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Chapter 4
My Life, My Story:
A Narrative Life History Activity to Humanize the Veteran Patient Experience

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EXECUTIVE SUMMARY

Contemporary healthcare institutions strive to provide humanistic and patient-centered healthcare. To reach this goal, healthcare systems must first look to the patient as a person, before treating a specific malady or pathology. This chapter will illustrate a humanistic approach to the provision of healthcare using the case of the My Life, My Story program in the United States Veterans Health Administration. My Life, My Story is a patient-centered, life story work intervention where learners complete a life story interview with a veteran using standardized prompts from the My Life, My Story protocol. This chapter will describe the My Life My Story program at the VA Boston Healthcare System, the steps and rationale in program development and discussion of impact on the learners, the patients, and humanizing the healthcare system.

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INTRODUCTION

We can sometimes forget that our patients are more than their medical or psychiatric conditions. They are whole people with a lifetime of history that is influencing how they are coping with their condition and interacting with their providers. I think that the project allows us as providers to remember this and might also be a reminder to the patient that they are more than their medical condition. -Learner comment

Contemporary healthcare institutions strive to provide humanistic and patient-centered medical care. To reach this goal, healthcare systems must first look to the patient as a person, before treating a specific malady or pathology. To train future health professions practitioners in a way that emphasizes humanistic care, it is necessary to operationalize what it means to "know the patient as a person." This chapter will illustrate a humanistic approach to the provision of healthcare using the case of the My Life, My Story (MLMS) program in the United States Veterans Health Administration (VHA).

Life story work is a term given to biographical approaches in health care that give people the opportunity to talk about their life experiences (McKeown, Clarke & Repper, 2005). MLMS is a life story work intervention where learners complete a life story interview with a veteran patient using standardized prompts from the MLMS protocol. The interview is written up as a concise, roughly 1,000-word-first person narrative, which is then read back to the veteran. The veteran may provide feedback and adjustments before it is entered into the electronic health record with the veteran's approval, available for subsequent health care team members to view. The veteran is offered copies of the story for themselves, which they may share with family or friends. After completion of the story, interviewers can debrief their experience either in a facilitated small group setting with other learners or directly with their educational preceptor.

This program provides a direct service to the veteran, in the form of the learner bearing witness to the veteran's life story. The veteran is allowed a degree of agency in the telling and documentation of his or her own story. This is in contrast to usual healthcare, which is typically delivered in a hierarchical manner and with emphasis placed on the perspective of the healthcare system. The veteran can review and edit the story that is entered into the healthcare record, unlike the typical healthcare notes that only reflect the clinician's voice. The use of the first-person voice empowers the veteran and allows them to tell their own story as the expert in their own lived experience, rather than being relegated to the passive, third person. Rather than being a transcript of the interview, the learner writes a story, allowing the narrative to capture the associated lyricism and emotional impact on the veteran, the learner conducting the interview, and the healthcare team who have access to the final

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story. This chapter will describe the MLMS program at the VA Boston Healthcare System (VABHS), and the potential impact on learners, veterans, and humanizing the healthcare system.

BACKGROUND

Humanities in Health Professions Education: Filling a Critical Need

In the sufferer let me only see the human being…

These words, from a physician's oath attributed to the medieval physician and rabbi Moses Maimonides, evoke the longstanding challenge of maintaining empathy in the face of human illness for those who care for patients (Rosner, 1967). Health professions education has long turned to the humanities to maintain empathy and to humanize the clinical training experience, using a variety of different approaches, including literature, visual arts, and music (Schwartz, et al., 2009). Recent years have seen an increase in humanities-oriented activities aimed at helping health professions trainees maintain compassion during training, avoid burnout, and see patients as whole people (Peterkin & Skorzewska, 2018). In addition to promoting empathy for patients, humanities in health professions education may help trainees remain resilient and avoid burnout (Jones, 2014). For example, an undergraduate medical education course for first and second year Harvard Medical School students entitled "The Developing Physician: Lifelong Integration of Personal and Professional Growth, with Sensitive, Compassionate Care," provides an opportunity for students to share stories and reflections on the intense process of becoming a physician (Berensin, et al., 2016). Similarly, internal medicine residents from Brigham and Women's Hospital in Boston, Massachusetts participate in a program called *The Humanistic Curriculum*, which provides an opportunity for them to engage in art and reflection amidst the busy and at times emotionally difficult work of training to be a physician (Gooding, Quinn, Martin, Charrow & Katz, 2016). On a national level, the American Academy of Medical Colleges (AAMC), in collaboration and with grant funding from the National Endowment for the Humanities, is exploring the current landscape of arts and humanities in medicine to think about how best to integrate and advance the role of humanities and the arts in medical education and physician development. (Mann, 2017; The Role of Arts and Humanities in Physician Development, n.d).

