2022 Fall (Edited 9-3-22)
HCB501 Compassionate Care, Medical Humanities, and the Illness Experience
Instructors: Stephen G. Post, PhD & Jeffrey Trilling, MD
Semester: Fall 2022
Schedule: Mondays, 6-8:30 pm
Location: FPPM Conference room 067
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COMPASSIONATE CARE, MEDICAL HUMANITIES & THE ILLNESS EXPERIENCE

The care of the patient is both a science and an art. It is on the one hand the competent application of science and the mastery of technical skill sets; on the other hand, it is the art of being attentively present to the patient in the subjective meaning of his or her illness experience. In general, being present to the patient in their illness facilitates patient well-being, security, treatment adherence, and even healing itself. Kindness is a relatively uncomplicated mode of acknowledging patients (as Dr. Trilling puts is, a "gentle curiosity"), whereas empathy requires focused listening and understanding, clarification, and some degree of affective resonance. Compassion is an action to alleviate suffering as shaped by empathy in the context of suffering. Can these assets be taught? How do role modeling and narrative medicine fit in? Where does the idea of the "wounded healer" enter in? What does it mean to be an attentive listener? How does the clinician demonstrate respect for patient hope? How does compassionate care contribute to hope? How do empathy and hope influence patient physiology and adherence to treatment? How does a compassionate practice contribute to clinician meaning, well-being, and professional gratification?

Disease refers to the abnormalities of the structure and function of organs and systems that clinicians diagnose. To diagnose and treat the disease alone is to reduce the patient to a very complex machine, or to a biological "puzzle" to be figured out. *Illness* refers to how disease is subjectively experienced and interpreted by the patient who has meaning systems, social networks, hopes, emotions, spirituality, and values. Illness refers to the overall subjective response of the patient to being sick. As a technical term in medical anthropology, "illness" refers to the psychological, social and cultural reaction to the disease process.

READINGS

The books below should all be ordered via Amazon. They are written by experienced clinicians who have articulated in powerful ways the art of clinical care with attention to the subjective dimensions of illness.

All articles will be provided in a weekly email from Dr. Post or Dr. Trilling as attachments.

Required Inexpensive Paperback Books (Purchase)
(These are all written by renowned experienced clinicians who have great wisdom.)

Jerome Groopman, MD, *The Anatomy of Hope: How People Prevail in the Face of Illness*. New York: Random House, 2005.

Jodi Halpern, *From Detached Concern to Empathy: Humanizing Medical Practice.* New York: Oxford University Press (2010). (**ISBN** 978-0-19-976870-7 paperback)

Paul Kalanithi, *When Breath Becomes Air*, "Foreword" by Abraham Verghese. New York: Random House (2016).

Arthur Kleinman. *The Illness Narratives: Suffering, Healing & The Human Condition.* Basic Books, 1988.

Agnes M.F. Wong, *The Art and Science of Compassion, A Primer*. New York: Oxford, 2021.

All assigned articles will be emailed to you as attachments weekly.

BIG QUESTIONS **Big Questions for each class**

Students come to class each session with a hard copy of a really good Big Question that they want to present to the class and lead a 5-minute + (flexible) conversation. Your BIG QUESTION should be handed into the instructors at the beginning of class. *The BIG QUESTION should be stated in a single sentence not more than two lines long.*

2022 COURSE OUTLINE (Mondays)
PART ONE

August 22, 2022
Facilitator: Post/Trilling
Topic 1: Thinking Hard About "Disease" and "Illness"? Where Does Culture Come In? What is Suffering? How Do We Diagnosis It?

What is a "disease"? What is an "illness"?

