Physician and Poet Michael Barthman

Michael Barthman is a Wisconsin native, poet, and resident physician in the department of emergency medicine at the Alpert Medical School of Brown University. He is the co-founder and Editor-in-Chief of *triage* Health Humanities Blog. He resides with his wife Kathryn and their cats Bijou and Miki in Providence, Rhode Island.

Sarah Berry //

This interview series features educators, scholars, artists, and healthcare providers whose work is vital to the growth of the health humanities. On Friday, September 4, I interviewed Dr. Barthman about his work as an emergency physician, medical educator, health humanities blogger, and poet.

Sarah Berry: Can you tell us about your blog *triage*, how you created it and why?

Michael Barthman: I was working with [Dr.] Jay Baruch to develop an online course. [Beyond Medical Histories: Gaining Insight from Patient Stories] And one thing that came up regularly in our conversations was that we wanted to create a space where people with a broad range of experience from different disciplines and roles in healthcare could ask questions and unpack the kinds of things that people who work in a clinical setting talk about when they get together after work. Things that are joyous and exciting about their jobs, but also the stuff that's really challenging, problems they face—the kinds of things that don't always come up in a work meeting. The experiences that aren't clear-cut.

We want people to be able to explore the questions that come up for them without focusing on reaching a conclusion or citing a study that tells us what we should do as a result [of data analysis]. In that way, I think it can be a safe place for people at various points in their education and career to ask questions. Contributors have written short essays and also shared their visual art. We have some creative pieces that will be posted soon. Some contributors have done interviews with people of interest, such as the one that's going to come out with [Dr.] Alyson J. McGregor—one of the many brilliant ER doctors to help train me—who wrote *Sex Matters: How Male-Centric Medicine Endangers Women's Health and What We Can Do About It*.

All in all, it's very much an iterative process for us and, hopefully, for our readers and contributors.

SB: **I think it's a really valuable project. What is your impression of the benefits of giving your colleagues this space?**

MB: I know that being a pre-med student, medical student, or resident—especially when you're going through training—is empowering in some ways, but also really disempowering because you're trying to learn so many things from so many people at the same time, and you're trying to model what you see in them and make a good impression. In turn, it can make the rest of your life feel overwhelming because you don't have extra bandwidth. This is on top of the daily challenges that all healthcare workers face. My co-residents are the people I talk to the most about the blog, and what I've heard from them and our attending physicians is that the pieces on *triage* give them something to identify with. When they read another [healthcare worker's piece] they think, "Well, I hadn't thought about it, but I've felt that way for a long time." I think it's validating for people to recognize their own experiences and challenges in those of another.

The quote that comes to mind is from Samuel Shem, who wrote *House of God*. In one of his articles, he talks about medical training and how one of the biggest hazards that trainees—or really anybody who works in healthcare—faces is that you'll start to think (and I'm paraphrasing), "'I am crazy' instead of 'this is crazy.'" *Triage* offers people a reference point to help them acknowledge

there are a lot of brutal, scary things that happen to both patients and the people that take care of them. By pausing for a few minutes to read a post, it can give people the footing that enables them to confront those things, whether it's in their interactions at work, their department, the local community, or even the entire health care system. I think that's what's really important. But honestly, if the blog does nothing more than make one person feel like they can head in to work knowing that someone else understands how they feel when they're doing this challenging work, then I think that makes it worth it for me.

SB: **It seems to me like *triage* does that pretty well. You have the "How Are You (Honestly)? Pandemic Questionnaire" series, asking questions about medical care during the pandemic and collecting the anonymous replies in curated posts. How did that series come about?**

MB: As the pandemic was ramping up, securing enough personal protective equipment [PPE] for healthcare workers became a big issue, especially within the resident community in our department. It was a hot issue, and there were lots of meetings and conversations between the residents, program directors, and hospital leadership. Everyone was trying to sort out if we'd have enough PPE, where we were going to get it, whether we would receive any at all, and so many sticky questions that orbited around these issues. We were in crisis.

