See One, Be One, Teach One:
Faculty Use of Their Personal Health Narratives in Teaching

Dennis J. Butler, PhD; Alan S. Wolkenstein, MSW; Rhena Ruiz-Novero, MD; Brian K. Wallace, MD

BACKGROUND AND OBJECTIVES: Despite extensive examination of physician self-disclosure to patients and colleagues, no studies have directly investigated if physician faculty disclose personal health information to trainees for clinical teaching purposes. This study examines the types of personal medical information (personal health narratives) family medicine faculty use during resident teaching encounters and the beliefs of family medicine faculty about such disclosure.

METHODS: Due to the exploratory nature of this study, the authors relied upon the triangulation of qualitative research methods to verify the use of and purpose for sharing personal health narratives by family physician faculty during teaching encounters. Direct observation, depth interviews, an attitude survey, and focus groups were sequentially used to evoke their beliefs about the purpose, benefits, and risks of sharing personal health narratives with residents.

RESULTS: Ninety-eight percent of survey respondents acknowledged using personal health narratives in teaching, and half reported doing so infrequently. A large majority considered the practice an effective teaching method, but respondents were divided on potential risks. Focus group participants believed that disclosing health information is a powerful teaching method that should be utilized purposefully. Participants identified a need for guidance on how to effectively incorporate personal health narratives during teaching.

CONCLUSIONS: The use of personal health narratives in teaching is well accepted among the physician faculty in this study. Although participants endorsed the practice, none had been trained to integrate self-disclosure in teaching, and most had not consciously considered the limits and risks of sharing their health histories with residents. Further research is needed to determine the prevalence, range, and depth of faculty disclosure in teaching and to assess the impact on learners.

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Recent medical research discusses physicians’ self-disclosure and the potential risks and benefits associated with this practice.1-8 Physicians are encouraged to share their reactions to clinical experiences with colleagues in order to promote self-awareness,9-11 and personal narratives by physicians are routinely published in medical journals (eg, JAMA’s “A Piece of My Mind”). In contrast, self-disclosure by primary care physicians to patients has not been found to have a strong positive effect on the physician-patient relationship, and, in some instances, studies discovered negative and disruptive effects.6-8

However, there is a notable absence in the medical literature about what, if any, personal information teaching faculty share with residents. It is quite likely that in the duration of a faculty-resident teaching relationship, teachers and learners will reveal personal information. Given that the purpose of faculty to resident teaching is to advance residents’ acquisition of medical knowledge and clinical skills for patient care, it is thus also likely that physician faculty have ample opportunity to share their personal health experiences relevant to patient encounters. Whether physician faculty do so has not been examined.

Extensive research in higher education on personal disclosure by faculty for teaching purposes finds the practice common and associated with highly positive outcomes. A
that findings are robust and well developed. The study proceeded sequentially from direct observation of staffing encounters to administration of an evocative survey, then to individual depth interviews, and finally to focus groups with family physician faculty reacting to video trigger tapes.

In the initial phase of the study, the authors sought (1) to confirm if physician faculty use personal health narratives (personal health information, medical diagnoses, or health care experiences) during teaching and (2) to organize such disclosures into a typology that reflects the teaching purpose of the disclosure. To do so, the authors observed clinical staffing encounters at two family medicine residency outpatient clinics on a weekly basis for 6 months and logged occurrences when physician faculty preceptors disclosed personal health narratives to residents for teaching purposes. The two residency programs are community-based urban programs staffed predominantly by full-time faculty. Each program is affiliated with a medical school or university.

Physician faculty members were informed prior to the study that observations of teaching encounters would be randomly conducted to examine teaching styles and were given the option to not be observed. One faculty chose not to participate. Authors completed observations a minimum of 1 half day per week per clinic for 6 months. Observers did not maintain a cumulative count of faculty disclosure of personal health narratives over the 6 months nor were examples linked to specific faculty. Faculty self-disclosure ranged from 0–4 examples per session. The authors independently reviewed and organized the examples into preliminary categories based on the apparent teaching purpose of the disclosure.