Eric Cassell (d 2021) was the foremost physician writer on illness and suffering in the last half century. His book *The Nature of Suffering and the Goals of Medicine* is considered a classic. He offers that "disease is something an organ has; illness is something a man has." He taught that the goal of modern medicine must be treat an individual's suffering and overall well-bring, and not just the disease. Medicine should not be alienated from patient experience. His views on suffering are close to canonical in medicine today, as he advanced a subjective view of suffering, in which the beliefs and perceptions of the person experiencing the disease are paramount. Illness revolves around

big questions: What has happened? Why has it happened? Why to me? Why now? What does it mean? What do I fear most? What are my hopes? How can I be resilient? What about my relationships? Is this a punishment? A blessing in disguise? The good doctor has, to quote Jeffrey Trilling MD, a "gentle curiosity" about the patient experience.

Compassion is a response to suffering. *But what is suffering? Is everyone suffering all the time, as the Buddha and Schopenhauer believed?* Drawing on the two articles by Eric J. Cassell MD below, try to come up with your definition of suffering and how you might diagnosis it.

Before Class Video:
https://www.youtube.com/watch?v=cDDWvj_q-o8
(Empathy: The Human Connection to Patient Care)

Readings:
Norman Cousins, "Anatomy of an Illness (As Perceived by the Patient)." *The New England Journal of Medicine,* Vol. 295(26), 1976, pp. 1458-1463.

Eric J. Cassell, "Diagnosing Suffering," *Annals of Internal Medicine,* Vol. 131, 1999, pp. 531-534.

Eric J. Cassell, "Illness and Disease," *The Hastings Center Report,* Vol. 6(2), 1976, pp. 27-37.

Richard B. Weinberg, "Communion," *Annals of Internal Medicine,* Vol. 123(10), 1995, pp. 804-805.

Structure:
Brief presentation on Cousins and positive psychology (Post)
Discussion of illness and suffering in the light of Cassell based on **BIG QUESTIONS** (facilitated by Trilling)

August 29
Facilitators: Post/Trilling
Topic 2: Suffering and Hope in an Illness Narrative

An illness narrative elegantly written by a dying physician, *When Breath Becomes Air* was deservedly a best-seller in 2016. The words jump right off the page. It seems to touch everyone who reads it. Pay special attention to themes such as suffering, hope, love, "success," creativity, meaning, perseverance, spirituality, grit, and resilience. Come to class with some ideas about these states of being in the author's illness narrative.

Readings:

Read Paul Kalanithi, *When Breath Becomes Air*. New York: Random House (2016).

Structure:
Everyone, come in with a really good BIG QUESTION and facilitate a conversation over it for five minutes or so.

(September 5 Labor Day Vacation NO CLASS)

September 12
Facilitator: Trilling
Topic 3: Empathic Virtues: Humility, Kindness, "Gentle Curiosity," Listening, Empathic & Compassionate Care. There are also important virtues in the categories of "grit" and of "self-care.")

Care as an external activity is grounded in the expectations of the clinical environment in a very task-oriented sense, and can be disconnected from the underpinnings of empathic concern. We propose a model in which compassion is not redundant with care, but a special modulation and intensification of it under conditions of suffering as follows: CARE ⇒ COGNITIVE EMPATHY ⇒ AFFECTIVE EMPATHY ⇒ COMPASSIONATE CARE.

What is humility? How does it connect with empathy and compassion? Listening?

In Class Videos:
https://www.youtube.com/watch?v=7s22HX18wDY&app=desktop

Readings:
John L. Coulehan, "On Humility," *Annals of Internal Medicine*, Vol. 153(3), 2010, pp. 200-2001 (Is humility the mother of all virtues?)

John L. Coulehan, Frederic W. Platt, Barry Egener, Richard Frankel, Chen-Tan Lin, Beth Lown, William H. Salazar, "'Let Me See If I Have This Right…': Words That Help Build Empathy," *Annals of Internal Medicine,* Vol. 135(3), 2001, pp. 221-227.
(But is it about more than words?)

