

Commentary: A Sense of Story, or Why Teach Reflective Writing?

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Abstract

Reflective writing is being introduced in many medical schools in the United States and abroad for a variety of reasons and with a variety of goals in mind. As Wald and colleagues write, multiple methods, including the rubric introduced in their study, have been

proposed for rating or grading this writing to quantify the gains obtained. The authors of this commentary detail the assumptions both about reflection and about writing implied in Wald and colleagues' work. They then describe a reciprocal model of writing as discovery,

suggesting that the writing itself is what teaches the skills of reflection. Equipping medical students with a sense of story may well be the active ingredient in whatever gains are observed in teaching reflective writing.

Editor's Note: This is a commentary on Wald HS, Borkan JM, Taylor JS, Anthony D, Reis SP. Fostering and Evaluating Reflective Capacity in Medical Education: Developing the REFLECT Rubric for Assessing Reflective Writing. Acad Med. 2012;87:41–50.

Two women are walking down the hallway between Children's Hospital and Presbyterian Hospital. "It is such a big place," says one woman. "I bet you could get lost in here.... I always need to know where I am going." Then she asks the second woman a question. "Sure," the second woman answers. "Go straight down this hallway, turn left at that corner, then go down in the elevator to B to get to Radiation Oncology."

This brief exchange, overheard by one of the authors of this Commentary in our hospital, seems to make visible the plight of the cancer patient starting out on treatment. Reflecting on the first speaker's words, we wonder about her lostness, the vastness of that in which she fears getting lost, the probable futility of finding in Radiation Oncology the certainty she seeks. Even though the speaker might not "mean" to talk about

her experience of having cancer, is that what she is doing? The story, such as it is, displays, without spelling it out, potential meaning, much as a graph of statistical data might display something to a viewer who knows how to read it. The meanings are emitted by their forms.

Most of us overhearing those disconnected utterances would have naturally *narrativized* the fragment of talk, making visible that which it might have contained while realizing, of course, that we might be wrong. By identifying a mood, noting particular words, filling in the said with the unsaid, we would imagine the situation of the teller. If the speaker were a patient and the listener her doctor, clinical practice would entail testing the hypotheses generated in this imaginative effort, and the doctor would, we hope, ask the patient about her words: "I wonder if you feel lost in the uncertainty of this cancer and its treatment. If so, what might I do to lessen your suffering?"

It is this *sense of story* that proponents of reflective writing in medical schools are seeking to enhance in their students. Psychologists Jens Brockmeier and Rom Harré¹ suggest that

the story form, both oral and written, constitutes a fundamental linguistic, psychological, cultural, and philosophical framework for our attempts to come to terms with the nature and conditions of our existence.

If the practice of medicine is not the attempt to come to terms with the nature and conditions of our existence, what is?

The field of reflective writing in medical education is at a most productive and perilous stage. Those who study and

teach reflective writing hover somewhere between epiphany and proof, knowing they are on to something important for medical education but having yet to establish what, in fact, the field can do or how it does it. Such visionaries as George Engel, Robert Coles, Arthur Kleinman, and Rachel Remen early understood that medical practice was being hampered by its positivist and reductive bent, and they suggested that admitting singular stories of patients and doctors into medical education might aid doctors to recognize patients' lived experiences and might support doctors' awareness of the meanings of their own experiences. Bringing about these two changes together, it was proposed, could improve both the effectiveness of the health care and the process of learning how to give it.

We have covered a considerable distance since these early realizations. The article by Wald and colleagues² discussing a new rubric for rating reflective writing by medical students contributes to this sweep of discovery and change. We have learned from this team about methods of giving structured individualized feedback to students about their reflective writing. They and others working in this area of educational research are to be commended for their serious and productive commitment to examining, articulating, and instrumentalizing some messy concepts and messier learning behaviors, especially in view of the contrary reception such work often gets from mainstream educators.

The research approach adopted by Wald and colleagues locates reflective writing within mainstream pedagogic frameworks derived from adult learning

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psychology and applies these concepts to medical education. The rating strategy proposed is congruent with mainstream medical education's assessment routines and is grounded in an extensive list of references from the medical, nursing, pharmacy, and physical therapy education literatures. This and similar projects purposefully support the comparative rating of students' performance of reflection against one another or against their own earlier performance. The aim, that is to say, is for faculty members to judge and then rank students singly and within cohorts on their attainment of a measureable skill in a way that fits with traditional educational practices.

Conceptual Models for Reflective Writing

Wald and colleagues² define reflection as an "expertise-enhancing metacognitive, tacit process whereby personal experience informs practice." The following assumptions seem to be implied here and in other current work on reflective writing: (1) Reflection is a skill that progresses linearly in time. (2) Medical school faculty possess this skill and can, with a minimum of preparation, both teach it to others and assess it in others. (3) Reflection is taught, learned, and accomplished through psychological operations applied to life experiences. (4) Writing is a method used to display and then to measure the attainment of the skill of reflection. (5) Written texts display their writers transparently, allowing the reader unambiguous access to the writer's earnest thoughts, motives, and feelings. (6) Written texts will be read and interpreted by all readers in similar ways. (7) The writing appropriate to medical training is first-person prose about quandary events written to directive prompts in prescribed forms and in chronological sequences.

Others of us start from different conceptual assumptions about reflection, writing, and reading that both complement and contest the assumptions on display here. These assumptions arise from different beliefs about the nature and consequences of reflection and the relation of reflection to reading and writing.

