STORYTELLING AND OTHER DEVICES USED BY FIRST CONTACT PHYSICIANS IN TRINIDAD AND TOBAGO

A Thesis
Submitted in Fulfilment of the Requirement for DM in Family Medicine

Of

The University of the West Indies

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2020

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ABSTRACT

BACKGROUND AND OBJECTIVE

The transformational power of storytelling has been noted in many different studies, and there is evidence that first contact physicians use storytelling during primary health care consultations. These stories are used as tools to educate patients and to influence a change in their behaviour. There is an ethnic link of storytelling with health education and Trinidad and Tobago has a rich storytelling tradition such as the *Anansi* stories handed down from one generation to another which set the pace for rebellion and eventual abolition of the slave trade. It is this rich stories and other devices use by the first contact physicians in Trinidad and Tobago that this study aims to capture.

METHOD

This was a qualitative study design with focus group interview using semi-structured questions. 36 participants were purposefully sampled in the 5 different Regional Health Authorities in Trinidad and Tobago.32 Participants were interviewed, their responses recorded with an audio device and transcribed. Transcripts were analysed by the Principal Investigator and 3 additional researchers. Concepts were generated from the utterances and themes derived from these concepts.

RESULTS

The two overarching themes that emerged were firstly that stories were used as an educational strategy or secondly, as strategy to improve adherence to treatment.

CONCLUSION

First contact physicians use stories in their consultation, and these stories are used either as an educational tool or as a tool to improve their patient’s adherence to treatment.

KEY WORDS: Storytelling, Narrative, Primary health care physicians, doctors` stories.

ACKNOWLEDGEMENT

I wish to thank all those who contributed to the success of this project; my teachers, medical colleagues, the transcriptionist, physicians who donated their time for the interviews, the University of the West Indies and my lecturers. I also wish to thank my family and God for his kindness

DEDICATION

This project is dedicated to my late mother Mrs Felicia Okali (Gold) who passed away on the 19th of March 2020

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LIST OF ABBREVIATIONS

ERHA...Eastern Regional Health Authority

GP..General Practitioner

HPV..Human Papilloma Virus

NCD...Non Communicable Disease

NCRHA..North Central Regional Health Authority

NWRHA...North West Regional Health Authority

PI...Principal Investigator

RHA..Regional Health Authority

SWRHA..South West Regional Health Authority

TRHA...Tobago Regional Health Authority

WHO...World Health Organization

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CHAPTER 1
INTRODUCTION

BACKGROUND

Storytelling has been the means of communication for humans for centuries. The customs and traditions of different ethnic groups were handed down from one generation to another through stories told by their parents or elders of their communities through the oral storytelling tradition. Ancient people used storytelling for entertainment and educational purposes (1). Storytelling is defined as *the interactive art of using words and actions to reveal the elements and images of a story while encouraging the listener's imagination.* (2)

As an educational tool storytelling is very powerful, be it biblical stories, bedtime stories or folklore stories when executed by the teller could be transformational. This is because it is interactive, stimulates the imagination of the listener, sends a message and encourages narrative transportation of the listener to the element of the story (3). The *Jamaican Anansi stories* written by Martha Warren Beckwith an American ethnographer, is a collection of transcribed folklore riddles and music told by Afro-Caribbean people of Jamaica. The character of *Anansi* the clever spider has its origin from west Africa and despite the cruelty of the slave masters, these stories of the crafty and rebellious *Anansi* was able to survive the 'middle passage', handed down from one generation to another in most Caribbean Islands where the African slaves settled. The character of *Anansi*, represents a conscious message that freedom and dignity are worth fighting for and formed the bases for the struggle against slavery till it was abolished. (4)

Even medical clinical practice relies on the documentation of the patient's illness history in a story form in order to complete the evaluation of the patient's condition during a consultation. Medical education also expects the medical student to be a good communicator (a quality of a good storyteller) when presenting a case to the medical team after a medical encounter with a patient (5), thus emphasising the importance of storytelling in either way during a consultation. Furthermore medical researchers constantly seek to improve the scope of medical practice to accommodate its holistic nature in dealing with human suffering; We see the introduction of the *Biopsychosocial* model by George Engel which recognises the psychosocial issues of health from the disease-focused Biomedical model (6) and recently the introduction of the narrative medicine model of health care delivery by Rita Charon of Columbia University(7).Narrative medicine requires narrative competence which expects the physician to *recognize ,absorb, interpret and be moved by the stories of illness*(8).

There is no better time to promote storytelling under the narrative medicine model of health care delivery in the primary health care setting than now that there is this persistent global challenge of increasing chronic non communicable disease burden, particularly diabetes and hypertension in low and middle income countries including Trinidad and Tobago. In 2016, Non communicable diseases NCDs alone accounted for 81%of all deaths in Trinidad and Tobago with a 21% risk of dying prematurely between the ages of 30-70 years as reported by the world health organization WHO (9).

These figures are very alarming and call for a more serious look on different ways to mitigate this escalating scourge of chronic non communicable diseases affecting our communities. Storytelling as an intervention has been shown to produce reasonable and important reduction in blood pressure in some patients with uncontrolled mild hypertension (10). Patient centeredness of care must be the cornerstone of primary health care delivery because there is strong evidence that a robust primary health care system grounded on patient centred care and evidence based medicine positively influences patients satisfaction and self management or compliance(11) which is associated with good outcomes in chronic disease management.

Storytelling is also very effective when used to explain scientific medical information to a non medical audience due to its enhancement of the individual's ability to make meaning of the scientific information(12) hence when utilized in patient self management education programs, could be very beneficial to the patient(13).For any primary health care consultation to be effective, the doctor-patient relationship must be interactive with good communication playing the significant role as the vehicle bridging the gap between the patient and the physician(14). When this communication is done through storytelling, it stimulates mutual reflection and interactive meaning- making of experiences, which triggers action on the part of the patient (15).

This interaction exists between the primary health care first contact physician and his patient routinely in primary health care clinics in Trinidad and Tobago as he tries to influence a change in his patient's behaviour by telling stories in order to achieve a positive health outcome. It is this storytelling that underlies the bases of this research design which was carried out on both islands with key informant as participants.

The interactive focus group discussion on the research topic of ***storytelling and other devices used by first contact physicians in Trinidad and Tobago*** saw contributions from primary health care physicians of diverse back ground, experience, age, gender, ethnicity and cultural exposure making their own contributions which was captured by audio recording and transcribed verbatim by a certified medical transcriptionist. The findings of the analysed transcript presented in this document reveal what we already know in studies done outside Trinidad and Tobago as the literature shows.

AIMS

This Study aims at finding out the nature of stories and other devices that is being used by first contact physicians in Trinidad and Tobago clinics.

REASEARCH QUESTION

What stories do first contact physicians tell their patients during a consultation and for what purpose?

CHAPTER 2

2.1 LITERATURE REVIEW

The art of storytelling by doctors in the patient-doctor encounter is not a new phenomenon for there is evidence that primary health care physicians use storytelling in their consultations with patients (16).

A search of the literature using terms such as: “storytelling”, “Narrative”, “Doctor`s story”, “primary health care stories” was carried out with no limits on years. The data bases searched included: Medline, CINAHL, Embase through EBSCO, PubMed, Cochrane data bases and Google Scholar. However no study on storytelling in Trinidad and Tobago clinics was found.

