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POETRY OF APPLIED ANTHROPOLOGY AS LIFE QUALITY ENHANCEMENT: SOME EXAMPLES FROM AMERICAN BIOMEDICINE

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ABSTRACT

I argue that an applied anthropologist's poetry (and other art forms) can be used as a tool of ethnographic imagination, insight, empathy, understanding, interpretation, explanation, and action/ intervention in day-to-day collaborative work. Such poetry can be understood as an expression of the applied anthropologist's use of the self (countertransference) in consulting, interdisciplinary and transdisciplinary teamwork, development projects, and the like. I further argue that the humanities (poetry, fiction, film, music, visual art, sculpture, etc.) can help to humanize technologically-oriented and productivity-driven physicians and their relationships with patients (and, by extension, all professional relationships) by enhancing the quality of physicians' experiences. I use three of my clinically-based poems to illustrate how this approach unfolds in bringing to life physicians' clinical work in a safe, non-judgmental learning context. I conclude with some suggestions for generalizing this approach more widely in the practice of applied anthropology.

KEY WORDS: medical education, self-reflection, residency training, clinical anthropology

"It is difficult to get the news from poems; yet men die miserably every day for lack of what is found there." (William Carlos Williams, "Asphodel, That Greeny Flower," In *Journey to Love*. New York: Random House, 1955.)

INTRODUCTION: A METHODOLOGICAL CONTRIBUTION

This paper introduces a new tool or method an applied anthropologist can use to supplement more conventional ethnographic methods: the use of his or her own poetry (or other art form) that is stimulated in response to working with people on applied anthropological projects in healthcare settings. The goal of such an approach is to enhance the life quality of the practicing physician and, in turn, the quality of the physician's relationship with patients, the patients' family members, fellow healthcare professionals, and in fact the others who are part of the physician's network of relationships. I argue that, perhaps counterintuitively, the poetry of the applied medical ethnographer can contribute to *methodology*, and in turn to a deepening of relationships, data, explanations, and collaboration. I wish to emphasize from the outset that the central theme of this paper is not poetry per se, but on poetry as one among many possible manifestations of the applied ethnographer's use of self in collaborative work with physicians and other healthcare professionals.

The specific *cultural content* of this paper derives from my work for forty years as a clinical teacher with physicians at various stages of their training (medical students,

interns [first year of residency or apprenticeship], and residents [second and subsequent years of apprenticeship]), and with faculty physician colleagues. The three examples presented later in the paper are drawn from Family Medicine. However, if the proposed method is valid, it could be transposed from American (US) biomedical settings to virtually any applied project and context.

I first raise the question of why physicians could benefit from such life quality enhancement. The paper continues with a discussion of the use of the applied anthropologist's poetry as an extension of the disciplined use of the self on applied projects. I then present three poems and a discussion of each, to illustrate how this process is operationalized. Finally, the paper concludes with the question of the applicability of this approach in any applied anthropology relationship, team, or project.

LIFE QUALITY ENHANCEMENT WITH PHYSICIANS: WHY THE NEED?

The reader might wonder why physician interns, residents, faculty, and community doctors *need* life quality enhancement in the first place. The popular American stereotype is that of "rich doctors" who, apart from their time in the outpatient and inpatient settings, live a life of luxury. This picture is far from true. Physicians constantly see, touch, and cope with those facets of life that most other Americans seek to avoid. Further the life of medical students (Shapiro 2009) and of apprentice and community physicians (Stein 1990; Hafferty 1998; Haidet and Stein

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2006) is not only one of dealing constantly with infirmity, death, decay, body fluids, uncertainty, and lack of control, but is also one that is often psychologically brutal, degrading, and dehumanizing. The current system of medical education contributes to if not creates the need for life quality enhancement among healthcare professionals. Johanna Shapiro succinctly describes the institutional, interpersonal, and inner world of physicians-in-training:

“Part of the socialization process in medicine often means that conversations about the heart of doctoring – the emotional demands of the profession triggered by overwork, stress, loss, uncertainty, suffering, and death – are rarely discussed. Even when they are addressed, physicians often do not feel they have permission within the profession to fully articulate their distress and must rely on routine formulations, depersonalization and distancing, or humor, forms that do not adequately speak to their real confusion and suffering. The result can be burnout, including emotional exhaustion, feelings of cynicism and depersonalization, and a sense of ineffectiveness and lack of personal accomplishment as well as a more existential diminution of values, dignity, spirit, and will, ‘an erosion of the human soul’ (last phrase as quoted in Malasch and Leiter 1997: 17).” (Shapiro 2010: 500).

