

Interview with Linda Honan

[VIDEO TRANSCRIPT – February 8, 2023]

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Lisa Bonsall: Hi, I'm Lisa Bonsall, Senior Clinical Editor for Lippincott NursingCenter. I'm here at the 2022 Nursing Education Innovation Summit and right now, I have the pleasure of speaking with Linda Honan. Linda Honan is a professor emerita at Yale University School of Nursing. Thank you for joining me today.

Linda Honan: Thanks for having me.

Lisa Bonsall: You are known for your creativity and development of novel and effective teaching strategies. Can you tell us about some of the innovative techniques you put into your nursing education practice?

Linda Honan: Sure. So the first one that we've probably been doing the longest is called "Looking is Not Seeing." And if you've been a clinical instructor, you know the truth of those words. Our experience is that students' vision is naturally limited, particularly when you put them in a high stress environment. And there is no higher stress than putting a neophyte into a clinical situation, because as we all know, patients don't come into the hospital with one problem. Patients come in with multisystem problems. People are older, they're living longer. There's polypharmacy. And the increase in technology from when I was a nursing student has just increased exponentially.

So imagine coming in to a clinical unit where everything alarms, everything buzzes, and patients don't have one problem, they have three and you're asking them to tell me what they see. So their vision naturally limits, and we needed to think about creating space for them to practice the skill of observation alone. So it was Maria Montessori who said, "You just can't say observe. You have to give them the curriculum with which they need to observe."

That naturally led me to the British Art Center, where I was privileged to meet a brilliant woman named Linda Friedlaender, who introduced me to the use of art to improve clinical observation. And it was used at the time in dermatology, at the School of Medicine. But in dermatology, the issue was to bring the lens narrower and narrower and narrower, and I needed the lens to be opened up, the exact opposite.

So I wanted the patient's body to be seen as a piece of artwork where everything was observed and then they needed to practice clustering their observations of either what they were seeing or what was absent that they should have seen, right? And then clustered those things to come up with some options for, "What do you think is happening with the patient?"

So we worked on it for a number of years. We actually did it for, I think probably eight years. And then finally we researched it. So we took half the class and they had the exact same content as everyone else. But the other half of the class went over to the British Art Center for 3 hours. So we selected paintings

that had what we call a rich visual inventory. That is, there's lots of things to observe in this. There's a story. Some of those things mean something. And then we also wanted to look at some of the pieces that had things that didn't belong, pieces that don't fit with what you think the story of the painting is about. Because I believe that that plays out in clinical practice, that too often we think that the patient's diagnosis is only in our pre-ordained area of specialty. So cardiology only finds cardiology, nephrology only finds nephrology, dermatology only finds lesions when where but in nursing, are we looking at everything, right? The whole body.

So we studied it and it was amazing. On average, the students who spent 3 hours - and that's the only difference - they all had the same clinical hours. They all had the same didactic content. If you spent 3 hours at the museum with Linda Friedlaender and myself or Linda's designate because she trained art docents in this technique. So we break the students up into groups of 6 to 1 docent, and they move from painting to painting to painting to work on what we call "deep seeing." Tell me what you see; be as objective as possible. No subjective interpretation is allowed. We will bring you back and tell you no, that's not real. Tell me exactly what the dress is. What's the color? What do you think the texture is? What's making you think it's that texture, etc...And the students that went to the museum saw 13 more objective physical examination findings when using now photographs of patients with specific disease processes and offered more of a differential diagnosis than just one thing. On average, there was one more differential diagnosis that was offered. And that's important because we don't want you going down a preordained line that this is what's happening. We need that net to be wide to think, you know, if you have chest pain, okay, it could be a myocardial infarction, it could be GERD or gastric reflux disease. Right? So you want them thinking more broadly about what lies in front, what lies behind, what lies to the left or lies to the right, to think about all of that when it comes to making a list of potential problems for your patient.

And once it was clear that looking worked, then the second kind of creative thing I thought about was heart, lung and bowel sounds are your body's music. And I believe we are over reliant on medical technology because it's easier to order a test rather than train your ears to make a differential diagnosis based upon what you're hearing. So my students also are going to be typically working with the underserved, so there isn't access. So it's a moral obligation to make sure that they're trained as thoroughly and competently as they can to understand what pneumonia sounds like. You know, what does a systolic murmur sound like? What's the difference between an S3 and an S4? What's a split S2? And what does it mean if I'm a pediatric person versus an adult? And so since I thought they were all sounds and I thought they were music, I went over, I Googled Yale School of Music because I'm fortunate to work at an institution that values interdisciplinary sharing and stretching. So I Googled and who was Tom Duffy... Dr. Tom Duffy was the Dean at that point at the School of Music. So I made an appointment with him. I told him I had an idea, I had absolutely no money and he needed to help me and he did. So when he listened to all these sounds, to a musician, they all made sense because he thinks about them in terms of rhythm and tone and whether sound is louder or softer amplitude. Just to him, it was music. To me, it was pathology.

