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The Humanism Pocket Tool



Techniques for Clinicians and Trainees

Developed by the Department of Veterans Affairs
to improve the care of homeless veterans

Developed at:

VA West Los Angeles Healthcare Center

Developed by:

VA Center of Excellence: Inter-professional Academic - Homeless
Patient Aligned Care Team (COE-IA-HPACT)

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The Humanism Pocket Tool: A guide for clinicians and trainees.

Version 5.0 (9-8-18)

This guide explains why and how to use seven techniques to stay humanistic with challenging patients. The following pocket reminder card summarizes the seven techniques and is available from the authors.

<p>The Humanism Pocket Tool* version 5.3</p> <p>Techniques for Clinicians and Trainees</p> <p>Concept: Your brain is equipped with inborn, automatic, emotional responses biased to protect you from people who <i>might</i> be dangerous, infectious or time-consuming. These emotions can sneak up on you. Use the following techniques to adjust your brain and stay humanistic.</p> <ol style="list-style-type: none">1. Coach yourself toward a caring frame of mind For example, tell yourself “I may be frustrated AND I can choose compassion.” Or, “Mr. Smith is not himself today.” Or, “I’ve got a strong and compassionate team.” (See numbers 5, 6 and 7, on back of card).2. Be warm Use your non-verbal behavior—tone of voice, physical proximity, touch, and mirroring patient movements—to reassure a patient that you are not angry, frightened, or disgusted. Begin by comparing your behavior in warm, professional relationships with your behavior with challenging patients. Then, adjust your behavior with patients in the warm direction.3. Listen actively Begin with a question like “What brings you here today?” For 3-5 minutes, use only open-ended questions, minimal encouragements to continue, restatement, and empathic remarks.4. Create a vivid vignette Use active listening and questions such as “What matters to you?”, “What brings you joy?” and “What gets in the way?” to discover the patient’s aspirations and obstacles. Distill them into a vignette such as “35-year-old Marine Corps veteran studying to be a pastor but haunted by an Iraqi torture chamber.” Tell the patient how you will use the vignette (see below). Read the vignette to the patient and ask what changes you should make. The vignette reassures the patient that you see him or her as a person, not simply a diagnosis.	 <ol style="list-style-type: none">5. Use the vivid vignette with other professionals to inspire and coordinate care. Refer to the patient using the vivid vignette in discussions with colleagues and in the ID or summary section of progress notes. This helps you and your colleagues to see the patient more vividly as a person, and to see your interactions with the patient as part of an evolving story, one in which you may become an important character. As you get to know the patient and the story evolves, update the vignette.6. During interprofessional meetings, listen actively and appreciate differences. These two techniques help you understand others’ assessments and treatment proposals and thereby create overall treatment plans no one person could design or deliver. Knowing that your team is both willing and effective allows you to remain humanistic with complex patients who would otherwise seem overwhelming (see number 1).7. Know your colleagues as people The better you know your colleagues, the better you can see their points of view and the better you can understand their assessments and treatment proposals. Try this: On Monday mornings, check in with some of your team members by asking about their weekend. This will help you know them better. <hr/> <p><i>Under continuous development by:</i> <i>The VA Center of Excellence: Interprofessional Academic - Homeless Patient Aligned Care Team (COE-IA-HPACT) at the VA West Los Angeles Healthcare Center with support from the Arnold P. Gold Foundation.</i></p> <p><i>*For more cards to give to colleagues, send your address to: Andrew.Shaner@va.gov or Andrew.Shaner@gmail.com. We'll also send you the full manual and an offer to collaborate on further development.</i></p>
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Please collaborate with us: This is a work in progress. Some sections are incomplete. Moreover, we are sure there are other techniques waiting to be discovered. So, please offer us your suggestions, try the techniques, and give us feedback.

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Introduction

Treating homeless veterans is challenging. They often suffer from vexing combinations of physical disorders, mental disorders, and poverty, so healthcare teams must have considerable technical expertise in health care and social services. In addition, homeless veterans are often angry, threatening, malodorous, and poorly adherent to treatment. As HPACT clinicians we have, at times, struggled with our own impulses to keep our distance from them, including emotionally. We have learned to do a variety of things to stay focused on them as people, and we want to share a few key techniques. We call these crucial few techniques “The Humanism Pocket Tool” or HPT.

What’s a pocket tool? Consider the Swiss Army Knife or the Leatherman Multi-tool, especially the tiny versions with just a half-dozen individual tools. People use these to keep handy the key tools they need to modify the physical world—a knife to whittle a stick, a driver to turn a screw.

Likewise, the HPT comprises a few individual tools, or more correctly, techniques. We use these techniques to counteract our own inborn, automatic, dehumanizing responses, and help us stay humanistic with a challenging patient population.

Humans are very social, but only to a point. Automatic dehumanizing mechanisms evolved to prevent others from taking advantage of our altruism and to protect us from dangerous people and pathogens. In a modern healthcare setting, we have other ways to protect ourselves—detailed medical records, security personnel, and hand sanitizer—so we can be humanistic without putting ourselves in danger. But, this does not stop our automatic responses. The tools in an actual Swiss Army Knife help you modify

your physical world. The tools in the HPT will help you adjust your mental world. They will help you understand and temper your automatic emotions, thoughts, and behaviors, so that you can continue to be both humanistic and safe even with patients who push all your de-humanizing buttons.

When you take a humanistic approach, patients notice. Many homeless patients have come to expect fear, contempt, or disgust from others, including clinicians. So, when you show compassion instead, you stand out and are in a better position to guide patients through recovery.

We have included tools to be used before you see a patient, while you see a patient, and when you interact with other members of your inter-professional team. The way you interact with other professionals helps establish a culture of humanism; this culture will help you stay focused on your patients as people. Several tools – active listening, for example – come in two versions, one for use with patients and another for use with other professionals.

Why the word “Pocket?” Many activities, for example, gardening, backpacking, bike riding, require tools. But, you can’t carry every tool you might need. A pocket tool, such as a Swiss Army Knife, allows you to conveniently carry a few tools likely to prove crucial and get you out of a jam. Likewise, the HPT contains a few crucial tools that every clinician needs at the ready to stay humanistic with homeless veterans. We have also created a reminder card that really does fit in your pocket.

Overview of the Tools on the Humanism Pocket Tool

Following is an annotated list of the current tools. Detailed instructions, for some, begin on page 6.