There were public conversations where opinions seemed unified, but then there were so many private conversations where the differences in opinion were abundant. Some people felt it didn't matter how much PPE we had; it's our obligation to take care of patients. Other people took the position that if we get sick there would be no one to take care of the patients, so we need to make a stand and say we're not going to take care of patients unless the hospital provides PPE. At the same time as all of this, there's the fact that it's not just our hospital—it's the whole country. There are so many systemic forces preventing those resources from getting where they need to be. On top of that, on a national level, there's Twitter and the news pushing and pulling people's consciences and opinions.

What I saw was that people didn't feel safe expressing in basic, personal terms what is important to them and what scares them. That was the realization behind creating the questionnaire, sending it out anonymously, and letting everybody see the collected replies. It was so that we could share, in a safe, non-threatening way, where everybody is at. It was to bring people together during a moment of division. On top of that, it serves as a place where people who aren't frontline healthcare workers can get a sense of that experience.

SB: **Yes, as somebody outside of healthcare, I was really awed by all the responses to those questions. It felt like a great privilege to be able to see into this community. The replies are so close to the bone, and I think there's a huge advantage not just for healthcare professionals to be able to see what others are going through but for the public as well.**

MB: As I look through the responses, one sign that people were being candid is that while some replies are heartbreaking, others capture the mundane stuff, which is reflective of reality. People were willing to talk about whatever was going on, whether they were fishing, bleaching shoes,

watching TV with their kids, doing laundry every night, or recalling the patients who were potentially going to die or did die. In a time when all of us are unavoidably distanced from each other, it lets us feel like we're a little bit closer, I think.

SB: **Do you also teach medical students?**

MB: I work with two other instructors to teach a cohort of eight second-year medical students in the Doctoring course at Brown's Medical School. The students are preparing for clinical rotations and learning how to take a history and do a physical exam. I also do clinical teaching with medical students in the emergency department. Last year, my training focused on critical care, and I took care of a lot of really sick patients. As a fourth-year resident, I'm now responsible for the interns, and they staff their patients with me. This is the year of training where there's lots of teaching.

SB: **Are there new layers and obligations because of the pandemic with your teaching, either content-wise or methods-wise with remote learning?**

MB: With teaching the Doctoring course at the medical school, the logistics have become really complicated, but the team of people who run the course have handled the logistics really well. The course involves examining Standardized Patients (actors who serve as patients), but you can only have so many people in a room, so there's a lot of shuffling around. Next week, we're going to teach the examination of the ear, nose, and throat; however, everybody has to wear masks and face shields. It's tricky.

For residents, like for other hospital staff, we try to minimize exposure because we're the primary physician workforce in the hospital. For the new interns, I try to moderate the patients they're exposed to who might have COVID-19, so that we can minimize the risk of them getting infected. It's a tricky balance, because they need to see those patients to understand the disease, but we need them to be safe and healthy. It's a similar situation with medical students who were pulled out of the hospital when the pandemic started. Now, they're coming back to get clinical experience. For the group I'm teaching, when they started a few weeks ago, they were champing at the bit to actually perform physical exams and take histories on real human beings since they hadn't gotten to do that for months. It's definitely made them enthusiastic, but also nervous that they've fallen behind.

SB: **What is your favorite teaching activity?**

MB: I feel really passionate about any kind of teaching that enables learners, healthcare workers, and especially patients to be treated with respect. Every aspect of clinical teaching relates to that kind of consideration for patients. That respect and equity underlies my clinical practice and so much of what I do, whether I write about it or publish others' work. In the Doctoring course this year, as a result of the advocacy of Brown's medical students, anti-racism content has become a key part of the curriculum. They have introduced training modules on anti-racism for all of the faculty and Dr. [Ibram X.] Kendi's book *How to Be an Anti-Racist* is required reading for the students and faculty. We do a 45-minute discussion at the beginning of each week where we explore articles on

anti-racism and how they relate to clinical practice. That has been one of my favorite teaching activities. We hear so many interesting perspectives from the students, and they ask questions that can be really, really challenging to answer. It has forced me to really reflect on what's important to me in my clinical practice, and I translate that into an idea or concept that I can convey to students in a usable way. How do I pose a question to them that'll make them think critically about the text or how they're going to fold these ideas into their own clinical practice?