So he created synthesized heart, lung and bowel sounds, and then I taught him what it would mean if there was a systolic murmur and how it would sound and he would accent it. So we created a fake heart. It sounds like a fake heart, a bum bum. But then knowing what a systolic murmur was, he said, "Well,

that's just an accent. You just put an accent on this." I of course, I'm like, I have no idea. All I know is it's louder, it's rougher. And so he created all of these synthesized sounds.

And then after we did all that, then I said, okay, now here's the problem. So I teach, typically, I teach it the same way I'm sure everybody in the country does. You teach the heart this week, you teach the lung next week, you teach GI the following week, neuro the next, whatever, and then you send them up to clinical and you say, "Listen to the heart sounds." And if they're listening at the aortic area, it's right here. And that happens to be where the lungs are. And if I'm hungry, I'm going to hear growling going up and the students look at me like, "Are you kidding me? You want me to hear that muffled, quiet sound that's way down there?" And I'd be like, "Yeah, you got to get to it." So Tom said, "Well, that's masking." And I once again said, "I have no idea what you're talking about." And he said, "You know, when you walk into a room and there's 100 people and you can hear your significant other's voice, that's masking. Your brain is learning how to tune out and tune in." So he created masking. So we have the synthesized heart, lung and bowel sounds all together. So if you come in as a stranger, you think, Oh my God, But no, you teach the student, okay, in that cacophony of noise, find the lung, find the lung, and let's hear - Can you make out the normal lung or is it abnormal and if it's abnormal, which of the abnormal synthesized sounds was it? And then, okay, you got that. Now find the heart, find the heart in that. Now hear all that. Okay. Find the lungs in that. So it's much more clinically relevant and it just plays into practice.

So we did it for a number of years. I think we refined it for probably five years and then we tested our students, so we tested them pre any teaching at all. And because I assumed in the beginning that anybody would know a wheeze, you didn't need to be a medical provider to get a wheeze...well, my assumptions were wrong. So we pre tested them on 25 different heart, lung and bowel sounds. We asked them to tell us what organ was making that sound. That was amazing because sometimes they thought an organ like some somebody wrote the brain. So like they were so novice, they didn't even know the brain doesn't make a sound, right? But, you know, sometimes they can, you know, sometimes heart and lung sounds can get confusing, especially if there's abnormalities. So we pre tested them and then we took half the class and put them through the intervention and the other class we didn't. And the students that went to the museum went nuts for it. Absolutely loved it so much that the other students rebelled and we had to then hurry up, analyze the data and give the intervention to the other ones. Since that time, it is now part of the curriculum. So it's now part of the curriculum at Yale, for not only the nursing students, which is where we did it, but also first year med and first year PA students.

Today we have all these great nurse educators here, but we're all nurse educators, right? What my research shows is that innovation comes when another lens looks at your problem, not somebody in the same boat. But when you go to your problem and say they're not seeing it. You know what I mean? They're too scared. They're not seeing it. Who else but art people could help with observation? Who else but music, with interpretation? And my last intervention was I worked with engineering because I noticed that students don't know how to check pedal or posterior tibs. And again, this is all students. It's not just nursing students because I teach all three professions or taught at all three professional schools. They go in to hard or they go in to soft...so soft that they can't feel it, so hard they obliterate it. So I worked with engineering to create a device that the students called the beatbox, where they could put their fingers on this device and turn the machine up. And we made it so that you would have a pulsation that would never be found in a human being, it is just too strong. But it would get your fingers to feel

that, and then you could lower the dial down to a four, and then you could lower it down to a three, which is normal. Get used to the normal then to two, weaker than normal, to a one, barely palpable. But these are things that are different ways of creating pedagogy, using different schools of thought. That's what has enriched our students.

And then probably the last innovative thing I did was, which is on for I think it's 19 years, is I started the creative writing award at Yale School of Nursing. So I would say to all my students, the first year, the first day of school, I'm going to do everything I can to help you be successful. I'm just going to work my backside off for you. So you owe me something. And I say, what you owe me is a promise to go buy a 99 cent notebook and write what this process is like for you. What's the process of...remember, I teach people that already are adults, so I've taught lawyers, and I've taught people that were physicians outside of the country. I've taught Oscar winners, Pulitzer Prizewinners, dancers, lawyers. So people that have a rich history. Right? And I, I wanted them to remember how hard this is, right? Because sometimes we forget. And it's important to be able to look back and see what the struggle was like so you have compassion 20 years from now from those people that are struggling.