William Osler, "Aequanimitas," 1889, Address at University of Pennsylvania

S.G. Post, L.E. Ng, J.E. Fischel, L. Bily, et al., "Routine, Empathic and Compassionate Patient Care: Definitions, Developmental Levels, Educational Goals, and Beneficiaries," *20th Anniversary Issue of the Journal of Evaluation in Clinical Practice: International Journal of Public Health Policy and Health Services Research,* Vol. 20(6), 2014, pp. 872-880.

Jodi Halpern, *From Detached Concern to Empathy: Humanizing Medical Practice.* New York: Oxford University Press (2010). (*Preface x-xvii,* and chapters 1 & 2).

Due Today: Reflection Essay One Due (15%) 4-page essay on *When Breath Becomes Air* with an emphasis on illness in relation to suffering, hope, and resilience. Email attachments are fine.

September 19
Facilitator: Trilling
Topic 4: Hope in Clinical Ethics

What does hope mean to Groopman?

Any caring professional must be a minister to hope. From the early 19th century American Codes of Medical Ethics have emphasized the physician's responsibility to sustain hope in patients. This is a perennial aspect of the "art of medicine." Thomas Percival famously described the physician as "minister of hope and comfort to the sick." How can professionals respect the dynamic of hope in patients? Harvard hematologist-oncologist Jerome Groopman, in his *The Anatomy of Hope* (2004), writes that hope is "the elevated feeling we experience when we see – in the mind's eye – a path to a better future. Hope acknowledges the significant obstacles and pitfalls along the path. True hope has no room for delusion" (p. xivi). Without endorsing the exaggerated popular literature on hope and healing, Groopman notes that belief and expectation, two aspects of hope, are fundamental to the placebo effect, and activate brain circuits that release endorphins (natural opiates) and dopamine (a feelgood chemical). A careful assessment of the existing research compels Groopman to conclude, "Hope, I have come to believe, is as vital to our lives as the very oxygen that we breathe" (p. 208). Current researchers focus on the neurobiology of optimism, psychological resilience, physical health and optimism, and the promotion of optimism and hope. Significant NIH-funded investigations link hope to longevity, enhanced wound healing, stress reduction, dopamine release, and endorphin release. Hope for patients is about the uncertain expectations around which they constitute their lives in time of serious diagnosis or illness. The skilled clinician must handle patient hope empathically, and be able to redirect hope from one goal to another – e.g., from cure of cancer to the comfort care of hospice, from an earlier vision of a flourishing life to a modified vision, etc.

Skilled healers, aware of how the emotion of hope can make or break a patient, must be builders of hope, even while facilitating a shift in patient goals.

Questions (focused on Groopman)
**Is there such a thing as false hope in patients?*
**Where does patient hope come from? Individual experience, special relationships, communities, spiritualities, religion, the physician?*
**Is it justifiable to disclose diagnosis, but not a clear prognosis, in order to sustain hope?*
**What is the difference between optimism and hope?*
**Does a state of hopelessness have any bearing on respect for decisional capacity?*

**How does hope vary under differing illness conditions?*

Pre-class Video (6 minutes):
https://www.youtube.com/watch?v=5FWn4JB2YLU

Readings
Jerome Groopman, MD, *The Anatomy of Hope: How People Prevail in the Face of Illness* (all chapters).

September 26
Facilitator: Post/Trilling
Topic 5: Illness and the Wounded Healer

Sometimes healthcare professionals only realize the importance of healing relationships when they become ill themselves, and are suddenly wearing the shoes of a patient. The psychoanalyst Carl Jung referred to the "wounded healer" who, through his or her own illness experience, is able to heal others through increased empathy. Few ideas are new. The ancient Roman philosopher Seneca wrote, "The wounded doctor heals best." Falling ill and seeing the other side of the coin can be tremendously creative and transforming. Perhaps it is the "wounded healer" who can most be trusted to carve out a space in daily practice where connection and personal care receive their rightful place of honor even in environments that do not nurture these things. Yet the idea of being a "wounded healer" is somewhat controversial, especially in psychiatry.

