'Patient stories: how they influence us as physicians'

When you are a medical student, there comes a day after years of studying basic sciences when you step into the hospital ward and for the first time you are allowed to talk to a patient. This is what you have been preparing for. This is your first chance to make contact with a patient. This is why you wanted to be a doctor.

I clearly remember my own introduction to clinical medicine. A little group of us were taken in to the ward and briefed by one of our teachers before each of us was assigned to a patient. The most important thing, our professor told us, is **to let the patient tell his story in his own words**. To me this sounded perfect. I was always ready to hear a story and now a very important story would be told - - to me alone - - by the person who had experienced it. But it wasn't that simple. The next thing our professor did was to give us each a long list of questions. We had to interrogate our patient about the functioning of all his bodily systems in a systematic way, missing nothing out.
It soon became clear to me that our teachers regarded the questions as much more important than the patient's narrative. In fact a good deal of what the patient said was untrustworthy or irrelevant and could be ignored. Many patient were described as 'poor historians' which meant that that they were unable or unwilling to tell the kind of story that would lead straight to a textbook diagnosis. It was necessary to fire questions to keep them to the point and make sure we missed no important clues.
This list had a dispiriting effect on me. I found it hard to concentrate on my patient's story because I was worrying about whether I would have time to get in all my questions.

Much later on, when I had absorbed the technical side of medicine and ceased to be so afraid of it I was able to challenge the concept of the 'poor historian.'
As a family doctor I began to realise that to diagnose the illness we need to listen to the whole story and not a censored, edited version. Then we can start to questions.
But we need to do more than diagnose the illness. To really be a physician we need to understand the person: who he is and where he is coming from. Our patients don't just have symptoms and diseases. They have thoughts and feelings. They have experienced joy and terror. They have been lifted up by hope and cast down by despair. They have been in love. They have a life outside the office. They are just like us.

Frieda and the story of her life.
Now I'd like to tell you a story from my own practice.

I am a family doctor working in a suburb of London. I do consulting sessions in my office and I also do home visits. One day, a few months ago, I was sitting at home having a cup of tea before going to my evening clinic. It was 4 o' clock and I don't need to tell you how important it is in England to have tea at 4 o'clock. As I raised the cup to my lips the telephone rang. It was my receptionist from the Health Centre. An elderly lady of 90 with heart disease was having chest pain and needed an immediate home visit. She lived alone and no one could bring her

to me. My clinic was due to start at 4.30 and I don't like to be late because we are so busy. I had half an hour in which to see the old lady, deal with her chest pain and get to my clinic. I felt very upset about the whole thing.

My recollection of the old lady was that her chest pains were mainly a form of panic attack. This visit was not likely to be a real medical emergency but - she was a heart patient – I had to go all the same.

When I arrived at the home I tried to be calm and polite and not look at my watch .I sat down and said: tell me about the problem. She didn't seem to be in pain at all. To my surprise she said: 'Would you like to hear the story of my life?'

This was difficult. I had now only twenty minutes to spare and ten minutes of that would be needed to drive to the clinic. My first feeling was that I definitely did not want to hear her life story. It would take much too long, it would not help me with her chest pain and it probably wasn't very interesting anyway. But then a voice inside me said: 'I can't believe you are thinking these thoughts. You are always talking about how much you like listening to stories. This is what makes your job really interesting. If you say 'no' to this offer you will be betraying everything you hold most dear about general practice. Does it really matter if you are half an hour late? Relax and listen. That's what you would tell your students to do.'

[Do you have one of these inner voices? It doesn't mean you are schizophrenic or even Joan of Arc. It may be just another part of you that is trying to make itself heard.]

So I took a deep breath and said: Yes. I would like to hear your story. And, do you know, it really was interesting.

Her name is Frieda. She had been born in England in 1912. Her parents were Jewish immigrants from Poland. Then in 1920, when she was 8 years old her father decided to take the family back to Poland. He was 35 and chronically unwell having survived a shipwreck on his way over to England. He had developed rheumatic fever and he thought that if he went back to Poland his life would be prolonged. What can he have been thinking of? Perhaps he had some idea of regaining his youth, of starting life again. Anyway it was a really bad idea. The family went to live in a small town in Poland. They were desperately poor without enough to eat. Eight-year old Frieda developed tuberculosis of the spine. Then, in 1924, her father died and she and her mother and sister returned to England. Frieda was treated in various hospitals for her tuberculosis. She was in hospital more or less continuously for 8 years, much of the time in a plaster jacket, unable to walk. She did not leave hospital until she was 20.