Among the many modalities of arts and humanities in medicine, storytelling serves an important purpose in humanizing health professions education. Telling

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and listening to stories forms the core of the field of Narrative Medicine, providing training to clinicians in the art of eliciting and understanding patients' stories (Charon, 2001). Ideally, in a clinical encounter, the learner or clinician should elicit a story from the patient. However, many learners or clinicians operate in healthcare settings in which the electronic health record shapes the way in which the story is solicited, often reducing the patient's experience to a series of checkboxes (Koven, 2019). Stories may serve as 'inoculations' against the erosion of empathy, helping learners remember to fulfill those ancient words of seeing the person amidst the disease (Treadway, 2005). Examples abound of health professions trainees (Shapiro, Bezzubova & Koons, 2011) or health professionals (Silverman, 2017) sharing patients' stories with one another to help support each other to remain empathic and cope with the challenges of providing healthcare.

Despite the documented benefits of participating in humanities in general, and story-telling in particular (Bleakley, 2015), barriers remain to fully integrating these practices into health professions education. While educators and learners agree on the value of these practices, time limits and logistical considerations often stand in the way of their inclusion in curricula (Pories, et al., 2018). In many health professions programs, participation in humanities initiatives is optional. Therefore, only learners who are already interested may participate, but these may not be the learners who can benefit the most from this programming (Lam, et al., 2015). Evidence of impact is lacking in many of these programs, which diminishes their rigor in the health professions education setting and weakens the argument for their inclusion in curricula (Taylor, Lehman & Chisholm, 2017).

The My Life, My Story program addresses several of these deficits. By requiring devoted time for learners to interview a veteran, document the story, read it back to the veteran, and include it in the healthcare record, a broader swath of learners can participate and benefit from this unique patient encounter. By sharing the stories in the healthcare record, subsequent members of the health care team can learn about the veteran as a person and potentially enhance their connection to caring for that individual. Finally, both providers and veterans find the MLMS storytelling experience to be positive and meaningful, promoting trust and connection that has the potential to have a profound impact on the healthcare system (Ringler, Ahearn, Wise, Lee & Krahn, 2015).

My Life, My Story

My Life, My Story was developed at the William S. Middleton VA in 2013 through a grant from the VA Office of Patient Centered Care and has since spread to 49 other VA Healthcare Systems (Ringler, et al. 2015; VAntage Point blog, 2019).

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At VABHS, MLMS has been framed as a structured educational intervention to enhance veteran-centered care competencies, with a focus on knowing the whole person, eliciting values and goals, and strengthening the therapeutic relationship. MLMS allows healthcare providers to learn who the veteran is beyond their medical problem list, and beyond the one moment in time of that encounter. It is the hope that this approach will ultimately foster increased veteran-centered healthcare.

Education is one of the four statutory missions of the United States Department of Veterans Affairs (VA). VA has a long-established historical commitment to education and has a broad impact on health professions training in the US, with the largest education and training effort for health professionals in the US. In 2018, 120,890 learners from a diverse group of health and social professions received some or all their clinical training in VA and more than forty health professions are represented by affiliations with over 1,800 colleges and universities. Over 65% of US-trained physicians, and almost 70% of VA physicians have had VA training prior to employment (Mission of the Office of Academic Affiliations, 2019). Given this position in the educational landscape, VA is well positioned to implement innovative programs that have a broad impact. The primary clinical aim of VA: “To care for him who shall have borne the battle, and for his widow, and his orphan” (Lincoln, 1865) by serving and honoring the men and women who are America’s veterans and the educational mission align in the MLMS program to put the identity of the veteran at the forefront of his or her care.