This group is well-read and well-versed in social justice and anti-racism. On the first day of class, they said, "Yeah, it's great that the administration introduced this content, but we want more of it. We need to know how to practically apply these concepts." They're activists, and they're ready to push and push to make change, like they should, like all of us should. It's been a good challenge for me to explain, "Yeah, we read about this, but this is how you can use it when you're sitting there one-on-one with a patient." I've enjoyed it because it's hard and exciting and sometimes scary and a little awkward—all of the things that make for good learning for everybody. Sometimes I feel like all those people I teach are way smarter than I am, but what I've got is some experience to share that can connect anti-racism to caring for patients.

SB: **You're in a really important role, having the ED experience and being proactive along with your students about bringing in questions of race and anti-racism and how they specifically translate into clinical practice. As racialized violence escalates, we're starting to see intersecting medical and police system failure. For example, [warning: the following embedded link contains an image and content that may be disturbing to some] an African American man's family sought psychiatric aid for him in Rochester, NY. The man was not admitted to a behavioral health unit, and the next day he was killed under restraint by police in a public place in Rochester, NY. Then the footage was released, which unleashes a new level of trauma for African Americans and mental health clients. Can you speak to what medical systems can do for patients who may need advocacy?**

MB: Lots of things come up when I hear that story. It's horrible and unacceptable that this is happening in our "modern society." One of the biggest challenges for me is when I talk with people who don't seem to recognize the horrible legacy of racism and its entwinement with capitalism and the structures in our country that oppress people. One of the reasons I chose emergency medicine and what I love about it is people. I don't think you can do emergency medicine and be happy unless you really love people. You take care of human beings who come from every walk of life, usually on the worst day of their week, month, year, or life. We have the privilege of getting to take care of everyone, and it doesn't matter if they have insurance or not, which from a moral standpoint is really important to me.

Reading Dr. Kendi's book, I'm looking at interactions between people and institutions and seeing racism and classism and so many different -isms. One thing that I find to be empowering is realizing that making changes in your own personal sphere can be as simple as how you talk to patients, in how you model to staff, junior residents, and learners the right way to treat patients. You can demonstrate leadership by realizing that leadership means working for people and

doesn't mean telling them what to do. In many ways, it means sticking up for your patients and finding ways to stick up for your staff and learners. Anybody can do that. You don't have to be a policymaker to change the culture around you. There are different ways for all of us to engage. In a time when it's easy to feel disempowered by how messed up everything seems to be when you turn on the news, sometimes you just have to look at the ground in front of your feet and try to do those little things.

SB: **I agree. What are some of those little ways? Can you think of any examples?**

MB: We were talking this week in my Doctoring course about intersectionality. No one belongs to just one group. I take care of a very diverse patient population, and many patients face housing instability or homelessness. At the same time, they are also addicted to a substance, especially opioids. I think a lot of healthcare workers find it challenging to take care of these patients, and they're stigmatized. A number of people still perceive addiction as a moral failure rather than an actual disease. Patients come in with infections and complications from their substance use and a lack of access to healthcare. In really insidious ways, they receive worse healthcare because they won't be treated with the same respect as an 85-year-old elderly patient who fell down and has a urinary tract infection.

My thought process in clinical care and teaching is that if you can learn how to take good care of patients that many perceive as "challenging," if you can do a good job and make them feel respected and cared for, you can take care of any patient. As people become more socially complex, it's usually because they are facing more and more forces in our society, such as racism. You have to engage with patients as people and come to them with humility, listening to them and suspending disbelief when they tell you what they have going on. Sometimes patients will seem standoffish or guarded. I will tell them that I would bet they've probably met doctors and nurses who made them feel like an idiot or a jerk or like they don't deserve to be in the hospital. And, they'll say, "Yeah, I have." I'll acknowledge that and tell them that I'm not going to treat them like that because nobody should be treated that way.