She showed me old black and white photographs of herself in hospital and has kindly allowed me to show them to you.
SLIDE

Here is a picture of one of the old fashioned wards in which she was a patient confined to bed for so many years. And here is another view.(SLIDE) At least they seem to be spacious with high ceilings.

SLIDE Here is Frieda herself at the age of 19. You can see that the patients were allowed outside the hospital to benefit from fresh air, but most of the time in their beds.
SLIDE Here she is again with her sunshade
SLIDE And here she is with a nurse and a fellow patient.

She said there wasn't much education in the hospitals and felt quite rightly that she had been deprived of half her childhood and her adolescence. I asked what happened afterwards. She said she that when she finally left hospital they found her a job in a hat factory. She was given a block and some pieces of felt and told to design a hat. Everyone laughed at her first effort but the manager used it and it was the best selling hat of that year. After that she went into business with her sister and brother-in-law 'A big mistake' she said, 'but that is another story'.

That seemed a good moment to take my leave. I examined her heart briefly before I left but she no longer seemed concerned about it and her chest pain had gone. Of course I still had to return to my afternoon clinic. I wasn't even late. But my attitude to Freda had completely changed. Instead of being a boring, complaining old person she had become an engaging story-teller. I really hoped she would call me out again soon so I could hear about the brother in law and the hat business. And I wondered why she had never married. Had there been no hospital romances (As you can see from the pictures she was a lively attractive young woman).

Medicine is difficult: There is a lot of technical stuff to learn and remember. We are afraid of missing a serious diagnosis. There is never enough time. There is also the question of the doctor's feelings.
In medical school we are taught by example to exclude our feelings and be 'professional'. But listening to stories makes this difficult.
Stories inevitably arouse our feelings. Feelings about our patients and ourselves. Our relationship with the patient becomes closer and more emotional. Their experiences may resonate with our own, perhaps at an unconscious level. This can be upsetting.
We have a tendency to defend ourselves against too much story telling, too much understanding and unwanted empathy. We are afraid that if we feel too much of the patient's suffering we will lose concentration, be unable to do our job. So we develop a hard protective shell. To some extent this is a necessary self protection.

The trouble is that when we are in that mode, we ignore or brush aside those all important patient stories. In doing so we damage both the patient and ourselves. As I tried to show in my anecdote about Freda, a patient's story can open us up to a new appreciation of the people who bring us their problems. And ask us to be witnesses to their lives.

When we are children we love listening to stories and being moved by them. As adults and doctors who have been through the rigors of a medical training it seems that we have to learn to listen to stories all over again. How should we do this?
How can we relearn to listen to stories and understand at least something of what our patients are trying to tell us about themselves and their inner lives?
I would like to recommend three different ways which have been helpful to me.

1. Telling doctor stories. Balint and other groups

Doctors like telling stories as well as listening to them. Sometimes these are about rare clinical syndromes without much human interest. But we also like to talk about our patients' personalities and the strange encounters we have had with them. Some experiences with patients are gruesome at the time but funny when we talk about them afterwards. We feel unburdened and perhaps pleased to have entertained our colleagues.

But there is an even better way of telling doctor stories and that is in a more formal setting of education, reflection and supervision. One of the best known examples is the Balint group, pioneered in London in the 1950s by Michael Balint, a Hungarian psychoanalyst with an interest in family medicine (SLIDE) The Balint group consists of a group of doctors or other health workers who meet at regular intervals, to discuss their patient stories.

SLIDE This picture shows a Balint group at the conclusion of meeting in Oxford.

Anyone who has a case in mind is free to present it to the group. The group members listen in a friendly supportive way. As you can see they do not look threatening. They are not out to criticise or find fault because they know the difficulties all too well. The group is facilitated by an experienced leader who may be a physician or a psychoanalyst or often in the USA a behavioural scientist. Or maybe there will be two facilitators. The aim of the group is to provide support but also to help its members towards a better understanding of the emotional content of the stories. Balint groups are not universally popular because although they are very supportive they need commitment both of time and willingness to explore one's own inner world. However, they are flourishing in a number of European countries, notably Germany, France and Belgium, Scandinavia and in Eastern Europe. In the USA there has been a considerable spread of interest in Balint groups in Family Medicine training programs thanks to the work of the American Balint Society.

