors and the way they practise. However, humour is likely to be beneficial for doctors. It helps them cope with difficult problems, helps team building, and undoubtedly assists in learning. It has been suggested that the CCST should not be granted to specialist registrars until the candidate is able to laugh at specialty jokes and understand them.

But perhaps a health warning should be issued. There may well be ethical problems in the use of humour in relation to

patients, or indeed in relation to one's own colleagues. There are cruel aspects of humour: it can be used to mock and to ridicule and indeed to dominate. Freud would have been pleased to learn all this. Humour is not a panacea, and should be used sparingly.

Storytelling and learning

The knowledge base of medicine is changing rapidly, as is the social context of medicine. The ability to continue to learn and change practice is thus crucial. Patients expect it. There are two ways in which learning can occur, knowledge accumulate, and thus behaviour be changed. The first is by the logical processing of information, generally with factual knowledge. This occurs via books, journals, lectures and seminars. The second relates to the transmission of feelings and attitudes, essentially emotional information. This can be achieved via patients, relatives and staff from all professional backgrounds. It might include poetry, plays and the wider literature, and mnemonics and aphorisms add to it. Both of these methods are complementary and overlapping; in general, storytelling is most appropriate for acquiring emotional information. The apprenticeship model remains important – learning from one's more experienced colleagues. Judgement and wisdom are difficult to learn from textbooks, and perhaps can best be acquired by watching others at work. Sometimes in the middle of a story there is a sudden insight, in which the individual 'sees' the answer – this is sometimes referred to as 'epiphany'. It is an increasingly interesting aspect of curiosity and discovery.

Medical writing

The oldest forms of medical writing relate to the use of aphorisms, 'burrs that stick in the mind'. These short pithy statements are easy to remember in time of need, and are generally helpful; for some, however, there is no evidence. For example, according to Hippocrates 'people who lisp are especially liable to prolonged diarrhoea'; one suspects this is not necessarily true. A second form of medical writing which bears examination is that of the use of medical notes. Again from the time of Hippocrates onwards, such medical notes provide detailed descriptions of patients and the kinds of treatments used. Textbooks take this a stage further and, in William Osler's words, bring the writer 'mind to mind' with the reader. The classic textbooks over the years have helped generations of doctors find their way through difficult clinical problems. The Internet and the Web will assist this, and make access to information faster. However, there will still be a need for a guide, someone who will simplify and set the direction for learning so that new areas can be taken on board as rapidly as possible. This is the role of the textbook.

Other ways of telling stories

Stories may not only be told in words, but in many other ways. The use of body language, touch, mime and planning are examples of this. The arts are also important: music, the visual

arts, culture, dance, theatre, film and television, can all be used to illustrate particular problems. Cartoons and caricatures are a particular aspect of this. The implication is that students might be exposed to these different methods throughout the course.

Stories and ethics

Stories have been used through the ages as parables and moral stories to illustrate good and evil. In a similar way stories can highlight difficult problems when teaching medical ethics. Literature in many forms, including poetry, can highlight ethical dilemmas. The problem, as always, is uncertainty. The difficulty of predicting the outcome on a particular patient with a particular problem can often best be illustrated by a story, but not necessarily solved by one. While core values have remained the same, some ethical issues and our response to them have shifted over the years – the concept of ‘evolutionary ethics’. This has been in response to changing knowledge, but is also related to changing social attitudes.

The contagious theory of behaviour change

It is suggested that behaviour can change because of ideas transmitted, often in the form of stories from one person to another. Such a mechanism may involve transmits (transmitted ideas). The analogy can be developed further, in that such contagion depends on virulence, and on the resistance of the listener. Like micro-organisms, some ideas are dangerous. There are several different ways in which the behaviour change can be transmitted, but they are generally through the senses. There are of course good and bad organisms, and ideas can remain latent or dormant for a long time. If this analogy is stretched further, then it has several implications. First the person who relates the story

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is critical, as indeed is the nature of the story itself. How it is presented, and the nature of the listener and the environment in which the story is told, also are important factors. In terms of learning, however, this emphasises that teachers do matter. The influence of the teacher can change the student and provide inspiration and enthusiasm for the subject.

Conclusions

This essay set out to examine storytelling, humour and learning in relation to medicine. Several important points have been identified. The first is that stories matter, and that they can assist in building up trust between the patient and the doctor. Healing skills are real, and the importance of quality of life clinical practice cannot be emphasised too strongly. Stories help us to identify and deal with ethical problems. Stories are also about conversation, and how we use words and language. The medical society, the College and the social contact between doctors are thus very important. This essay is partly an exploration of happiness: quality of life is crucial to all of us, and doctors need to remain explorers and adventurers – seeking new ways to improve treatment and quality of care and to tell new and exciting stories.

Reference

- 1 Calman KC. *A study of storytelling, humour and learning in medicine*. The Eighth Queen Mother Fellowship, The Nuffield Trust. The Stationery Office, 2000.

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