

Story-Based Health Policy: An Interview with Fitzhugh Mullan, MD

By Jon Stewart, Editor

Editor Introduction

Pediatrician, writer, editor, and health policy expert Fitzhugh Mullan, MD, is perhaps best known as the founding editor of (and contributor to) the popular column “Narrative Matters” in the influential health policy journal *Health Affairs*. For many readers of the journal, the column—which features first-person narratives, or stories, that illuminate often-complex health policy issues—is the first thing to turn to when cracking open a new edition.

When not writing or editing, Dr Mullan is the Murdock Head Professor of Medicine and Health Policy at the George Washington University School of Public Health and a Clinical Professor of Pediatrics at the George Washington University School of Medicine. He is also a member of the medical staff at the Upper Cardozo Community Health Center in Washington, DC.

Following graduation from Harvard University and the University of Chicago Medical School (1968) and an internship at the Jacobi and Lincoln Hospitals in the Bronx, New York, Dr Mullan began a distinguished medical, academic, and administrative career. It has included serving as Director of the National Health Service Corps in Washington, DC; Scholar-in-Residence at the Institute of Medicine; senior medical officer at the National Institutes of Health; Director of the Bureau of Health Professions; and, in 1991, promotion to the rank of Assistant Surgeon General (Rear Admiral). In 1996, he retired from the Public Health Service and joined the staff of *Health Affairs*, where he continues to edit the “Narrative Matters” section.

In addition to his journal contributions, Dr Mullan is the author of *White Coat Clenched Fist: The Political Education of an American Physician* (Macmillan, 1977); *Vital Signs: A Young Doctor’s Struggle with Cancer* (Farrar, Straus and Giroux, 1983), *Plagues and Politics: The Story of the United States Public Health Service* (Basic Books, 1989), *Big Doctoring in America: Profiles in Primary Care* (University of California Press/Milbank Fund, 2002). He is the senior editor of *Healers Abroad: Americans Responding to Human Resource Crisis in the HIV/AIDS* (National Academy Press, 2005).



Fitzhugh Mullan, MD

Narrative

Jon Stewart (JS): You’ve been involved in health policy and politics right from the beginning of your career. How did you come upon this very personal, narrative approach as a way to discuss something as abstract and academic as health policy?

Fitzhugh Mullan, MD (FM): The first time I thought about it in any conscious way was when I joined the editorial staff of *Health Affairs* in the latter part of the 1990s and conceived of a column devoted to narrative writing, what we now call the “policy narrative.” I realized then that much of what I had written over a number of years was policy narrative, even if I hadn’t planned to do it. In my second book, especially, *Vital Signs: A Young Doctor’s Struggle with Cancer*, I was writing about medicine from the other end of the stethoscope, coming from a very personal perspective. So I was a practitioner of the policy narrative long before I’d ever used that word.

A Story of Uncoordinated Care

JS: You wrote a wonderful piece in *Health Affairs*¹ about the death of your father that spoke very eloquently to the issue of uncoordinated care. Can you recap that story and tell us how you came to write it?

FM: Going through what turned out to be a terminal experience with my dad was kind of an eye opener to me in that I lived through some of the concerns that many have expressed about the inefficiency and nonsensical nature of our health care system. It was a meet-your-worst-nightmare experience.

To recap: at age 91, frail but in reasonable shape, my father had gone downhill the previous few years. He had both gallbladder disease and probably a chronically inflamed appendix. He had a superb primary care internist for many years who had retired a couple years before. The new guy wasn’t terribly diligent and he particularly didn’t like hospital practice, so he had no interest in admitting or



Jon Stewart is Communications Practice Leader for Government Relations and Health Policy, Kaiser Foundation Health Plan. E-mail: jon.stewart@kp.org.

in following my dad. His surgeon admitted him, and he spent about two months in the hospital. Because he was old and had multisystem disease, the surgeon asked for a cardiac consult and a pulmonary consult before surgery and a GI consult because it was a GI problem. After the surgery, because of confusion and poor mental status recovery, he had to see a psychiatrist and a neurologist. He picked up an endocrinologist along the way. He had six or seven different internal medicine subspecialists following him, without any coordination, without a general internist in sight. They were all very cordial and fairly diligent, but they didn't talk much to each other, and the notes, which I followed, were legible or not, depending on the doctor.

Fortunately, nothing went way off track. My dad did not do very well. He went to a nursing home where he was cared for very efficiently by general internists and a nurse practitioner, and he died some months later. But the failure of coordination, and the large Medicare bills that piled up with these various subspecialists doing diligent but kind of "smokestack" work, each in their own chimney, was a graphic demonstration of what I think is a major ailment in our system, which is gross inefficiency. That needs to be addressed, and I believe a managed care system with full coordination of care and prudent use of resources would have been far better. Actually, I'm a great fan of Kaiser Permanente (KP) but I think about how we could have an American system that "smelled and tasted American" and worked for the nation, and it would look a lot like KP.

The final word was that my father, as a psychiatrist, had become very involved in medical ethics, particularly as it relates to equity and access to services. And he would have been profoundly discouraged by his own experience, not because it brought him pain or medical calamity, but because it was a terribly wasteful way for him to leave life.

A Good Policy Narrative

JS: Every hospital probably has 1000 stories to tell every week, but not every one of them is necessarily a good policy narrative. What are the characteristics of a good policy narrative that also illuminates health policy issues?

FM: You're right. There are stories happening to us all the time that are instructive, particularly in hospitals, where people are under stress, their lives are at stake.