BLANK SLIDE

The Balint method is by no means the only way for doctors to talk about their work and reflect on their patients' stories. If you talk to a psychotherapist or a social case worker you are likely to find that they all regard receiving 'supervision' as an essential foundation for their work with clients. The supervisor in this context is not a

line manager but someone with whom the therapist can share her concerns and reflect on what has been going on in the therapy. The process is both supportive and educational. As physicians we are only just beginning to realise that we can't always be self sufficient and that we could do with someone to share our stories with as well. Supervision may take place in a group, between colleagues. Or it may be on a one to one basis in which one doctor mentors the other or they may even take turns to be the storyteller. In some groups use is made of techniques of narrative medicine. Here the aim is to reconcile two differing stories; the patient's version and the doctor's version which may be quite different. This reconciliation of stories can help patients to see their illness and their experience in a more constructive way.

2. Writing stories and poems

My second strategy for learning to listen involves having the courage to try a little creative writing. This is what my friend in England Gillie Bolton calls 'reflective writing'. She has run lots of workshops for doctors and other professionals in which she encourages them to reflect on some episode from their professional practice that comes easily to mind – and then write about it as quickly and freely as possible. The result may be a short story or a poem; or just a page of writing. I must stress that you don't have to be a skilled writer or have any experience to do this. What you write isn't for publication; but you may want to share it with a colleague or a mentor or the other members of a small group. You may just want to keep it to yourself. Whatever you do with your writing there is a good chance that it will change the way you think about the person whose story inspired you to write in the first place.

I'd like to give you an example from my own experience. Back home I help to run a weekly teaching session for the doctors in our GP training program. We often have guests come to facilitate a session and a few months ago we had a visit from a poet who runs creative writing sessions for doctors. She told us that we were all going to write a poem during the session. This was a little scary. She gave us some examples from real poets to inspire us and then told us not to try to make anything rhyme. Then she gave us each a piece of paper and told us to get on with it. Within half an hour everyone in the room had written something and everyone seemed to have enjoyed the experience.

As I sat with my pen and my blank piece of paper I found myself thinking about a patient I had seen earlier in the day. He is an Afro-Caribbean man in his 40s whom I will call Tony. Tony was born in England but his mother sent him back to the West Indies when he was six to be brought up by his grandmother. When he was about 12 his mother came back to live in the West Indies too but according to Tony she never wanted to see him and would tell him to stay away from her. He thinks he reminds her of a shameful secret – perhaps she had an affair with a married man and never talks about it. At any rate there was no one to be a father for him. From the age of 14 he wanted to come back to London and he finally did when he was 25. But the streets were not paved with gold and now Tony finds himself struggling to survive. He has two miserable, poorly paid jobs: one cleaning toilets and the other as a kitchen porter.

He lives alone and never seems to have had a regular partner. I have known him for several years. He appears in my clinic now and then, mainly to complain about his hard meaningless life. My one success was to cure his facial acne but it didn't lead to any major changes in his life. Tony is small and thin. He walks with a rather strange stooping gait that reminds me of Sir Laurence Olivier playing Richard the Third. On the morning of the poetry session Tony had been in to see me. He was feeling suicidal. I was having a bad day too and was not very sympathetic.

Here is the poem I wrote about Tony:
(SLIDES: READ FROM SLIDES AS THEY COME UP)

TONY

I am not in good humour today
So when little Tony limps in like Richard the Third
And says 'I'm thinking I might commit suicide'
I don't respond

This job is too much says Tony,
I've told you. You know.
Too many toilets to clean in two hours, all this stress
Can you get me a job somewhere?
And the money I owe since that man came to stay
On the phone and the rent (and he shows me the list
But I don't want to read it).

'I feel like suicide, do you know what I mean?'
I said I do, but what then?
I don't do prozac any more and besides
Tony generally prefers something to rub on.

He comes from an island, the runt of the family
Unloved by his mother, her shameful secret, or so he thinks
Never grew tall, never grew up,
Like a little stray dog,
That people throw stones at
To make him run away.

'Could there be a curse on me?
Do you believe that?' says Tony.
I don't know what to say.
I don't want any more
And then, as he limps to the door
'Aren't you scared? Of what I might do?'
I say: 'Try to be like a man'.