An excellent account of compassionate transformation comes from a book entitled *A Taste of My Own Medicine*, written by Ed Rosenbaum about Jack MacKee, MD. The author, a successful surgeon whose bedside manner is unkind and discourteous, is too busy to show personal concern toward his patients or his family. One night he coughs blood and is soon diagnosed with throat cancer. During protracted treatment, he befriends June Ellis, a fellow cancer patient who eventually dies. Jack's cancer is cured, but the experience transforms his practice as he begins to teach medical interns the importance of compassion and personal concern for patients in making them better doctors. We will discuss segments of *The Doctor*, a movie based on MacKee's book.

Before Class Video:
Watch "The Doctor" starring William Hurt

Readings:
M.E. Pagano, S.G. Post, S.M. Johnson, "Alcoholics Anonymous-Related Helping and the Helper Therapy Principle," *Alcoholism Treatment Quarterly,* Vol. 29, No. 1, 2011, pp. 23-34.

M.E. Pagano, B.B. Zeltner, S.G. Post, J. Jaber, W.H. Zywiak, R.L. Stout, "Helping Others and Long-term Sobriety: Who Should I Help to Stay Sober?" Alcoholism Treatment Quarterly, Vol. 27, No. 1, 2009, pp. 38-50.

Katie Lynch, “Consideration for the Wounded Healer” (unpublished essay, 2015)

R. Klitzman, “Improving Education on Doctor-Patient Relationships and Communication: Lessons from Doctors Who Become Patients,” *Academic Medicine*, Vol. 81, No. 5, 2005, pp. 447-453.

Due Today: Reflection Essay Two Due (15%) 4-page essay on the nature of humility in relation to compassionate care

October 3
Facilitator: Post/Mehta
Topic 4: The Art and Science of Compassion

What does compassion mean to you?

(From Krisha Mehta MD) “Compassionate care makes a measurable difference in patient experience and outcomes, and enhances clinician meaning, resilience and well-being. It is a quality of being and doing that marks professional identity formation (PIF) as emphasized by the AAMC and AOA. Compassion in its truest form is the desire to alleviate the suffering of a sentient being. While empathy is understanding the emotions, perspective, or situation of an individual, compassion is a multistep process that begins with an awareness of an individual’s suffering and cumulates in a desire and willingness to help relieve the suffering. Compassion from a clinician has proven to significantly improve patient outcomes, quality of care and patient self-care and is also associated with greater clinician well-being. Research has also shown that such compassion can be trained using evidence-based meditative and visualization practices.

Exercise – Students will engage in a brief in class reflective writing exercise wherein they will explore their personal definition of compassion. In this exercise, they can describe a time in which they either received or provided compassion or generally describe what they feel compassion means to them and what place it has in relationships and the world.

Optional Readings
Lutz A, Brefczynski-Lewis J, Johnstone T, Davidson RJ (2008) Regulation of the Neural Circuitry of Emotion by Compassion Meditation: Effects of Meditative Expertise. *PLOS ONE* 3(3): e1897. https://doi.org/10.1371/journal.pone.0001897

Scarlet, J., Altmeyer, N., Knier, S. and Harpin, R.E. (2017), The effects of Compassion Cultivation Training (CCT) on health-care workers. *Clin Psychol*, 21: 116-124. https://doi.org/10.1111/cp.12130

Readings
Agnes M.F. Wong, *The Art and Science of Compassion, A Primer*. New York: Oxford, 2021 (Chapters 1-3).