Steps to Complete a My Life, My Story Interview

The MLMS process consists of finite, structured segments in a specified order, but with flexibility such that the process can be tailored to the various time and logistical constraints of the setting. MLMS has been completed in a variety of clinical settings, including but not limited to: outpatient clinic, at home, urgent care, emergency department, acute care hospital-medical/surgical wards, intensive care unit-post-acute care (i.e. subacute rehabilitation, skilled nursing facility), inpatient hospice and palliative care unit, and via telephone. All veterans are eligible to participate and should be invited to partake. It is not possible to predict who may or may not be willing to share their story. The ideal participant is anyone who says ‘yes’. A foundation for MLMS is to create the space and tools in training and in the healthcare system for the veteran to tell the story and for the learner to bear witness and share that story so the veteran and their story may continue to be heard and honored by the healthcare team.

Interviews can be conducted by learners at any stage of training. Participants have included pre-clinical students, and graduate or post-graduate fellows. Stories might also be written by clinical or administrative staff and some VA sites have

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engaged with community-based volunteers who are trained as writers/interviewers. Learners may conduct interviews as a pair-with one as the main interviewer and both taking notes and co-writing the story. Interviewers are given a sample script on how to introduce the program to a veteran participant. This script includes an overview of the MLMS program and its purpose. Interviewers may describe the program, its growth over time, and potential benefits of participating. It is essential that the veteran understands they can talk about any topic that is important to them, which may not be related to their military service or to their healthcare. It is specified that the veteran does not have to share anything they do not want to and that the interview is not specifically focused on their military service, although basic questions about military history are asked with their permission. Some veterans will only participate if they do not have to talk about their military experience, while other veterans will focus their whole story on their time in the military.

Veterans are told that once the interview is transcribed into a story, it will be read back to them. This allows them the opportunity to make edits, additions, or subtractions. Once the veteran is in the mode of storytelling, he or she might share more than initially planned. Having the opportunity to review the story gives the veteran the chance to think about what was shared and take out components that may be too personal. While every veteran is offered the opportunity to review their story, veterans may opt not to. It is not unusual that the veteran agrees to share his or her story but does not wish to hear it back prior to it being entered into the healthcare record.

Interviews are preferentially read back rather than left with the veteran to review on their own for a variety of reasons. The impact of the experience extends beyond the interview and writing portion and into the reading back of the story for both the veteran and the learners. In hearing their own story back, the veteran has the opportunity to reflect on some of their experiences from a different vantage point, which may allow them to identify narrative, thematic arcs. At this point in the process the veteran might remark to the writer/ interviewer: "*You did a good job.*" To which the writer/interviewer might respond: "*I just listened to you and wrote down what you said.*" The reality is somewhere in between, with the veteran sharing their story which is then synthesized into the narrative that is crafted by the writer. Within the sharing of the story and the craft of synthesizing the interview by the writer there is now something unique that has been created.

There are also practical considerations in reading back the story to the veteran. The framework was designed to be mindful of variable literacy levels. For interviews done in an inpatient setting, there is a constant flow of papers, handouts, and other detritus that is accumulated and cleared away as well as other practical considerations like potential room changes. Leaving a printed story at the bedside increases the risk that the story would be thrown away without review. Additionally, in the inpatient

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setting there are clinical elements, including the veteran's fluctuating clinical status, that may impact the veteran's ability to read the story on their own. For the veteran who wants to review his or her story, it is not considered 'complete' until the veteran can review and make edits. The veteran may also choose to take the story and do the review on his or her own and return the edited story to the writer.

Once the veteran approves the final draft of the story and with the veteran's permission it is entered into their healthcare record and can be accessed by the healthcare team. The story is entered into the healthcare record in an easy to find location, and with a simple note-title (MY STORY), to reduce foreseeable barriers to healthcare team members being able to find it.

There are many branch points in program participation that allow the veteran to have control and agency over the degree of their participation as well as the content of the story. Participation in this program is optional. Roughly half of veterans who are offered the chance to participate will decline. Common reasons veterans offer for opting not to participate include: *I'm private; I want to leave the past in the past; I already did this; I want to focus on my medical conditions.* It is not the aim of the interviewer to convince anyone to participate, only to offer.