That seemed all I could offer.
I just wished he would go.

Tony shrugged and, thank goodness, he left
But now I feel scared.

BLANK SLIDE

OK it's not much of a poem and its not going to win any prizes. But it did start my mind working about Tony. About Me and Tony. Why had I told him to be a man? Perhaps I felt like a frustrated and disappointed father whose son seems to be a failure. He was doing his best, working away at his two jobs. But he wasn't quite ready to be a man. He needed a bit more nurturing, from a more kindly supportive father. I realised that I was worried that he might harm himself.

The next morning I telephoned him but there was no reply. So I went to his flat (fortunately just across the car park from my clinic) and knocked on his door. No reply. I wondered if he was lying in there dead. I wrote a quick note asking him to come and see me again and shoved it into the mail box. The next day I knocked again. Still no reply but the mailbox was empty so perhaps he had read my note. A few days later Tony came to see me again. To my great relief. He looked at me quizzically and said: why did you want to see me again? I said I was worried about you and I hope you are feeling better. He seemed pleased but still curious. I didn't tell him about the poetry session. No he wasn't planning to kill himself now but life was still hard. He had foolishly allowed a strange man he met in a pub to occupy his spare room for several months during which he had made no contribution to the household and run up a large phone bill. Now Tony was worried about how he was going to pay off his debts. I gave him some suggestions including going to the Citizens Advice Bureau where I know they are good at debt counselling and about trying to find a better job. He comes about once a month now. I don't know if life will ever get better for him. But at least, in a small way, I feel I am there for him now. And all because of that rather clumsy attempt at writing a poem.

3. Reading: The link between medicine and literature

My third way of learning to listen to patients stories is through reading.
SLIDE:CICERO This is a picture of the Roman orator Cicero as a schoolboy. It was painted in the 15th century and is not historically accurate as Cicero would probably have read from a scroll rather than a book. But I think you will agree it's a lovely picture.

Ever since *my* school days I have had enormous pleasure from reading novels, especially the classics.
There are some classic books that I first read in my teens that have remained an important part of my life. I can return to them every few years and enjoy them all

over again and always discover something fresh. Some of my favourites would be Tolstoy's *Anna Karenina*, Jane Austen's *Emma*, Thomas Hardy's *Tess of the D'Urbervilles* and Flaubert's *Madame Bovary.* These are all very traditional. But I am also very fond of some 20th Century classics such as Kafka's short stories and James Joyce's *Ulysses.* Kafka is often thought of as gloomy and paranoid and Joyce completely unintelligible. So why do I love them so much? I think it was because I was able to find a way in, the right place to start, not necessarily at the beginning. Perhaps we can come back to that thought later on.

But how can reading these books help me to listen to the stories of my patients? You may think that I just use them as a means of relaxation; a way of escaping from the stresses of the real world. Yet the strange thing is that reading makes me sit up and take more notice of my patients as people. I am often struck by the way the patients sitting in front of me resemble the characters in the great novels. That makes me feel more interested in their lives and helps me to relax and listen to their stories; instead of irritably scratching them for a diagnosis. I feel more tolerant towards strange and difficult people if I think of them as close relatives of the characters in Dickens or Dostoievsky. For instance, among my patients I have a family of three brothers of whom the two elder ones both have schizophrenia. Their chaotic lives and wild ideas remind of the elder Karamazov brothers. The only difference is that their younger sibling isn't a religious visionary. He's a successful accountant.

And some of the characters from literature seem to me just as real as the patients in the consulting room. I think especially of Tolstoy perhaps the greatest of Russian novelists. SLIDE Here he is with his younger colleague Anton Chekhov whose work we will be discussing a little later. Tolstoy of course is the older man with the more impressive beard on the right of the picture.
Tolstoy had the gift of creating characters who seem to come alive as soon as we meet them. Once we have got to know them they take up residence in our inner world and become part of who we are.
[I am thinking of Prince Andrei and Pierre and Natasha from *War and Peace* and the unfortunate Ivan Ilych whose terminal illness is illness is I am sad to say very badly handled by his doctors.]
My favourite Tolstoy novel is *Anna Karenina.*

Before we get on to the words, I thought you might like to see some pictures of Anna and who better to represent her than the legendary Swedish screen actress Greta Garbo. I hope you are not all too young to have heard of her.