Next, the study authors distributed a 10-item, author-developed survey to all family medicine clinical teaching faculty (n=63) at five urban and suburban family medicine residency programs (including the two residencies where initial observations were conducted). The survey was constructed with dichotomous, provocative, and controversial statements in order to evoke attitudes and beliefs. Surveys of this nature, known as “opinionnaires,” are routinely used in political research to uncover voter attitudes, in marketing research to test consumers’ preferences, and in education to elicit students’ reactions to literary works.

Research on physicians’ attitudes about self-disclosure to patients guided the construction of the items. Respondents could only agree or disagree with items (Table 1). The definition of self-disclosure used in the survey was: the intentional communication of medical information of a personal and private nature to patients during teaching encounters. The survey did not include any items seeking identifying information but did include one item asking participants to estimate the frequency of their use of personal health narratives during teaching in the past year.

To foster triangulation, the investigators invited all faculty who received the survey to participate in individual interviews about the use of personal health narratives while teaching. Two authors (ASW, DJB) conducted depth interviews relying on the survey questions as a guide. One author conducted the interview, the second made process notes of the respondents’ comments. After six faculty were interviewed, the investigators concluded that the experiences, opinions, and attitudes expressed were consistent with the staffing encounter logs and the survey findings and did not contribute further understanding of the topic, a condition known as saturation.

In order to explore faculty attitudes about sharing personal medical information in teaching, the authors next reviewed the staffing encounter logs and the depth interviews to categorize the intended teaching purpose of personal health narrative disclosure. Examples of
Table 1: Opinion Survey Items and Responses*

<table>
<thead>
<tr>
<th>Opinion Survey Statement</th>
<th>Agree</th>
<th>Disagree</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sharing personal health information with residents is not complicated.</td>
<td>29</td>
<td>10</td>
<td>39</td>
</tr>
<tr>
<td>Faculty should never reveal personal health information while teaching.</td>
<td>0</td>
<td>42</td>
<td>42</td>
</tr>
<tr>
<td>Revealing personal health information is not burdensome to residents.</td>
<td>20</td>
<td>20</td>
<td>40</td>
</tr>
<tr>
<td>Faculty should consider a resident’s readiness to learn before sharing personal health information.</td>
<td>35</td>
<td>5</td>
<td>40</td>
</tr>
<tr>
<td>Residents will understand the teaching point if I share personal health information.</td>
<td>20</td>
<td>20</td>
<td>40</td>
</tr>
<tr>
<td>I would not share personal health information with residents if it is uncomfortable for me.</td>
<td>1</td>
<td>40</td>
<td>41</td>
</tr>
<tr>
<td>I am not concerned about being judged by residents if I share personal health information while teaching.</td>
<td>21</td>
<td>18</td>
<td>39</td>
</tr>
<tr>
<td>There are ethical problems when faculty use personal health information to teach residents.</td>
<td>16</td>
<td>24</td>
<td>40</td>
</tr>
<tr>
<td>The professional boundary between teacher and learner should not be breached by sharing personal health information.</td>
<td>4</td>
<td>36</td>
<td>40</td>
</tr>
<tr>
<td>The value of using personal health information in teaching outweighs any negative effects on residents.</td>
<td>15</td>
<td>25</td>
<td>40</td>
</tr>
</tbody>
</table>

* Total surveys distributed: 63; total surveys returned: 42

disclosures served four different purposes: (1) to impart medical knowledge, (2) to demonstrate or describe a clinical technique or procedural skill, (3) to encourage an interpersonal ability (empathy, sensitivity, compassion), and (4) to advocate a philosophy of care (Table 2). One author (ASW) reviewed the categories with a physician colleague (non-participant, non-author) who concurred with the final categories. The typology only reflects occurrence, and no attempt was made to determine the frequency with which any of the four types occurred.

