The Principles and Practice of Narrative Medicine

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CHAPTER 2

This Is What We Do, and These Things Happen

LITERATURE, EXPERIENCE, EMOTION, AND RELATIONALITY IN THE CLASSROOM

Maura Spiegel and Danielle Spencer

. . . we have much less control over our own affective experience than is generally comfortable for us. Our emotions and our behaviors have, to some degree, a messy life of their own, in the gaps, the spaces, between oneself and others.
—Stephen A. Mitchell, *"An Interactional Hierarchy"*[1]

How can it be described? How can any of it be described? The trip and the story of the trip are always two different things. The narrator is the one who has stayed home, but then, afterward, presses her mouth upon the traveler's mouth, in order to make the mouth work, to make the mouth say, say, say. One cannot go to a place and speak of it; one cannot both see and say, not really. One can go, and upon returning make a lot of hand motions and indications with the arms. The mouth itself; working at the speed of light, at the eye's instructions, is necessarily struck still; so fast, so much to report, it hangs open and dumb as a gutted bell. All that unsayable life! That's where the narrator comes in. The narrator comes with her kisses and mimicry and tidying up. The narrator comes and makes a slow, fake song of the mouth's eager devastation.
—Lorrie Moore, *"People like that are the only people here"*[2]

At six-thirty in the morning of July the first, I was swallowed by the House of God and found myself walking down an endless bile-colored corridor on the sixth floor. This was ward 6-South, where I was to begin. A nurse with magnificently hairy forearms pointed me to the House Officer's On-Call Room, where rounds were in progress. I opened the door and went in. I felt pure terror. As Freud had said via Berry, my terror was "a straight shot from the id."
—Samuel Shem, *House of God*[3]

Socio-relational Dynamics and Medical Education

First-year medical students often wonder whether it is "right or wrong" to really feel for the patients they are just beginning to encounter in clinical settings. In narrative medicine electives at the Columbia College of Physicians and Surgeons, the question is reliably voiced in one way or another: Do we *need* to/should we *feel* sympathy for a patient—or can appropriate concern and gestures serve as well? Strong feelings of inadequacy can surface if students find themselves unable to achieve the depth of emotion they would feel "if that were my grandmother" while contending with the tremendous stresses and challenges of medical education.

Most clinicians agree that regulating the expression of emotions is a necessary and important feature of professionalism. A colleague recalled that after the birth of her son, her obstetrician burst into tears breaking the news to her that her baby had Down Syndrome: "It made me so mad that she cried. Doctors are supposed to make you feel that everything is going to be alright." Another person described feeling comforted and less alone when he saw a trace of a tear in the corner of his physician's eye when he was delivering a cancer diagnosis. Perhaps, then, it is not surprising that contradictory and mixed messages about what to feel and how to express it are common in medical education. Such contradictions may account in part for the paucity of attention to emotion in medical education. As Joanna Shapiro writes, "The formal [medical school] curriculum rarely considers trainee emotions directly, although it periodically enumerates officially desirable attitudes and values of respect, altruism and caring."[4] She goes on to point out, however, that the informal curriculum can convey the alternate message that "emotional distance and detachment" are the appropriate professional postures. Among physicians, she proposes, the dominant attitude is that emotions are "untrustworthy, having little or no place in the practice of medicine" because they are perceived as either self-indulgent or leading to "compassion fatigue." The overwhelming message received by medical trainees, according to Shapiro, is that inadequate emotional control, or "caring too much," can result in "emotional exhaustion" and "professional failures."[5] Such suspicion of emotion extends to both negative *and* positive feelings.

Educators have long understood that emotions are not a neutral factor in learning. Psychologist Daniel Goleman writes, "Students who are anxious, angry, or depressed don't learn; people who are caught in these states do not take in information efficiently. . . ."[6] Feminists and race theorists recognize both the pedagogical and *political* value of learning to speak about feeling in the classroom. As Derald Wing Sue describes in *Race Talk and the Conspiracy of Silence*, students appreciate instructors who are unafraid to recognize the

racial tension that can emerge in class discussion and to name the feelings that can attend it: "The skilled facilitator helps others make sense of these feelings and frees the individual from being controlled by them. As long as feelings remain unnamed and unacknowledged, they represent emotional roadblocks to having a successful dialogue."[7] What's more, as educator Elizabeth Vogel points out:

> Who gets to show emotions and who does not is not politically neutral. The people who get silenced are usually the ones on the margins—people of color, females, etc. Often this silence is a reaction to real pain, and so not an inappropriate reaction. In this way, emotions create a web of influence that is difficult to untangle and analyze.[8]

Such complex dynamics occur on every level of interaction, from the medical school classroom to the clinic. Rhetorician Lynn Worsham argues for making a place for emotion in the classroom, and she offers a definition of emotion that is helpful in this context. Emotions are

> a tight braid of affect and judgment, socially and historically constructed and bodily lived, through which the symbolic takes hold of and binds the individual, in complex and contradictory ways, to the social order and its structure of meaning.[9]

As medical educators and clinicians grow increasingly aware that attention to emotional self-awareness is a crucial missing dimension in classrooms and in healthcare training, the consequences of this neglect are coming into greater clarity. As many have observed, medical students and young physicians are not encouraged to become familiar with their own emotional responses nor those of others. Prominent among these feelings is the understandable need to defend one's emotional investment in the values of the dominant medical culture. What's more, as Shapiro observes, "little effort is exerted to develop emotional honesty in medical students or residents." One consequence is that when trainees experience "confusing, unsafe, and difficult" feelings, "they sometimes decide to adopt a position of emotional detachment and distance."[10]

In *What Doctors Feel: How Emotions Affect the Practice of Medicine*, Dr. Danielle Ofri observes that clinicians, throughout their careers, are plagued by such negative emotions as fear, shame grief and anger. Further, their experience of being emotionally overwhelmed leads to burnout. Such "primal emotions" understandably follow from the onslaught of sickness and death faced by young doctors training in hospitals, as well as from the anguish of medical error and from the hazard of disillusionment in medicine itself, when ideals

and reality come into conflict.[11] Other educators observe that vulnerable patients, in particular, "can evoke fear, revulsion and pity in medical students" because, having entered medicine to " 'help' patients and 'fix' problems," they may "feel overwhelmed by the extent and number of problems vulnerable patients present."[12] How are doctors to navigate this difficult professional terrain? What messages are conveyed when students are exposed to emotionally jarring scenarios of profound suffering, fear, poverty, and health disparities, and are not provided strategies for integrating these experiences into their sense of the world or of themselves?