Of the veterans who choose to participate, they may further choose whether the story is entered in the chart. Most participants are agreeable to having the story placed into their healthcare record. Many participants will elect to share their story but will not wish to review it or have copies of the finished product. Furthermore, veterans who participate can have their story shared beyond the confines of their healthcare record. Common scenarios where stories might be shared beyond the record might be for training or education purposes-either within VA or in the community.

When the writer/interviewer is part of the clinical care team, and the story is to remain in the healthcare record only, then no special consent is required for participation, as this is a part of routine care. If the veteran is agreeable to have the story shared beyond the confines of the record then the veteran needs to sign a consent form. Or, if the person conducting the interview is not part of the clinical care team, and the veteran agrees to have the story entered into the record, the veteran signs a consent that allows the writer/interviewer to access their record, solely for the purpose of entering the story. Stories that are shared with the consent of the veteran are deidentified of protected health information and details are further obfuscated prior to being shared to protect the privacy of the veteran. Veterans will often express the desire to share their story and their experiences if it might help other veterans or if others can learn from what they have been through.

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The Interview

Interviewers begin the conversation with broad introductory statements, such as: "It is important for us to understand the stories of your life. This will help us understand who you are as a person and what is important to you." Interviewers should allow veterans to share their stories and provide little re-direction to veterans as they are speaking. The interviewer might ask clarifying questions, or if the veteran shares something that the interviewer is not familiar with (i.e., military vernacular) the interviewer may ask the veteran to provide additional details. This exchange flips the typical power dynamic in the healthcare encounter, where the healthcare provider is the expert in the condition and the patient is there to seek counsel. Now it is the veteran who is the expert who can lead the encounter and share his or her specific knowledge and experience. A common starting point for the interview could be a simple question: "*Where did you grow up and what was it like?"* And that might be the only question that is asked until the end of the interview. Interviewers are advised to avoid an opening question that is too broad, i.e. "*So tell me your life story*." Often in a healthcare setting the patient is primed to tell their medical story, or their '*History of Present Illness*' and may veer into that illness story. By asking a more specific question to start off, that is intentionally non-medical, it sets the focus on veteran as person, and helps guide him or her back to the personal story rather than strictly the medical story. While there are no specific medical questions included in the interview guide, the illness story and the life story are often interwoven in the telling.

The interviewer may use open-ended prompt questions from the suggested interview question guide if additional prompts are needed to facilitate the interview. These questions can cover several topics including:

- Veteran's childhood experiences ("What were you like as a kid?", "What was it like growing up in your hometown?")
- Military service ("How did you pick the branch of the service you were in?", "What did you do after discharge?")
- Significant relationships ("Who have been important people in your life?")
- Life lessons learned ("What do you value most in life?", "What advice or wisdom would you like to pass on to others?", "What do you want your healthcare team to know that they don't already know?")
- Future plans ("What are your hopes for your future?", "How would you describe your family legacy?")

Interviewers focus less on specific dates and names, and more on the gestalt of the veteran's story. At times, the veteran may become emotional when describing

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life experiences. Interviewers can provide empathy and supportive statements and allow the veterans to take breaks as needed. The writer might ask the veteran if they want the difficult parts included in the story and often the response is affirmative, because it is part of the story and part of what brought the veteran to this present moment in time.

Following the interview, interviewers thank the veteran for their service and for taking the time to share his or her story and participate in MLMS.

The Write-Up

The interviewer takes written notes while the veteran is speaking. No technology is needed for the interview. The interviewer is advised to enter the conversation with a notepad and two pens. The story is written from these notes. This no technology structure serves multiple purposes. By keeping the intervention technologically streamlined, the physical and technological barrier that is often presented by the computer or the workstation in the healthcare encounter has been removed (Pearce, Arnold, Phillips, Trumble, & Dwan, 2011). As the interviewer is listening and writing intently, it reinforces that this is the time for the veteran to speak rather than time for a conversation. Because of this streamlined, no technology approach, there is no associated cost for program supplies (i.e., encrypted audio recorders), thus removing financial barriers for institutional implementation.

Interviews average 40 minutes long and the target length of the story is roughly 1000 words. This suggested story length was designed with the context in mind-specifically that this is to be accessed by a healthcare team member in the process of their clinical work. The interviewer may provide the veteran with a longer version of the story, while entering a more concisely edited version for the healthcare record. As the interviewer is listening and taking notes, he or she will develop a shorthand of sorts which will amount to editing down the interview as they go, ultimately streamlining the writing process.