SLIDES Here are some pictures from the 1935 film which starred Greta Garbo.
1) This is Anna with Kitty the book's other heroine played by Maureen O'Sullivan
2) with Vronsky her lover (Fredric March)
3) shows Anna's triangle with Vronsky and her husband (Basil Rathbone)
4) with her little boy (Freddie Bartholomew)

Tolstoy's tragic Anna is unforgettable, but so too are Levin and Kitty the young couple whose 'normal' everyday life is contrasted with hers. Do you remember the first sentence of AK? (SLIDE) That one is very famous. But what about the second sentence? (SLIDE)This gets the story moving by introducing Anna's brother-in –law, Steve Oblonsky. He is a really nice easy going chap who can't understand why his marriage is collapsing – simply because he's been caught having an affair with the children's governess. Just about everything that can happen to a person (or a patient) happens in *Anna Karenina. (SLIDE)*. We witness love, courtship, marriage, family conflicts, adultery, childbirth, childcare, psychosomatic illness, the problems of teenage daughters, depression, borderline states, suicide and terminal illness as well as a good deal of discussion about the meaning of life. Of course you get sagas like this from modern writers too, not to mention television soaps. But nobody can do it quite like Tolstoy because he was a genius. Writers like Tolstoy have an ability to really breathe life into their characters. They can also create scenes so vivid that you feel you have been there. And they can produce phrases which send a tingle down your spine and make you think: 'Yes! I know exactly how that feels.'

One day you may find that the beautiful Anna Karenina walks into your consultation room with suicidal thoughts. Or someone very like her. Or you may be consulted about young Kitty whose handsome boyfriend has dumped her. She has developed all sorts of psychosomatic symptoms and her parents, frantic with worry, want you to refer her to a specialist. That clever but tormented student drop out could be James Joyce's Stephen Dedalus - or even young Raskolnikov from *Crime and Punishment*. And save some time in your schedule for Jane Eyre, that fiery little orphan whose heart is burning for love and justice.

****

Another of my favourite writers is Franz Kafka who was born in Prague in 1883 and died of tuberculosis in 1924. The struggles of his hero Joseph K in *The Trial* and *The Castle* remind me of the frustrations of many of my patients as they try to negotiate the bureaucracy of our Kafka-esque Health Care System. You may also have read Kafka's story *The Metamorphosis.* On the surface this is a science fiction story about a man who turns into a giant beetle. Like all Kafka's writing it can bear many different interpretations but on one level it is very much like a metaphor for a sudden devastating illness.

Here is the opening of the story: (SLIDE)

When Gregor Samsa awoke one morning from troubled dreams he found himself transformed into a monstrous insect (BEETLE) . He was lying on his hard shell-like back and by lifting his head a little, he could see his curved brown belly, divided by stiff arching ribs, on top of which the bed quilt was precariously posed and seemed about to slip off completely. His numerous legs, which were pathetically thin compared to the rest of his bulk, danced helplessly before his eyes.

'What has happened to me?' he thought. It was no dream. (Franz Kafka 1883-1924)

BLANK

. At first he believes that the situation if not a dream is only temporary. Or at any rate that once he has learned to walk on his new legs his life will carry on as normal. His chief anxiety in the early stages is that he will be late for work. He just can't take in the size of the catastrophe that has happened to him. Gradually he realises that life will never be the same again. His body seems unfamiliar an uncontrollable. He can't stand erect or speak. His family are horrified but he can't communicate with them. It all reminds me strongly of the waking nightmare which must be experienced by a stroke patient. There are many other examples in Kafka's stories of metaphors of illness which can enhance our empathy and understanding of the sick persons plight.

****

. Then there are the patients, usually elderly men, who come into the surgery and, instead of telling you their symptoms in a concise and orderly fashion, embark on some interminable tale which seems to be going nowhere. These are the patients whom our teachers described as 'poor historians'. Well that may be true but they are often brilliant story tellers. When this happens to me now, I try not to interrupt. I think of a book called *The Life and opinions of Tristram Shandy* written in the eighteenth century by an eccentric clergyman called Lawrence Sterne. (SLIDE) In this wonderful book, the hero Tristram Shandy attempts to tell his life story. But he is constantly interrupted by his own digressions. Everything he says reminds him of some other story that he simply has to tell us as well. He even discusses this problem with the reader and complains that although he has been at work for six weeks on his autobiography he still hasn't managed to get himself born yet. (SLIDE) Or to put it in his own words. Does this remind of some of your patients trying to tell their stories? BUT, and this is the important bit, he then urges the reader to have patience because the digressions are really the best part of the book. SLIDE:

'Digressions (he says) incontestably are the sunshine' – they are the life, the soul of reading: - take them out of this book for instance, - you might as well take the book along with them;'

And you know, if I just sit back and listen to the old fellow who is rambling on, his digressions becomes really interesting and may even lead to the diagnosis. Or if not that, they will surely lead to some new realisation about the patient or myself or the human condition or the state of the world or something.