Jodi Halpern, *From Detached Concern to Empathy: Humanizing Medical Practice.* New York: Oxford University Press (Chapters 3 & 4)

Brian W. Roberts, et al., "Development and Validation of a Tool to Measure Patients Assessment of Clinical Compassion," *JAMA Open Network 2019* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6537812/

October 10 No Class (fall break)

Keep reading independently Agnes M.F. Wong, *The Art and Science of Compassion, A Primer*

October 17
Facilitator: Jeffrey Trilling
Topic 7: The Case of Ms. Forevermore – An introduction to Impasse, First-Order & Second-Order Change

Educational Objectives

This session begins to address the relevance of the clinician-patient relationship within a meaning-centered model of illness, one in which *the experience and meanings of illness are at the center of clinical practice*. It introduces the importance of *context* (the circumstances in which a problem occurs), including the mistakes we make when context is ignored. Through story, this section is an introduction to clinical impasse, inviting the reader to appraise the need for a contextual approach to primary care problem-solving. Additionally, it lays the groundwork for conceptualizing and applying principles of Systems Theory, such as "First" and "Second-Order Change", to clinical situations.

At the conclusion of this session, you will have the information necessary to:

1. Define and understand "impasse" within the medical setting, distinguishing it from "conflict"
2. Be able to articulate some of the consequences that conflict and impasse may have on patients, clinicians, and society
3. Define" context" and how understanding the context of disease may be helpful in prevention, diagnosis & management
4. Define, understand, and explain the application of First and Second-Order Change
5. Critique my management of Ms. Forevermore's case from a straight-linear, biomedical standpoint – had I done my job?
6. Critique my management of Ms. Forevermore's case from a biopsychosocial standpoint – had I done my job?
7. Define and explain the need for and application of "Gentle Curiosity" in good doctoring
8. Explain the nature of a meaning-centered model of illness
9. Explain the nature of the biomedical model of medicine

Readings
Arthur Kleinman, *The Illness Narratives: Suffering, Healing & The Human Condition*. Basic Books, 1988. Preface xiii, pp. 3-10.

George L. Engel, "The Need for a New Medical Model: A Challenge for Biomedicine," *Science,* Vol. 196, 1977, pp. 129-136.

George L. Engel, "The Clinical Application of the Biopsychosocial Model," *American J of Psychiatry,* Vol. 137 (5), 1980, pp. 535-544.

Due Today: Reflection Essay Three Due (15%) 4-page essay on the wounded healer, pros and cons

October 24
Facilitator: Jeffrey Trilling Session 2
Topic 8: The Significance of the Patient's Story

Educational Objectives:

Session Two highlights the significance of uncovering the patient's story (and the luggage they carry) in helping us understand how impasse and conflict occur. It is within the patient's narrative that one may find explanations to otherwise inexplicable behaviors such as non-adherence to treatment plans, aggressive attitudes, and resistance to change. Through narrative, this session makes a case for appreciating the human element in the practice of medicine, stressing that the clinician-patient relationship is not unidirectional. Clinicians may also have "stories" carried beneath the surface, laden with perceptual memories of negative impact that manifest behaviors that foster or maintain impasse and conflict. As such, self-awareness is not simply ornamental or a soft, curricular cake-topping, but a key aspect of good doctoring to be emphasized and taught.

At the conclusion of this session, you will have the information necessary to:
1. Appreciate the involvement of both patient's & clinician's individual stories (and the "luggage they carry") in the formation of clinical impasse & conflict
2. Understand the difference between a natural science and applied science
3. Self-reflect on what feelings arise within you when someone does not follow your advice
4. Self-reflect on how far you should push when your advice is not followed
5. Be acquainted with the clinician-patient relationship and its variations
6. Appreciate, understand, and be able to articulate how differences between clinician style and patient expectations can be a source of clinical impasse
7. Self-reflect on what your own natural tendencies are towards clinician style, and the response you might expect patients to have pro or con about you
8. Self-reflect on the appropriateness of changing your "style" of practice to meet a patient's expectations
9. Self-reflect on the expectations you hold as a patient when it comes to your own physicians, and ponder any instances where expectations were not met

10. Appreciate, understand, and be able to articulate how clinician self-knowledge can contribute to good doctoring

Readings
Arthur Kleinman, *The Illness Narratives: Suffering, Healing & The Human Condition.* Basic Books, 1988. (The case of William Steele pp. 121-128 and Mrs. Flowers pp. 130-136.)