A further challenge to correcting this missing element in medical education and training is that, as Sarah de Leeuw et al. observe, "Too much emotionality, complexity, or critical and self-reflective focus is viewed, by some students, as detracting from what they were meant to learn in medicine, particularly in the 'practical and applied/clinical' realm."[13] Indeed, asking students to "talk about their feelings" often leads to embarrassed silences and resentment on the part of the students toward the well-meaning educators. As sociologist Arthur Frank observes, "Professional culture has little space for *personal becoming*. Young doctors are not trained to think of the careers ahead of them as trajectories of their own moral development."[14] Recognizing that medical culture can become a training ground for the silencing of emotion, literary scholar and teacher Suzanne Poirier encourages emotional honesty in medical learners, with the goal of recognizing and acknowledging one's own feelings and those of others, and their implications.[15]

These are exemplary goals, but the question remains: how exactly does one teach "emotional honesty"? While the right questions regarding emotion in medical training have been raised, the "solutions" remain scant. Some medical educators have invoked the model of "emotional intelligence" (Shapiro) or "emotional skill" or "labour" (McNaughton) or training in emotional regulation, but the strategies for achieving these goals are not clear.[16] We have found, in narrative medicine, that close reading of works of creative representation provides the distance or mediation that allows students to speak about feelings, to enter into experiences that are meaningful to them. Reading a compelling story or looking at a scene from a film can bring feelings forward, and, through such mediation and the pleasurable act of drawing connections, students find themselves drawn to consider the ways their own stories interface with those under discussion. As we proceed to describe "what we do and what happens," we will endeavor to lay down some of the philosophical and psychological ground on which we base our work.

Among our propositions is the notion that it is better to know something about your affective responses, to explore them honestly, than to

1. Extend energy trying to make your feelings conform to an idealized model of bottomless compassion
2. Bring to your encounter with a patient a confused or defended affective state
3. Push down or away your unwelcome feelings, be they too much feeling or an absence of feeling

And our premises include the following:

1. Narrative medicine does not seek to judge, correct, or educate affective responses. Rather, it aims to reduce fear of them and to find words to name—or other modes of expression to express—emotions in order to develop a greater capacity to be present to self and other
2. People are uncannily sensitive to what others feel toward them; there is really no hiding your feelings
3. It is not possible to shut out the suffering of others. It will find its way into your mental life, or keeping it at bay will be psychically costly and contribute to burnout
4. As we continue to locate the many ways in which narrative medicine can be put at the service of social justice, we are attentive to the role emotions play in the nature and structure of bias and racism
5. Narrative medicine seeks to create an environment where aesthetic experience can unlock affective responses, where trust and collaboration replace competition, and where the nature of engagement allows for recognition of self and other

In medicine, one affective term has dominated in recent years and has generated an enormous bibliography: *empathy* is commonly proposed as the most important if not the only relevant feeling in the medical context. We do not have room here to explore the ongoing discussions and disputes surrounding this term except to note that some are critical of this concept, finding in it a misguided assumption that one can enter into or know another's experience. Some wonder whether empathy is "teachable," while others are offended by the suggestion that practitioners and students need to be taught what to feel. We have not found empathy to be a useful term in our work for some of these reasons, and also because there are so many dimensions to any human interaction that to focus on one idealized relational affect or dynamic is simply inadequate. After describing "what happens" in the classroom, we will turn below to philosopher-educator John Dewey to assist us in understanding and articulating the complex interactions between aesthetic, affective, and learning experiences as they relate to our classroom and workshop methods. For Dewey, the

arts and aesthetic experiences must never be segregated from everyday life; there is "no such thing in perception as seeing or hearing plus emotion. The perceived object or scene is emotionally pervaded throughout."[17]

The classroom is a complicated, rich combination of information processing and emotional responding. In narrative medicine we seek to establish that emotional responses are part and parcel of our intellectual work and to allow and invite emotion into the room, recognizing the role emotion plays in relationship and relatedness. This chapter explores some of the affective and experiential dimensions of the methods we employ in narrative medicine workshops and classrooms toward addressing the relational dimension of healthcare—what we might call its *socio-relational dynamics*. In the previous chapter we explored the theme of relationality in literature; here we will investigate the role of emotions and relationality through group discussion of a literary work and prompted writing.

A Narrative Medicine Classroom / Workshop

There are a range of different contexts for this work. A narrative medicine seminar in a university program (undergraduate or graduate, in a healthcare professions school or in another context) typically has a recognizable "academic" form involving assigned readings, analytic papers, and formal assessment of student work. The academic classroom serves many goals, including training students to practice and teach narrative medicine, either within their own clinical practice or working with clinicians, patients, families and others involved in healthcare as well as fields such as social work, law, and chaplaincy. The workshop is a much more flexible entity: it may be a single or recurring meeting or an intensive immersion; it may take place in a hospital conference room with pagers arrayed on the table; or in a nursing home, with caregivers, patients, or families; as part of an international gathering of chaplains or social workers; with a group of public school teachers; or with a team of colleagues in a high-stress environment. Workshop participants may be offered supplemental readings, but the emphasis is typically on short works of prose, poetry, spoken-word pieces, or other creative media that can be read or heard together during the session and then discussed.

Within these different spaces our methods vary, but there are common themes and practices. Close reading—of literary texts, film, visual art, dance, music—is integral, as is short prompted writing and discussion. In all contexts we call upon our analytic faculties while remaining attentive to our affective responses to the texts and to one another. We encourage participants to listen to their own observations, to what they can find in themselves that is

informative and useful to them. In the workshop setting we see ourselves more as facilitators, while in the "classroom" our roles may shift between teacher and facilitator with the goal of creating a collaborative learning environment in which all play an active role. Here we will explore some of the ways in which we approach this work in different contexts, including specific work with a text and the exercises we may utilize.