A 2015 study to understand if narrative could be an effective tool for diabetes empowerment was carried out on African-Americans attending a Diabetic Empowerment Program (DEP), by Researchers of the University of Chicago at the South Side of Chicago. The DEP has role play, a movie clip and storytelling as part of its components, and lasts for 10 weeks with monthly support group meetings. In-depth interviews and focus groups were conducted with graduates of the program, asking if narrative had contributed to their behaviour change. African-American adults (n=36) reported that narrative or storytelling positively influenced the diabetes behaviour change they had experienced (17).

A cluster Randomised control trial study was done in Vietnam in 2017 with 160 patients who had hypertension (mean age 66years) in which storytelling was used as the intervention and didactic information used as the control .The result showed compliant to treatment by the storytelling group as well as decrease in mean systolic blood pressure by 8.2mmHg [95% CI 4.1-12.2] with the storytelling group and 5.5 mmHg [95% CI 1.4-9.5] with the didactic group (18).

A 2018 Japanese study done to show the effect of storytelling compared to picture-book-reading on the brain of school children, using Near Infrared Spectroscopy (NIRS) revealed more sustained brain activation with storytelling than with picture-book-reading, suggesting possible advantage of storytelling as a psychological and education medium(19).

In a recent 2020 pilot study carried out in the US on Korean American women termed *Randomized Control trial to evaluate the preliminary effectiveness to promote HPV vaccination in Korean American college women,* a storytelling intervention using mobile web based technology saw 104 Korean American women randomised in either the experimental group (storytelling video) or comparison group (information- based written material).The result of the immediate assessment showed both group improving in the knowledge of and attitude toward HPV vaccine. However a 2 month follow up showed the experimental group twice as likely to receive the HPV vaccine compared to the comparison group; an indication of the significance of storytelling intervention(20).

In the Trinidad and Tobago setting, we have a very rich culture which is laced with lots of allegorical stories and folklore in the art forms such as in *Calypso*, ` *Extempo*’ and the Tobago speech band (21, 22).This means that we are not alien to storytelling since it is part of our culture and we use it to express ourselves in our everyday life.

When health care delivery is grounded with the culture of the community through effective communication in the form of Storytelling to explain biomedical disease process in a patient centred fashion we see an improvement in health outcome (23). This is being used very effectively in Australia for example in the form of "clinical yarning" among the aboriginal population ,Where health care delivery is grounded with the culture of the community through effective communication in the form of Storytelling to explain biomedical disease process in a patient centred fashion. Clinical Yarning is defined as a patient centred approach to care which combines aboriginal cultural communication preferences with biomedical understanding of health and disease. Clinical yarning consists of three interconnected parts which are; social yarn in which the doctor finds common grounds to develop interpersonal relationships, the diagnostic yarn which he facilitates the patient story giving it a biomedical interpretation and the management yarn which utilises stories to aid the understanding and collaborative management of the patient's condition(24).See fig.1

Figure 1: Key elements of Clinical yarning[24]

2.2 THEORETICAL FRAMEWORK

Doctors in Trinidad and Tobago do interact with their patients like in other parts of the world using storytelling .However the nature of these stories being used by primary health care doctors when they try to persuade their patients with chronic non communicable disease conditions, particularly diabetes and hypertension to change behaviour has not been fully explored in Trinidad and Tobago as a search in the literature revealed.

Using storytelling to teach has been found to improve knowledge and promote health in different studies (23, 25, 26, 27).The conceptual benefit of storytelling is in the theory that recognises the significance of storytelling as an essential communicating tool in creating meaning through *realism*, *identification* and *transportation*. Realism will occur when the storyline is made to be as close to life as possible, stimulating the listener's innate tendency to imitate what is in the story .In identification, the listener takes the perspective of the character in the story as though he is experiencing what the character is experiencing while transportation involves the adoption and change in perspective by the listener which ultimately leads to a change in behaviour of the listener (15).See figure 2

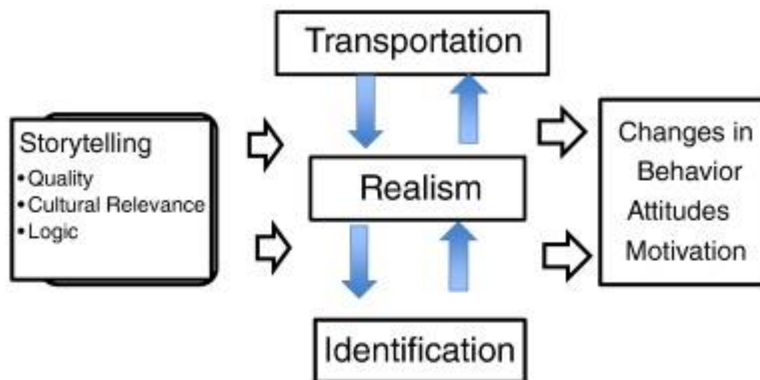

Figure 2: Storytelling theory[15]

CHAPTER 3

METHODOLOGY

3.1 STUDY SETTING

This study was carried out as part of the requirement for the DM in Family medicine program offered by the University of the West Indies. The study period was for six months from the beginning of September 2019 to the end of March 2020.

Primary health care physicians practicing on both Islands of Trinidad and Tobago were the target of this study and the study took into consideration the geographic setting of primary health care delivery on both islands as participants were chosen from both Islands. This arguably is contrary to most situations where study participants are recruited mainly from Trinidad to reflect an outcome on both Islands. The delivery of Primary health care in Trinidad and Tobago is through the public health care system managed by the different Regional Health Authorities (RHA); namely Tobago Regional Health Authority (TRHA), Eastern Regional Health Authority (ERHA), Southwest Regional Health Authority (SWRHA), North Central Regional Health Authority (NCRHA), and Northwest Regional Health Authority as well as through private General Practitioner (GP) clinics. See Fig.3

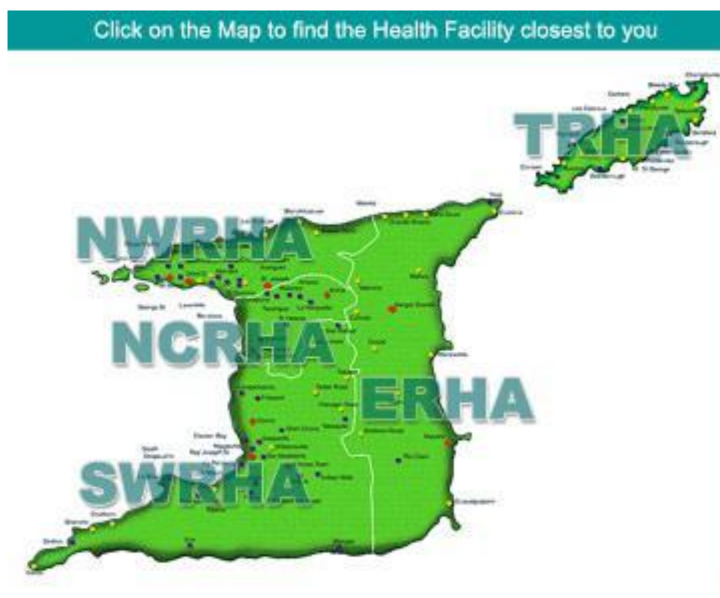

Figure3: Map of Trinidad and Tobago showing location of the different Regional health Authorities (courtesy news.gov.tt)

Primary health care physicians and GPs working under these catchment areas were targeted and enrolled in the project as participants. Focus group interviews were carried out in four comfortable private doctors' offices; three located in Trinidad (San Fernando, Dabadie, and Port of Spain) and one in Scarborough Tobago.