A common adaptation medical students, interns, residents, and practicing physicians make is “ignoring, detaching from, and distancing from emotions” (Shapiro 2011:326). To these I would add unconscious defenses such as repression, dissociation, denial, splitting, and projection. The result is a combination of not feeling, not recognizing, and not expressing emotions, producing a kind of induced alexythymia (Shapiro 2011).

Clearly, what Fred Hafferty (1998) calls the “hidden curriculum,” and what I have called the “meta curriculum” (Stein 1990), are a different order of learning from the explicit curriculum. In fact the emotionally shaming and deadening experience of medical education ironically undermines the formal curriculum and espoused values of scientific curiosity and rigor, rationality and objectivity, compassion and empathy. As a result of psychological adaptation to the culture(s) of biomedicine, there is a significant deficit in the life quality of physician and physician trainee experiences.

The espoused value of empathy is especially important in doctor-patient communication, as will be demonstrated in this paper. It refers to the capacity for participating in another’s feelings and ideas, while still maintaining a boundary between self and other. Unfortunately, empathy is sabotaged in day-to-day clinical teaching relationships.

Certainly today all medical school curricula feature training in physician-patient communication. The long-dominant physician-, disease-, and technology-centered model has, at least officially, been supplemented if not supplanted by the patient-centered model, if not the even more recent relationship-centered model that encompasses all participants in the care of patients. The current behavioral medicine/mental health component of medical education increasingly encourages clinicians to share their experiences and feelings with colleagues and patients (e.g., in the Balint Groups present in many Family Medicine residencies).

In recent years the official accrediting bodies of American undergraduate (medical school), graduate (intern and residency), and discipline-specific (e.g., Family Medicine) medical education have emphasized the importance of the social and behavioral sciences in all phases of physician training. Likewise there has been a burgeoning of programs and courses in the medical humanities and biomedical healthcare ethics in medical schools and residency training programs. The problem, however, is that the emotionally valent “hidden” or “meta” curriculum noted earlier tends to subvert these ideals and formal curricula in the day-to-day relationships throughout the long apprenticeship phase of clinical training.

Increasingly, medical training and corporate-based medical practice press physicians to see larger numbers of patients in ever-shorter periods of time. The industrial language of “production,” “production reports,” and “productivity” crowds out the humanity of physician and patient alike. Further, the electronic medical/health record (EMR/EHR) is often enlisted in the service of the industrialization of medicine, leading to the truncation of imagination and relationship into ever-more simplified clinical stories, protocols, disease codes, and check-lists. These contribute to the deterioration of physicians’ life quality.

METHODOLOGY, THEORY, AND RATIONALE

How can an applied anthropologist address and attempt to reduce this deficit? Let me place the question in a broad context. Historically the ideological objective/subjective divide has long characterized and plagued the natural, social, and clinical sciences. C.P. Snow explored the history and consequences of this chasm in his 1959 Rede Lectures, *The Two Cultures*. By contrast, I argue that (1) what we often disparagingly call observer/researcher “subjectivity” can in fact provide crucial clinical/scientific data that enhance rather than detract from what we call “objectivity,” and that (2) all knowledge is “personal knowledge” (Polanyi 1974) infused with values (Bronowski 1956). Following the line of thought from Kant to Freud and Devereux (1967), I argue that all knowledge of others and of the external world is mediated by the self of the



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observer/researcher/clinician. The answer to the question, "Where are the data we seek?", becomes at once internal, between, and outside. Paradoxically, what Erik Erikson (1964: 53) called "disciplined subjectivity" becomes a research tool of greater, rather than necessarily diminished and distorted, knowledge of others.

Pursuing this perspective, I "use" my own clinically-based poetry as a guide not only to my own personal internal world, but also to the world of physicians, patients, and families via this internal world stimulated by my relationship with these others. Poetry, as well as the other arts, then can become a vital research tool of the observer/researcher/clinician. Epistemologically, this poetry is a distillation and condensation of experience into metaphor. It also constitutes a kind of analysis, albeit in non-linear form. Later I give several examples of my clinical poetry, and my use of it in clinical teaching, to illustrate this process.