We have found the story "Floating Bridge" by Alice Munro to be an inviting and evocative text to work with in the academic classroom as well as in workshops and other contexts where participants are able to read longer texts in advance of the meeting. This is the story of a woman, Jinny, undergoing treatment for advanced cancer. As noted in the previous chapter and elsewhere in this volume, we often choose texts which do not address themes of healthcare directly; here we are not focused primarily on the protagonist's experience as a person undergoing an experience of illness, but rather on the rich complexity and relational dynamics of the story. Jinny's cancer, her medical treatment, and mortality are all elements of the narrative, but part of the strength of Munro's storytelling is that it challenges a reductive pathologizing lens. And while some workshops and classrooms will take as the starting point of discussion the particular circumstances of a work's production—its historical, racial, cultural, socioeconomic context—some, like the example offered below, focus on the text with relatively little attention to such context. Particularly in a workshop setting, participants may interpret the biographical details of a work's author as authoritative—*Oh, his wife died of cancer; that's what this work is "about"*—and while such understandings are certainly valid, they may foreclose the kind of open and generative discussion we seek to engender. We are keenly aware that there is no neutral pedagogical stance, and we are not arguing that expediency obviates consideration of social and cultural context—quite the contrary. This is a particular choice—one of a great range of narrative medicine strategies—which often serves to open readers to different interpretations and perspectives, including considerations of ideology, gender, ethnicity, and other aspects of personal and cultural identity.

"Floating Bridge" takes place over the course of a hot summer afternoon. Jinny's husband Neal is picking her up after she has been to see her oncologist, where she received some news about her prognosis. In the van with them is a young woman, Helen, whom Neal has employed to look after Jinny in what they anticipate will be her final months. Neal is preoccupied with his excitement and delight at Helen's presence, and so Jinny decides not to inform him (or the reader) of the news the doctor has just delivered. Neal insists on making a detour to pick up Helen's shoes, though Jinny is feeling depleted by the heat. The three ultimately drive some way out of town to the trailer home of Matt and June, Helen's foster parents, where Neal accepts an invitation to stop for

a beer. Jinny remains outside despite the others' appeals for her to join them, inciting Neal's irritation at what he interprets as her coolness toward their hosts. Jinny walks into a cornfield, urinates, nearly becomes lost, and then makes her way back to the car. Matt and June's son Ricky—a young man, 17 or 18—arrives on his bicycle and, adeptly perceiving Jinny's state of physical exhaustion, asks if she would like him to drive her home. She surprises herself by accepting the offer and they leave without telling the others. As the evening darkens, Ricky takes an unexpected route, excitedly promising to show her something she has never seen before. "If this was happening back in her old, normal life," Jinny thinks to herself, "it was possible that she might now begin to be frightened."[18] They step out of the car and he urges her onto a floating bridge of wooden planks. The experience stirs her imagination unexpectedly as they observe the reflection of the stars in the water; the young man then surprises her with a kiss, which she accepts with a sense of wonder and even gratitude, and the story ends with her thoughts returning to Neal.

When we read this story in an academic setting we may ask students to write responses online, before class, to one of several different discussion prompts. In replying, readers must gather and articulate their thoughts, making the critical move from passive to active engagement with the text. The responses offer a valuable glimpse of readers' initial reactions to the story which can aid the instructor/facilitator in orienting the classroom discussion. The replies also come into conversation with one another, which helps foster dialogue; class discussion, then, may draw upon points made in the posts, including examples of different reactions to the text. The topics of these prompts and of class discussion often highlight themes that are particularly relevant to healthcare, such as relationality, memory, judgment, and so forth. They range from the analytic —we often pair the text with a particular theorist also on the syllabus—to more creative prompts. It is quite purposeful that we mix these modes together, as analytical thinking is also creative, and creativity can, of course, be highly analytical. One example of a discussion prompt for "Floating Bridge" engaging with a critical text begins with a quotation: *Elaine Scarry writes in the Introduction to* The Body in Pain *that her book "is about the way other persons become visible to us, or cease to be visible to us."*[19] *Discuss the idea of people becoming visible or invisible in the story.* Another productive prompt emphasizing the theme of relationality asks students to *Provide a close reading of one interaction or exchange (spoken or unspoken) between two or more characters.*

The diversity of responses to these questions demonstrates the myriad ways of interacting with and responding to a text. When asked to point to a particular passage or aspect of a literary work which a reader finds compelling, the response can also become a form of personal expression. Some readers focus

on Neal's behavior and castigate him for his apparent callousness toward his wife, expressing unbridled moral censure and disgust. One writes of Neal and Jinny's "monotonous and trying marriage," describing Jinny's unwanted ride in her "deadbeat husband's hippie van in search of some missing shoes of a nubile young girl hired to step into Jinny's own figurative shoes as she is leaving this earthly world." Another criticizes Neal for his flirtation with Helen, asserting that he is attentive to his wife's comfort only out of obligation, as she has, in fact—invoking Scarry—"become invisible" to him. Some are quite surprised—dismayed or intrigued—when others do not share these reactions. Neal's character tends to evoke memories of reviled ex-partners, of failed relationships, perhaps of experiences of illness and caregiving, and when other readers respond differently they may become proxies for such figures and trials from one's own past.

In any setting we remain hypervigilant about privacy and do not probe into personal experiences, nor do we set any expectation for self-disclosure. With such safeguards in place, the relational space of the classroom or workshop may become suffused with powerful feelings. The potent life experiences of participants hover in the air and are expressed through close reading and reflection on the piece under discussion. The text creates the opportunity for a productive projection, allowing readers to locate their own feelings and to discuss and examine their judgments and responses. Through such shared close reading we are challenged to open ourselves to different interpretations beyond an initial reflexive distaste at a character's behavior. For example, some might point toward passages in "Floating Bridge" that complicate a neat judgmental interpretation, such as Neal's expressions of tenderness, the ways in which Jinny's death remains, in some way, unthinkable to him. When Jinny jokes about her death, warning Neal not to "let the Grief Counselors in," he responds "in a voice of rare anger": "Don't harrow me."[20] Drawing on such nuanced moments in the text, we might discuss the ways in which the seeming heedlessness of Neal's actions in the story is evidence of a reciprocity characteristic of long-term relationships; by not behaving in an overly solicitous manner toward his sick wife he is also refusing to reduce her to the status of "sick wife." By making jokes about the cemetery as they drive past he asserts their continued humor and humanity. Some readers note that he is dedicated to looking after her, picking her up from appointments, and preparing the home for her care down to the smallest detail.