So I would say if I did anything for you, you owe me a story. And the story is tell me about a day in the life of a student. Just tell me what it was like this year. So I had this treasure trove of stories that were just unbelievable and let me tell you those stories tell more about the process of becoming a nurse, about teaching nursing, about what curriculum works and what curriculum doesn't work, about what are the things that really are barriers that we don't even think about as a barrier, you know, because we've been living the life. Where but when our youngest neophytes come in, that's where we really can see where the problems are, right? So I had all these stories and I showed them to the then Dean, Catherine Gilliss, who said, like, "Are you kidding me? Like, these are like, Linda, we have to give voice to these." So I started raising money and finally was able to have an endowed program at Yale School of Nursing, where we give out \$1,000 to the top three writers.

When you write about what's happening to you, it gives you insight into what you're experiencing and some understanding about what's happening to you. I wrote a piece, so I journal too. So I would just write. Veneta Masson is a nurse practitioner who was a great poet, and she wrote an article called Uncharted Lines. And it's about just putting in your calendar like, you may have LH for me and you may put 66 year old came in...just little, little tidbits. Well, those are like Hansel and Gretel. It's amazing that if you wrote those little tidbits down, you actually rush back to where it happened and you can visualize it, right? But if you don't write the notes, I would say to the students, then you're going to be like me, haunted by patients in the past, because I always had the hubris that I would remember, that I would remember. But the truth is, at 66, I'm lucky I remember where I put my keys. So like, why am I haunted by patients? I think it's because there were lessons that I needed to unearth, but I didn't write down the breadcrumbs that would get me there. So one day, it was long time ago. One time I go up to clinical and I teach med/surg. So I am, you know, And I wrote a book on it. So I'll write down this is what fluid volume deficit looks like. So I'll have the list - flat neck veins, dry mucous membranes, delayed skin turgor or low blood pressure. I'll have a whole list down and then I'll write the exact opposite. You know, what does it look like when they're excess...edema, moist mucous membranes, You know, you go through, full neck veins, you go through the exact opposite, and then you bring them up to clinical where you know, good luck finding the one patient that looks like that, because the truth is they got some of each. So if they have some of each because they've had kidney failure in the past, right?

Because they had heart failure or whatever...It doesn't mean that that patient can't be dry. So I would say to the student, okay, so we have half the things that say they're wet. We got half the parameters to say they're dry. What else could we do? So then I said, "Well, we could check urine for specific gravity," which we did all the time. So I go out to the lab, to the utility room to go get it. They're all gone. Like all of a sudden, miraculously, they're all gone. And now we have to charge our patient by sending the urine down to the lab. And I was like, I remember I was furious. Where's my stuff? Like, there's stuff I need to do patient care. And I was furious.

So I went home and I wrote what I was feeling. Right? And then you put it away, and then you come back to it later and you start looking at it. And that's when the learning happens. And that's when I realized, well, maybe it wasn't just the hospital. Maybe I needed to start thinking about JCAHO, the Joint Commission that was supposed to improve patient care. So now all of a sudden, because you need to evaluate the competency of my ability to tell where the number is, now it became too expensive for hospitals to do this. So you see how just by writing it down and spending some time, you actually start throwing the net wider. So first I was furious at the nurses on the unit, I was furious at the head nurse, I was furious at the vice president for nursing then I was furious at everybody. But you know, but my point is I published that in AJN and I heard from nurses all over the country about how the same thing was happening. That's the power of narrative. So if you use stories...stories can help you not only gain insight into what I'm learning, what I'm feeling, but they also writ large, help us understand the systemic factors that affect our practice. So that needs to be celebrated.

So those are just three things that are pretty big, that are considered interdisciplinary. You know, the use of narrative writing he use of art, the art experts helping us and music expert helping us. And then the rest is I think we get I think we I don't know, we delude ourselves into thinking if we stand up in front of the room and wax eloquently about something that somehow that feeds us, when to me, the best educators work really hard at breaking down complex biochemical processes into something that is so simple that it becomes elegant. And so I teach surfactant with balloons. I go to - I'm sure you have dollar stores here - So I go to dollar stores and buy 100 balloons for a dollar. Let's just imagine, like how great the quality of these balloons are. And I make the students blow them all up. And I'm telling you, they feel like their cheeks are going to rip out just because they're so hard. But they all have to blow them up. And then you deflate them and then you blow them up again. And I say, "So what did that do?" It's a piece of cake the second time. Why? You change the surface tension. So think about that - what surfactant does. So you understand the importance of surfactant, whether you're a maternity nurse, whether you're a pediatric nurse or you're a surgical nurse. So think about things. You know, I teach compliance with elastic bands, fluid and electrolyte with M&Ms; small M&Ms, peanut M&Ms to teach about colloid osmotic pressure and what's serum osmolality. So I think we need to, like, create a database somewhere of commonsense curriculum that works and stop getting caught up in this false narrative that, you know, somehow you're better if you sound smarter. To me, the smartest people value simplicity.

Lisa Bonsall: Thank you so much.

[Music]