Tools to use with patients:

- 1) **Coach yourself:** Say sentences to yourself to put yourself in a humanistic frame of mind, either before you see a patient, or when you feel a dehumanizing impulse. For example, before seeing a patient likely to prompt dehumanizing responses, one HPACT psychologist says to herself, “I may be frustrated AND I can choose compassion.” Faced with a patient whose homelessness appears especially hard to solve, one HPACT social worker prepares herself for collaboration by saying to herself, “We are in this together. How are we going to get out of this mess?” When a patient unexpectedly becomes angry and abusive, one HPACT LVN says to herself, “Mr. X is not himself today,” indicating that Mr. X, at core, is not like this, that something else is causing the disruptive behavior and this leads her to specific steps needed to understand and intervene in a way that keeps staff safe while ensuring the patient gets the care he or she needs.

Remind yourself that you are not alone in providing care. For example, faced with a patient with multiple, seemingly intractable medical and social problems, one HPACT psychiatrist says to himself, “I’ve got a strong and compassionate team.” (See tools 5, 6 and 7, on back of card).

- 2) **Be warm:** Your non-verbal behavior—tone of voice, physical proximity, touch, and mirroring patient movements—can reassure a patient that you are not angry, frightened, or disgusted. You almost always shake hands, but beyond that it’s complicated and depends on your personality, profession, gender and culture, as well as the patient’s culture, gender, and so on. So, you must personalize your adjustments. Begin by comparing your behavior in warm,

professional relationships with your behavior with challenging patients. Then, adjust your behavior with patients in the warm direction.

- 3) **Listen Actively:** Early in an interview, reserve a few minutes for open-ended interviewing, beginning with a question such as “What brings you here today?” For the next three to five minutes use only four “listening responses”: open-ended questions, minimal encouragements to continue, restatement, and empathic remarks. Avoid questions that can be answered “yes” or “no” or with any short answer. This encourages patients to talk about what they see as important, allowing you to hear their story and to better see things from their perspective. It helps establish rapport, and gets you a more reliable history because it sharpens the closed-ended interviewing that follows. It can also be used to develop a *vivid vignette*. See Tool 4, below.

Especially important questions to ask of homeless veterans are the following: Where are you living? How did you become homeless? What is the worst thing that ever happened to you? What brings you joy? What is standing in the way?

- 4) **Create a Vivid Vignette:** Use active listening and questions such as “What matters to you?”, “What brings you joy?” and “What gets in the way?” to discover the patient’s aspirations and obstacles. Distill them into a vignette such as “35-year-old Marine Corps veteran studying to be a pastor but haunted by an Iraqi torture chamber.” Tell the patient how you will use the vignette (see below). Read the vignette to the patient and ask what changes you should make. The vignette reassures the patient that you see him or her as a person, not simply a diagnosis.

Tools to use with other healthcare professionals:

- 5) **Use the Vivid vignette with other professionals:** Develop the vignette in collaboration with the patient. See tool 4 above. Refer to the patient this way at the beginning of progress notes and in discussions with colleagues. This helps you and your colleagues to see the patient more vividly as a person, and to see your interactions with the patient as part of an evolving story, one in which you may be an important character. As the story evolves, update the vignette, e.g., “...recently ordained minister.”
- 6) **During interprofessional meetings, listen actively and appreciate differences:** These two techniques help you understand others’ assessments and treatment proposals and thereby create overall treatment plans no one person could design or deliver. Knowing that your team is both willing and effective allows you to remain humanistic with complex patients who would otherwise seem overwhelming (see number 1).
- 7) **Know your colleagues as people:** The better you know your colleagues, the better you can see their points of view and the better you can understand their assessments and treatment proposals. You can begin simply by asking one of your team members about their weekend. This will help you know them better.

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How the techniques work together to create a culture of humanism.

Here is the overall sequence whereby an effective and inspired team allows individual team members to be more humanistic with patients in a virtuous cycle in which humanism makes a team more effective and being more effective makes them more humanistic.

1. The vivid vignette inspires you and your team to assist people with daunting biological, psychological and social obstacles.
2. So inspired, your team must draw on the disparate strengths of its members to create effective treatment plans no one person could design or deliver.
3. This requires that team members know not only the role each member plays, but also the person filling that role.
4. When team members are inspired, and they know each other well, they can use active listening to take each other's perspectives and to understand potentially disparate assessments and treatment proposals. From these various proposals they can craft effective treatment plans.
5. Knowing that your team is willing and effective allows you to remain humanistic with complex patients who would otherwise seem overwhelming.

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Approaches and Tools Under Development by COE and HPACT Staff

We are constantly developing the HPT. Following is a list of approaches, themes and tools under consideration or under development.

Retell the patient's personal story: We designed the Humanism Pocket Tool to encourage patients to tell their personal stories. Be prepared for powerful, even shocking stories that you cannot ignore or forget, stories you feel you must retell, stories that make you and your team go the extra mile to improve patients' health and social circumstances, stories that evolve and that include you as an important character. In a sense, the Humanism Pocket Tool can be seen as a set of techniques that allow patients' personal stories to inspire and coordinate the interprofessional healthcare they so desperately need.

Special tools for clerical staff: Clerical staff face special challenges in dealing with a lobby full of veterans with a wide range of yet-to-be-assessed concerns and problems. One HPACT clerk makes it a point to put herself in each patient's shoes, at least partially. As she explains it, "They are sick and homeless, they may not be themselves...but we are." From this perspective she assesses patients as they enter the lobby. Are they new? Often disruptive? Currently disruptive? She also makes it a point to know which clinician has the best relationship with the patient should she need help.

Be an accessible expert: This is the goal of a set of thoughts and behaviors designed to mitigate the barriers stemming from differences in social rank between the clinician and the homeless patient while preserving the clinician’s role in such a manner as to inspire both trust and confidence. They include giving medical information in accessible language while preserving expertise, sharing personal details when appropriate, and using non-verbal behavior to express warmth.

Suspend judgment: People are built with a propensity to judge and punish wrong-doers. We even punish those who fail to punish wrong-doers. Many homeless patients have done things that are wrong, illegal, or immoral, and your natural propensity to judge and punish could interfere with treatment. For example, among our patients are some who have molested children or committed murder. Or, more commonly, during treatment they repeatedly do things that undermine their own health and safety, for example by repeatedly using methamphetamine. Your social brain may naturally attempt to determine whether or not it was their fault and whether or not they deserve punishment. Of course, neither determination is useful in healthcare. You can provide more humanistic and effective care if you suspend judgment and focus not on intent or fault, but on the chain of events that produced the wrong-doing and on the consequences of that wrong-doing. The pocket tool helps you do just that.