Participants were informed in advance of this arrangement with the exact address and locations communicated to them by phone and through Google map. They were made to seat comfortably in a round table arrangement. Eight different focus group sessions were held with each focus group having an average of about 4 participants per focus group, making a total of 32 participants involved in the focus group sessions, which is in line with the Criteria for focus group interviews (28). Out of the eight focus group sessions, four were carried out in one location in Tobago while the remaining four were held in four different locations in Trinidad. The first Tobago focus group session was a trial session which came out successful after reviewing with the study supervisor and Principal Investigator and thus was incorporated in the analysis as well. Light refreshments and water were provided to the participants.

3.2 STUDY DESIGN

This research study is a qualitative design using focus groups with semi structured questions. The questions were designed in a format to better answer the research topic, after an extensive review of the existing literature on storytelling or narrative .

3.3 PARTICIPANT RECRUITMENT

Few key informants were conveniently sampled and they assisted the investigator in recruiting subjects into the study, with the handed down eligibility criteria. Convenience sampling was used here because the investigator knew the key informants to have met the criteria for recruitment and their ability to identify good storytellers within their practice jurisdiction .Furthermore, the short period of this study necessitates convenient sampling since time is of essence to complete the study. Consequently, it was those participants without any limits to ethnicity or gender who responded positively and met the eligibility criteria that were sampled.

36 eligible participants responded and were recruited through purposeful and snowball sampling methods. Eligibility criteria for recruitment into the study were any primary health care physician and General practitioner with more than five years of practice experience or with postgraduate training in family medicine and primary health care, irrespective of gender or ethnicity, and participant must be practicing in one of the areas covered by the RHA in Trinidad and Tobago.

Though some participants who made the eligibility criteria came from different countries and ethnicity, those who were not born in Trinidad and Tobago had lived in the country long enough to have acquired full medical board registration and Residency, which is one of the Medical Board criteria for foreign medical graduates to practice as a primary health care physician or General practitioner in Trinidad and Tobago. This is ample time for these participants to have adapted to the culture of the people of Trinidad and Tobago. Contact was made through telephone calls, *Whatsapp* social media messaging and physical visits to some of the targeted participants. The study information was explained to participants and voluntary participation was emphasised. Focus group interview dates and venue was given out to participants.

Out of the 36 sampled participants, one participant declined to be in the study, stating he has plans to travel abroad during the period of the interview. Of the remaining 35 participants, 3 participants did not

show up on different scheduled days of the focus group interview for different reasons such as short notice given, babysitting issues and excessive tiredness (fig.4). This left 32 sampled Participants comprising 22 males (69%) and 10 females (31%) made up of family physicians and general practitioners who were recruited using multiple sampling techniques into the study. From the 32 participants, 28% stated they engage in private primary health care practice, 38% public and 34% stated that they practice at both private and public health care institutions (Table 1).

PRACTICE TYPE	MALE	FEMALE	PARTICIPANTS	FREQUENCY (%)
PRIVATE	5	4	9	28
PUBLIC	8	4	12	38
BOTH	9	2	11	34
TOTAL	22	10	32	100
FREQUENCY (%)	68.75	31.25	100	

Table 1.Frequency distribution of participants in practice type and gender

3.4 ETHICAL CONSIDERATION

The research methodology was explained to participants and all burning questions answered to their satisfaction.Individual confidentiality was assured and it was stressed that no sensitive information was required from participants.The names of the participants will not be disclosed in the result and freedom to withraw at any point of the study was emphasised.Participants were debriefed at the of the study and the collected data, assessible only to the principal Investigator and the researcher, will be kept for 5years then destroyed. Approval for this study was granted by the Institutional review board of the University of the West Indies St. Augustine Campus Trinidad.

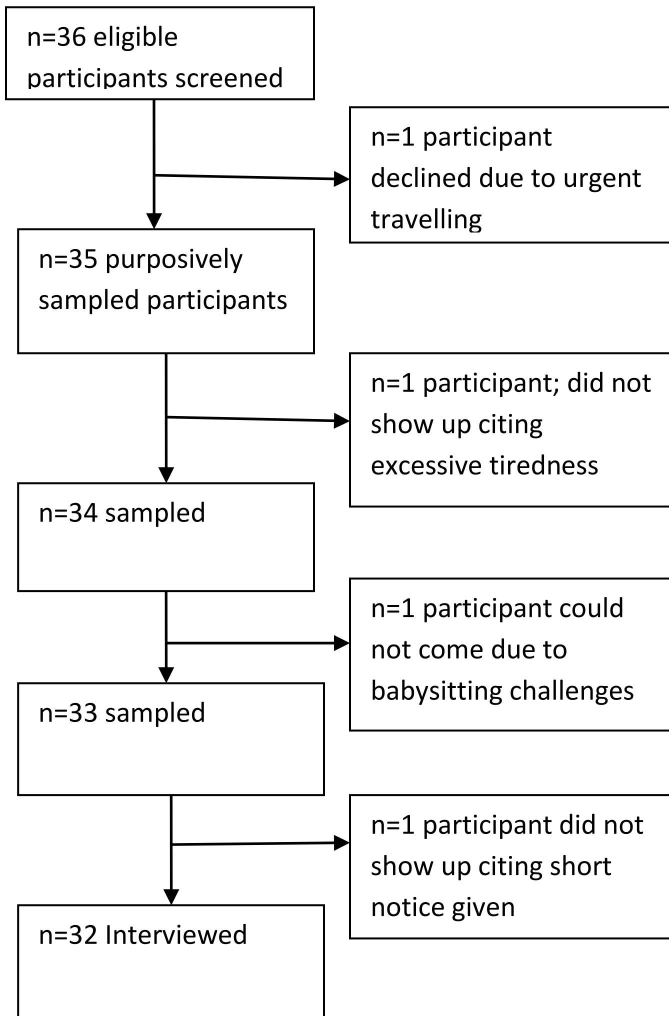

Figure 4: Participant Recruitment

3.5 DATA COLLECTION

The first focus group interview was conducted in September 2019 at a private doctor's office located in Scarborough Tobago as a pilot to the subsequent focus group interviews.4 key informants comprising of one female General Practitioner and 3 primary care physicians involved in both private and public primary health care delivery in Tobago were in attendance. The result of this first recorded interview was thoroughly reviewed by my research supervisor and Principal Investigator who approved its incorporation into the study.

Participants were ushered into the interview area, made to seat comfortably at their name identification position. They were given an introductory letter expressing the research approval by the University of the West Indies St. Augustine campus Institutional Review Board for Research. This document also explained the research concisely and emphasised the option of voluntary participation, freedom to withdraw at any time and a written informed consent form to sign if they feel comfortable to do so. They were reassured of confidentiality and it was stressed that no video recording will be part of the interview process. They were given enough time to ask questions which were answered to their satisfaction. The ground rules for the duration of the focus group interview was explained to the participants and they were given enough time again to ask questions which were answered to their satisfaction.