This would seem to give some credence to the admittedly controversial position of English poet Percy Bysshe Shelley in his 1821 essay, "Defence of Poetry," in which he proposed that "[P]oetry is at once the centre and circumference of knowledge; it is that which comprehends all science, and that to which all science must be referred." If not the singular "centre and circumference" of all knowledge, then poetry can at least be construed to be a different and complementary way of knowing – and contributing to knowing – what Octavio Paz called "the other voice" (Paz 1991).

This would in turn offer a new perspective on the epigram from William Carlos Williams that prefaces this essay: "It is difficult to get the news from poems; yet men die miserably every day for lack of what is found there" (1955). Poetry, at least some poetry, can indeed provide ethnographic "news" (data) – knowledge of reality – but it is a source of ethnographic "news" that differs from the standard. What is found in poetry is in fact indispensable knowledge and wisdom to help us construct a more comprehensive picture of cultural reality. If I may rephrase this point in the at-times complicated vocabulary of our field: Greater access in oneself to the polyvocality of the (applied) ethnographer is an instrument for understanding more deeply the polyvocality of the informant(s)/team member/colleagues – and for responding to it in the service of more mutually comprehending collaboration and project enhancement. Thus this approach, if valid, should yield enhancement of life quality to individuals, groups, and the tasks themselves, through personal and group insights facilitated by the use of the ethnographer's poetry.

HOW WE UNDERSTAND OTHERS AND HELP OTHERS TO FEEL UNDERSTOOD

Let me further situate the ethnographer's poetry in an applied clinical context. What is the relationship between

(1) the self of the applied anthropologist, (2) the people with whom he/she is working on some project, and (3) the nature or the problem or task they are addressing? The conventional anthropological answer is a caution, a warning: "Beware of the anthropologist's self and its biases" (similar to Freud's admonition against countertransference in the therapist). Here, the goal of self-reflection is vigilance and subtraction. While partly true, it is an incomplete statement.

For the self of the applied anthropologist is *also* the ultimate instrument of perception, observation, interpretation, explanation, understanding, and collaboration (Devereux 1967; La Barre 1978; Boyer 1999; Ogden 1989). Operationalized, this means that the emotional impact of "the data" upon the applied ethnographer in turn becomes part of, and further generates, cultural data. Stated differently, looking "inward" is a means of more clearly looking "outward." In practice, how does one do this? It is a matter of attending to one's own thoughts, daydreams, fantasies, images, and bodily sensation *while* one is attending to another person or to a group of people. The poem, as a form of understanding or comprehension, emerges from this dual (dialectical) attentiveness.

Here, the applied anthropologist's role is less exclusively "doing" as it is also a way of *being* in relationship with others and being attuned to one's inner resonances with that relationship. The anthropologist is thus both witness and collaborator, and the poem generated in the anthropologist is a way of bearing witness, whatever else it may also be.

John Van Maanen writes that the ethnographer represents "the social reality of others through the analysis of one's own experience" (1988: ix). The applied ethnographer further gives voice to and interprets the experience of others in part by reflecting upon and interpreting self experience. He/she often tells them what they already know but had not consciously thought about and put into words.

Through empathy, the applied ethnographer reflects upon oneself as if he/she were the other. Beyond observing and interviewing others, one *imagines* them as well. It is as though the applied ethnographer helps to create or expand mental space at once in oneself, in those with whom one is working, and in the relational region between them.

For me, writing and using poetry in my work with physicians, is simply one more facet or instrument of on-going participant observation fieldwork in our working relationship on a project or task. Through my clinical poems, I try to process and put into words the thoughts, emotions, fantasies, anxieties, conflicts, and values of physicians, so that they may in turn take them in and reflect on them. This mental process of self-reflection can be visualized as an ever-expanding spiral, where reflection on the part of one mem-



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ber of the relationship spawns further reflection on the part of the other. (Ideas in the previous three paragraphs are indebted to email conversations with Carrie M. Duncan and Michael A. Diamond.)