Remaining close to the text, we might also reconsider Neal's flirtatious behavior toward Helen in light of Jinny's interior reflections: "When Neal was around other people, even one person other than Jinny, his behavior changed, becoming more animated, enthusiastic, ingratiating. Jinny was not bothered by that anymore—they had been together for twenty-one years. And she

herself changed—as a reaction, she used to think—becoming more reserved and slightly ironic."[21] Perhaps these behavioral "transgressions" are a testament to Neal and Jinny's foundational presence to one another, to their compact that he will never leave her and will continue to bring a messy vitality to their shared lives, whatever the circumstances. We may see Neal fulfilling his role as the one doing the imperfect and sometimes inappropriate *expressing*—connecting Jinny to herself and the world—while Jinny remains reserved and impassive. For example, the story begins, "One time she had left him"—and what follows is Jinny's recollection of her anger at Neal after a perceived slight, contemplating her departure and her future solitude, reading the graffiti on the walls of the bus shelter:

> She felt herself connected at present with the way people felt when they had to write certain things down—she was connected by her feelings of anger, of petty outrage (perhaps it was petty?), and her excitement at what she was doing to Neal, to pay him back. But the life she was carrying herself into might not give her anybody to be angry at, or anybody who owed her anything, anybody who could possibly be rewarded or punished or truly affected by what she might do. Her feelings might become of no importance to anybody but herself, and yet they would be bulging up inside her, squeezing her heart and breath.[22]

To be connected by anger is perhaps a counterintuitive notion. But as we read attentively, we begin to respect the specific forms that intimacy takes between these two people in Munro's complex, subtle portrait. We begin to glimpse, too, the specter of aloneness for Jinny—interestingly, the suffocation of solitude in this passage evokes the apparition of cancer, "bulging up inside her, squeezing her heart and breath." Each of these characters is a relational self, as we all are, and our understanding of them is embedded in their complex connections with one another as Munro depicts them in such a rich and intricate fashion.

By attending to the intricacy and particularity of these characters and these relationships in a dynamic discussion, participants begin to step outside of their own identifications and projections; together we can listen to a voice which is not our own, and can better see where we stop and something else begins. Moreover, we can observe our own initial responses to the story, and perhaps marvel at how our experiences can always find their way into our relationships—including relationships with characters in a story. In a conventional literature class such emotional readerly responses may be of little or no interest, while in our practice they become a vehicle to acknowledge and recognize our own judgments, how they often operate without our conscious awareness.

Becoming alert to those times when we are projecting our own emotions and values onto others is of critical importance in healthcare, and discussion of a fictional text can be especially helpful in this context. For example, many years ago a medical student began a response to the prompt, "Write about the suffering of someone that moved you" with the following: "I felt sorry for Mrs. T. because she was the only person in the ER that night who hadn't brought her problems upon herself." This was a challenging moment. How to open a discussion of such a sentiment without shaming the student—without placing a judgment on the student's judgment? On another occasion a similar feeling was expressed by a medical student, but this time the judgment was directed toward a fictional character—in fact a quite sympathetic character, Sister Rosa, played by Penelope Cruz, who contracts AIDS in Almodovar's film *All About My Mother*: "I feel no sympathy for her because she brought her disease upon herself," he wrote. In contrast to the prior example, it was a simple matter to ask the class how they felt about the character, one they all had encountered on an even footing. A fruitful discussion ensued regarding the complex contingencies of sympathy. Asked to write to the prompt, "Write about a time you wanted to feel sympathy for someone but couldn't," the students opened up and explored their own judgments—including those they regretted. Because it is particularly challenging to find ways to effectively address people's judgments and feelings, the mediating function of a creative work becomes especially apparent.

In discussing "Floating Bridge" we are interested in what provokes our own judgments and reactions, and also in how the story itself is working to explore the question of judgment. Part of the attraction of judging a literary character is that it can serve to "solve" the story and puts it to rest; in this case judgment of Neal may ascribe Jinny's plight to his failings—a more accessible demon than illness and mortality. Static closure, however, is precisely what we seek to challenge. The judgment of Neal's behavior is not at all *wrong*, but it is not *enough*, and close reading demonstrates that reductivism does not do justice to the enormous complexity of relationships and human experience—just as perceiving Jinny solely through the lens of her disease does not do justice to her experience and character. The discussion may not eradicate people's assessments of or hostility towards Neal—nor need it—but the point is to open ourselves to recognize how much room there is for interpretation in even a brief exchange. Hearing classmates' perspectives can enlarge or alter our own, and they can help us observe the shape of our own response.

Returning to the story, we attend not just to its events but also to its structure. Within the text are the happenings which occurred—what literary critic Gerard Genette terms *histoire*, or story—but of course there is also the

particular way that events unfold—what Genette calls *récit*, or narrative.[23] The summary of "Floating Bridge" we offered above is mostly an account of the "story" in this sense, of the events in chronological order. Yet a focus on plot can be quite reductive; in taking up questions of temporality, point of view, narrative structure, and figurative language in class discussion, we become aware of the story's many layers and nuances. For example, "Floating Bridge" begins not with Neal picking up Jinny from her appointment but with Jinny's recollection of the time she had "left" her husband, followed by her recollection of the oncologist's "priestly demeanor" during their appointment; we only enter the oppressively hot van with Neal and Helen on the third page.[24] Jinny's memories are woven into the narration throughout the story, such as her vivid memory of a woman calling her a "*nice nellie*" years in the past, and her outrage at "having to sit there and listen to people's opinions of her."[25] She revisits these moments in her past, and our understanding of the story is further shaped by these narrative choices. In addition to discussing sequence and temporality, we may ask the group to consider the type of narrator. Indeed, the story is told largely from Jinny's perspective with a "third person limited" narration; we hear many of her interior thoughts and recollections but none from the other characters in the story, and our understanding (and perhaps our sympathies) are necessarily informed by this type of narration. As we discuss the role of perspective in the story we are made aware of our own and other readers' particular perspectives.