The focus group interview was recorded with an audio recording device and a mobile phone recorder as a backup recording device. At the end of each focus group session, the discussion will be summarized from notes taken and its content verified with participants to ensure all the points was validated. In addition, at the end of the study, a virtual debriefing was done with participants through zoom due to the COVID19 guidelines of social distancing. The researcher moderated the focus group interview with an interview guide which lasted about 90minutes. (Table 2)

Table 2: Focus group interview dates, number of participants and catchment area

Focus group description	Date of focus group interview	catchment area of participant	No of Participant present	Duration of interview session
1 (Pilot)	September 2019	TRHA	4	52min 8 sec
2	31/10/19	TRHA	5	1hr 12min 04 sec
3	03/11/19	TRHA	4	1hr 10min 25sec
4	10/11/19	ERHA	4	1hr 26min 43 sec
5	14/11/19	TRHA	4	1hr 7min 29 sec
6	17/11/19	NWRHA	4	1hr 21min 52 sec
7	24/11/19	NCRHA	4	1hr 24min 02 sec
8	01/12/19	SWRHA	3	1hr 26min 15sec

3.6 DATA ANALYSIS

Demographics

A total of 32 participants were interviewed over a 4 months period, from September 2019 to December 2019 using focus groups. A total of 8 focus group sessions were held between the Islands of Trinidad and Tobago at different Regional Health Authority (RHA) catchment areas, with 5 participants being the most and 3 being the least in each of the 8 sessions. The duration of each interview session ranges from 52 minutes to 1hour 26 minutes. Out of the 32 participants, 10 were females and 22 were males

The audio recording was played and listened to several times, familiarizing with the data then transcribed verbatim by a certified medical transcriptionist. Each extensively perused transcript was analysed by the Principal Investigator (PI) in conjunction with three additional researchers. The utterances by the participants were manually coded for significant information related to the research question of ***storytelling and other devices used by first contact physicians in Trinidad and Tobago.*** The coding process involved underlining significant information in the data related to storytelling with the research question in mind and assigning a concept to this chunk of data by analytical observation of the pattern of the utterances. The concepts emerging were then summarized into themes (29).

Manual coding was used instead of coding software because of the novelty of the study and the inexperience of the researcher; it was agreed by both the Principal Investigator and the researcher that it is best and more rewarding to the inexperienced researcher to learn from first principles on how the coding and analysis process is done manually. The reason behind this is that, moving forward any challenges that may arise from using coding software could be identified and surmounted easily with such acquired knowledge of the first principles on coding a qualitative research data. Saturation was reached by the 6th focus group interview, when no new information was emerging from the data. However all the data collected was analysed, this being a novel study.

Two overarching themes emerged from the final coding process. These themes were then verified with the principal investigator and two other researchers to ensure all the relevant themes were captured from the transcripts.

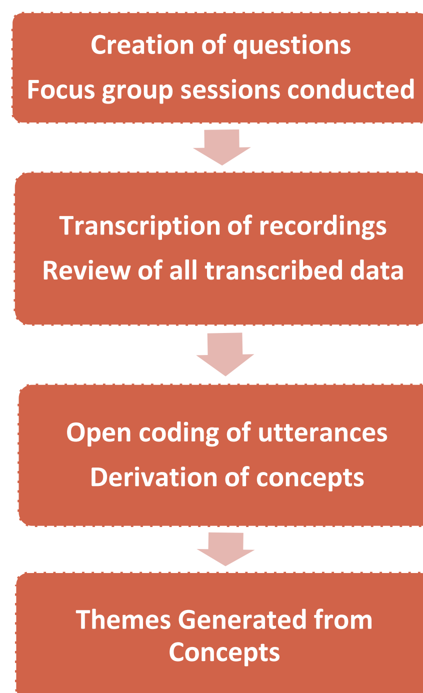

Figure 5: Schematic summary of methodology

CHAPTER 4

RESULTS

The two overarching themes that emerged were firstly that stories were used as an educational strategy or secondly, as strategy to improve adherence to treatment.

4.1 EDUCATIONAL STRATEGY

The concepts under this strategy were;

'the body as a mechanical instrument' ,'my ancestors were strong so I will be', 'just to make it simple for them',' to build rapport', 'breaking bad news', 'using personal stories', 'digital images', 'motivational approaches', 'scare tactic', 'spirituality' ,'enough time is needed', 'modern physicians communicate better', 'choosing who to tell stories to', 'body shaming', 'fictional Depiction' and 'cultural analogy'.

The body as a mechanical instrument

This concept was the most frequently used, accounting for more than a quarter of the utterances. Participants used the concept to associate disease conditions or the body`s anatomical structures to educate patients .Dr F in explaining the effects of obesity to the joints had this to say to his patient;

Dr. F: *"...I would tell some of my patients to take a bottle of water and fill it and put a cement block on top of it and leave it there for a while. After three months, then you go back and look for the bottle and you will see what happens. The bottle would be almost smashed up and that is what is happening to your knee. The cartilage in your knees are being destroyed, so you therefore need to lose some weight and try to relieve that knee of that pressure and you will feel much better..."*

Participants also frequently use the services supplied by the utility companies to explain disease conditions such as hypertension or diabetes. One of the participants in trying to educate his patient on effects of uncontrolled high blood pressure associated the home plumbing system with high water pressures coming from the Water and Sewerage Authority WASA.

Dr. A: *"...a very good example that I would talk about is using the plumbing systems for instance WASA in Trinidad, for someone with high blood pressure because they have experienced a burst pipe before and you tell them how the pressure was increased from the source, so the pipe could not withstand the pressure so it exploded..."*

The whole idea is to draw the patient's attention to the effects of the everyday problems that may occur with the services of these utility companies and making them see their problems within the same context when things go bad. For example another participant used the electricity company T&TEC in describing hypertension to make it easy to comprehend

Dr. C:*"...the example with high blood pressure and T&TEC giving you high voltage, they can understand high voltage and the damaging of appliances in your house and the effects of high blood pressure*

damaging other parts of the body and I think it helps them to understand more about their disease if done properly and appropriately..."

Diabetes was another chronic non communicable disease that was frequently addressed using storytelling by participants referring to the body as a mechanical instrument. A participant who was educating his diabetic patient on dietary control had this to say;

Dr. A: *"...I had a patient once from Trinidad. She loves 'roti' [flour based sandwich] and she wanted to eat it every day. She came to my office and she was trying but she can't stay away from it. So I told her a story, I think I was in high school my uncle had a rail bridge there was one right next to the gas station. There was only a certain amount of weight allowed for you to go on the truck. So one day a truck came on the rail bridge and the loader is placing cement pallets on the back and the truck can only carry one ton. After that the business fellas was so greedy, he wanted to put more cement on it and then the whole bridge eventually broke down, so I told the story to that lady. That the body can only take so much amount of fuel and you would have to go on a diabetic diet if you do continue to take 'roti' every day you will break like my uncle's rail bridge..."*

However some will also use biomedical descriptive terms to explain the effects of uncontrolled high blood pressure by referring to the heart as a bag of muscles

Dr. S: *"... The heart is a bag of muscle, if you go to the gym when you lift up weights you put on muscle and they get bigger so if your heart was to pump against high blood pressure, your heart is going to get enlarged and your heart is going to start to fail and that puts you at risk for a heart attack and they respond.." really Doc?" and I say yes" .*

My ancestors were strong so will I be

This concept emerged from patients who have a disease condition yet in denial believing that they come from a strong family .They feel it will be against the family tradition of good health if they accept the condition and change behaviour. That belief system has to be broken as explained by Dr. A while educating his patient.