I am arguing, then, that poems by the ethnographer generated "in the field" are not extraneous or a distraction, but constitute crucial data about relationships with others, and about the group being studied/consulted with/helped (cf. Boyer 1999). Poetry can be understood as "reflective data," as a product of mindfulness. The applied anthropologist reflects internally upon the conscious and unconscious resonance between self and work with others, and in the process learns something simultaneously about self, others, and his/her relationship with them. Poetry is thus one example of the use of the applied anthropologist's self in collaborative work. As such, this poetry is both art and science. I have most recently addressed this process in *Insight and Imagination* (Stein 2007a).

Before I present three examples of this process, let me try to evoke how I think this process takes place in my clinical teaching of Family Medicine residents. To put it rather formulistically, how do I get from the "story-in" phase (where I take in the physician's story) to the "poem-out" phase (where I am moved to write a poem), and later to its use by the physician, the group, or myself? To begin with, I have an experience – say, a conversation with a physician about a patient, participation in a case conference or a physician's lecture presentation, or even recognition of a recurrent theme from living in Family Medicine. I then both consciously and unconsciously mull over the experience, sometimes for a few hours, sometimes for months, even years. I allow myself, so to speak, to resonate emotionally with both the person or group, and the subject matter on which we are working.

In other words, I take in, ingest, the story and the relationship with the person or group with whom I am interacting. To continue the metaphor: I then both consciously and unconsciously digest and metabolize the material I have taken in. It interacts with my empathies, sensibilities, interpretive skills, emotions, personal history, and the history of my relationship with this person or group. Sometimes from this mulling-over emerges a poem. Ethnographically, the poem is a product of immersion, relationship, and my inner processing. In turn the poem then becomes new data about the relationship and about the person(s) with whom I am interacting. It is a distillation or condensation of this experience. It literally grew out of their experience, their sharing it with me, and my reflection upon it, so that when I give it back to them in the form of a poem, it is both theirs and mine – ours.

Further, when offered back to the individual or group

whose information and relationship gave rise to it, this poem produces further insights, understandings, emotions, and perspectives that the recipients take in and process, and in turn ideally leads to a greater sense of well-being in the recipients. This process enhances the quality of life of the physicians with whom I consult and whom I teach. They feel heard, understood, attended to at a deep emotional level. Their anxiety thus contained and processed, they can listen and interact more empathically with their patients and others.

I put their inchoate – hitherto unthought and unfelt – feelings and words are put into compelling metaphors, images, and language. They recognize themselves in them. Moreover, they may in turn develop additional insights, awareness, and compassion, once their stories are returned to them. They also appreciate knowing that I will share (anonymously) their stories and the poems with others, that their experiences will benefit other physicians.

I now turn from theory and method to three poems that came into being in applied anthropological situations in healthcare. They will be used to both illustrate and test the approach I have thus far taken.

THREE POEMS AND DISCUSSION

1. Why We're Here

Change accrues like ice
Wraps itself around
Tree limbs and branches
Until they sag.
Some break from the strain;
Others somehow hold.
New rules, new routines,
New procedures, new technology –
Just when you've mastered one change,
Another comes along like an ambush.
After a while, it's almost easy
To forget why we're here:
To care for sick folks –
For a lot of the poorest ones,
We're the end of the line.
Sometimes we have to remember
To remember, that what we're here for
Is just to do the right thing –
That stays the same.

When I wrote this poem, I hoped that it would strike a "responsive chord" among physicians I knew who were reeling with change and constantly re-adapting to it. It was as if there now was *only* change, and no "base line" to build upon. I could not know how much the poem would resonate with physicians beyond my personal circle. I originally wrote this poem as a Christmas 2007 gift to the members of the Enid Family Medicine Clinic, Enid, Oklahoma, a rural



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family medicine residency training site where I had been teaching for thirty years. I had long admired the medical, nursing, and administrative staff for their dedication to caring for sick people in rural Oklahoma. Their devotion inspired me. In part, I identified with them, and reflection upon that identification provided me insight into the emotional landscape of their work-world. In this poem, I imagined myself as one of the clinic personnel, and projected what the workplace experience might be like. The physicians in the Enid program care for patients both in the outpatient/ambulatory clinic and in the hospitals.