In the final phase of the investigation, the authors videorecorded four simulated faculty-resident encounters in which a physician faculty uses one of the four types of disclosure in a clinical teaching encounter with a resident (Table 2). These “trigger” recordings were shown to two focus groups of 22 family physician faculty participating in a faculty development program. All participants were family physician faculty at the same Midwestern medical schools previously referenced in the Methods section. Participants watched the vignettes and responded to six open-ended questions designed to explore their reactions to the simulations (Table 3). The authors transcribed responses and sorted them into themes and trends and then identified core themes using a Delphi method.

**Results**

Forty-two of 63 surveys were returned (67% response). Forty-one respondents (98%) indicated they used personal health narratives in clinical teaching encounters with residents in the past year. Almost half (n=20) estimated doing so infrequently (six or fewer times in the past year); 10% shared their health information with trainees on a frequent basis (>12 times in the past year). All respondents believed it was acceptable to share personal health experiences while teaching. Respondents were divided as to whether trainees understand the teaching point, whether sharing personal information could be burdensome on trainees, or if sharing personal information could result in negative judgment (Table 1). A large majority (88%) believed that faculty should consider the trainees’ educational level before sharing health information. Two thirds held the opinion that the teaching value of using personal health narratives outweighed potential negative effects.

Findings from the focus groups are described based on two types of analysis: a thematic content analysis and a process analysis of the two focus group interactions. Content themes are not derived from discrete discussion topics but rather are extracted from multiple topics discussed in the focus group exchanges. Three content themes emerged from the focus groups (Figures 1–3).

The authors identified the first content theme as the perceived power of disclosure to effect change in the faculty-resident dyad, in learner knowledge, attitudes, and beliefs and to influence clinical decision making (Figure 1). Physician faculty viewed disclosure as altering relationships by making the faculty an authentic, genuine person willing to share personal information with learners. From a clinical perspective, faculty perceived disclosure as powerful because being a “case” could either challenge or verify an evidence-based approach. Faculty became experts,
not because of medical knowledge or clinical experience but from having been a physician-patient. Participants remarked that sharing such information quickly captured the attention of learners. One respondent noted that sharing personal health narratives was so powerful it altered the traditional adage about learning in medicine from “See one, do one, teach one” to “See one, be one, teach one.”

The second dominant theme addressed an inherent tension associated with disclosure (Figure 2). Among the dilemmas discussed were the time involved in telling one’s story, potential ambiguity about the teaching point of disclosed information, personal discomfort with disclosure, and concerns that shared information might be at odds with traditional training. Other participants noted the need to be cautious about the readiness or reaction of trainees, and some faculty felt it was important to consider the developmental stage of the resident learner. Being an “n of 1” was also seen as fostering a “zebra mentality,” potentially leading residents to become preoccupied with atypical diagnoses or circumstances. For some faculty, resident responses to the disclosure of personal health narratives was not always as positive as anticipated, and one faculty admitted to subsequently de-identifying his health information with such phrases as “I once saw a patient who...”

The third theme to emerge was about intentionality and purposefulness (Figure 3). Participants acknowledged that their use of disclosure was influenced by a variety
of idiosyncratic factors. They emphasized the need to take a purposeful approach when using personal health narratives in teaching encounters but did not achieve consensus on what would influence their decision to share. They discouraged impulsive sharing of personal information and emphasized the importance of “setting the stage” for disclosure but could not specify a strategy for choosing the right time, place, and learner. Extensive discussion focused on what was appropriate to share and the boundaries of disclosure. A few indicated using personal health narratives to challenge residents who appeared biased or insensitive toward patients. Some participants offered recollections of residents who were taken aback to learn of their health conditions, and some acknowledged retroactively being concerned about potential embarrassment from disclosure.

The process analysis of the focus group discussions produced the observation that as the groups proceeded, participants experienced “realization and reconsideration” about sharing personal information in teaching. Such unfolding is anticipated when qualitative methods are triangulated because participants often achieve a broader, deeper understanding of the phenomenon through participation. For example, because of examples shared by other participants, faculty members came to the “realization” that the range of personal information disclosed was greater than they’d initially considered. For some, disclosures by other participants exceeded their comfort level. Information disclosed in teaching ranged from the mundane to the highly personal, from an experience with cerumen extraction to side effects of anti-depressant use, treatment of menstrual distress, and an experience with cystoscopy. “Reconsideration” included statements that while their disclosures were deliberate, they hadn’t consciously thought about how to effectively share their personal health information but were now reconsidering how to proceed. None recalled ever receiving any guidance on how to use disclosure for teaching.