Admittedly, not every story makes for a good policy narrative, which is an essay form that falls between the editorial and the short story or memoir. There are stories that are powerful because they invoke sentiments and emotions and circumstances that we all recognize and

that resonate with us, but they may be absent of any implications for what ought to be done to change things on a policy level. At the other end of the spectrum are editorials which are all about policy, with little or no use of personal experience. The policy narrative falls between those. It calls for the use of the artful or the insightful in a human and personal way, but with a point, so that the reader leaves not just with an engaging story, but with a kind of an "aha moment" based on what happened to Dr Jones or Miss Smith—we really ought to have better gun laws or antismoking rules or better coverage for children.

JS: Some people think storytellers should be "licensed to carry a story" because they can also be dangerously misused. The Harry and Louise TV ads in the early 1990s were in effect very brief stories that managed to kill off the Clinton health reform proposals. We see health care anecdotes being misused all the time in the popular media to discredit managed care practices, for instance. How do you defend the use of the one-off anecdote in serious health policy discussions?

FM: Several responses: The first is we're never going to get away from stories. They are so quintessentially human. From the Neanderthal campfire to the halls of Congress, people have always offered stories to influence other people. But how do you handle the issue of abuse, which you mention? At *Health Affairs*, we've handled it in a very straightforward way, which is the review process. Stories that are submitted to the "Narrative Matters" column are vetted by the editors first, and if they're deemed in the ballpark, they're then sent out to at least three readers who are chosen because of some knowledge in the field, whether it's aging or pediatric policy or whatever. We also send it to someone who is an established writer and can critique it from that point of view.

Now, reviewing is not the world's most scientific process, as we all know. But it achieves a couple things: If people feel that something is way out of town in terms of reality, we at least point it out, and then we can decline the story. And we get a lot of judicious commentary on how to make it stronger or more accurate that we can feed back to the author.

Storytelling and Medicine

JS: A number of physicians these days are discovering, or rediscovering, the relationship between storytelling and medicine. Because relationships are really at the

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heart of both stories and medical encounters.

FM: The medical history, in a sense, is a story. We've developed it in a fairly formulated way so it's not a wandering history; it's a systematic information-retrieval process, but it is basically asking the patient's story. I

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think that's terribly important for forming a relationship. In pediatrics, and particularly where I practice, a clinic that sees mostly new immigrants, the stories are rich. Sometimes they're hard to get at because of linguistic problems. I speak passable Spanish, but I'm aware that I miss the nuances from not being fluent. People come with incredible stories of upheaval very often. I find

that young residents blow by the social history—you know, did your grandmother have hypertension? They miss the point that this is relationship building, and that knowing that the grandma had hypertension contributes a tiny bit, but knowing that these folks arrived two months ago from a war zone begins to tell the doctor a lot about the patient. And the patient, in the vast majority of cases, is impressed that the doctor cares enough to find out about their story, and that's what builds relationship. I find that very meaningful, and not just on an external level, but in the sense of what their challenges are going to be medically and socially, which I'm going to be involved with. So, I think stories are the essence of good medical practice. I worry that many docs, and certainly many of my trainees, need to be pushed to appreciate the richness of that.

JS: We're talking about the use of story and the value of storytelling in two different realms: one in clinical practice and one in promoting health policy. There are obvious differences there. Do you think that in the clinical arena, for instance, that medical schools should require, or at least encourage, students to take a course in narrative writing?

FM: Funny you should ask, because I've begun teaching a course for medical and public health students here at George Washington. It's been terrifically rewarding. I'm in the middle of the first time doing it, so this is a work in progress. I took three essays from the Narrative Matters column that probe the issue of racism in medicine through the narrative format, and the group just went wild. I've become converted to the notion that the use of teaching narrative—reading and writing narratives—is a good way to teach social medicine, because you can do it for a lot of different issues, like racism, children's issues, death and dying, sexuality. So the short answer is yes, I think we ought

to teach narrative on a much more regularized basis in medical school.

JS: Maybe we should teach it in policy schools, too. Abraham Verghese, MD, who wrote that nice introduction to your book, makes the comment that he writes in order to understand what he's thinking. That would be particularly useful for policymakers, don't you think?

FM: I know Abe and he's much more soulful than I am. I'm more—oh I don't know—mechanical or strategic. What I do find, though, is that I come back to my stories and they help me interpret my life, at least in retrospect. My own story is framed by the stories I've told, because I remember them, whereas other stuff I don't remember. Abe feels something and wants to explore it and gets into it, whereas I sort of see the story, tell it, and think about it afterwards.

Health Care Reform

JS: You've been around the national health policy world long enough to have a valuable perspective on the current prospects for some sort of meaningful health care reform. I believe you were involved in the health reform proposals over a decade ago and, of course, nothing happened at that time for a variety of reasons. Do you have any reason for optimism today?

FM: I'd like to say yes, but I guess I'm—what is it?—once burned a victim; twice burned a fool. I have been saying for years, well, the next election I'm sure we'll have a system of national health insurance with universal coverage. But we're still lacking political leadership. The problem is that the solutions are highly political because they involve about one sixth of our economy, and one person's reform is another person's lunch bucket getting trashed.

I think it's going to take two things: One is political leadership from somebody who is as determined as the Clintons in the early 1990s, but more strategic and more cunning than they were. It's got to be leadership that knocks heads and appeals to the civic sense or the communitarian sense of the nation. The second is that it will depend on how desperate the situation gets. In other words, the worse it gets—the more the middle class is affected by the erosion of coverage—the larger the constituency for change and the more tolerant of compromise people are going to be.

JS: Thank you. ❖

Reference

1. Mullan F. My dad was not a prepaid group practice patient. *Health Aff (Millwood)* 2004 Jan-Jun;Suppl Web Exclusives: W4-43-59.