Dr. A: "...*The belief is that my grandfather was strong, my father was strong and I can't break that trend, so sometimes we have to break that belief system and bring them to terms that this is a human body and yes you may be strong but as certain age reaches you need to start taking care of it better..."*

This concept was also seen with patients who have a misconception about their disease condition and who relied on negative past experience of others in making decision

Just to make it simple for them

Storytelling helps to simplify complex medical information for patients making it easy to comprehend. When information is given to a patient using stories and a feed back is in tandem with the information given, it signifies understanding from the part of the patient as explained by Dr. C

Dr. C: *“...So sometimes you tell them a story and they tell you back one as well, it’s just to make it simple for them...”*

Another example of making simple for the patient was when a participant was describing the pathophysiology of multiple sclerosis;

Dr. N: “...*I could remember recently, my wife was watching a program on the television and they mentioned MS (multiple sclerosis) and she asked what this is. I started to explain...The myelination of the... and she was like ‘what are you talking about?’ I then explained that it was the wrapping around the nerves and that wrapping is what helps the nerves work properly. When you remove the wrapping, the nerves are not able to work properly, so the wrapping is what she would understand, that makes her to understand what myelination and demyelination means...”*

To build rapport

Rapport building is very important for a patient to build trust in a physician and be encouraged by his words of advice. When a patient feels comfortable with the physician, communication becomes easier and the physician is more likely to educate the patient. One Participant however admits it is just the first step towards gaining the full trust of the patient.

Dr. C: *“...allows them to have a little confidence in you the physician. So when they come in they won’t just see you as doing a job the good rapport would be there. They would know they can talk to you...”*

Another participant has this to say about building rapport

DR. P: “*Story telling also can be used to create rapport, break the ice and it eventually makes them comfortable. When the patient accepts you and believes you are compassionate and understand what is going on there is a possibility of the patient being compliant and they would want to come back. The patient would also want to share the story with his or her friends in order for them to have the same thing. It makes for a smoother consultation”.*

Breaking bad news

First contact physicians deal with the pain and suffering of patients daily and must have the capacity to help their patients navigate the challenges of illness by giving them hope especially when breaking bad

news. A participant utilised storytelling in breaking bad news of a malignancy to his patient while educating and encouraging them to have hope;

Dr. J: *"...For instance, informing a patient about a malignancy that you just found out, you try to educate them give an example like it had someone before who had this condition and they got support from their family. So you tell them what the person did so they understand that it has options and this person would know you gave them hope..."*

Using personal stories

Physicians are dedicated to their patients and the drive to make significant change in the lives of their patients through patient education. This drive sometimes forces the physician to use their own personal stories of the illness experience in educating the patient. Not all the participants agreed on using their personal story to influence a change in the behaviour of the patient; however those who support the use of personal story admit its significant influence to encourage behaviour change. The impact and transformational power of a personal story can be seen when Dr. W revealed to her patient her own personal struggle with illness while encouraging and educating the patient.

Dr. W: *"...This shocked him; he looked and asked me if I was sick and how I did not look sick and eventually smiled. This is the very first time I would have told a patient about my health issues. I told him then the reason I do not look sick is because I have to live on certain meds to take that make me not look sick and I can function and like you I have good days and bad days".*

Not all the participants had agreed to share their personal story with their patients

Dr. M: *"...I think there should be a boundary, because there are certain personal issues that you may try to share with the patient but they may actually out of nothing use it against you or feel that if this person has this they would not be able to take care of me properly, those kinds of feelings..."*

However those who admitted using their personal stories had done so with the fear of breach of confidentiality or stigmatization as seen by the utterance of this participant who believe her patient must be trusted before such disclosure

Dr. L: *"If you trust them and if they clearly need to hear something like that. For example, I had a patient once and she was one of my regulars and I have known the family pretty long, she came into the clinic then into my office and started crying. So I saw the emotional distress, told her to sit down and tell me what was wrong. I was trying to comfort her and find out what was wrong, she then started to explain what has been happening and how she was feeling. She had made the criteria for depression and I was trying to explain what depression was about and we have this clinic and there was help for it but she was being resistant. I thought twice and three times before confiding because there is a stigma attached to mental disorders and I saw what she was going through. It broke my heart enough for me to tell her my own experience, when I was diagnosed with interstitial lung disease and going through with all of that I experienced a period of depression for about a year. I was on medication and therapy and what not..."*

Digital images

There is the saying that a picture is worth a thousand words hence some first contact physicians are using digital images from their digital devices in educating patients. Most of the participants agreed on using one form of digital image or the other in educating their patients. When these images are familiar or culturally identifiable it has an impact on the patient as a participant Dr. O puts it;

Dr. O: "...*The thing with using images it brings it home to them and the realization that the solution is not farfetched but right in front of them as close as you and I are talking now..."*

Motivational approaches

The versatility of storytelling in health education cannot be over emphasised. Be it in situation of educating life style changes, understanding disease process or motivating a reluctant patient storytelling fits in perfectly .Dr. I explain the use of storytelling in motivating a patient.

Dr. I: *"...some of them are stories to make them understand the implication of the lifestyle that they are living and some of them are stories of good times, in terms of the benefit that they will achieve if they modify their lifestyle..."*

Scare tactics

Fright was used as a strategy to educate patients by some participants. Though participants agreed frightening the patient was not a good approach to educating them, participant who use scare tactics admit to using it as a last resort especially on patients who are adamant to change of their behaviour. For example Dr. F used this tactic in educating a non compliant patient with hypertension.

Dr. F: *"...seeing that his brother died and they said it was because of his high blood pressure and never used to get it treated. So that was a story I took from him and I use with other patients to let them know this is a possibility because persons right here have experienced this same thing..."*

Spirituality

There are first contact physicians who bring their spiritual perceptions into their practice while dealing with their patients. Patient's illness and behaviour are perceived in both a biomedical and spiritual dimension for example one participant Dr. O combines his spiritual belief and biomedical knowledge in dealing with patients issues when trying to change their behaviour;

Dr. O: *"...They do not usually see it from that angle and for those of us who combine medical and sometimes pastoral teachings you see some persons who come with all sorts of pains..."*

Enough time is needed

For any intervention to be effective there should be enough time as suggested by most of the participants. There was a general perception among the participant that the work load in primary health

care is usually heavy thus enough time is needed in order to use storytelling to change behaviour. Participants however overcome the time challenges by summarizing the story as described by Dr. O

Dr. O: *"...Time is important depending on the work load that you have and how many patients you have to see. You may need to summarize the stories as quickly as you can and allow them to ask questions to clarify some of these things..."*

Modern day primary health care physicians communicate better

The delivery of medical care has moved from medical paternalism where the doctor has all the responsibility and answers to patients' problems, to a patient-centred care model with patient autonomy being its high light. An elderly participant with over 30 years of General practice assert that younger and modern day first contact physicians have better communication with their patients than the past generation of General practitioners in his revelation.