At VABHS, most of these interviews have taken place in an inpatient setting. The inpatient setting provides some process advantages, in that the veteran is on site and coordinating the read-back portion of the interview is more predictable. For interviews done in an outpatient setting, additional coordination is required as to when, where and how the veteran will have the opportunity to review the first draft of the story. This might be done over the phone at a pre-determined time or might be done in person if the veteran and writer are able to coordinate a time where both parties are on site at the healthcare center. Or the writer might coordinate with the veteran around a time the veteran will already be at the healthcare center for another scheduled appointments. The veteran may be given a draft of the story to review on his or her own, which still leaves the step to coordinate the veteran returning

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the draft to the writer for updates. The goal is not to create additional burden to the veteran in the completion of the interview.

As part of a faculty implementation guide, several feasible implementation strategies have been outlined depending on the clinical setting and the rotation duration of the learner participant (My Life, My Story VA Boston Education, 2019).

Inpatient Setting 1: All in One Session

This works best if there is an afternoon that can be blocked off specifically for this experience. After lunch or later in afternoon often works well; early evening also can work well depending on schedules. This keeps in mind the workflow in the inpatient hospital setting, when the team conducts rounds and other direct care events are in process. This might take two hours total with some variation.

Inpatient Setting 2: In Segments Over the Course of a Few Days

Do the interview on day one. Write the interview that day or next day. Read back within next few days. This can fit more seamlessly into clinical care if a full afternoon is not able to devote to the experience. Ideal if the veteran will be inpatient for a predictable length of time.

Outpatient Setting 1: All in One Day

This might work if the veteran has a predictable day with multiple appointments or is able to spend extra time at the VA that day. The learner might do the interview in the earlier portion of the day and coordinate a time later in the day to meet and review the story.

Outpatient Setting 2: At Various Time Points

This works well if there is a longitudinal experience for the learner and a longitudinal relationship with the veteran. The interview can be done at visit one. The read back can be done at a following visit or another time when the veteran and learner are both at VA.

Outpatient Setting 3: One Question at a Time.

This works well if there is a longitudinal experience for the learner and a longitudinal relationship with the veteran and devoting a whole block of time is not feasible. The ultimate synthesis and writing of the story may take more skill but this might fit more seamlessly into a clinical encounter.

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Debriefing

The interviews are a powerful experience for the learner. Following the interview, learners can meet with their faculty preceptors or mentors to discuss the impact of the interview on the trainee and on the veteran. These meetings can be conducted individually or in small groups and can focus on reflection around the learning experience. The questions below may be used as prompts to facilitate discussion or for a reflective writing exercise-either done ahead of time of the debrief and brought to discuss or done at the beginning of the session.

- What surprised you about this experience?
- What were you expecting going into the interview? How did this change by the end?
- What parts of it were comfortable? Uncomfortable?
- How was this different from other patient interactions?
- What has impacted you about this experience?
- Why was this meaningful/important?
- How will/might this impact your future practice?
- How does participating in this experience relate to competencies in your profession?

Conducting the debrief as a group can help put into words what can otherwise live on as a feeling within the participant that is not formally given a name. By having the debrief opportunity, the students can move forward from the experience with concrete examples of how to provide veteran-centered care.

What Makes a Good Story?

There are a number of features of a "good story." A good story has a linear structure with a beginning, middle, and end, and a clear narrative arc. It might be filled with tales of triumph over adversity and lessons learned. For the purposes of MLMS, a good story is one that accurately reflects the veteran's experience and the tone of the veteran. A team member reading the story might respond: 'It's like he's standing here talking to me.' There is wide variability in what a final version of a MLMS interview may look like. All these iterations are considered 'good' stories if they reflect the voice of the veteran. For two such examples of stories, please refer to sample stories included in Appendix 1.

