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Reflective Writing in Medical Education: A Writing Professional's Exploration of Purposes and Practices

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Abstract

The practice of reflective writing (RW), which tends to be exploratory prose employed for the purpose of helping healthcare practitioners grapple with psychosocial aspects of medicine, has become widely employed in medical education. Its entrance into the field in the late 1990s was a direct response to the *bio*medical model common in Western medicine, which situates patients as a sum of their biological parts and physicians as disembodied minds. While medical education has done an excellent job researching the efficacy of RW in addressing this dualistic model, very little scholarship has explored the theoretical and pedagogical approaches informing its instruction and production. As a result, essential questions and practices have remained unexplored in scholarly conversations, which sequesters knowledge within the confines of individual institutions and leaves those embarking upon their journeys as RW facilitators unsupported. Accordingly, through thick teacher research emerging from my experience as a RW facilitator in medical education and my field of composition studies' extensive theoretical and pedagogical engagement with related writing practices, I address this gap through several moves. First, emerging from student reflections and correlating feedback from members of our RW team, I present "listening," "guiding," and "encouraging" approaches to feedback, what I term a "feedback framework," and explore their individual functions and value in responding to subject matter and writing craft. Next, grounded in an illness narrative project I designed and implemented with second-year students, I outline student concerns relating to both the composition and sharing of vulnerable narratives and present facilitators with theoretical and pedagogical responses grounded in my teaching experience, composition studies, and the voices of students who

had transformative experiences. Third, through analysis of the writings from a small, third-year clerkship RW group, I present and explore students' use of writing to "cathart negative emotions," "process uncertainty in medicine," and "bear witness to the lives of others and self for the development of empathy," rhetorical moves that provide what I term as a "manageable framework" for understanding, discussing, and guiding RW work. Finally, drawing upon the pedagogical conclusions emerging from the research projects, I outline a comprehensive four-year RW curriculum in order to provide a foundation upon which RW instructors may tailor curriculum to meet specific institutional needs. In performing this work, I hope to contribute a composition studies perspective to the pedagogical understanding and practice of RW in medical education in order to strengthen this important work and, as a result, aid in the process of helping students become the type of empathetic and thoughtful physicians making medicine a more humane practice.

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Introduction

By writing about traumatic experiences, we discover and rediscover them, move them out of the ephemeral flow and space of talk onto the more permanent surface of the page where they can be considered, reconsidered, left, and taken up again. Through the dual possibilities of permanence and revision, the chief healing effect of writing is thus to recover and to exert a measure of control over that which we can never control—the past.

~Charles Anderson & Marilyn MacCurdy

This dissertation is about lives and the stories they write. Or, perhaps, it's about stories and the lives they write. Some would say there is no difference. It seems fitting, therefore, that I begin with stories for a couple of reasons. One, this work is about unifying the illusion of separation between body and mind, emotion and intellect. To understand the research contained within these pages, it is important to understand who I am as human and why I do what I do, what is termed "exigency" in my academic work. And, beyond the meaning I attempt to convey through story, I would also like to show how I have used writing to process what has happened in my life, to have a sense of agency over uncontrollable experiences, to let go of toxic emotions, to bear witness to the lives of others and myself. This brings me to the second reason why I want to begin with story. My wife Danae died of brain cancer in October 2016 and left a two-year old daughter and four-year old son behind. And me. I don't disclose this for pity, though empathy is always welcome. Rather, I disclose this because it is essential that I bear witness to her, to acknowledge that were it not for her beauty and, tragically, her suffering, I would neither have begun nor finished this research. No chance. Therefore, I include the following stories for her. Third, and more academically—though, particularly in this context, the separation between personal and academic is problematic—I use two terms throughout this dissertation to describe two quite different philosophical models of

medicine: "*bio*medical" and "*bio*psychosocial." I will, of course, define these in the clear and straightforward language of scholarship. However, since stories contextualize, enrich, and embody meaning, I thought it useful to first present them in the language of lived experiences. Finally, the following stories illustrate how medically orientated reflective writing can look, and, hopefully, demonstrate the power of this type of writing to grapple with and bear witness to the challenges of navigating through medical trauma.[1]