Interact with people, not just roles: People can form complex and effective social structures based on our roles within those structures. When you know a person’s role in the clinic, you know quite a bit about how to interact with them. But, the relationship can be far more successful if you interact with both the role AND the person in the role. For example, knowing both the person and the role will help you take your colleagues perspective. (See also, Case Example #2 on p. 12.) The same holds for patients. They play a role, too, the most important role. You could interact with their role as patient only and avoid any seemingly extraneous personal details. However, you will be far more effective, especially with homeless patients, if you also interact with the person playing that role. (See the active listening and vivid vignette tools.)

Practice Mindfulness-Based Stress Reduction (MBSR): We use this before many faculty and staff meetings because it clears the mind of distractions and allows full participation. We are exploring the possibility of incorporating a reminder cue or hook into MBSR (such as touching the roof of one’s mouth with one’s tongue, or using scents such as lavender), such that the provider can tap this hook when needed to pause before responding to the patient, allowing the provider to tamp down unconstructive responses (such as passing moral judgment, getting angry, disgusted, or frightened, etc.).

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Each Tool and How to Use It.

1. Coach Yourself

Purpose: [insert description of how and why self-talk is a good way to prevent and to manage dehumanizing responses such as contempt, fear, disgust, indifference and anger.]

Specific Examples:

- a. **“I may be frustrated AND I can choose compassion”:** This is useful when you are about to see an especially challenging patient, particularly if the patient is interpersonally difficult or demonstrating symptoms of psychosis, mania, personality disorder, etc. You may recall a previous visit that was aversive and you may have already predicted how the visit today will end. This sentence will help you acknowledge and validate your own emotional response to the patient. It simultaneously brings you back to a present focus, able to take an active stance in the direction of being humanistic and meeting the needs of the patient.

- b. **“Mr. X is not himself today:** Suppose you prepared yourself for a sometimes-disruptive patient by saying “I may be frustrated AND I can choose compassion.” Nevertheless, during the exam, the patient flies into a rage and storms out of the building before you can fully address some very important healthcare problems, and your next patient is already waiting. Exactly how do you “choose compassion”?

This sentence can help. When a veteran’s disruptive behavior worsens suddenly and interferes with treatment delivery, it’s easy to become angry with the veteran because the disruption is a setback and is going to require extra time and energy. Your anger can interfere with compassion and lead you to behave in ways that are dehumanizing. For example, you could become disinterested in his recovery or become punitive. So, you need a way to stay humanistic and compassionate as you continue to work on the problem.

The sentence is simple, but it means a lot. It implies that Mr. X, at core, is not like this, that something else is causing the disruptive behavior. This is crucial, because it suggests a problem-solving strategy designed to help the patient. Exactly how is he not himself? What are the likely immediate and remote causes of this difference? If there are competing hypotheses, how can you resolve them? Considering the likely causes, what is best course of action?

In circumstances just like this, an HPACT LVN was alerted to the situation. She said to herself **“Mr. X is not himself today”**. Then she took a minute to think about what to do. She developed a plan with the following logic: Go see him at the shuttle stop and determine if he is intoxicated. If yes, don’t bring him back, but encourage him to return at another time. If he is not intoxicated, ask if he still wants to see Dr. W as he had planned. If yes, then keep him focused only on that visit and maneuver him back into the exam room. She then executed the plan, and, when he started to rant about an “evil” clerk, she said, “We are not going to talk about that, Mr. X. We are just going to make sure you can see Dr. W.” It worked and he received the care he needed.

- c. **“Leave it in the past.”** An HPACT LVN says this to himself to remind himself of a strategy he learned during years of work in acute inpatient psychiatry. He wants patients to have the

experience that no matter how they behaved in the past, no matter how demanding, threatening, or even assaultive they have been, this particular LVN is always friendly, caring, and helpful. This creates at least one interpersonal relationship in which there is always an invitation and opportunity for the patient to improve.

2. Be warm

Your non-verbal behavior—tone of voice, physical proximity, touch, and mirroring patient movements—can reassure a patient that you are not angry, frightened, or disgusted. You almost always shake hands, but beyond that it's complicated and depends on your personality, profession, gender and culture, as well as the patient's culture, gender, and so on. So, you must personalize your adjustments. Begin by comparing your behavior in warm, professional relationships with your behavior with challenging patients. Then, adjust your behavior with patients in the warm direction.

3. Listen Actively

Purpose: This tool is crucial when seeing a patient for the first time, when exploring any topic for the first time, or when re-exploring a topic. It helps you see things from the patient's perspective, gives you spontaneous and often more reliable descriptions of symptoms, shows the patient that you listen well, and helps you establish rapport. Following is a description of how to use it during the first three to five minutes of an initial psychiatric interview. With minor modifications you can use it for almost any clinical interview and at any point you begin to explore a new topic. Moreover, you can use the tool to learn about aspirations (see the Vivid Vignette tool). For example, you can ask "What brings you joy?"

You can begin with a wide variety of questions, including queries as simple as "How are you?", "How can I help?", "How does it happen that you came to the clinic today?" or, to explore a specific symptom, "Tell me about the panic attacks."

General instructions:

- 1) During the next three to five minutes, use only listening responses (enumerated below); do not ask questions that can be answered with "yes", "no," or any other very short answer.
- 2) This can be difficult, so note the time the interview begins and write down what time it will be when five minutes are up. Otherwise, you are likely to begin closed-ended questions too early.
- 3) Think each question over carefully before you ask it. If it is closed-ended, convert it to an open-ended question or some other listening response. For example, instead of "Are you depressed?" ask "How's your mood?"
- 4) In most cases, after five minutes of listening responses, you will have identified the prominent clinical features. In the rest of the interview you can add closed-ended questions to further clarify these features and arrive at provisional and differential diagnoses.

- 5) Note that there is no need to continue open-ended questioning for five minutes if it is clearly unproductive. For example, disorganized speech may make it impossible to obtain information using open-ended questions. If so, then the disorganized speech itself becomes a prominent feature to be understood diagnostically.