Finally, we discuss the floating bridge, both its literal function and its symbolic role within the story. What does it mean for Jinny, whose future is now less certain? For we have learned, late in the story, shortly before we travel to the floating bridge, that the medical news she has been carrying from her visit to the oncologist is in fact cautiously optimistic. As she is ostensibly listening to Helen's foster father Matt tell a joke, she is replaying her doctor's voice: "*I do not wish to give the wrong impression. We must not get carried away with optimism. But it looks as if we have some unexpected results here.*"[26] The delay of this revelation and its awkward insertion during the conversation with Matt may reflect a fear of acknowledging the news. Hope can be dangerous, and she is in some sense newly afraid: "A dull, protecting membrane that she had not even known was there had been pulled away and left her raw."[27] And so the floating bridge is also a bridge toward an uncertain future for Jinny—and for Neal, too, though he is not physically present—a passage over dark waters that cannot be seen, can only be felt. It also mirrors the structure of the story itself, as we do not know where we are headed, do not know what is a beginning and what is an end. It is an unexpected and perhaps bewildering plot twist, yet as we rest on the floating bridge we must sit quietly with what is around us, with the uncertainty and doubt that subtends human experience. The tone of the

narration shifts as well, and we are bathed in rich figurative language, a new and unexpected lyricism and poeticism:

> The slight movement of the bridge made her imagine that all the trees and the reed beds were set on saucers of earth and the road was a floating ribbon of earth and underneath all was water. And the water seemed so still, but it could not really be still because if you tried to keep your eye on one reflected star, you saw how it winked and changed shape and slid from sight. Then it was back again—but maybe not the same one.[28]

In class we spend time reading aloud these luminous descriptive passages and discussing the scene. We then offer a writing prompt. The guidelines for this exercise have been explained thoroughly to the group: participants have a short amount of time to write, typically around 5 minutes. Those who wish to share what they have written may do so, sometimes with a partner but more often with the entire group. The facilitator/instructor writes to the prompt as well, and often shares what she has written with the group. No one is required to read, and in an academic setting a student is not graded on willingness to share the writing nor do we attempt to assess the creativity of the response. Every context is different and must be approached with great sensitivity. For example, prompts that tend to elicit more personal stories may become appropriate only after a group has met several times and the facilitator has gauged the level of trust and willingness. Regardless of the setting, a prompt should certainly not aim to directly elicit painful experiences; it must be open-ended enough to allow the writer to decide how to calibrate her response. In some settings, particularly those with strong institutional hierarchy (such as a group of clinical fellows, residents, medical students, and their supervising attending physician) we may specify that participants have the option to write from their own voices or from the imagined perspective of another. Discussion leaders *must* be attentive to the dynamics of a particular setting and the needs of each individual. At the same time, emotions play a valuable role in the classroom or workshop setting—a theme to which we will return later in this chapter.

The writing prompt relates to the discussion of the story which has just taken place and invites readers to articulate their individual personal relationship to the text, including associations that are often brought into awareness through the writing exercise. Crafting a narrative medicine prompt is a delicate balance. It must not be too specific, such as *Write about a time you were driven around in a hot car for hours looking for someone's shoes and then were kissed by a teenager on a floating bridge*—nor too pointedly personal, such as *Write about a time you cared for someone with a terminal diagnosis*—nor too vague, such as *Write about a time something unexpected happened*. With "Floating Bridge"

we often ask participants to *Write about a time you were on a floating bridge*. The prompt evokes the physical description of standing on a floating bridge in the story as well as its metaphoric associations, while relating them to the writer's own experiences. While there is no set amount of writing expected or required, respondents are aware that time is limited so they tend to begin fairly swiftly. Within the span of 5 minutes one can write quite a bit, typically ranging from one to several paragraphs.

The short pieces which emerge from this process are often fresh and surprising. The format allows people to discover and articulate what the story elicits in them and gives them an opportunity to elaborate on what they found most meaningful. Sometimes they observe that they had no idea what they were going to write when they started, but that the exercise helped them achieve a new angle on a feature of their own experience. They are often amazed at the voice that emerges and the complexity of what they have written, and reflecting those qualities back to the writer is an important and gratifying element of the discussion. Here are some examples of responses to the *Write about a time you were on a floating bridge* prompt from students in a master's program class in narrative medicine:

> I have never been on a floating bridge, although I have driven on a swinging bridge, known as the largest suspension bridge in the world—the Mackinaw Bridge, which connects the Upper and Lower Peninsula of Michigan. But when I think of a floating bridge, I am drawn to the metaphorical meaning. I think of how my relationships are floating bridges that sometimes have broken apart and sometimes hold together in an uneasy fashion. Take my brother. We once had more a solid bridge—or at least that's how I saw it. Then he was my older brother, a hero, a role model and I was the younger brother. Used to be I thought if I had one phone call to make before I'd die, I'd call him. It seemed that this relationship was rock solid. But then things changed and sometimes I wonder if the relationship we could have is still out there in the swamp, waiting to connect us, but we can't connect because we cannot forget the old stationary bridge.
>
> * * *
>
> I interviewed a friend of mine for our oral history class because of her work in advocacy, or so I thought. But yesterday when I was writing my final essay for the class and listening again to our interviews, I realized that I really interviewed her for the story we share. Our fathers both died suddenly when we were young—and we both have spent our lives caring for our mothers. Listening to the interviews I could hear in my friend the story I tell myself about resilience and responsibility. A story that makes me at once sad and in a certain sense proud. The bridge my friend and I are on is the shifting waters of our mothers'

needs and the work we do to keep our balance—to keep ourselves afloat.