A Bio*medical Model: "Fixed up"*

I'm seated in the corner of a large ENT examining room at Stanford Hospital. My wife Danae occupies what looks like a chair out of a science fiction film. Long instruments protrude from a gleaming, sterile machine floating above her and, as the doctor reaches for a slender camera and suction tool to be inserted through her sinus to the border of the brain cavity, I see her grip the arm of the chair in terror. The doctor is soft spoken and not unkind. But, after he'd asked how she was doing when we first entered and she answered, "It feels like my head is slowly being crushed," his response had been, "Hmm, well, let's take a look and see if we can help." End of conversation. And that's what he does. Her sinus and, eventually, the base of the nasty tumor are projected onto a massive television screen on the wall. She doesn't want to see it and shifts her head to avoid the image. I don't either; yet I watch. The ENT, oblivious to the cause of her movement, asks her to keep her head still. Frustrated, I tell him, "She doesn't

[1] It is important to note that my more polished, narrative approach to reflective writing is not necessarily how it always looks. Many students produce texts that are more along the lines of "contemplation in writing" to the point of nearly being stream of consciousness at times. Also, *all* names throughout the dissertation have been changed to protect anonymity *except* Dr. Van Meter whose compassionate care deserves to be attached to her identity.

want to see the tumor." Without looking up from his work, he says, "Okay, sure, I understand," and rotates her chair away from the screen. A nurse enters to assist him in the suctioning of dead tissue and, as the process begins, Danae begins to cry. I get up and cross to her but there's not really space for my presence there. So, after I give her hand a squeeze, I return to my chair. The nurse, seeing Danae's distress, tries to be my surrogate and holds her hand. A small move. A big gesture.

At this moment another physician enters the room with a clipboard and a cadre of medical students. They spread into a half circle around Danae like pedestrians watching a street performer. Some of them seem eager, some anxious, and some have a deep exhaustion in their eyes. They stare at the television screen and listen while their attending physician, their mentor, talks about Danae without a hello first. "The patient's diagnosis of osteosarcoma was originally complicated due to an aberration in symptomology, which indicated muscular . . ."

What the doctor does not know is that Danae is an elementary school teacher, a yoga instructor, an avid dancer, a mother of a one-year-old daughter and a three-year-old-son, and a woman who had saved me in more ways than one. He does not know that she felt beautiful before cancer mutilated her face and blinded her eye. He does not know that the wretched smell coming from her nose and the massive swelling in her ankles, neck, and back from the steroids have robbed her of her dignity and ability to move with ease. This is irrelevant for the lesson at hand. After some question and answers with the students, the attending physician thanks the ENT and, smiling at Danae, tells her, "I hope they get you all fixed up young lady." Not once is my presence acknowledged in any way by the man. As the procession departs, one young woman splits from the group, walks

over to Danae, and says, “I’m so sorry this is happening to you.” Then, looking over at me, she adds, “to you both” before scuttling off to catch up with the group that had left her behind. Again, like the nurse holding Danae’s hand, the small gesture is huge. While I’d already been in similar situations many times during our cancer struggle, this is the first time I consciously think, “There is something very wrong happening here.” And later, as I struggle to sleep in a recliner chair beside her hospital bed, I wonder if there is anything I have to offer to help change it.

A Bio*medical Model: “The Deli”*

She sits on wax paper, her back exposed despite my efforts to cinch the gown shut. It doesn’t fit. I get up from a chair and attempt to pace but the room is too small. We’d sat for four hours in the waiting area playing Yahtzee, talking about Christmas plans and, like always, chatting about our two toddlers. Normal conversation, almost as if we were waiting sitting in a coffee shop passing time. Except, it had felt profoundly hollow. Whistling in the dark.

An older man with silver hair, a reputable surgeon at a top-notch medical institution, bustles into the room, eyes on a chart in hand, and says, “Hi Danae, I’m Doctor Edwards. Nice to meet you.” She thanks him for seeing us and tries to exude an air of optimistic bravery, but her trembling hands tell a different story. Sitting in the corner, invisible, I feel the same. Without preamble, as if explaining an insurance policy, he tells her, “Unfortunately, the new CT scan shows more growth than we expected. No new masses, but there are offshoots, like tentacles, surrounding a major artery in the frontal cortex.”

We absorb this news silently. Then she asks the million-dollar question. “Can it be removed? Can you get it all out?”