Listening responses:

- 1) *Minimal (or brief) encouragements to continue*, such as nodding your head, or saying "Uh-huh," "go on," and "tell me more".
- 2) *Open-ended questions* that patients cannot answer easily with "yes," "no," or other brief responses. Example: "What brings you to the clinic today?"
- 3) *Restatement*. Example: "So, you were feeling fine until about three weeks ago, when you became aware that you were being watched. You noticed that..." This allows you to develop the history of present illness and have the patient check it for accuracy.
- 4) *Empathy*. Describe an important emotion that a patient apparently experienced or is conveying now. For example, "You are very angry because you believe that..."

More on empathic remarks:

- 1) Empathic remarks are useful in diagnostic interviewing because they often lead to information you would not otherwise have obtained. They are part of the specialized skills of mental health specialists, but can be used by others as well.
- 2) Use empathic remarks sparingly, and only when needed to deepen rapport and thereby obtain information you need to clarify the nature and depth of suffering. In a sense, your open-ended interviewing is a bit like a surgeon examining a patient for the possibility of appendicitis. And, your empathic remark is like the surgeon's test for "rebound tenderness" in the right lower quadrant of the belly. It can hurt, but also reveals crucial information that may otherwise remain hidden.
- 3) Craft empathic remarks carefully. State the emotion as precisely as possible without speculating too much about the patient's emotions. For example, a patient talks fondly of his recently deceased mother. He says that he has put his mother's death behind him, but he swallows hard and touches the corner of his eye. You say, "You loved her deeply." He starts to cry and says how difficult it is to live without her. Of course, there is some risk that he also hated her, but empathic remarks seem to work best when they are precise enough to carry some risk of being wrong. For example, saying, "It's hard to lose a parent," has no risk of being wrong, but is unlikely to deepen rapport or provide useful information.

4. Create a Vivid Vignette

Purpose: Inter-professional care requires frequent discussions about patients. At a very practical level, it is hard for team members to be sure which patient is under discussion; their demographics and problem lists are rarely unique. So, it is difficult for team members to recall the patient being discussed.

Reminding team members of a patient's key *aspiration* and *obstacle* not only solves the problem of identification, it reminds the team what we are working towards and what stands in the way. We can concern ourselves not only with what diseases the person has, but what person has the disease. Moreover, stating an aspiration and an obstacle sets up a dramatic tension that draws us into the story as participants. Will the patient achieve his or her aspiration? What will the treatment team do to help? In this way, the Vivid Vignette tool is consistent with Narrative and Humanistic Medicine.

General Instructions: During open-ended interviewing ask questions such as:

“What brings you joy?” “Where would you like to see yourself in the future?” “What is getting in the way?”

Follow-up using listening responses only (see Active Listening). Use empathic remarks here too, but with respect to positive emotions. For example, a patient beams at the thought of returning to his artwork and you say, “You’d love to be known as the artist, not the addict.” Use what you learn to identify important aspirations and obstacles.

Get the patient’s input as follows:

“Our team will meet frequently to discuss how to help you. I want to make sure everybody knows who I am talking about when I bring up your name. I’m thinking of introducing you as follows. What do you think?”

5. Use the Vivid vignette with other professionals

Develop the vignette in collaboration with the patient. See tool 4 above. Refer to the patient this way at the beginning of progress notes and in discussions with colleagues. This helps you and your colleagues to see the patient more vividly as a person, and to see your interactions with the patient as part of an evolving story, one in which you may be an important character. As the story evolves, update the vignette, e.g., “...recently ordained minister.”

Here are some examples:

- 36-year-old Latino male Marine Corps veteran studying to become a pastor, but haunted by a torture chamber he toured in Iraq.
- 26-year-old Caucasian male Navy veteran and aspiring actor who panics during social interactions.
- 38-year-old African American female Army veteran, who studied criminology, but is now convinced she is trapped in a fake version of America while being eaten alive by parasites.

6. During interprofessional meetings, listen actively and appreciate differences.

These two techniques help you understand others' assessments and treatment proposals and thereby create overall treatment plans no one person could design or deliver. Knowing that your team is both willing and effective allows you to remain humanistic with complex patients who would otherwise seem overwhelming (see number 1).

Active listening in clinical team meetings is very similar to active listening to a patient. Use open-ended questions such as "What's your perspective?". Particularly important is to restate the other team-members point of view as accurately as you can. Appreciative Inquiry is a method of focusing on what is already working well rather than on fixing what is broken. The focus on success helps to form the vision of the way forward. This approach emphasizes capability rather than blame and hope rather than fear. Appreciative conversations strengthen the capacity of team members to seek and understand each other's needs and perspectives.

7. Know your colleagues as people.

The better you know your colleagues, the better you can see their points of view and the better you can understand their assessments and treatment proposals. You can begin simply by asking one of your team members about their weekend. This will help you know them better.

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Case Examples

Case 1: "He's unwilling to cut down."

You're a member of a VA inter-professional team working with a 55-year-old man, morbidly obese despite a previous bariatric surgery, who continues to gain weight despite motivational interviewing and individual health coaching. He is so large that housing programs cannot meet his physical needs. He knows that losing weight would improve his hypertension, diabetes, and chronic pain. Yet, he does not follow team recommendations and continues to buy and consume fast food every day. You and your colleagues are increasingly frustrated, even angry with him.

Analysis: Your anger is understandable. The patient asked for your help and you have invested considerable time and effort. The patient understands that medical complications of obesity are making him miserable and will eventually kill him. He agreed to make changes in his diet and to exercise, and then failed to do so. He is not holding up his end of the bargain, and so you and the team are angry.

The anger arises from your social brain which evolved to help our hunter-gather ancestors regulate cooperative relationships. It still works very well in many modern contexts. For example, suppose you go out to dinner with some friends and agree in advance that you will split the bill. One friend proceeds to order an outlandishly expensive meal and drinks, while everyone else orders modestly. Everybody else is angry because he appears to be a "free-rider", willfully exploiting the cooperative relationship for

his own personal gain (see Conceptual Framework). You'll certainly make a mental note not to invite that friend again, or to insist on separate checks.

Your social brain notices when you have entered into what appears to be a cooperative relationship with another adult. It compares your efforts with those of the other participant. It notices when you have invested considerable effort in the shared endeavor, but the other person has not. It prepares you to take action by triggering the anger that will drive you to either correct the problem or end the relationship.