October 31
Facilitator: Jeffrey Trilling Session 3
Topic 9: Formulation of the Doctor-Patient Impasse

Educational Objectives

Session Two introduced personality differences in both clinician style and patient expectations that can often result in impasse. Session Three illustrates additional predisposing factors contributing to the genesis of impasse, while identifying and defining specific components of the patient's story such as explanatory models of illness and consequences of change that help us understand impasse formulation and other seemingly inexplicable negative behaviors.

At the conclusion of this session, you will have the information necessary to:

1. Understand and articulate how lack of self-awareness may lead to judgmental thinking
2. Think about what "luggage" you carry with you that may trigger reactive behavior
3. Appreciate and articulate the usefulness of obtaining knowledge about the patient, family, and physician perceptions of a patient's illness experience and attendant meanings
4. Be able to explain how inability to categorize or diagnose symptoms contributes to the genesis of a clinician-patient impasse in the face of acute illness vs. chronic illness
5. Define and discuss the components of the Explanatory Model of Illness
6. Understand and explain how differing illness attributions amongst members of a system can precipitate impasse
7. Explain how a patient's hidden fears, previous experience with an illness, or previous encounters with the medical system can foster and maintain impasse
8. Define and discuss the Consequences of Change
9. Understand and explain how the Consequences of Change can foster and maintain patient impasse to change
10. Define what is meant by dependent and independent variables
11. Explain the clinical and research significance of the Perceptual Frame as a function of Explanatory Models and Consequences of Change
12. Articulate some of the medical consequences and social ramifications of clinician-patient impasse

Readings:
Jeffrey Trilling & R. Jaber R. "Formulation of the Physician/patient Impasse. *Family Systems Medicine,* Vol. 11, 1993, pp. 281-286.

R. Jaber, S. Steinhardt, J. Trilling, "Explanatory Models of Illness: A Pilot Study." *Family Systems Medicine,* Vol. 9, 1991, pp. 39-51.

Jeffrey Trilling, R. Jaber R., W. Mendelson, A. Pandya, "Attribution Models, Consequences of Change and Chronic Sleep Symptomatology: A Pilot Study," *Family Systems Medicine,* Vol. 12, 1994, pp. 61-64.

November 7
Facilitator: Jeffrey Trilling Session 4
Topic 10: Problem-solving Clinical Impasse utilizing the Circle of Change

Educational Objectives

In Session Three, we introduced *explanatory models of illness* and the *consequences of change*, the two major elements of the patient's story or *illness experience* that underlie the patient's *perceptual frame*. We also noted that when the patient's and clinician's perceptual frames differ, an impasse may occur. Delineating and understanding the formulation of the clinician-patient impasse is the first step in problem-solving its resolution. Understanding a problem's formulation, while not solving it, often has its own positive ripple effect in that it may effect change, first, in the clinician. Once the patient's story has come to light and the fears or concerns emanating from past experiences are understood, clinician frustration is often replaced by feelings of empathy or even compassion. The opportunity for problem resolution is then increased by the resultant maintenance of the clinician-patient relationship.

In this session we explore what follows problem-delineation, introducing the components of the structured, six-step, problem-solving technique, **The Circle of Change.** We will examine this problem-solving model's utility in assessing, organizing, and implementing second-order change solutions in situations of impasse and conflict.

At the conclusion of this session, you will have the information necessary to appreciate and have a basic understanding of how to:

1. Assess patients' assumptions regarding symptoms and signs
2. Assess developing patterns leading to impasse
3. Uncover and change implicit rules of the interaction
4. Re-evaluate solutions attempted and their contributions to maintaining impasse
5. Discern when negative consequences of change are an obstacle to problem resolution.

6. Implement the six steps comprising the Circle and understand their reciprocal nature
7. Generate hypotheses from information garnered from the Explanatory Model of Illness, Generated Patterns, and Consequences of Change
8. Implement the art of reframing and co-creating (together with the patient) a new and more inclusive Perceptual Frame

Readings
R. Jaber, J. Trilling, EB Kelso, "The Circle of Change: An Approach to Difficult Clinical Interactions," *Family Systems & Health,* Vol. 15(2), 1997, pp.163-174.