He pauses for second and I hope for hope, but he continues with the facts. “What we can do is enter through your sinus and hollow out the primary mass. But, from that point of entry we won’t have access to the newer growth. The only way to get to at it surgically would be to enter from the side of the skull.” He steps over and runs a finger from her hairline down the temple demonstrating where the hypothetical incision would take place, his finger an imaginary scalpel. It’s the first time he’s touched her. “But,” he continues, “it would be a terribly disfiguring and risky procedure. And, to be honest, I doubt even this aggressive approach would be entirely successful. So, we’ll get as much out as we can through the sinus and, hopefully, buy you at least a year.” It’s the first time we’ve been told her cancer is terminal, that she is going to die for certain. Reality turns hazy, like a fever dream. She starts to cry, and I go to her. The doctor says something about radiation treatments possibly extending time even further, an attempt to soothe, but it’s an afterthought.

The rest of the visit is a blur of complex medical information and logistics that I am unable to process despite the fact I’m supposed to be writing this stuff down. I feel like a little boy. Afterward, on our way out, she rushes into a family bathroom to vomit. I hold her hair, but nothing comes out. We haven’t eaten. Back in the car, as I try to figure out how to exit the hospital maze, she’s unusually silent. I don’t know what to do. I don’t know how to find help. I don’t know how to save her.

That night I pull out my laptop and write. It doesn’t cure her tumor, but I get to vent and figure out what the hell is happening. Or, at least, put some structure to it. And, I

get to cry. After posting the day's story online, fifteen emails arrive within an hour, and I read them over and over again while she sleeps.

A Bio*psychosocial Model: "Specialized"*

The first time we meet Dr. Margaret Van Meter, my wife's new oncologist, she bustles into the small exam room carrying a tablet, her energy rushed and nearly discombobulated. I expect quick introductions and then straight to the business of staving off death—what we'd gotten used to. Instead, she flops into a chair next to the wax-papered exam table upon which Danae sits. Margaret, as I would come to know her, lets out a big breath, smiles, and says, "Sorry, it's a mad house out there today; we've been backed up since 8am." She's young, mid-thirties—Danae's age—and there's something about her that feels, I don't know, approachable. Like a new teammate. After catching her breath, she takes close to thirty minutes to ask us questions about our journey with cancer, including if we have any kind of emotional support. So far, only nurses had asked us that. What really surprises me is that while Danae tells Margaret about a seizure she'd had and includes a vast amount of details that, from my perspective, are irrelevant, Margaret listens. As in, really listens. Head nodding. Small comments and questions inserted for clarification. Afterward, as we leave the office, Danae says, "I like her. A lot." Although Margaret hadn't told us any great news, the rest of the afternoon Danae is in an unusually good mood.

We continue to see Margaret over the course of the next year. Danae goes blind in one eye. A hump begins to grow at the base of her neck from steroids. Her hair litters the shower floor like dead soldiers. She has seizures with increasing frequency, speaking gibberish for ten, twenty minutes after, sometimes getting angry when I don't understand.

But, even as Danae's ability to coherently communicate wanes and her desperate search for miracle cures increases, Margaret listens with patience despite an ever-full waiting room. In fact, she's far more patient than I. Danae tells her about an article on the miraculous properties of CBD oil for shrinking tumors. Margaret listens and, when pressed to give her opinion, simply comments, "Well, to be honest, the research isn't really supportive of its efficacy, but it certainly won't hurt and, you know what, I have seen things that amazed me. So, go for it." The only time I see Margaret frustrated is when Danae tells her about a "tumor shrinking diet" involving "starving the tumor" through horrible dietary restrictions. When Danae argues after Margaret states that the diet is not legitimate, Margaret pauses for a long moment and then says, "I've spent most of my adult life trying to find everything I can on helping people heal from cancer. Believe me, if there was evidence that this was effective, I would know about it. Try to trust me. You have enough on your plate without feeling miserable due to a starvation diet." Danae accepts this with a nod. She does trust Margaret.

Once, near the end, we are in the middle of an office exam when the fire alarm goes off, the piercing tone shattering reality and frightening an increasingly childlike Danae. We "bustle" out to the sidewalk as quickly as possible and join the crowd of patients, many of them bald, trapped in their own private hells. Suddenly, Margaret is beside us, her hand gently laid on the hump at the base of Danae's neck. Not an exam touch. A touch of reassurance. Like the way I lay my hand on my two-year old daughter's back when she's scared there's monsters in her room. But, to my surprise, she does examine Danae, taking vitals with her fingers and watch, softly palpitating areas of

Danae's body. It's such an oddly compassionate vision, the street exam. I can't tell if I want to cry or laugh.