To your social brain, the clinical relationship felt like a cooperative relationship in which there was an unspoken agreement, something like "We will work hard to help you, if you will work hard to help yourself." From this perspective, the patient's repeated failure to follow your advice appears as a willful violation of the agreement, and this prompts anger and even an impulse to end the treatment relationship.

However, your social brain has made an error. This is no ordinary cooperative relationship and your social brain did not evolve to cope with it. The Department of Veterans Affairs pays your team to go all out to help this veteran stay healthy. If he fails to follow recommendations, the team is supposed to figure out why and to try new approaches. At some point, you may run out of approaches to try, but even then, you still can't end the treatment relationship. The problem is that your anger and your feeling that the patient is to blame arise from a social brain that evolved long before modern publicly-funded medicine.

Recommendations: First, it's important to notice that you are angry and to understand that it is a natural response to a relationship that your social brain did not evolve to manage. Next, re-frame the relationship to help your social brain deal with it in a way that is in the patient's best interests. The key difference is that the clinical relationship is much more asymmetrical than it seemed. The patient is free to end the relationship, but you are not. You are supposed to keep searching for ways to help, even if the patient seems to undermine those efforts. To some degree the relationship is similar to a parent-child relationship, so it can be useful to think of this analogy. Of course, you must also keep in mind that while your role is like that of a parent—always trying to help, always maintaining the relationship—the role of the patient remains that of an adult, free to accept or reject your help. That said, the idea of a parent-child relationship can serve as a kind of shorthand to remind you of the deep asymmetry in this relationship. It can help quell the anger and propel you to take action, not to end the relationship, but to understand and solve the problem.

But, what happens when you run out of treatment approaches? What happens when further efforts are clearly futile? This can lead to contempt. Some team members might harbor a nagging feeling that the patient is "a loser" who is unworthy of your efforts. In this way, contempt prepares you to end the relationship. Several approaches may be useful here. The first is to recognize that there is always one tool left – the treatment relationship itself, and if you maintain it, you are never completely out of options. Second, notice that by labeling the patient's actions as "willful" your social brain is taking a shortcut that assigns blame to the patient and absolves you of further responsibility in this cooperative

relationship. This shortcut is quite useful in many cooperative relationships, but not here, because it ends the relationship -- even if it does not, it provides no guide as to how to maintain the relationship.

Instead, it may be useful to view the patient's actions, including apparently "willful" ones, as yet another product of his cells—brain cells in this case. It may be that the team will run out of ways to influence his brain cells to produce a different product—actions that actually follow treatment recommendations. In this mechanistic view, "will" is irrelevant and the situation resembles other types of medical futility. For example, when we run out of cancer treatment regimens, we don't blame the patient. This is because we see physical processes as outside his control. Yet, brain processes are physical processes. They can't be anything else. Yes, they are physical processes we can sometimes influence with language, with recommendations, but often not. When the patient's language processing is clearly impaired and he fails to understand the recommendations, we don't consider it willful. When the patient's frontal lobe executive systems are compromised and he can't carry out an action plan, we still don't blame the patient.

But, even when there is no known cognitive problem, there must still be a mechanism that produces the apparently willful failure to follow recommendations. And, it may be that we cannot influence that mechanism. But, it serves no purpose to blame the patient. What may be useful is to have a conversation with the patient, like the one you might have with a cancer patient whose options have run out, a conversation in which you describe what has been tried so far, and the lack of results. In this context, the continued overeating is a key fact, akin to the continued replication of cancer cells, but not a reason for anger, contempt or blame. The conversation is not aimed at changing the patient's behavior, but instead at informing him of the current state of affairs, namely that you are out of options and this is headed in a deadly direction. This stance will allow you to stick with the patient, but with a realistic and shared understanding of the likely consequences. Paradoxically, thinking of the patient as a complex machine may allow you to deliver more humanistic care, because it disengages the part of your social brain bent on ending an apparently costly relationship.

Case 2: Whose job is this?

A VA inter-professional team is working with an elderly Korean American man who speaks limited English, often so rapidly that he is very hard to understand. The PCP sends a message to the team social worker asking her to obtain a translator for the next clinical appointment. Instead, the social worker sends a link to a website that the PCP can use to find a translator. The PCP is angry.

Analysis: Social relationships are structured through roles (see Conceptual Framework). Cooperative tasks are divided according to roles, and we get angry when we believe another has not fulfilled their role. Naturally, if the participants don't have completely shared descriptions of those roles, both parties can feel disappointed and put upon. In this case, the role of finding a translator was never previously discussed. The PCP believed it was the social worker's role, but the social worker had no such preconception. Moreover, the PCP's electronic request did not say "please find a translator." Instead it asked "please help us find a translator." So, the social worker believed that finding a translator was a shared responsibility and thought that by finding a website, she had been helpful. Both the PCP and the

social worker thought they were doing the right thing, but the PCP was disappointed—and could have made matters even worse by accusing the social worker of shirking her responsibility.

It is important to notice that the PCP jumped to the conclusion that the social worker had shirked her responsibility. This is true even though, in other domains, the PCP is very good at considering multiple possible explanations. For example, the PCP is expert at thinking through all the possible diagnoses that could account for a patient's symptoms. However, cooperative social relationships are complex and vulnerable to free-riders, so our social brains have evolved to be very sensitive to the possibility of free-riders and to sound an alarm which we experience as anger (see Conceptual Framework).

Remedy: To a large extent, such disputes can be avoided by making roles clear up front. However, you can't detail everything, and the role of "finding a translator" had never been assigned to any particular team member. How should the team handle such conflicts?

We are experimenting with a structured approach we call "role consultation." It works like this: The PCP visits the social worker and says, "I need a role consultation." The social worker understands this as shorthand for "I thought I asked you do something that's your role, but you didn't do it. My social brain started to get angry, but I think it's safe to assume that I wasn't clear, or this is a new task, or there is some other reasonable disagreement. I'd like to follow our usual procedure for sorting this out." The social worker says, "Sure, what's up?" The PCP then describes the request she thinks she made, and the response she thinks she got. The social worker describes the request she perceived and the response she thought she made. The two then categorize the potential conflict and devise a solution, perhaps with help from the rest of team at a team meeting.