Reflection can be understood to be an active interior state that uses cognitive, affective, imaginative, and creative means

to perceive, represent in language, and thereby undergo one's lived experience. Through sustained and lifelong states of reflection, one experiences one's life. Drawing on narrative theory, aesthetic theory, and phenomenology, reflection is recognized as a narrative and *narrating* avenue toward presence, identity, self-awareness, intersubjectivity, and ethical discernment.³⁻⁵ The reflecting self is one with the attentive self, the present self, the feeling self, the self with the sense of story. It is, to borrow Henry James⁶ definition of the novelist, "one of the people on whom nothing is lost."

The role of writing in reflection changes dramatically with this conception of reflection. According to Wald and colleagues' study, writing is used to measure the attainment of the skill of reflection after that skill has somehow been attained elsewhere. In this alternate conception, writing is used to *attain* the state of reflection. Not report but discovery, writing unlocks reservoirs of thought or knowledge otherwise inaccessible to the writer.⁷ Representing one's experience in language is perhaps the most forceful means by which one can render it visible and, hence, comprehensible. Writing is how one reflects on one's experience. It is as if that which is experienced has to be somehow "gotten outside" of the person so that it can be apprehended and then comprehended.

Narrative theory defines a narrative act as having a teller and a listener. The listener in medical student reflection is the reader or auditor of whatever is written. As composition theorists teach us, writing is not a solitary act.⁸ Intersubjective, daring, exposing—the writing act, when coupled with the reading act, permits deep congress of self with other and, as a corollary, self with self. The passage of the account of self "through" the receiver is critical to the enterprise and transforms writing and reading from something unilaterally "ratable" to something reciprocal.

Teaching Reflection by Teaching Writing

Within the sights of this conception of writing-as-reflection, the teaching and learning of reflection take on specific forms. Arising at Columbia University but now becoming evident in other

medical centers in North America and abroad, the primary effort is to equip learners—students, house officers, faculty, health professionals of all sorts, patients—with the language skills to represent and recognize complex events and states of affairs. We reclaim for students the narrative skills to recognize stories, skills that they perhaps used to use in their lives but have deemed not salient to medicine, and we invite them to use these skills here and now. Learners learn to read while they practice writing, as most teaching sessions begin with the close reading of a written text—a poem, a paragraph from a novel, an illness narrative, an intern's progress note, a prayer. Writing prompts are short and painstakingly developed, not to pose specific questions but to expand the writers' minds and to invite learners to write in the shadow of the text they just read. Prompts can but do not have to guide students to write of clinical experiences.

The writing is unpredictable in form and content, often marked by the lyrical, the ironic, the surreal, the comic, or the experimental. Instead of writing in solitude and uploading their work, students participate in collaborative workshops where they often read aloud what they have written and their writing is actively coached. Every written text deserves and gets a reader or auditor and usually gets the benefit of several receivers. At least some of the readers are skilled in the acts of close reading. By definition, this means every written text gets multiple interpretations, for no two readers will derive the same "emission" from a text. It is understood that the writer is the last person to know what's contained in his or her writing and that others carefully examining the text—for such narrative features as its metaphors, temporal structure, narrative voice, genre, diction, allusions, and plot—can illuminate for the writer what might be contained within it. By listening nonjudgmentally and with no fixed expectations, writers and readers are encouraged to actively recognize what one another does with words, how the writing strikes them, and what it might mean.

The Duty of the Teacher

The duty of the teacher in this model is not to judge and rate but, rather, to read

and tell what is seen. Our teachers, having been trained in the acts of close reading, are equipped not with rating rubrics but, rather, with a reading guide that prompts the reader to attend to several narrative features of a text. The reader/coach can thereby first see and then *show* the writer what is contained in the written text, at least from that reader's vantage point, helping along the process not only of the writing but also of the reflection the writing birthed. Multiple readers swell and complicate the lessons learned. As a dividend, we have observed, the group of readers/writers form strong, trusting, collaborative teams. And so our training for reflection also fulfills other difficult missions of medical education in teamwork, peer learning, trust, and care.

We worry that in our commitment to bring reflective writing to our students, we might hurry to provide our schools with what we think they want, like quantified markers of individual learners' achievements. This impulse perhaps distorts and squanders the potential deep dividends of the work of reflective writing. We might remember that it is a profound achievement to equip our students—and ourselves—with the capacity to tell and listen to stories. We

can certainly demonstrate this learning, but in ways that will not distort the undertaking itself. The medical student who has developed skills in representing complex situations or states of affairs and in receiving and decoding the utterances of others is equipped to accomplish central clinical tasks. This student will be a nuanced receiver of all that patients emit—in words, appearance, gestures, physical findings, silences. Attentive, receptive, grateful to patients for sharing their interior states, the student will absorb the situation of the patient in its complexity and will then be able to act, on behalf of the patient, on that knowledge. He or she may represent that clinical encounter in language, not in order to fulfill an assignment but, rather, to undergo and, hence, understand what has happened in his or her brush with this patient. In the preface to *The Golden Bowl*, Henry James³ suggests that “to put things is very exactly and responsibly and interminably to do them.” Our deepening sense of story will open us to the vastness, the lostness, the uncertainty, and the meanings that unite all who are ill and all of us who do our best to care for them.

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