Discussion

Among the family physician faculty who participated in this investigation, virtually all acknowledged intermittently using personal health narratives in teaching encounters, and none opposed or disapproved of using such narratives with residents. The high proportion of faculty who...
Inappropriate information about (as identified by learners) disclose ineffective collegiate-level teachers teaching. Research indicating that purposeful use of self-disclosure in clinical structured training on the effects physician educators could benefit from accepted as this study suggests, physicians whose body becomes relevant while disclosure can personalize resident relationship. Focus group discussions suggest that the prevalence of disclosure is likely more frequent than the survey suggests. Participant responses indicate the practice is accepted, perceived as a powerful teaching method, and should be used in a purposeful manner.

Despite broad acceptance, the guidelines faculty developed for the personal health information they share, when they share it, and with whom they share are idiosyncratic. Their personal standards were not immediately accessible, well-structured, or cohesive and appeared to have developed through trial and error or were formulated retrospectively. If using personal health narratives for teaching purposes is as accepted as this study suggests, physician educators could benefit from structured training on the effective use of self-disclosure in clinical teaching. Research indicating that ineffective collegiate-level teachers (as identified by learners) disclose inappropriate information about themselves and others at inappropriate times supports the need to examine this teaching practice. Studies that have found negative and disruptive effects of physician self-disclosure in clinical practice also provide a cautionary warning about the potential risks associated with sharing personal information in professional settings. Family physician faculty need guidance on the depth, breadth, timing, frequency, amount, tone, structure, and assessment of self-disclosed information in teaching.

There was a lack of consensus among the focus group participants about the boundaries of sharing personal health narratives. Disclosure of sensitive and serious health information acceptable to some participants was clearly regarded by others as unacceptable, distracting, burdensome, or having crossed professional boundaries. Self-disclosure with residents is not without risk due to asymmetries in power and position that create the potential for boundary violations, underscoring the importance of maintaining clear boundaries in the faculty-resident relationship. And, while disclosure can personalize faculty, Candib notes that “a physician whose body becomes relevant may risk losing his/her identity as a physician.”

The purpose of this study was to explore and addresses a topic that has received little attention in the literature or in faculty development programs. The findings reflect the opinions, experiences, and beliefs of family medicine faculty in a Midwestern setting and are based on participant recall from the previous year, findings potentially subject to recall bias. Further, in qualitative research, identifying themes from focus group and depth interviews can be affected by investigators’ preconceived hypotheses, bias, or loss of perspective. Because the authors conducted the depth interviews and focus groups, external comment was sought, and the identification of themes was pursued through both independent and collaborative analysis.

Sharing personal health narratives with learners is a unique form of narrative teaching that appears to have the potential to provide learners a deeper, grounded understanding of health and illness. This study provides verification that some family physician faculty purposely use personal health narratives during clinical teaching encounters. The faculty who engage in such disclosure believe it entails limited risk and that the method influences resident acquisition of clinical knowledge and skills. Further research is needed to determine if faculty assumptions about this method are accurate and to identify “best practices” for using personal health narratives. The findings of this investigation also elicit questions about how residents react when faculty use personal health narratives in teaching. Do residents perceive faculty disclosure negatively or positively? Do residents experience such sharing as crossing a boundary? Further research is needed to determine if faculty personal health narratives
have the desired effect on the recipient learners.

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CORRESPONDING AUTHOR: Address correspondence to Dr. Butler, Columbia-St. Mary’s Family Medicine Program, 1121 E. North Avenue, Milwaukee, WI 53212. 414-267-6533. Fax: 414-267-3892. dbutler@mcw.edu.

References