Case 3: Choked-up

A 30-year-old, homeless, male, Marine Corps veteran, sleeping in a laundromat, occasionally using methamphetamine, and complaining of PTSD, was seen for an initial psychiatric evaluation. He was proud of his combat role leading a four-man team, engaging the enemy and protecting the other three men. So, he was deeply disappointed when, half-way through his second deployment, he developed painful degenerative changes in his lower legs and ankles and was told he was to be discharged from the Marines. He was devastated, especially when he told his teammates he was shipping out. As he began to describe their reactions, he swallowed hard, looked at the ground, covered his face, asked for water and then bolted from the office into the bathroom. He returned and explained that he could not shake the feeling that he had abandoned his team.

The psychiatrist was surprised that each time he described this interview to various HPACT clinicians he choked up at that same point in the story as did the patient, even though he tried to suppress it. Is this secondary traumatization? Does our humanistic approach to care expose us to stories of trauma that then traumatize us as well?

Considerable clinical literature suggests that therapists, clergy and others who work with trauma survivors experience strong emotional reactions, including PTSD-like symptoms. However, the psychiatrist said he was not overwhelmed during the interview and has not been feeling unsafe or

hypervigilant, was sleeping fine and in general was unchanged. It's only when he tells the story to other staff that he chokes-up and only at that point in the story. He believes it is connected to his desire to work with the interdisciplinary team to help the patient recover from the trauma of separation from his team.

Getting choked up may indeed be linked to the psychiatrist's desire to enlist other team members in helping this patient. It may be what evolutionary biologists call an "honest signal." The term refers to bodily or behavioral traits that reliably indicate some quality critically important to another individual. They are reliable or "honest" because they are hard-to-fake.

When shopping for potential members in a cooperative enterprise, one needs to avoid those who value their own welfare far above others' welfare, and instead identify those who value others highly. Simply picking those who say they are concerned about others is not as good as picking those who also show evidence of such concern, especially evidence beyond their control.

Getting choked-up despite obvious efforts to suppress the emotion, may be an honest signal of concern for others, expressed involuntarily in the context of team building. It signals to actual and potential members of a cooperative team that he is the kind of person who cares about others' welfare so much that he experiences their pain.

This also explains why people would ordinarily empathically experience the emotions of someone whose welfare they care about; it's the same honest signal of genuine concern, but sent to the person suffering the painful event. The psychiatrist did not get choked-up when he heard the story directly from the patient because he has extensive training and practice maintaining a professional countenance with patients, converting his own emotional response into carefully constructed empathic remarks.

Another possibility is that some stories, well-told, have the power to cause most people to choke up. The psychiatrist in this case noted that he choked up in the same way he did re-telling similarly powerful patient stories, all of which would make for riveting books, movies or TV shows. So, while choking up may have been a signal, it might also be as much a feature of the story as it is a feature of the psychiatrist.

Case #4: Slow vs. Fast Developmental Strategies.

At a faculty development meeting, an undergraduate summer intern reported the following experience: "I was working in the lobby of a community health clinic when a woman walked in with a couple children. As soon as they entered, she began cursing at them, and being extremely mean and critical. The children had no reaction to this, as if this was something they were used to. The mother continued chastising the children and cursing, and then walked out of the waiting room. I didn't interact directly with her, but it was still very impactful and shocking." – Rachel Spronz 2016

The intern was appalled by the mother's behavior and puzzled by the behavior of the children. Had the intern been the treating clinician for the mother or the children, being appalled could have led her to behave in ways that were not in the best interests of either the mother or the children.

This situation is very similar to many we face with homeless veterans, especially when we see their behavior as impulsive, short-sighted, and very detrimental to their long-term interests. As in many other aspects of humanistic care, understanding the underlying causes of others' behavior can help us to both better regulate our own reactions to them and identify constructive interventional and treatment options. In this case, it may be productive to view the woman's interactions with her children as manifestations of a lifelong pattern of behavior, one that ramifies across many domains, and is largely outside of conscious control. Specifically, after considerable discussion we decided that clinicians familiar with Life History Theory (LHT) could temper their own emotional responses to such situations by telling themselves: "Considering her childhood history, she may be executing a fast life history strategy." LHT provides a way of understanding the mother's otherwise appalling behavior as an evolved adaptive response to harsh early-life experiences.

Here's a brief summary of Life History Theory (LHT): A mainstay of modern evolutionary biology, it pursues the idea that just as natural selection shapes the bodies of organisms; it must also shape how those bodies grow, and what they do during the course of their lives, so as to maximize their reproductive success. The theory focuses especially on how organisms allocate their limited supply of time and energy to key life tasks such as building and maintaining their bodies and producing offspring. It recognizes that allocating a limited supply of time and energy involves trade-offs. For example, spending lots of time and energy building and maintaining a body leaves less time and energy to produce offspring and vice-versa.

Just as there are different ways to shape bodies, there are different ways to allocate resources, and just as some shapes are better for some niches than others, certain patterns of resource allocation are better for some niches than for others. In LHT, these patterns of resource allocation are called "life history strategies," or "strategies" for short. Much LHT research focuses on differences between species in developmental and reproductive speed. At one end of this spectrum are organisms that grow fast, mature quickly, and reproduce massively and then die, providing no care for offspring. At the other end of the spectrum are organism such as humans, elephants and whales which grow and mature slowly, produce a few offspring over the course of decades, and care for these offspring extensively.

LHT is also concerned with how individual organisms within a species sense differences in their environments and, during the course of maturation, adjust their life history strategies accordingly. This ability to alter developmental trajectory in response to environmental cues is called "adaptive developmental plasticity." It is at the heart of our suggested self-talk sentence—"Considering her childhood history, she may be executing a fast developmental strategy."

Here's what we mean: Imagine a child born to a married couple, who supply the child with plenty of food, love, and a safe neighborhood. From the child's perspective, these experiences are cues that allow it to forecast the type of environment in which it will likely live as an adult – an environment in which adequate resources will be available, there will be little danger, and couples will cooperate to raise a few children on whom they lavish a great deal of care. Given this, it makes sense, from an evolutionary perspective, for the child to follow a development strategy that will be optimal in such a future environment. So, the child should follow a slow developmental strategy, delaying reproduction to focus

instead on building its body, knowledge, skills, and social network, and then having a small number of children in the context of a stable relationship focused on long-term, high-investing parenting.