While the activity of writing a MLMS interview might initially seem separate from other types of writing that is done as part of the healthcare encounter, there are overlapping themes and transferable skills involved. To practice in a healthcare

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setting in the present-day environment is to spend a significant time in writing and documentation activities. More and more time is spent in documentation and reading the chart (Mamykina, Vawdrey, Hripcsak, 2016). The task set forth with MLMS is to listen to someone's life story - which may be a large and winding entity with twists and turns, perhaps told in a non-linear fashion - and synthesize it into a concise narrative that reflects the content that the veteran has shared. This might seem different, when contrasted to a clinical interview, where a specific clinical question must be addressed. However, in the telling and ultimately writing of the clinical encounter, the answer that is provided by the patient might mimic some of features of the life story interview, in that the response to what might seemingly be a simple and straight forward question, i.e., *What brought you in today,* might similarly have an indirect course in getting to that answer, that must then be synthesized and documented in a way that accurately reflects the information provided and in a way that might be used to guide additional care by team members going forward.

Impact

From April 2016 to December 2019 over 800 stories total have been written at VABHS. Over 500 learners from various health professions training programs including, physician assistant, medicine, social work, pharmacy, psychology, speech and language pathology, occupational therapy and nursing, have participated.

Program evaluation was conducted using voluntary and anonymous electronic surveys sent to the learner after completion of the MLMS experience (Nathan, et al., 2019). The survey consisted of two parts. In the first part learners were asked to rate themselves in five patient-centered-care domains and asked how participation in MLMS affected those competencies (not at all, somewhat, a great deal). The survey design was based off the CARE (Consultation and Relational Empathy measure) questionnaire - a validated tool designed to be administered to patients in an outpatient setting, where the patient is asked to rate their provider on a variety of domains with a focus on empathy (Mercer, Maxwell, Heaney & Watt, 2004). VABHS MLMS program coordinators reviewed the 12 item CARE questionnaire and identified questions most aligned with PCC using the Mead & Bower framework (Mead & Bower, 2000). The following domains were selected:

- Make the patient feel at ease (introducing yourself, explaining your position, being friendly and warm towards patients, treating patients with respect; not cold or abrupt).
- Let the patient tell their story (giving time to fully describe their condition in their own words; not interrupting, rushing or diverting).

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- Really listen (pay close attention to what the patient is saying, not looking at notes or computer as patient is talking)
- Be interested in the patient as a whole person (asking/ knowing relevant details about the patient's life and situation; not treating the patient as "just a number")
- Show care and compassion (seeing genuinely concerned, connecting with the patient on a human level; not being indifferent or detached).

The survey also contained several open-ended questions:

- What did you find most valuable about participating in the "My Life My Story" project?
- Why (if at all) do you think this is an important thing to do? If we wanted to convince others to do more of this in the VA, why is it important? How does it affect you? the family? the patient?
- Is there anything you would change or anything you would suggest we do differently in the future?

Thematic analysis was conducted on open-ended survey responses. These responses were collected during a two-year period from 3/31/2017-4/2/2019. During this time frame learners completed 482 stories and evaluation was done on 141 available survey responses. The most stories in this time frame were completed by physician assistant students, followed by learners in medicine (students, residents and fellows), pharmacy (students and residents), social work interns, mental health (psychology and psychiatry students, interns, residents and fellows), nursing students and a few individuals from other professions (speech language pathology, health administration). Themes were grouped into three main categories: perceived effects on patient-centered care competencies, perceived effects on health outcomes, and perceived positive impact for the family, patient and professional. Regarding perceived effects on patient centered care competencies, the most frequently observed comment related to better understanding the whole person. For example:

Getting to know a patient beyond the medical side of things that is often lost while caring for patients in the hospital; I think it is important because it allows you to more wholly know the patient; treat them more as an individual than just another patient. I think it is important for these reasons; I got the opportunity to witness how important her family is to her and the joys and hardships she has dealt with and deals with. -Learner comment

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The subsequent most common comment related to perceived effects on improved empathy, followed by comments on how the activity built the relationship with the veteran. For example:

This is important to do to let the patient know we are here to help them and genuinely want to work with them for their best interest. This affects me, because I now am able to develop a relationship with the patient. -Learner comment

Additional comments were made relating to improvement in the ability to really listen or 'hear' the veteran in a different way and building knowledge of values and goals. Under the umbrella theme of *Perceived Effects on Health Outcomes* the most prevalent theme was that the MLMS experience provides a contrast to usual healthcare.

The most common elements of constructive feedback included length restrictions, questions around use of the first-person voice in the story and in that same vein, concerns about accurately reflecting the veteran voice without the use of audio recording.