There is a space back home, a 4x4' spot of leveled roofing material on the pinnacle of a sloping roof—the rest of the roof's shingles reaching both for the heavens and earth at a sharp 30°.

The surface of this small patch of lofted architecture is black—dirtied with the wash of rainy winters and gusty dry summers.

But this is my spot. In the summer, during the late sunsets, I often lie curled up on this 4x4' expanse—warmed by the sun-soaked material.

I watch the grapefruit sunsets fall to indigo until the light of the cosmos reveals itself to me. Here . . . in the countryside, the stars are clear and infinite. And it is here that I both begin to think and cease thought—as I become infinite under the late summer's sky.

Passage
With six months left
hovering, early January
75 degree Southern California winter boasting through
fresh roses parading in the streets
football on everyone else's mind
and our small house on Mar Vista Avenue
suspended about it all
tubes of morphine, swabs of saline
stains of blood, shit, scraps of hair
looking out we'd see
signs of life
brown squirrels budgeting
blue jays jousting
ivy climbing the gazebo
she wouldn't sit beneath

Yesterday I came home to my 13 year-old sister wearing my boots when she did not ask me and it was the last straw. My dad says "Well, you weren't here to ask." I can't bring it up because I know I must respect the unwritten rules of the house and God knows I've "borrowed" shoes before, but just fucking ask. I'll say yes, just let me say yes.

I was late for my MRI appointment because the shoe debacle delayed my dad from going grocery shopping and I had to wait for a ride in the one-car-for-seven-people system. My dad offered to wait and go in with me but I knew Sarah (the 13 year old) had basketball practice and it would throw off the one-car-for-seven-people system. So I went up alone.

> I took off my clothes and all metal jewelry and got strapped into the stretcher and thought how this pain is probably all mental anyway and I probably just wasted an hour and $20 copay. They turned the machine on and drew me into the huge loud whirring structure and told me not to move even though it was uncomfortable. They moved me in further to the machine than I expected and I couldn't breathe but I couldn't move because I had to get the picture of my pounding hip. I sat and prayed and listened to the bad pop music and felt my muscles spasming from my control until I heard, "good job, you were very still."
>
> I let my parents take care of my sister first, and still didn't mention the shoes. It was over.

As these pieces demonstrate, good narrative medicine prompts do not ask for an answer or an analysis but rather ask readers to look inward, to find a resonance with the text's ambitions and allow them to co-mingle with one's own memories and experiences. It is often striking and intriguing to note the ways in which the literary work that has just been discussed is literally and/or figuratively echoed in the pieces' tone and subject matter, often to the surprise of the writer. Such mediation is helpful as it reframes, reinfuses, reinterprets, readjudicates a moment which was important to the writer, perhaps an experience which the writer needed to tell to themselves. For example, the piece which is set on a square of roofing material reflects a feeling of pleasurable solitude akin to Jinny's experience in Munro's story; it evokes a sense of timelessness and an enigmatic yet powerful feeling of melting into the cosmos which characterizes the scene of the floating bridge. As the prompted piece concludes, "the stars are clear and infinite. And it is here that I both begin to think and cease thought—as I become infinite under the late summer's sky." In contrast, another response may begin by stating a *lack* of literal connection with the prompt: "I have never been on a floating bridge . . ." Yet more often than not such an assertion serves to spark a series of associations. Beginning with a negative—a lack of connection—also reflects the theme of uncertainty in the story, and we may ask this author if he knew where he was headed when he began. Indeed, this response can be read as a floating bridge into uncertainty, with the painful recognition of loss: "I wonder if the relationship [my brother and I] could have is still out there in the swamp, waiting to connect us, but we can't connect because we cannot forget the old stationary bridge." This piece reflects, too, the importance of relationality, a theme we see again and again, as in the piece about the Oral History interview. *How do we tell our own stories through one another*?—is the question the author poses. This is one of the fundamental objectives in our work, to explore the ways in which we express ourselves *through* other texts and selves—through our response to a short story, to a discussion question,

to a writing prompt, and to one another's writing. Indeed, the richness of participants' writing arises directly from the relational space of the group and the combinations of these different factors.

These are just a few examples of possible responses to the prompted writing—ideally arising in discussion, with dynamic engagement from the participants—and of course it will vary in different contexts. In addition, depending upon the composition of the group, it can be revelatory to note the ways in which writing styles reflect the ways people are trained and expected to write and think professionally. For example, clinicians will often break a narrative down into discrete sequential steps, with short sentences: *First this happened. Then this happened*—echoing the highly structured form of a clinic note or a patient history. In addition, it is interesting to note whether or not people write directly in the first person—how much they write themselves into the story, *finding* themselves in the experience—something clinicians and scientists are trained *not* to do, in a field where the passive voice is greatly encouraged and deployed. When we highlight such stylistic trends it may prompt a discussion about the ways in which participants have been influenced by their training and by the rubrics governing their professional thinking and writing. In such discussions, clinicians frequently note the length of time since they last had the opportunity to write in a more "creative" or open-ended format; sadly, it is often a long time in the past.

As facilitators we typically write and share what we have written as well, with the goal of forging mutual trust. We encourage all who share to read what they have written without prefacing or commentary. The premise is similar to that of a writing workshop, with an emphasis on what is written. Participants may have varying skill levels in writing and fluency, and it is understood that they are not evaluated on such abilities. Central to our work is the fact that people articulate things in writing quite differently than they do in speech, and reading what one has written expresses a different type of commitment and, again, creates a different kind of rapport in the room. Readers sometimes wish to qualify what they have written or to offer modest disparagement (*It's no good, I didn't get to finish . . .*) yet they are frequently pleasantly surprised by the work's positive reception—indeed, these short pieces often feel complete within themselves, without offering a sense of forced closure. Sometimes the writer is tempted to elaborate verbally on the story she has just read, though we try to forestall such extemporaneous storytelling. Likewise, there can be an inclination for others to respond to a written account with concerned questions about the writer's predicament. Such expressions of kind sympathy can be quite natural, but in this context they effect a change of register, shift the emphasis away from *forms* of expression, when in fact it is the mediation of the exercise that has, in many cases, allowed the person to share that particular

experience and the feelings that accompany it. Moreover, we preface these exercises with—and reinforce as needed—a caution about privacy, that even if an individual has chosen to share a personal experience in a workshop, others must respect each participant's confidentiality. In this context, writing about a topic is not an invitation to others to offer opinions or to have a conversation about the experience outside the parameters of what the writer has chosen to share. Two students in our master's program addressed this issue in a workshop they were co-facilitating; they described the episode as follows:

> One participant wrote about memories—and the wish to alter these memories—of hardship facing cancer. The writing was clear, imaginative, and powerful. However, other students, two in particular, began to ask questions about this personal experience, unrelated to the writing exercise. The questions felt prying and invasive: "How long have you had this cancer? Has it affected your schoolwork?" The participant was brave and willing to answer these questions, but this discussion was clearly too much for the workshop setting. We (the facilitators) turned the conversation back to his writing, and thanked him for sharing. Then [my co-facilitator] stated, stretching his hand out to the center of the table, "I would like to jump in, and point out . . ." He discussed the importance of commenting only on participants' writing during the workshop, and acknowledging the writing as a means of giving respect to people's stories and to their personal choices of sharing.

This incident exemplifies the risks of this work and the importance of proper training for facilitators who must frame the exercise with great care and model the response to participants' written work, emphasizing the structure and style of the text, practicing close reading with attentiveness and rigor, just as with the Munro story.

Conclusion

> Meaningful learning underlies the constructive integration of thinking, feeling, and acting leading to empowerment for commitment . . .
>
> Joseph D. Novak[29]

In medical training and practice there are few opportunities for attending to the emotional content of a difficult experience or encounter, or for deploying strategies to help one's patients or colleagues grapple with what discomforts or troubles them. Those strategies that are offered are frequently inept or inapt. One such ineffective strategy was recently parodied by two Columbia University medical students in a screenplay they co-wrote about third-year rotations, a

project they developed as part of a fourth-year project in narrative medicine. Here they depict a non–narrative-medicine curricular activity designed—with the help of a clown—to sensitize third-year students to be more observant and mindful of their patients' unvoiced emotions. The student, Elizabeth, is waiting outside the classroom to be summoned back to guess which emotion her classmates are expressing by miming gestures and facial expressions:

> INT. HALLWAY OUTSIDE GENERIC CLASSROOM – DAY
>
> ELIZABETH is waiting in the hallway and walks aimlessly for a moment before fixing her hair in the semi-reflective glass surface of a portrait in the hallway. She glances at her watch and then knocks on the door to the classroom. The clown opens the door and ELIZABETH walks into a silent room. Some students are sitting, some are standing, and they all exhibit empathetic posturing and facial expressions.
>
> One walks up to ELIZABETH and briefly places her hand on her shoulder. ELIZABETH looks confused and concentrates as she looks from student to student.
>
> ELIZABETH
>
> Pity?
>
> The students continue to look at her.
>
> CLOWN
>
> Close . . . empathy. So you see, we can convey a lot through body language alone. Humor can be equally important. So remember, you always have a red nose in your pocket!
>
> JAMIE takes an actual foam red nose out of her pocket, puts it on her nose, and sternly whispers to ELIZABETH.
>
> JAMIE
>
> You have cancer.
>
> ELIZABETH looks at her with confusion and disdain.

In this scene, the exercise (exaggerated here but not by much) does not have its intended effect; it takes the students, Elizabeth and Jamie, in the wrong direction, arousing their contempt. Elizabeth reads "pity" in the expressions of her classmates who intend to simulate empathy. Pity is no one's idea of a desirable emotion, so the scenario wittily undercuts the discursive distinction drawn in medical school argot between empathy—the approved affect—and pity. One looks just like the other, as far as Elizabeth is concerned, so what are we playing at? The clown's reminder that humor serves as an additional affective resource also backfires. Forced humor (in the form of a red nose) does not correspond with Jamie's state of mind, and instead the two students share a moment of *black* humor—a reliable, if defensive, fallback for medical students. Throughout their screenplay these medical students employ humor to explore the charged emotional dimensions of medical training, beautifully illustrating

such bundled feelings as eagerness and fear; inadequacy and self-importance; competitiveness and remorse for feeling competitive; loss of identity; and loss of free time (one medical student recently began to cry when reading a piece she'd written about taking half a day off from studying to take a walk in the woods). Along with these stressful emotions, the screenplay also depicts feelings of satisfaction and pride in accomplishments, joy in learning, admiration for colleagues and teachers, and a warm sense of comradery.

Similar to the possibilities opened by the screenplay-writing exercise, one of the unexpected consequences of the work we do with close reading and prompted writing is that participants often observe that they feel less afraid to approach difficult topics, experiences, or emotions. They command an increased confidence in their capacity to examine and metabolize what in the past they might have held at bay or fended off—including in consultations with patients. We don't know exactly how to account for this effect. Are we seeing an increase in affective agility? A greater creative and critical capacity to contextualize a moment or circumstance? A burnished trust that difficult situations and feelings can be explored without disastrous results? A greater confidence in others' ability to take in what one has to say, and that one can communicate with greater nuance? Unlike in the clown exercise portrayed above, our work focuses on connecting with others from where you are in a specific moment in time. Checking in with and working on yourself are part and parcel of the job for healthcare providers—for healers. A professional demeanor, like a red nose in your pocket, can come in handy but only goes so far.

In this chapter we have described some of what happens in a narrative medicine classroom or workshop. More than a sum of its parts, these procedures involve participants in a rigorous aesthetic experience, a collaborative and creative unpacking of a literary text or work of art, an opportunity to speak and/or write about something of importance, and the surprise and delight of commissioning language in a fresh way. When a group member shares an insight or experience in a candid fashion, the level of trust accelerates dramatically in the room. Participants find the activity of making sense of their internal experience—their responses to a work of art or to a recent professional encounter—deeply satisfying and *interesting*. As John Dewey might put it, they are engaged in an act of *integration*, of bringing together their professional, intellectual, and existential selves. Competition and mistrust, two enormous factors in the erosion of collegiality, are banished from the experience. Each person is engaged in asking questions and in allowing for the limits of their own certainty.