Now imagine a child born to a single mother, living in a dangerous neighborhood and struggling to supply adequate food and attention. It would make sense for the child to follow a developmental strategy that recognizes that the future is highly uncertain. In such a world, it does not pay to take one's time building one's body, knowledge, skills, and social network before reproducing, as factors beyond one's control may lead to death or disability before this can take place. Rather, the optimal strategy is to reach sexual maturity early (at the expense of building a more robust body, skills, etc.) and reproduce before death strikes. Likewise, it does not pay to have a small number of children in whom a great deal is invested, as any given child may be struck down by the harsh and unforgiving environment; rather, the optimal strategy is to minimize the investment in each child in order to be able to have many children, thereby increasing the likelihood that some will survive to adulthood. Lastly, because cooperative relationships usually pay off over longer periods of time than do more instrumental relationships, someone who grows up in surroundings where death may come sooner rather than later is better off being less selective about their partners – there is no point waiting around for Mr. or Ms. Right if most people in one's environment are similarly following a fast strategy, as others will similarly prefer short-term rewards over long-term payoffs, and thus will not be highly reliable or cooperative.

Imagine that the mother described by the intern experienced such a harsh environment and is currently executing a fast life history strategy – most likely not by conscious choice. From her perspective she was simply drawn, as a teenager, to men who seemed powerful and combative, and bore children perhaps from different men, each of whom eventually left her. Notice that while this leaves her children without paternal care, it also ensures those children carry genes for being powerful and combative, and perhaps stand a better chance in a harsh environment. Meanwhile, she is under tremendous stress and lacks both the motivation to engage in high-investment parenting and the skills to do so (recall that she was reared in a similarly harsh environment.) So, she resorts to cursing and chastising, minimizing the demands that each child places on her. And, although her behavior may be disturbing to observers who don't share her orientation, it serves as another cue to her children that they too live in a harsh environment and should adopt a fast developmental strategy.

In general, we can expect that patients from harsh environments are likely to steeply discount the future. That is, they are likely to value immediate rewards (and costs) far more than later rewards (and costs). This leads to health problems for such patients, but also suggests treatment strategies. For example, we can expect such patients to suffer from obesity. Food insecurity likely leads to overconsumption and future discounting; at any given meal, the costs of obesity are in the future, but the benefits of high calorie foods are in the present. It also means that they are less likely to adhere to clinical regimens in which the payoffs are far off. Treatment programs that shift some of the benefits of losing weight into the near-future (i.e., perks or rewards for incremental weight loss) will succeed far better than warnings about diabetes or cardiovascular disease. Steeply discounting the future would also increase sexual promiscuity and lead to higher rates of sexual transmitted disease, unplanned pregnancy, etc. These obstacles to wellness are not easily overcome, but, clinicians who understand fast life history strategy might more successfully engage patients in strategies such as implant contraception.

By definition, the vast majority of clinicians have succeeded in their careers by executing a slow life history strategy supported by subcultures that valorize self-control and discipline – it is simply not possible to acquire the extensive training required to be a healthcare professional if one steeply discounts the future. Accordingly, from the clinician’s perspective, fast life-history patients may well appear foolish, lazy, or immoral. Recognizing that harsh environments lead to fast life history strategies with very different time preferences can lead to more effective and humanistic care – had our own life circumstances been different, we might very well have held such an orientation ourselves.

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Conceptual Framework

Understanding how and why humans cooperate can lead to better healthcare for vulnerable populations, including homeless veterans. This is especially true when the health care is delivered by an interprofessional team. Our approach has drawn from several fields including, of course, humanistic medicine. The most unusual, at least for a humanism project are the fields of evolutionary psychology and socio-narratology.

Evolutionary Psychology: In *The Origin of the Species*, Charles Darwin noted that mental abilities must have evolved through natural selection and predicted that this understanding would provide “a new foundation” for psychology.¹ He understood that evolution must shape behaviors as well as bodies, because having the best physical structures does a creature no good without the corresponding behaviors. For example, an octopus with an ink sac, who fails to squirt the ink to confuse a predator, is the same as one without an ink sac. A peacock with a spectacular tail, who doesn’t display it, is the same as one with a lousy tail. A bee with a stinger who doesn’t use the stinger to defend the hive is the same as a bee without a stinger.

As Darwin predicted, evolutionary psychologists now seek to understand how evolution shaped the mind and behavior. They view the mind as comprising a wide variety of psychological adaptations evolved to tackle a wide variety of problems faced by our ancestors, especially how to interact with other humans. For example, that children can learn any language is likely a psychological adaptation. Which language they learn depends on the culture in which they are reared. Likewise, that people can learn from others how to make key tools, for example, to hunt or fish, is likely a psychological adaptation. Which tools they make depends on the culture in which they live. That humans can cooperate with others, to forage, farm and defend themselves is likely a complex suite of adaptations also interacting with their cultures.

Humans are cooperative: Humans have spread all over the planet in large part because we are so cooperative. How we got to be so cooperative has been the focus of intense research in many fields. It’s a puzzle, because evolution by natural selection, operating on our genes, should favor individuals who act only in their own interests. This can lead to complex social interactions, with people helping each other and even believing that they are self-sacrificing, even though, ultimately, their helping behavior

favors their own genes or those of close kin. So, this view can explain a lot of social behavior, but it can't fully explain why humans are often truly self-sacrificing with no gain even to kin.

However, there is another kind of evolution. People have created complex cultures that encourage cooperation. And, culture is passed on, not via our genes, but via many kinds of learning and imitation. Cultures and cultural elements can and do compete with each other in a process called "cultural evolution." Moreover, individual evolution and cultural evolution affect each other, and this so-called "gene-culture co-evolution" can lead to truly self-sacrificing behavior that is of no benefit to the individual or his kin, but enormously helpful in preserving that culture.

Both kinds of evolution, individual and cultural, influence our behavior with colleagues and patients, and both kinds of evolution influence how patients behave with us. Understanding how these evolutionary forces have shaped our behavior and that of our patients can help us understand the challenges that patients face in obtaining care, and the challenges we face in providing care. This understanding can help us change our behavior in ways that strengthen these relationships and improve our chances of helping homeless veterans.

Natural selection acts on individuals: Evolution has shaped our brains, not only to negotiate and manipulate our physical environment, but also to negotiate and manipulate our social environment. Some scientists refer to these latter adaptations as our "social brain." Many of these adaptations allow us to detect particular kinds of social opportunities or threats and then to behave in particular ways to either exploit the opportunity or mitigate the threat. In many cases, a particular social situation triggers a particular emotion and that emotion calls forth the particular behaviors needed for that social situation. These behaviors have been shaped to maximize the individual's survival and reproduction. However, the ultimate function of these processes is often outside of the individual's awareness—they may experience the same behaviors as purely altruistic. When many people interact with each other repeatedly, each behaving in ways that serve themselves, this can result in social structure.