FUTURE DIRECTIONS

The aim during the pilot and implementation phase of MLMS within VABHS was to institute the program in a manner that was feasible and that would be framed in such a way as to be relevant for learners across professions and levels of training as a veteran-centered care educational activity. Attention was paid to create a process that could be directly integrated into both clinical care and the clinical educational experience in a way that complemented already established learning objectives and curricular requirements.

As program growth continues there are additional avenues of program development and scholarship that may be pursued. Further program development and targeted outreach and intervention may be instituted with the specific aim to reach veteran populations where amplifying individual stories may have an added element of advocacy. The MLMS program has the potential to amplify the voice of groups of people who are marginalized within VA or society as a whole, including veterans with medical, mental health or social conditions that might be stigmatizing.

Presently program evaluation has been focused on MLMS as an educational intervention and the impact on the learners. Further evaluation is needed to assess the impact on the veterans who participate in this program and elucidate how participation might affect the veteran experience, health outcomes, engagement with the healthcare system. Additional assessment is needed to understand the impact on

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the healthcare team members who read the stories in the matter of course of providing direct care to the veteran, including the impact on staff engagement and burnout.

CONCLUSION

My Life, My Story is an example of a life story work intervention that has been successfully implemented and evaluated as an educational intervention that is effective at enhancing veteran-centered care competencies in learners across professions and across levels or training and has a direct impact on the veteran and the learner. It is the hope that this educational tool can be adopted by other educational healthcare settings as a means of teaching humanistic and patient-centered healthcare and improving the quality of care provided to patients.

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KEY TERMS AND DEFINITIONS

Interprofessional Education: Collaborative educational activities that involves either learners or educators from at least two health professions backgrounds with aim to foster collaborative practice and learning.

Medical Humanities: An interdisciplinary field within medicine that incorporates the arts and humanities into medical education and medical practice.

Narrative Medicine: A medical approach that seeks to enhance clinical practice and patient care with the use of patient narrative and reflection to enhance narrative competence.

Patient-Centered Care: A philosophical approach to medical care that involves partnership with the patient and family to engage in shared decision making that is informed by the patient's values and goals.

Veterans Health Administration: The largest integrated health care system in the United States with the express aim to provide health care to people who have service in the active military, naval or air service.

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APPENDIX

Below are two examples of My Life, My Story interviews. These stories are shared with consent of the veterans. Details have been changed to protect the identity of the veterans.

My Life, My Story

I was born in Delaware - in an era where segregation was the norm - I spent the first 11 years of life raised by my grandfather, who had been born a slave. However, with hard work and diligence, my grandfather became a successful landscaping gardener, after the emancipation proclamation.

Even though I applied to and received rejections from nursing schools all over Delaware (due to the color of my skin), I never gave in to the discrimination. In the early 50's, I graduated from nursing school at Freedmen's Hospital S.O.N at Howard University. And a few years later I joined the United States Airforce Nurse's Corp.

When I first entered the Air Force Nurse's Corps for basic training, I was sent down to Montgomery, Alabama, during the time of the bus boycotts after Rosa Parks' arrest. While there, I got to witness Martin Luther King delivering speeches every Thursday at the local church. This sparked my extensive and lifelong advocacy for affirmative action and equal rights.

In the mid-60s, I went on to become the first African American nurse in the clinics of Mass General Hospital, Boston. But I did not stop there - in pursuit of further academic excellence, I went on to Boston University where I pursued a bachelor's degree in Education and a master's degree in Counseling Psychology.

I have paved the way chairing several committees. I was the Board Chair of the Boston YWCA, vice president of the Board of Trustees of Bunker Hill Community College, chair of the Advisory Committee of the Statewide Head Injury Program, president of the Board of Boston Senior Home Care Services and current president of the Mass Senior Action Council. I am most proud of my work with this council, resulting in approximately 40,000 more seniors being able to access the Medicare Savings Program. My favorite part of advocacy is working together with legislators to improve access and resources for others.

I value reflection and have reflected on the headway I have made throughout my life. I hope others can see the progress of people of color and recognize the odds of leading a successful life of advocacy, during segregation. My advice to healthcare providers is to be more open-minded in order to gain an appreciation about people from different backgrounds, cultures, and religions.