D.R. Feinberg, "Circular Questions: Establishing the Relational Context," *Family Systems Medicine, Vol.* 8, 1990, pp. 273-277.

November 14
Facilitator: Post/Trilling
Student Presentations of Rough Drafts of their Papers for Peer Feedback

Prepare 5-7 Powerpoint Slides
1. Big Question and Significance & Beneficiaries
2. Thesis and Approach
3. Outline with Clear Headings and Subheadings
4. Conclusions and New Questions Raised
5. Five References beyond Assigned Readings and Selection Process

These should be based on a developed draft. Present for about 15 minutes and take feedback from peers and faculty for about 10 minutes. Peer feedback is vital. This contributes **10% to your final grade.**

Reflection Essay Four Due (15%) 4-page essay reflection on the Doctor-Patient Impasse. This should be an essay reflecting upon your thoughts about such items as the clinician-patient relationship and its utility, impasse and conflict within the relationship and its consequences, impasse formulation & resolution, the purpose of medicine, the importance of the patient's story, what's wrong with today's medical system, or any of the topics that may have interested you from the seminars we have had.

November 21
Topic: Student Presentations of Rough Drafts of their Papers for Peer Feedback

November 28
Topic: Student Presentations of Rough Drafts of their Papers for Peer Feedback

December 5

Topic: Writing Time

Research Papers due December 12 (30% of final grade)

GRADING AND ATTENDANCE

Active participation in class, including attendance

BIG QUESTIONS **Big Questions for each class**

Students come to class each session with a hard copy of a really good Big Question that they want to present to the class and lead a 5-minute + (flexible) conversation. Your BIG QUESTION should be handed into the instructors at the beginning of class. *The BIG QUESTION should be stated in a single sentence not more than two lines long.*

Grading:

Reflection Essays (4 X 15 = 60%)
Student Presentations of Rough Drafts of their Papers (10%)
December 10: Final Research Paper Due (30%)

Research Paper
Students write an 8-page (max) final research paper (plus a page of references in alphabetical order per APA reference style) **due December 10. (30% of grade).** It is fine to focus on articles and books assigned in the course, but students should also use at least 7 carefully self-selected outside articles from journal sources (these can be on-line journals or hard-copy journals).
Use APA format in all papers.

Structure of Final Paper
Writing Your Final Paper
1. Introduction

A successful thesis-driven piece of scholarship will always begin **with a very clear big question replete with careful definition of terms. Then state your answer to the question in a clear thesis statement. This is best placed in the first paragraph of the paper.** You will need to work on this and revise as needed, but do not ever lose sight of your thesis statement. You do not want to veer off course, because the rest of the paper is an argument supporting your thesis. Every sentence in your paper ought to be connected to your thesis in some way. It might help introduce your audience to the nuances of the topic you are discussing so that they will understand how your thesis differs from claims made by others.

A good paper usually includes a second paragraph that discusses in brief why the question and thesis are important. Is the thesis important for solving a major problem? Is it innovative? Who might be impacted by your paper? What is your audience?

A third paragraph usually describes how you are planning to structure the paper, and some mention of key sources. It is a good idea to ask about every topic or point in your paper, "how will adding this information help my reader understand my thesis?"

The outline and headings (i.e., the organization of the paper) should be designed to move your thesis forward in a constructive way. Outline your thoughts before you begin to write.

2. Main Body

Be certain to use headings well. Headings are a roadmap for the reader. They are like signposts on the highway. They should not be complex or long, so choose a few effective words. Subheadings can sometimes also be quite helpful. **Headings** should be in bold, and *subheadings* should be in italics.