Notably, we do not ask participants to speak about their emotions or make the sharing of feelings an objective for the session. In a well-guided discussion of a story, a poem or any work of creative expression, feelings—with

all their ideational and social complexities—surface organically and not according to an assigned agenda. In the examples of prompted writings quoted above, we detect the presence of many different feelings; students, however, do not articulate these feelings directly, as in "this story reminded me of my guilt toward my sibling" or "this poem evoked the feeling of peaceful self-forgetting which I sometimes miss." Generally, we find that explicit or categorical expressions of this latter kind are less gratifying for the writer and listener both, whereas a more oblique or indirect delivery, by way of an image or as part of a storied memory, allows an emotion state to find more authentic expression.[30] To simply give a label to an experience does not necessarily bring us into contact with it or enliven it, nor does it express the complexity of our inner lives.

These many pedagogical elements produce a distinct atmosphere, one that is singular and experiential and belongs, in a sense, to the people in the room. John Dewey's theory of what he terms *an experience* offers one way to account for this rare alchemy in at least some of its aspects. In his book, *Art and Experience*, Dewey emphasizes that *aesthetic perceiving* is a commonplace experience; it is ubiquitous in everyday life and does not belong only to a trained or privileged few. The creative work of the artist, in its broad outline, belongs to all intelligent human activity. Like the making of art, the imaginative use of intelligence draws upon emotion, as does the aesthetic experience. Creative thought calls upon our many faculties. When we concentrate on a work of art, we approximate the activity of the maker; we become interested in noticing details and the connections between parts, we select and gather specific elements into a whole. This kind of aesthetic attentiveness draws us into a work of art, and, Dewey observes, it can draw us closer to aspects of our daily lives. Dewey is proposing that we can perceive aesthetically (in our terms, *close read*) events in our lives. Such activity can lift us out of our daily "non-experience" wherein we drift, evade, and compromise. "In much of our intercourse with our surroundings we withdraw;" Dewey writes, "sometimes from fear, if only of expending unduly our store of energy; sometimes from preoccupation with other matters . . ."[31] When we bring to our own experience the kind of pleasurable attentiveness we give to a work of art, then we have *undergone* something. In narrative medicine this *undergoing* allows people to meet one another in a different way. In such moments, aesthetic experience is not a solitary but a collective activity. For Dewey, such experiences help us to achieve greater aliveness.

Perception, Dewey writes, "involves surrender. But adequate yielding of the self is possible only through a controlled activity that may well be intense"—such as, we contend, close reading and prompted writing.[32] Inchoate happenings can, through aesthetic relatedness, find form and shape—and sometimes meaning. Addressing the role of aesthetic form in our mental lives, Dewey notes

that "the aesthetic is no intruder in experience from without, whether by way of idle luxury or transcendent ideality, but . . . it is the clarified and intensified development of traits that belong to every normally complete experience."[33]

One of the formative figures in early twentieth-century progressive education, John Dewey concerned himself with the subjective quality of a student's experience, focusing as much on process as on content, on *how* children learn as well as what they learn. By promoting a classroom culture where collaborative skills are honed toward developing creative solutions and where learning is understood to be a creative act that stimulates emotion and imagination along with thought, Dewey sought to create a classroom where learners and teachers are able to integrate elements of the self. Bringing one's whole (integrated) self to the task of teaching and learning is and should be a creative act—indeed, one on which responsible and active citizenship in democracy depends. In these and other ways, he offers a pedagogical model that informs our work in narrative medicine. Teaching is also a relationship of care.

In narrative medicine the attention to character actions, nuances, how the story is told, perspective, temporal unfolding, tone, images, and the rest is in the service of having an experience as Dewey describes it, and, as he implies, of creating habits of mind to become more noticing (via aesthetic engagement) of the dynamics of one's own experiences—with patients, colleagues, and institutional structures. This necessarily involves attending to crucial affective responses of bias, of making judgments, of uncertainty and impatience. Recognition that what one hears in someone else's story can depend on one's own experiences and state of mind can change everything—can be culture change. "Where am I in this patient's story?" and "Where am I in the story of healthcare today?" are questions that, if asked consistently and honestly, can change the face of healthcare.

Notes

1. Mitchell, *Relationality*, 67.
2. Moore, "People Like That," 237.
3. Shem, *House of God*, 33.
4. Shapiro, "Feeling Physician," 310.
5. Shapiro, "Feeling Physician," 310–11.
6. Goleman, *Emotional Intelligence*, 76.
7. Derald Wing Sue, *Race Talk*, 237.
8. Vogel, "What We Talk About," 12.
9. Worsham, "Coming to Terms," 105.
10. Shapiro, Movies Help us Explore," 22–23.
11. See Ofri, *What Doctors Feel*.
12. Shapiro, "Feeling Physician," 311.
13. De Leeuw, Parkes, and Thien, 6.

14. Frank, *Wounded Storyteller*, 159.
15. Poirier, *Doctors in the Making*.
16. See Shapiro, "Feeling Physician," and McNaughton, "Discourse(s) of Emotion."
17. Dewey, "Having an Experience," 51.
18. Munro, "Floating Bridge," 82.
19. Scarry, *Body in Pain*, 22.
20. Munro, "Floating Bridge," 60.
21. Munro, "Floating Bridge," 57.
22. Munro, "Floating Bridge," 56.
23. Genette, *Narrative Discourse*, 27.
24. Munro, "Floating Bridge," 55–57.
25. Munro, "Floating Bridge," 74.
26. Munro, "Floating Bridge," 76.
27. Munro, "Floating Bridge," 77.
28. Munro, "Floating Bridge," 84.
29. Novak, "Theory of Education," 1.
30. See Kuiken, "Locating Self-Modifying Feelings."
31. Dewey, *Art as Experience*, 55.
32. Dewey, *Art as Experience*, 55.
33. Dewey, *Art as Experience*, 48.