Dr. F: *"...In the older day's patients with high blood pressure for twenty years do not know that they have high blood pressure, they just know they need medication. Now it is different, I think it is because the primary care physicians pass on the information better than we use to before..."*

Choosing who to tell stories to

Participants selectively apply the use of storytelling to change behaviour. They look at other factors such as time available for the consultation, the patient's level of education and the patient's motivation to change behaviour because not all patients would like to hear stories. Some patients preferred that the medical facts be delivered to them concisely in a non storytelling patterned. Dr. G summarise this idea in explaining how and when he uses storytelling to educate a patient;

Dr. G: *"...You have to know, when you are seeing a patient what approach you are going to take and you can tell by education level, by the patient's motivation. Just by looking at a patient by their figures does this patient want to hear facts, do they want to hear your recommendation or is this person you going to tell a story because you want to take a different approach..."*

Body shaming

Men's health and the reluctance of men to voluntarily assess health care delivery in their communities were discussed by most participants and participants made reference to the belief that men love their cars significantly. The issue of screening for potential life threatening diseases by men saw a participant drawing attention using an allegory equating the patient's body to his car in order to educate the patient;

Dr. S: *"...it is difficult to get men to engage in preventative health, so I would draw an analogy and I might even shame them a little bit like you are treating your car better than you are treating your body. As I am sure you take your car to the mechanic every four months for its oil change, brakes change and so forth but you have not been here for a year so right now your car is getting better healthcare than you are..."*

Fictional depiction

Not all the stories participants use in persuading and educating their patients are real stories. Some participants use fictional depictions or fabricate their own stories to educate or reassure their patients. A female participant will use fake stories in reassuring her female patients with menopausal symptoms;

Dr. F: *"...sometimes for older women in particular who would come in for menopausal symptoms I would use my mother and I would admit half the time it is a fake story but just to say you are not alone..."*

Cultural analogy

Storytelling delivered within the cultural setting of the patient is usually better understood and impactful. More so when the patient`s level of education is not sufficient enough to enable comprehension of complex medical information. A participant sums it when explaining his use of storytelling to educate;

Dr. O: *"...Some patients have certain levels of education and within cultural complexes can be used in order to communicate the need for them to comply to the medical advice at the end of the day You want the patient to do well. That is why you use stories to drive down the point..."*

This concept was used frequently used by Tobago participants in educating their patients. A participant who was counselling an adolescent on responsible sexual behaviour used one of such concepts;

DR S: *"...So another example; I had to counsel a child who had been sexually active and the parents were worried about communicable disease and infections. So everything was done but at the end of the day you want to guide an adolescent into responsible behaviour. At first I would say my grandmother use to tell me that 'chicken Merry hawk there `bout which is to say you are there having a merry old time like chickens and without warning the hawk swoops and take them off and I am saying in the same way when you make a decision to have sex it comes with certain responsibility and protecting yourself is one of them. Using condoms, having HIV tests ever so often as long as you are sexually active you should have a pap smear every three years and as well your partner should join you in these checks..."*

4.2 STRATEGY TO IMPROVE ADHERENCE TO TREATMENT

The concepts under this strategy were;

‘allegorical reference’ , ‘using fright stories , ‘reassuring patients, ‘scary images’, ‘seeing is believing’, ‘using biblical stories’, ‘personal stories’, ‘cultural analogy’ and ‘understanding of disease’

Allegorical reference

Here participants used inanimate objects to equate disease processes with a hidden meaning to stimulate patients’ understanding .Allegorical reference accounts for one quarter of the concepts used by participants. This concept is used by participants specifically to encourage treatment adherence as can be seen when one of the participant educates about the consequences of not using hypertension medication

Dr. I: *“...I have a plastic pipe with water running through it repeatedly and I start to show them how the wear and tear would happen inside of that plastic pipe if the water has a lot of pressure. I then describe to them, that wear and tear within the plastic pipe is happening inside your blood vessel and them, boom! They begin to understand the impact of the blood pressure. By the time of the next visit, I would begin to see a better-controlled blood pressure or sometimes improved compliance and about eighty percent of them approximately that I told that story become compliant and move from uncontrolled blood pressure to having it controlled...”*

Another strategy for increased adherence to treatment for diabetes was used by a participant who compared the human body allegorically to a basin of sugar that attracts biting ants. The concept is to stimulate the patients imagination of what will happen to their body when diabetes is not controlled with treatment as more sugar concentration implies more ants coming to the basin of sugar to bite.

Dr. O: *“...Once more sugar gets in, then more insects get invited in and complicate everything within the cells and the tissues, so the primary reason is to get them to see a picture of themselves and their body as a basin of sugar and get them to not allow that basin of sugar to increase in concentration or quantity...”*

Using fright stories

Dr. H: *“...I use them more to persuade patients to follow through with treatment. So I might recommend something or refer them to another department and they would say I can’t go today I’ll go another day. So I use these fright stories especially with parents. The most recent one I’ve been using is; we had a 10-year-old who came in he had trauma to the left leg something minor and the doctor who saw him referred him to do an x-ray and he didn’t take the child. Apparently, the child was a little obese as well within one week; the child ended up in ICU and died...”*

Another participant who had a diabetic patient admitted using fright stories to encourage adherence to treatment;

DR. S: *“I would sometimes tell them a story of someone who had passed on [died] or who are on dialysis because they didn’t listen to me, in that respect yes, it may frighten them a little but I tell them again it is not for me but for you the patient that I’m trying to help”.*

Reassuring Patients

The problem of patient not complying with treatment was frequently raised in most of the discussion with participants and accounts for most of the reasons for the strategies to change behaviour. The concept of reassuring the patient sometimes gives hope to the patient

Dr. G: *“...some patients like to say they don’t like to be on all this medication and they don’t know why them alone have to be on all this medication. So what we do is try to bring up examples like you treat with different people like your parents or relatives and they’ve used it before and they’ve had a good outcome, so in that sense it’s more of a hopeful story...”*

Scary images

Participants also admitted to using graphic images to scare their patients when other methods fail. Such graphic images were pulled out from internet search on their mobile devices. A participant who became frustrated with one of his diabetic patients after counselling added a graphic image to enforce adherence.

Dr. G: *“...the patients who have diabetic foot or an ulcer and you are treating with it, one thing about diabetes you have to control your sugar otherwise it will go to a highly infectious stage. Besides that, if we give them antibiotics we have to counsel them and tell them to make sure and take it and you can show them pictures of a diabetic foot. That is a next frightening story; this is what could possibly happen if you are noncompliant...”*

Seeing is believing

Not all patients believe in stories and not all patients follow their treatment plan; especially those patients with hypertension who have not yet develop complications of uncontrolled hypertension. An elderly participant with over 30 years of experience in General practice made an observation about one of his patients who have no complications from her disease such;

Dr. I: *"...in my earlier years here every single time I would quarrel with her but I have not had that problem in the last 3 to 4 years as she does not take the medication but she is still more healthy than many others whose pressure is well controlled. Her blood pressure has not changed in the last 30 something years that I have known her and she is not complaining. Her husband who is much healthier than she is has already died...so people like that you cannot convince them to change with any story, they themselves are the story..."*

Using biblical stories

Biblical concepts are used in story form by some participants to enforce adherence to treatment. Such concepts though are applied to those patients who share a common religious back ground with the physician. A participant used this concept to encourage his patient to adhere to treatment and exercise;

Dr. S: *"...Jesus got from a little boy a little smattering of food, five loaves and two fish and it is all said that he prayed and there was a miracle and everyone was fed eventually. I would add, but I want you to consider that even for God nothing comes from nothing, the five loaves and two fishes had to be there first for the miracle to take place. This means, you must make a sacrifice, you must do something on your own for God to do something greater. So do not think that you can just sit with nothing in your hand, with no intention and with no work also you do not want to exercise or you do not want to do the chemotherapy and still hope the outcome would be favourable, it is not possible..."*