This poem was first published in the fall of 2008 in *Blood and Thunder: Musings on the Art of Medicine*, a medical humanities annual of the University of Oklahoma College of Medicine, Oklahoma City. Almost immediately thereafter it was included in the new issue of *OU Medicine*, the official publication of OU Physicians, Oklahoma's largest physician group (Stein 2008 a&b). I felt at once surprised, honored, and understood. They incorporated my poem about their world into their world, and it became an expression of their voice as well as mine. My voice helped to give them voice. It articulated thoughts they might have not yet put into words.

I soon realized that the recognition was mutual. Several physician colleagues told me that they "saw themselves" in the poem, that they felt understood. They expressed their appreciation for my "finding" and recognizing them in their world and understanding them. They said that I accurately depicted their plight, that I understood why it was increasingly difficult for them to live up to their ideals as professionals whose main purpose is to take care of sick people. This same response occurs when I read the poem to and with physicians in other medical settings.

American physicians feel beset by relentless change – which includes constant software updating of their electronic medical records, and new communication technology such as the availability of clinical information on hand-held smart phones. With the technological changes come the demands of increased "productivity" (seeing more patients in less time, bringing in more income). As a result they feel dehumanized by their own organizations. "Taylorism" (named for Frederick Winslow Taylor and the "principles of scientific management" he introduced to American industry early in the 20th century) and assembly-line thinking has industrialized medicine, and in turn has largely deprofessionalized medical practice. Through the poem, physicians appreciate that their situation, anxiety, demoralization, and trap are recognized and heard. They feel that poet has empathy for them. They begin to reflect on their situation – to think about it – and feel somewhat less isolated. The poem helps them to reaffirm their priorities, and to give words to how difficult it often is for them to reconcile professional ideals

with corporate demands.

With poems such as this, I often receive the comment from physicians that its discussion provides "a completely different perspective" and "helps us to step back and put patient care into context/big picture, something most of us need to do more of."

2. Appointment at the Doctor's

She tries to hold her life together
With baling wire and duct tape.
Sometimes it stays, other times
It unravels and breaks apart.
She and her mother – a grocery store
Cashier and a housekeeper –
Are the sole providers.
They can't afford a car,
And get around town by asking
Relatives for rides and taking the city bus.

It is a blustery winter day;
Her youngest of three kids
Is sick with high fever, cough,
Aches, kept her up all night.
She called the doctor's office
In early morning and was worked in
Their schedule today. Her mom
Stayed home and watched
The two other kids. She bundled
Up her little son and walked
To the first bus stop. They waited.
The bus was late – like it was sometimes
Early, you could never count
On the schedule. Then there was
The transfer, and waiting for
The second bus. At last they walked
From the bus stop to the doctor's
Office, more than an hour late
For their appointment. The receptionist
Scolded her for being late; so did
The nurse after her. They called her
Difficult, unreliable, inconsiderate.
Didn't she understand what a schedule is for?
Someone in the back of the clinic
– a doctor, a nurse? –
Overheard the clamor, and said,
"Let them stay. We'll work them in.
You never know what some people
Have to go through to get here."

This second poem was inspired by the confluence of many events, people, and roles into one recurrent situation. It is about the lives of patients and their families that physicians do not see, often do not think of, lives often quite



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opaque to the outpatient clinic or hospital. It is about the occasional absence of compassion and empathy on the part of some (e.g., receptionists, nurses, in “the front” of the outpatient clinic), and the presence of compassion and empathy on the part of others (e.g., doctors and nurses in “the back” of the clinic, where examination rooms are located and where medical care takes place). It is also about physicians and nurses realizing, through the poem, that they sometimes “bend the rules” of the clinic to accommodate patients’ very different realities. The poem affirms their compassion. As far as it goes, this is true. But much is different from what it seems.

When I work in Family Medicine departments and clinics as clinical teacher and ethnographer, I listen to stories told by everyone. I try to understand and experience each viewpoint. For instance, if receptionists are occasionally brusque and sharp toward patients, in a way they are also “set up to fail.” Receptionists are often seen by physicians and nurses as villains, e.g., people who do not schedule enough patients, or too many; people who put phone calls through to “the back” when they should “take care” of them themselves; people who are abrupt and rude with patients. Receptionists often feel that they can do nothing right. They think they are following or enforcing rules, only to be told that they are violating them. They have much responsibility but no power.