****

There is another major author who has been very much in my mind this year and that is Anton Chekhov who died 100 years ago in 1904. Chekhov must be the greatest writer who was also a practicing family doctor so we should be very proud of him. Here he is with Olga who was the principal actress in his plays at the Moscow Arts Theatre. How did he manage to combine medicine and writing masterpieces? (SLIDE). Chekhov's major plays such as *The Cherry Orchard* and *Three Sisters* are still frequently performed and are second only to Shakespeare's in popularity. He also wrote over 200 short stories and the best of these, the later ones, are masterpieces of compressed observation and empathy. They contain a good deal of humour and yet they can be quite disturbing to read. Especially if you like your stories to have a happy ending or even any ending at all. Chekhov's principal characters are very appealing but they seem incapable of getting

their lives together. They complain endlessly about the suffocating boredom of life in a small town but they never leave. Or if they do, they soon come back. They talk about the importance of progress but they don't seem to have the energy to contribute to it. They fall in love but are unable to commit - marriage seems too big a step. Life goes on; they take pleasure in nature and the countryside - which Chekhov describes beautifully – they enjoy food, drink and conversation. But their lives remain sad and unfulfilled. They miss every opportunity that comes their way.

Where did Chekhov find all these people?

When I put down my book of short stories and start to listen to my patients I think I know the answer. Most people visit the family doctor only occasionally perhaps once or twice year. But there is a small group of frequent attenders who always seem to sitting in the waiting room. They are not usually seriously ill (although they do get sick sometimes just like anyone else). But they are never really well either. They have many puzzling symptoms which make them anxious. They are unhappy with their work, if they are able to work at all. Some are unhappy in love or with their families. Some have problems with drugs or alcohol or obesity. They are always promising us that they are going to turn over a new leaf and we have a great desire to give them a makeover, to change their lives for the better. They may encourage us to think that they are going to change. But we shouldn't get too excited because we will probably be disappointed.

Yes, these patients are Chekhovian characters. And its my guess that he found his inspiration in the people who came to see him for medical advice. Like him I am fond of these patients but I now know not to expect too much. It also makes me realise that my patients have a perfect right to live their lives in their own way and not according to my prescriptions.

Ladies and gentlemen. I am now coming to the end of this talk. I hope that I have managed to convey to you something of the way I feel about the importance of listening to patients' stories. We all enjoy stories as children: the prospect of a story makes us thrill with anticipation. Unfortunately our medical training can lead us to feel suspicious and even contemptuous of patients stories. What do these storytellers know about medical science? Their accounts seem irrelevant and misleading. Unless we pin them down with our questions we will never reach a diagnosis. Our time is too precious to listen to stories. Worse still, if we do pay attention, our own feelings may be touched and we will be in danger of being losing our scientific objectivity.

These attitudes are slowly changing as a result of a more enlightened attitude to consultation and communication in our medical schools and postgraduate training programs. I have outlined three ways in which we can help ourselves to listen to patient stories and allow them to influence us. These are (SLIDE 1) the use of case discussion to reflect on the patient's story and our response to it; (SLIDE 2) the use of creative writing to free the imagination; and (SLIDE 3) the enjoyment of literature as a route to enjoying and appreciating our patients. SLIDE 4.

My experience as a family doctor over 30 years has convinced me that we can serve our patients much better if we allow their stories to influence our feelings about them as fellow human beings. We will understand them better and understand ourselves a little better too. We will be more effective as clinicians and as witnesses to our patients' lives. We will also find going to work a more pleasurable experience, when listening to our patients is something to look forward to rather to dread.

I'd like to leave you with a delightful picture that seems to me to be worth a thousand words. SLIDE Here is Tolstoy, the grand old man of world literature, telling a story to his grandchildren.

Ladies and gentlemen: thank you very much.