Most importantly, I believe one should cherish one's family. My son lives in another state but has taken after me with the same passion for helping others and

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advocating on behalf of veterans and civilians who have experienced traumatic brain injuries.

My Life, My Story

I grew up nearby, but I've lived all over. My life has taken me from the East Coast, to the South, out West, Vietnam, Oklahoma and back.

When I was growing up, I had a hard time in school and while I had a home it was abusive at times. I bounced between my grandmother and aunt's houses as a result. I'll admit- I was sort of a punk in the early years. I skipped school and didn't make it past the 9th grade, but a lot of this was to escape what was going on at home. At one point it was so bad that I skipped school for several months without my mom knowing. When it finally came out, I was forced to go to a correctional facility as a teenager. That was the first real scare I had and it definitely changed me, but it also built character. Some of the inmates suggested I try the military to straighten out. My father had been a WWII veteran and I figured I might as well try it out.

Unfortunately, I got turned down by recruiter after recruiter because of my lack of education. My last option was the Marine Corps. I took their test and flunked it too, but just by a few points. The recruiter asked me how bad I wanted to go and I told him I felt like it would make me a better man. He stepped back into his office for a few minutes and when he returned, he told me they had made a mistake in grading my test and that I had passed. He also reassured me that since I was the only boy in my family to carry on the family name, I wouldn't be sent to Vietnam for combat. I did Bootcamp at Parris Island and then basic training at Camp Lejeune in North Carolina. While I was on leave from training I received notice I was heading to San Francisco for overseas training. When I arrived there they told me I was headed to Vietnam, despite what I'd been told. I was 18 at the time. And so, I went, and I served for a year.

The Marine Corps made me more mature. When it came time to renew my commitment, they told me I couldn't continue because I didn't finish school. I tried for my GED at that time but missed it by 2 points so I was forced to come back to the states.

Sometimes I wonder if this was an omen, if my military time was not meant to be. At first it was hard. When I returned home, I bounced between over a 100 jobs-- from curtain factory to fishing vessel to tractor trailer driver, you name it. I got into fights and I struggled with post-traumatic stress. I was a loner. I walked away when others brought up the war. Finally, I ended up in a program for my PTSD with a psychiatrist. It was the best thing that happened to me when I got home. He helped bring me back. He taught me to search my soul, to figure out what I want and to stick to it. "You need to stomp your feet on the ground and say, 'I'm Home."

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This advice he gave me always stuck and helped me to keep out the bad thoughts and find the good. I learned how to talk about my experiences-that's what will heal you, it's about getting it all out of you. If you dwell on the negative, you never escape the negative.

I met a friend in the program who convinced me to move to Oklahoma to work on a hog farm. He was a great friend, so I decided to take the risk and make an investment to get him started. At this point in my life I was in a better place to learn and focus. I got my GED and went to college to study computer science. While I was living in OK, I had another experience that left me asking "What If? What if things had been different?" I was supposed to be at an appointment in the building that was blown up in the OKC bombings in 1995 but since I changed my schedule the week before, I was home instead that day. While I watched the news coverage I thought to myself, "You need to do something!" I met with the Mayor and my college dean and organized a fundraiser in support of efforts to fix all the damage and aid those affected by the bombings.

After growing up in a difficult family situation I was lucky to find love at various times in my life. I was married 4 times, and my last wife just passed away three years ago. She was an amazing woman and not a day goes by that I don't think about her and miss her. She gave me the opportunity to live with and love a family like I never did growing up. I have many children and now 5 grandchildren from 1 year old to 13-year-old. When she had the chance to take anyone, she wanted to her first school dance, my oldest granddaughter invited me. I was so excited I decided to buy a nice new suit with a marine corps collar. I spent $300 on it only to have her veto it when I arrived to take her to the dance, but it was still such an honor to be her guest. She will be a force to reckon with!

What if things were different? There's so much of life out there that none of us have ever touched. I like to think about all the possibilities and try to use those thoughts to make good choices. But what-if questions can play tricks on you. You can get wrapped up in decisions and miss out on life in front of you.

If I could do everything over again, sure I would do things differently. But would I change it all now? No. No, because I'm only me because of the experiences, good and bad, that I have lived through in my life. I've lived well and loved, and I found a balance of give and take to make the most of my time.