Personal stories

Personal stories emerge as a concept used in both to educate and to encourage adherence to treatment. Patient trust and familiarity were disclosed as some of the reason that will encourage participants to share their personal story to encourage adherence to treatment

Dr. C: *"...I use my own personal story to explain to them that in the beginning initially it may seem as though you are not losing the weight because that happened to me so you have to persist and after a while you would begin to notice the improvement in terms of the weight change that you are looking for. My personal experience and story I relay to them and I show them specifically in terms of the timeline with which I began to see the improvement in my weight..."*

Cultural analogy

Culturally appropriate storytelling is very impactful and this emerged as a concept used to encourage adherence to treatment as well. Tobago catchment saw many of such culturally appropriate stories and allegories as can be seen with the utterance of one of the participants from the Tobago catchment;

Dr. S: *"...in the way they are managing their own hypertension or their own sugar control, I might use a proverb that everyone knows in Tobago, it went like you know when leaves drop in the water it would*

not rotten at the same time. The idea in that is when there is an incident in your life regarding hypertension you do not see the effects immediately but the natural complications lead to compromise of your eyesight, the function of your kidneys, your vascular function and your heart function..."

Understanding of disease

When patient understand their disease condition and the reason for which they have to use medication, compliance becomes easier.

DR. L: *"...there are some of them that would like you to explain to them, what is actually happening. At times, I find when you do this even though it takes time to explain to patients many times in the long run it will help in terms of, for my patients I see, If the patient understands, what is going on they will be more compliant in terms of trying whatever recommendations you made for them whether it might be taking medication or making dietary adjustments or introducing exercise and so forth..."*

This concept can be seen with a participant who unsuccessfully tried all other methods to convince his diabetic patient to stick to his treatment plan until the patient was made to understand the complications of diabetes and how it may affect his job.

Dr. C: *"...This guy was a photographer, who was a diabetic who had liked to drink a lot of sweet drinks so he was always out of control in terms of his diabetes. I tried all sorts of stories and even showed them pictures of the amputations and it did not work until one day when we talking and I told him that I know patients who have diabetes and it was not controlled and they went blind and he was shocked..."*

CHAPTER 5

5.1 DISCUSSION

The results of this study showed two main themes through which physicians try to influence a change in their patient's behaviour. These two themes are either educational strategy to create understanding of disease processes with better communication or to improve their patient`s adherence to treatment. Under these two strategies are concepts and utterances made by the participants. The result showed what we already know that physicians use stories in their clinics to effect change (16).

The research question was to find out the nature of stories that first contact physicians use when they try to change their patient's behaviour and this enquiry saw the design of a qualitative research instrument, with data collection through focus group interviews of key informant participants of diverse ethnicity, gender and age. Semi structured questions were asked and participants made their contributions freely to the discussion. Participants use storytelling in situations where the encounter with the patient is not going well; such as when the patient is non compliant to treatment plan, misunderstands medical information, is in denial of his disease condition or need some form of psychosocial support.

Also emerging from the study is that physicians use storytelling to frighten their patients when other strategies fail. This concept however was not supported by most physicians. The use of personal stories to influence a change in behaviour also emerged but like it has been shown in a systematic review study done, there is insufficient evidence supporting the effectiveness of patients informed decision making with personal stories (30) .Most participants did not agree to the idea of sharing their personal stories with their patients for fear of confidentiality and stigmatization. Some admitted to have used fake stories or using pseudonyms to craft their stories. Female participants were more likely to disguise their identity in a story than their male counterpart.

The most utilised concept by participants is the concept of using the body as a mechanical instrument when educating patients and allegorical referencing when trying to increase adherence to therapy. These two concepts were used most frequently by the male participants. The car and the services offered by the two major utility companies were the choice of the participants. Participants use allegorical stories of high pressure water supply or high tension electric current to house hold in creating vivid imaginations of potential consequences of injury when treatment plans are not adhered to or pathophysiology of disease process to create better understanding as supported by the literature which shows the significance of storytelling in making scientific medical information comprehensible(12).

Participants also use digital images from their mobile internet devices, especially when they want to scare patients into adhering to treatment plan. However most participants agreed they choose who to utilize such concepts. One female participant during the discussions had raised concern about the ethics

in utilizing a mobile internet device with digital images during a consultation. There was a unanimous agreement among other participants of the effectiveness of such images; however studies suggest proper standardization of such intervention mobile internet devices for effective health care outcome (31).

Cultural analogy was another concept used to educate as well as to encourage adherence to treatment. Participants from the Tobago cluster used this concept as well as the concept of biblical stories in trying to change the behaviour of their patients. There is significant evidence from the literature of the power of culturally appropriate storytelling and its impact in bringing positive change in health outcome (17, 22).Other concepts were that more time is needed for consultation as well as the concept of using storytelling to break bad news.

An emerging concept that needs further investigation is that younger physicians communicate better with patients than their elderly counterpart.

5.2 LIMITATION

This study was a qualitative study with interviews conducted by an investigator who happens to be colleagues to the participants, with the possibility of influencing the type of stories some participants were willing to share due to social desirability. Participants relied on their memory for stories, making it difficult for those who could not recall significant story events. Storytelling is time consuming and the time allocated for each participant could not have been enough to hear more important stories.

The participant recruitment process involved sampling strategies with the possibility of selection bias but the large sample size of 32 participants in a qualitative study carried out within 6months, eliminates any significant impact this may have on the study outcome. In addition the participant frequency of 69% male and 31% female may give an impression of a selection bias as the investigator himself is male. However the emphasis on what the study aimed at capturing is the content of the story and not the quality of the storyteller since all the participants sampled met the criteria for inclusion. Furthermore, the researcher being an inexperienced investigator could have missed significant steps in conducting this study making room for a future more robust study.

5.3 CONCLUSION

The study showed that first contact physicians are using storytelling intervention in their clinics in Trinidad and Tobago .Storytelling is used as a strategy to educate patients as well as to encourage adherence to treatment plans. Some of these stories are fright stories while some are stories giving hope to patient and to make medical information easier to understand. Different concepts emerged

from this study, however the two major concepts were; ‘the body as a mechanical instrument’ used to educate and ‘allegorical reference’ used to improve or encourage adherence to treatment. Physicians also used images to frighten their patients when other methods have failed.

One concept that suggests older physicians are not communicating effectively with their patients need to be explored further.

5.4 RECOMMENDATION

Further study is needed to explore and categorize the stories being used by first contact physicians. Because Primary health care delivery involves a team of care givers such as nurses, pharmacists, dieticians and other stakeholders, it would be very interesting to hear the stories being told by this category of health care givers as they engage the patient in the delivery of health care. Consequently a study involving a complete team of care givers would be a good idea in order to get the bigger picture of the quality of communication in primary health care.

Meanwhile the outcome of this study will be presented to physicians to add to the body of scientific knowledge already present. However, a more objective quantitative study is needed to ascertain if storytelling as an intervention is affecting a change in behaviour of patients in Trinidad and Tobago.

There is also the need to explore the concept made by an experienced elderly General Practitioner that younger first contact physicians communicate better than their older colleagues in Trinidad and Tobago.

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Appendix 1: Interview Guide: Questions:

1. Give me your thoughts on using storytelling to change behaviour...

2. Tell me when you would use storytelling...

3. Tell me about any interesting case you had to use a story that you can remember...

4. Tell me about any positive or negative feedback from your patient...

5. Tell me how often you use storytelling...

6. Is there any other information you wish to add?

Thank you.