I think that approach does a lot of things. It gives those individuals hope that if they engage with the healthcare system, they're not going to be pushed away. It resets their expectations of what other doctors should do. Nobody needs to tolerate being mistreated when they come looking for help. Again, I think it's in the small things and treating everybody with respect. Different patients need different things. I don't think it's fair to say you should treat all patients the same way. Every single patient is a different person with different needs. If you are willing to engage with those needs, you will find yourself in conversations and situations where you are seeing the effects [of marginalization]. In dealing with things that relate to racism and poverty, you don't have to have all the answers. But you need to have the questions to ask that bring those issues forward and make people feel safe talking about them so that you can take care of them.

SB: **Yes, thanks for that. I think that engagement and ability to ask questions is essential to healthcare; I think that *is* healthcare and it's as important as the HPI and the prescription pad.**

Without that engagement, you're getting sicker and sicker patients because on top of structural barriers to getting healthcare, they are also avoiding psychological harm in clinical interactions. It's on healthcare, in my view, to fix that. It's refreshing to hear from providers like you who are actively promoting equity, like you're saying, on a patient-by-patient interaction basis. But I don't think it's a small thing at all; it's a grassroots movement with a lot of potential. Thinking in terms of pre-medical and medical students, I'm always working toward providing ways and tools for them to analyze how things could go better for patients, even under a preceptor who may not see those problems. And I encourage students to see how they will become academic leaders and leaders of the profession who can make change. I think we're at a critical moment, though the road has been traumatic, where anti-racist readings and discussions are becoming more urgent for medical and health professions programs.

To finish our conversation, let me ask one of my other burning questions: What books are on your shelf at the moment?

MB: The books I've been reading lately, which are lying in a pile next to me, are a lot of poetry-related stuff. I've got a batch of poems that I'm editing and want to turn into a manuscript for publication. I've been reading a lot more texts about writing poetry to help knock things loose in my head. Recently I read *The Sounds of Poetry* by Robert Pinsky. It covers meter and rhyme and all of the more boring stuff with poetry, but for dummies. And then I have been reading *Real Sofistikashun*, a book of essays by Tony Hoagland, about different aspects of poetic craft. And then [laughing] I've got my mail-in ballot. Under that is a book by Mary Oliver, *A Poetry Handbook*, and another one called *The Art of Voice*.

The one that I recently finished, that I spent probably 80% of the book not really knowing what the book was about, is *The Art of Recklessness: Poetry as Assertive Force and Contradiction* by Dean Young. If you've ever read any of his poems (which you should!), you can see that it's about expression. The "art of recklessness" is a good description of his approach to art and being spontaneous and willing to take risks. At like 90% of the way through the book, he starts a paragraph saying that if you're still wondering what this book is about, so is he. There are no chapters, it just goes and goes and goes, and it's really fun. At times, it's over my head when he gets into literary theory.

I inevitably wind up trying to relate a lot of that material to not just writing poetry—which is the nearest and dearest thing to my heart and my biggest artistic practice—but also to how you think as a doctor, especially working with Jay [Baruch], who has devoted so much of his work to how creativity and the humanities can play a role in improving clinical practice. I have a pile of poetry collections on my shelf and in my Amazon cart that I'll get to eventually, hopefully, when I have more free time.

SB: **Are there any poems you'd want to share with *Synapsis* readers?**

Resumption *(Summertime)*

Humidity salts his t-shirt
by lunchtime. after supper

come freckles of spare rain
on the wind, sheet lightning
over little towns east of here.

a fan you put in the doorway
flickers a tang of deodorant

off him, filling the bedroom
with the flavors of his wages.
the yard, the county: a giant

funeral. Fall showed up early
to work but took the week off.

quiet, dead stuff warms to rot.
the air tongues you. you leave
what may be the most terrible

thought you ever had behind.
you say *I'd do this all over again*.

it doesn't come back.

he does.