Develop your ideas and use transitions to link the major strands of your exposition. Remember, though your interlocutors may be able to follow certain moves you make because they are familiar with the literature the public will not. Make sure that an intelligent person who is not an expert in your topic could easily follow your argument. If you jump around without an indication of why, it will be extremely difficult for your reader to follow you.

When agreeing or disagreeing with an author don't merely state that you agree or disagree but make a case for why you do. Clearly identify the views of the author whom you will be discussing. Highlight important distinctions and concepts of which the author makes use. It is essential to use citations when doing this. This will indicate to your interlocutors precisely the point at which you disagree, while introducing the public to an important aspect of the conversation you are engaging in and of which they may not be aware.

If you plan to disagree with an author's position then raise at least one objection that you would advance against the view as you understand it. While the public may be interested

in simply learning alternative views on the matter, your interlocutors will want to know why your position differs from those already accepted. If you plan to agree with the author's position, then be sure to explain why it is important that you agree. Others may have raised objections to the position with which you agree. Explain these objections and then explain how it is that the position you endorse overcomes them. Once again, proper citation is essential to this aspect of your paper.

When in doubt, break up long sentences and split up long paragraphs. Semi-colons are hard to use well, so avoid them unless you are sure of your grammar, and avoid page-long paragraphs that beg to be broken up into two or three.

Be careful to select quoted phrases, sentences, or segments of several lines with scholarly precision. Only quote the material that makes your point best, and always reference it. There is no need to quote excessively, and you should help the reader understand what you want them to get from a block quote, rather than leave it dangling at the end of a paragraph. We will talk about quotes and style in class. Block quotes are okay if used wisely, but they should rarely, if ever, exceed five to ten lines.

So often, a student really gets clear on their thesis in the final and concluding paragraph of the paper. Therefore, it can be very useful to try placing that final paragraph up at the front of the paper as you go through drafts, and incorporate it into the thesis section. Then write a second conclusion in a later draft.

Conclusions
Conclude with a summary of your paper. Also, be sure to point to another Big Question (or two) that your paper has not answered, but that seems now to be the next one you would want to see answer in your topic area (and why).

From Official Stony Brook University Policy:
Statements required to appear in all syllabi on the Stony Brook campus:

Americans with Disabilities Act:
If you have a physical, psychological, medical or learning disability that may impact your course work, please contact Disability Support Services, ECC (Educational Communications Center) Building, room128, (631) 632-6748. They will determine with you what accommodations, if any, are necessary and appropriate.

Academic Integrity:
Each student must pursue his or her academic goals honestly and be personally accountable for all submitted work. Representing another person's work as your own is always wrong. Faculty are required to report and suspected instances of academic dishonesty to the Academic Judiciary. Faculty in the Health Sciences Center (Schools of Health Technology & Management, Nursing, Social Welfare, Dental Medicine) and School of Medicine are required to follow their school-specific procedures. For more comprehensive information on academic integrity, including categories of academic

dishonesty, please refer to the academic judiciary website at http://www.stonybrook.edu/uaa/academicjudiciary/

Critical Incident Management:
Stony Brook University expects students to respect the rights, privileges, and property of other people. Faculty are required to report to the Office of Judicial Affairs any disruptive behavior that interrupts their ability to teach, compromises the safety of the learning environment, or inhibits students' ability to learn. Faculty in the HSC Schools and School of medicine are required to follow their school-specific procedures.

Student Accessibility Support Center Statement
If you have a physical, psychological, medical, or learning disability that may impact your course work, please contact the Student Accessibility Support Center, 128 ECC Building, (631) 632-6748, or at sasc@stonybrook.edu. They will determine with you what accommodations are necessary and appropriate. All information and documentation is confidential. Students who require assistance during emergency evacuation are encouraged to discuss their needs with their professors and the Student Accessibility Support Center. For procedures and information go to the following website: https://ehs.stonybrook.edu/programs/fire-safety/emergency-evacuation/evacuation-guide-people-physical-disabilities and search Fire Safety and Evacuation and Disabilities.