(75 minutes)

END.

INSTRUMENT: Standard Audio Recorder.

Appendix 2: Ground Rules for Focus group

GROUND RULES....5 minutes

Before we go ahead, let me cover some ground rules for today's interview

1. This interview session will last for one hour and half (90 minutes.)

2. You are free to withdraw at anytime if you feel uncomfortable

3. I will be taking down some notes as well as audio recording our conversation. My assistant will be taking down notes as well. No video recording is involved.

4. The name Card in front of you is for Identification purposes only, in case we need to address each other by name.

5. The audio recording will be transcribed and your identity will not be made public.

6. Each of you have to talk but when I lift up my pen it will signify a call to give the next participant the opportunity to make their own contribution.

7. Please speak out loudly and avoid talking to your neighbour when someone else is talking.

8. You don't have to answer all the questions but your contribution is very important.

9. You will each have your turn to answer the question beginning from my right.

10. Light refreshment is provided. If you need to use the washroom please leave the room quietly.

Appendix 3: Ethical consideration document

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September 25 2019

Dr. Rohan Maharaj (Fidelis Okali)
Public Health and Primary Care Unit

Department of Paraclinical Sciences

Faculty of Medical Sciences
Email: rohan.maharaj@sta.uwi.edu

Dear Dr. Rohan Maharaj,

Ref: CREC-SA.0009/08/2019

Title: Stories Doctors tell in Primary Health Care Clinics in Trinidad and Tobago

I am pleased to advise that your application for research on the above captioned topic has met the criteria for Exemption from Review from the Campus Research Ethics Committee, St. Augustine.

Sincerely,

SArjoon

Surendra Arjoon (Prof.)
Chairman
Ethics Committee

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Study Introduction and Informed consent form*

Informed consent form for primary health care physicians and General practitioners (key informants)participating in the qualitative research titled; **stories doctors tell in primary health care clinics in Trinidad and Tobago**

NAME OF PRINCIPAL INVESTIGATOR: Prof. Rohan Maharaj

NAME OF CO-INVESTIGATOR: Fidelis Okali

NAME OF INSTITUTION GRANTING APPROVAL: The University of the West Indies (UWI), St. Augustine Campus Trinidad.

INTRODUCTION

I am a final year student in Family medicine studying at the University of the West Indies St. Augustine Campus and this form seeks to invite you to voluntarily participate in a research I am conducting to know about the stories you tell your patients during your consultations. I am going to provide you with information about my research and you are free to ask questions and be satisfied with the answers before you agree to participate. You do not have to decide immediately to participate and you can chose not to participate.

PURPOSE OF THE STUDY

This research seeks to find out the stories primary health care doctors tell their patients when they try to influence a change of their patient's behaviour during consultations. We know that patients tell stories about their illnesses so we want to capture the stories physicians tell when they try to influence their patients change in behaviour, whether to influence compliant, make clarity or educate their patients with chronic disease condition.

TYPE OF RESEARCH INTERVENTION

This research will involve your participating in a focus group discussion comprising of at least four other physicians like yourself. This will last for one and half hour.

PARTICIPANT SELECTION

You have been selected to participate because due to your vast knowledge and experience as a primary health care physician/family medical practitioner/ General practitioner your contribution will shed more light in the stories that you tell to influence behaviour change in your community.

Your participation will have no bearing on your employment or your job performance appraisal and you may change your mind and stop participating even if you agreed to participate earlier.

PROCEDURE

We are asking you to assist us in knowing more about the stories physicians use when they try to change patients' behaviour during their consultation in primary care. This may help us in understanding more about these stories and their impact on you and your patient.

The group discussion will start with me making sure that you are comfortable and you can also ask any question that you may have and be satisfied about the answer. Then I will ask about the stories you may be using during your consultation, when you use these stories, your personal experiences and any type of feedback you might have gotten from your patients using these stories. I will not be asking you any sensitive questions and you are free not to answer any question you deem too sensitive or make you feel uncomfortable.

This discussion will take place in a quiet and comfortable location and only I and those physicians who will be participating will be present. The entire discussion will be audio recorded with a mobile phone and a recorder so as to ensure there is a back up of the recording and only the principal investigator and me will have access to the recording. The information will be confidential and the recorded interview will be destroyed after 5years.

DURATION

The research study is part of the fulfilment of the Doctor of Medicine DM program in Family Medicine by the University of the West Indies St. Augustine. The study will last for about six months but you are only required to sit in a focus group discussion lasting about one and half hour. Any follow up phone call with you will only be to make clarifications with the interview if need be.

RISKS

Sensitive information will not be required hence there are none or minimal risks involved.

BENEFITS

There is no financial benefit to you in this study but the result will help to contribute to the body of scientific knowledge. A positive study outcome can also mean you can utilise stories in aiding the management of your patients' chronic disease conditions.

REIMBURSEMENTS

There will be no reimbursements, however light snacks, water and juices will be provided during the interview

CONFIDENTIALITY

Because we are discussing in a focus group format, there is no guarantee that a member of the group may not discuss with people outside the group. However every member of the group is made to agree to keep all information from the discussion confidential. Besides we will not be asking any sensitive questions.

SHARING THE RESULTS

The knowledge generated from the study will be shared broadly through publications and conferences but you can also request a copy of the publication and it will be made available to you.

RIGHT TO REFUSE OR WITHDRAW

Your participation is strictly voluntary and if you do not wish to take part in the interview you can withdraw at any time. I will summarise the interview at the end of the discussion and feel free to correct or adjust any information you had contributed in the discussion.

WHO TO CONTACT

This study was approved by the Institutional Review Board of the University of the West Indies with the certificate of approval attached.

You can contact me the co-Investigator (Dr. Fidelis Okali) at 1868 777-1018 or the Principal Investigator (Prof. Rohan Maharaj) at 1868 770-6953

Please feel free to ask any question before, during or after the interview.

END

(Please see certificate of consent attached to sign)

INFORMED CONSENT FORM

I have read the forgoing information on the research/the details of the research on **stories doctors tell in primary health care clinics in Trinidad and Tobago** has been read to me. I have had the opportunity to ask questions about it and any questions I have asked has been answered to my satisfaction. I consent voluntarily to be a participant in this study

NAME OF PARTICIPANT: FIRST..LAST....................................

GENDER: M [ ] F [ ] OTHER [ ]

PRACTICE TYPE: PRIVATE GP [ ]   PUBLIC PRIMARY CARE [ ] BOTH [ ]   (Tick)

AGE: 28-33 [] 34-39 [] 40-45 [] 46-51 [] 52-57 [] 58-63 [] 64-69 [] Above 70[]

SIGNATURE OF PARTICIPANT..

DATE (DD/MM/YYYY)...

I confirm that the participant was given an opportunity to ask questions about the study, and all the questions asked by the participant have been answered correctly and to the best of my ability confirm that the individual has not been coerced into giving consent, and the consent has been given freely and voluntarily.

A copy of the approval letter of Exemption from the University of the West Indies Campus Research Ethics Committee, St. Augustine Trinidad has been given to the Participant.

NAME OF RESEARCHER: FIDELIS OKALI

SIGNATURE OF RESEARCHER..

DATE (DD/MM/YYYY)..

*WHO |Templates for informed consent/qualitative research