Rank is an important aspect our social environment. Prestige is social position that is achieved through the freely-granted deference of others. Others grant such deference to individuals who are successful, for example at fishing or hunting. People want to learn the secrets of success, so they try to associate with the prestigious. Successful people will allow this to the extent that it helps the successful person. For example, the learners might help with hunting or fishing tasks. But, there is a limit—too many learners and the hunt is ruined. So, the successful choose to associate with those learners who seem most likely to be able to help, with the hunt, for example. This begins to create rank. And, rank has a powerful effect on how patients feel and behave with us and how we feel and behave toward them. See "Be an accessible expert" under "Approaches and Tools Under Development."

Our social brains are designed to detect free-riders: It is easy to make the mistake of forming a social relationship with a free-rider, and then be taken advantage of. It is important to detect free-riders early on, and evolution has made us very sensitive to the possibility others have taken advantage of us. This means that we often feel as if others have exploited us, even when this is not true. That can lead to

strained relationships. But, from the self-interested perspective of natural selection, the alternative, failing to detect a free-rider, is even worse. So, our social brains have evolved to sound an alarm long before we have convincing evidence that someone is a free-rider. This is like the design of the smoke detector in your house. Smoke could mean a dangerous fire, or it could mean you burned the toast. It might be possible to build a detector that could tell the difference, but it would be very expensive. The simple smoke detector could be made much less sensitive, so that it only sounds an alarm when there is much more smoke, but this would miss some dangerous fires. So, the detector is set to detect all real fire threats, but with this capability comes the limitation that it also erroneously sounds the alarm for even harmless causes of smoke. Similarly, when a biological function cannot be made to work perfectly, evolution biases the error in the least dangerous direction. The end result is that our social brains are very sensitive to potential free-riders – we are quick to jump to the conclusion that someone in a cooperative relationship with us (or what we categorize – rightly or wrongly – as such a relationship) is taking advantage of us.

Interprofessional care of vulnerable populations is evolutionarily novel in key respects: Our social brain evolved mostly during a period when humans formed small bands of hunter-gathers with a distinct division of labor, so we have evolved to work in teams. There is also evidence that our ancestors cared for the sick among them, keeping alive team-members who would have died if aid was not provided. However, our hunter-gather ancestors did not work together specifically to care for strangers. More likely, they were wary of strangers, particularly those who appeared to be sick, unpredictable, dangerous, or merely unsuccessful.

When we work in teams to provide healthcare to vulnerable populations, we are hampered to some degree by inborn automatic emotional responses—including anger, fear, contempt and disgust—designed to protect us from strangers who displayed similar attributes in our hunter-gatherer evolutionary past. Moreover, our social brains are set to be very sensitive to the possibility that strangers will hurt us, infect us, or drain our resources. These are very bad outcomes our ancestors could not afford. So, our social brains are biased in favor of avoiding the mistake of failing to detect a true threat, even though this means that we will erroneously see some harmless strangers as dangerous. As a result, these emotions can conspire to make vulnerable patients appear undeserving of care or more dangerous than they really are. They can also make the effort of caring for them seem more futile than it really is.

Counter-acting the effects of this error-bias is no easy task. First, these emotional responses are largely innate and rapid. Second, they affect our reasoning. That is, they can make our actions to limit care seem more reasonable than they really are. Third, our social brains are going to be right some of the time—some patients really are dangerous. So, it would be foolhardy to attempt to simply ignore these emotions.

However, protective mechanisms, such as the detection of free-riders, are strong in humans, because of our species' capacity to form strong social bonds even with complete strangers, a capacity that sets our species apart and accounts for our success in so many different and challenging environments. Most of the techniques in the Humanism Pocket Tool take advantage of this capacity.

Socio-Narratology: Socio-Narratology views stories as actors and studies how stories compel people to action, to become who they are individually and who they are as groups. Stories help make life social by connecting people into collectives and coordinating their actions according to certain story plots. “Stories and humans work together, in symbiotic dependency, creating the social that comprises all human relationships...The symbiotic work of stories and humans creating the social is the scope of socio-narratology.”² Stories, story tellers, listeners and the relationships among the three are seen as highly dynamic—“in the interpretation of a story, as in the telling of stories, no speaker is ever *FINALIZED*...no “last word” should ever be pronounced that forecloses what another person might become.”

As HPACT staff, we talk about our patients frequently. We tell stories about their traumas—“Did you notice his left ear is prosthetic?” “Did he tell you why? His roommate stabbed him, cut off his ear, slit his throat and left him for dead”—and about their successes and aspirations. For example in another case—“Did you know he was an AmTrak chef for 20 years?” “Yes, and now he wants to open a Bed and Breakfast in Colorado.” Exchanges like these are often followed by a discussion of what else could be done to help the patient achieve his or her aspirations despite extreme challenges.

The Humanism Pocket Tool can be seen as a set of techniques designed to acquire, transmit and modify these stories. The techniques allow a patient to tell his or her story and to see that clinicians have understood it. They cause team members to re-tell the story amongst themselves in a way that compels them to work together on behalf of the patient. In so doing, staff become characters in the patient’s ongoing story, working to help the patient achieve his or her aspirations, helping to write the next chapter. From the perspective of socio-narratology, the Humanism Pocket Tool allows patient stories to “breathe”, to be “on the loose” binding together both patients and team members in a common effort to create new stories of recovery.

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Footnotes:

Conceptual Framework

1. “In the distant future I see open fields for far more important researches. Psychology will be based on a new foundation, that of the necessary acquirement of each mental power and capacity by gradation.” --Charles Darwin, *The Origin of the Species*, 1859, p.449.

References:

1. Darwin C. *On the origin of species by means of natural selection*. London,: J. Murray; 1859.
2. Frank AW. *Letting Stories Breathe: A Socio-Narratology*. Chicago: University of Chicago Press; 2010.

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Appendix A: Training Exercises

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Appendix B: Evaluation Tools

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Appendix C: Quotations

The battle of being mortal is the battle to maintain the integrity of one's life--to avoid being so diminished or dissipated or subjugated that who you are becomes disconnected from who you were or who you want to be. Atul Gawande in Being Mortal, p 140-141.