They are literally in the middle. They are “the front line” – a military term – at the boundary between the outside world and the medical/ scientific world. They are both gate and gatekeeper. When I give poems such as this to receptionists, they come to see themselves as others see them, and tell me further stories. They come to better understand their situation – the pressures and constraints of the job – and to feel understood, acknowledged as persons, not mere functions.

Both physicians and receptionists come to “see themselves” and their situations in this poem, and begin to wonder whether it is possible to have a clinic where “heroes” (in this instance, physicians and nurses) do not presuppose “villains” (in this instance, receptionists). Physicians begin to wonder whether it is possible that there is enough empathy to go around to include everyone.

One physician friend read the poem after I told him that I had handed copies of the poem to the receptionists. At first he humorously and defensively remarked that I was fomenting a rebellion, and then said that he realized the multiple demands he and other clinicians in the clinic put on receptionists who had no power of their own in return. He said it gave him something to think about. Several physicians said that the scenario in the poem got them to thinking about situations they had taken for just-the-way-life-is for

many of their patients.

A Latina American physician who had grown up very poor, told me in a tearful voice that my poem had depicted the real world of her childhood – a world she shared with many of our patients, and one she could address in patient care. Many physicians who read the poem told me and others in their discussion group that they saw the clinical world differently now, at least for a time. I felt affirmed in turn that the poem was emotionally and organizationally useful.

3. Christmas Eve in the Hospital

Christmas Eve, sometime after midnight,
A young Mexican woman and her baby boy
Enter the hospital ED. * A pediatric intern
Is on duty, her turn to work the ED.
She imagines home, her husband,
Their baby, their tree.

She examines the sick baby boy,
Starts preparing paperwork
To admit him to the hospital.
Her supervising physician
Interrupts her sharply:
“We’re on divert, we’re full,
No room tonight – send her
To another hospital.”
“How can we do that!”
The intern protests in horror,
But to no avail. All she can do is to
Tell the mother in halting Spanish,
“We’re sorry, but you’ll have to try
The hospital across town.
I’ll call to see if there’s room.”

Ten years later, another Christmas Eve,
This time she is surrounded by family.
Images of that long-ago Christmas Eve
Percolate up, as if it were
Happening again today,
Unfinished with her.
It is like this every year.

* ED is a hospital emergency department, formerly called ER, emergency room

This poem draws upon a story that a pediatrician told me and a group of other healthcare professionals many years ago – a story she needed to tell and retell, a story she needed to be heard (contained, witnessed). It is a harrowing story, a tale of trauma, as much for the physician as



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for the baby and his mother – though traumatic in a different way. The physician yearns to be understood and to somehow find rest – salvation – from the haunting. The poem is about stories within stories, about how a clinical story that is troubling enough on its own, becomes catastrophic and unthinkable because it has cosmic and religious significance. The story and the poem are also about outsidership – the ethnicity of the mother and child, the resident physician who was unable to live up to her calling (“vocation”) as a physician and as a Christian.

The clinical case does not so much resemble as enact, relive, the Christmas drama of the itinerant couple of Joseph and Mary looking for shelter on the eve of the birth of the Christ Child. In the Christmas myth, the innkeeper who had no room in his inn, could at least provide them a barn, a manger with straw. The physician did not even have that consolation, that compromise, for the mother and her sick baby. She was compelled to send them across town to an unknown fate. As a resident, a trainee, she did not have the authority or power to make an exception to the rule, to improvise a temporary hospital “manger” for the sick baby. Physicians are trained to control, to expect to take charge, but she could do neither.

To compound the situation, hospitals are fraught with patients’ and families’ expectations of magic and miracle around Christmas. If ever biomedicine were more myth and rite than science, it was now, the eve of the birth of the Savior and of salvation. I have written about this in another poem (Stein 2006). In the present story and poem, the physician was helpless to save the baby, and by implication (via projective identification), turned away Mary, Joseph, and Jesus. She felt devastated. Her clinical deed was intolerable, unimaginable, *unforgivable*. Her tearful recounting of the story to a group of fellow medical practitioners in January, not long after Christmas, gave her a measure of relief (guilt, shame, remorse, anxiety), but I am certain that it did not resolve her vortex of emotions. She felt grateful for others to have heard the story. She would not be quite as alone.

As for the others, the listeners, they were able to find themselves in her, identify with her, simultaneously as clinicians and as Christians of many denominations. I was also one of the listeners, who, although neither a physician nor a Christian, was immersed and steeped in the worlds of both. Her telling of the story moved me to tears, and eventually to write a poem with which many physicians would identify – and then tell stories of their own. I had been a *witness* to the telling of a cosmic, not merely medical, tragedy. I knew that I had to record and preserve it, to give it voice. The poem represents my attempt to document that moment.

The poem would help later generations of physicians to emotionally (re-)connect to their lives and practices during the Christmas season. They recognize themselves in the poem that recognizes one of them. They would say to me, in so many words, “That could have been me.” Further, the poem, and our discussion of it, becomes a point of departure for sharing their own experiences and stories about the practice of medicine during Christmas and other emotionally-laden times of the year.

CONCLUSIONS AND BEYOND

In this paper I have attempted to explicate a method to help improve the life quality of physicians – those with whom I work, and beyond. I have tried to show how what occurs within me emotionally as I work as an applied anthropologist with physicians is not entirely my own property, but is the product of my relationship and collaboration with them. Although at one level the poetry is “mine,” at another level it constitutes “them-in-me,” or “ours.” After I have written a poem, I often use it in working with the people with whom the poem emerged. Alternately, I also try to use it with a different “ours,” in a teacher-physician relationship that may be remote in time and space from the original situation and relationship that prompted the poem. Here poetry is simultaneously a tool of research, reflection, and collaboration.

Through verbal feedback from Family Medicine interns, residents, and faculty, I infer that this approach enhances their own life quality, and in turn, helps them to have a more empathic, compassionate, and self-reflective relationship with patients. Impressionistically, I suggest that this applied approach also helps physicians to understand their patients’ situations – and to *want* to understand them. It helps to create mental space, so to speak, within the physician and in the physician-patient relationship. Put differently, perhaps my empathy for the emotional life of physicians becomes transposed into their empathy for the life experiences of their patients.

I believe that the approach offered here complements and enhances standard ethnographic methods in applied medical anthropology and in applied anthropology beyond it. It is an approach based on the internal processing of the applied anthropologist’s experience in day-to-day collaboration. Such an approach is only possible by anthropological immersion in the group relationships around the task or project. Beyond individual life quality enhancement, this approach enhances *group* relationships, morale, and task focus. Put differently, group life quality enhancement leads to project enhancement. A poem I might write mediates this process: the poem that is first prompted by group insights, conflicts, and metaphors, in turn helps to create a space in



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the group process for new, different perspectives, and sometimes leads to unthought-of solutions.

This process is akin to (1) my taking a photograph of them with my camera;(2) sharing the photograph with them and having a discussion about it; (3) offering the camera to them, resulting in their own photograph; which (4) they in turn share and discuss (I owe this metaphor to one of the reviewers of this manuscript.). The process becomes recursive, even a spiral of insights and increased empathy.

I wish to conclude by further individualizing and contextualizing this approach: for my main point is not so much the poetry of the applied anthropologist, but access to the self and uses of the self as one of the applied anthropologist's most valuable instruments of collaboration on a project. (For parallels of this approach with Donald Winnicott's "squiggle game" in psychoanalytic therapy with children, see Winnicott 1971; Stein 2007b). Other applied anthropologists may find writing a short story or novel, making a photograph or video, writing or performing music, or painting or drawing a picture, to be his or her preferred medium of discovery and representation. There is nothing unique or obligatory about poetry per se; it just happened to be my own idiom. Poetry is only one vehicle or instrument among many possible ones. The choice of mode is a matter of temperament, relationship, experience, and setting.

Finally, there are two complementary uses of the applied anthropologist's poem or other medium: (1) as a tool of one's own insight into people with whom one is working on a collaborative project (both those people who are a part of the "professional" team, and those who are a part of the so-called "indigenous" team); and (2) as a tool that itself is given to and shared with the other team members, and potentially becomes a part of the relationship, conversation, and work of the group. In either case, it is my hope that the approach presented in this paper will both (1) deepen the relationship among applied anthropologists and those with whom he or she is working, and (2) contribute to the quality of the project, the product, and the lives of all participants.

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