Six months later, two weeks before Christmas, Danae is gone, her ashes filling a little box I tenderly wrapped in the sarong she'd bought in Bali an afternoon we'd rented motor scooters. I keep thinking about thanking Margaret, so one day I walk into the oncology waiting room carrying a letter and a small pot with a juvenile Christmas cactus, a plant I'd chosen because they live 20-30 years with proper care. Per usual, the room is full—weariness and suffering nearly palpable in the air. I have no expectation to see Margaret. I hand the receptionist the plant and letter, tell her that it's for Dr. Van Meter and am turning to leave when Margaret hustles past in the hallway behind the divide. She glances over, sees me, stops in her tracks, and then heads my way. I tell her, "I just wanted to drop these off for you. I wasn't meaning to interrupt." She shakes her head as if what I had said was ridiculous and asks, "Do you have time to talk?"

A minute later she ushers me into a dimly lit, unused waiting room with boxes stacked in the corner. I sit on a chair next to the examining table, my usual spot. She sits on a cushioned rolling stool, her usual spot. Except, this time she rolls forward and stops a couple of feet across from me. Face to face. "How are you?" she asks in the way people do when they really mean it. With no premeditation, no control, my calm gone, I say, "I miss her so much," and start to cry. She's silent, and I wonder if I've made her uncomfortable until I notice tears rolling down her own cheeks. "I'm sorry," I say. Again, she shakes her head. "No, I'm glad you came." After another pause, she adds, "I wish I could have done more." And, then I tell her the same things written in the letter. That Danae liked her so much. Felt safe with her. That doctors had frightened us so many

times without even realizing they had done so. I tell her about how my children don't understand that their mommy wouldn't be coming home. How they keep asking me when she's coming back. I tell her that I'd been offered a position teaching writing at the medical school starting the following summer. That I was hoping to help students become doctors like her. She laughs good-naturedly at this, slightly embarrassed, and says, "I think you're giving me too much credit, but thanks." She writes down names of several books for me on her prescription pad, books exploring grief and one written by a doctor who advocates for medicine grounded in empathy. We talk for a couple of minutes longer and, before I leave, I ask, "How do you do it? How can you care so much and not eventually fall apart?" She pauses thoughtfully and then replies, "Well, Danae's case was especially tragic. Most of my patients are geriatric, which doesn't make it not sad, but, I don't know, it's different when patients are young." Smiling, she adds, "I really liked Danae. She seemed special."

As I leave the building and head toward my car, I think, "So are you Margaret."

Chapter 1: Exigencies, Research, and Objectives

In the Fall of 2017, I was hired by the University of Nevada, Reno School of Medicine to serve as a reflective writing (RW) researcher, program developer, and facilitator. As RW in medical education (Med Ed) is an interdisciplinary approach situating writing as a multifaceted, embodied, exploratory process through which meaning and human connections are made, they decided that having someone with a range of experience teaching and who was trained in a humanities-based, writing-focused field such as Composition Studies (CS) would add a useful dimension to a team of medical educators in the early stages of developing a RW curriculum. Furthermore, beyond my training as a writing professional, a reflective blog I maintained during my wife's eighteen-month battle with brain cancer, a battle she tragically lost, caught the attention of the curriculum director due to its vulnerable engagement with high intensity, heavy stakes medical contexts. In a sense, both my work as a writing teacher and as a reflective writer resulted in a program development and facilitation position at the medical school.

I fell in love with the work for multiple reasons. For one thing, the personal exigency I presented in the forward to this dissertation became named. I learned that RW had emerged in the field of Med Ed as a direct response to the type of medical callousness my wife and I had experienced at times throughout our grueling journey, the model of medicine illustrated by the physicians described within the first two narratives in the introduction. I learned that this calloused approach to medicine was a result of a long history of dualism in medicine—the situating of the patient as a *bio*machine in need of repair and the physician as the disembodied knower. I learned that this dualistic

approach to medicine had become entrenched in the field of Med Ed as a result of a 1910 Carnegie Foundation educational report emphasizing scientific knowledge over all else in its assertation that "every departure from this basis is at the expense of medical training itself" and that this approach to medicine is known as a "*bio*medical model" (Irvine and Spencer 69). I also learned that the type of compassionate care we received from Dr. Van Meter reflected a "*bio*psychosocial model" which honors the intersections of one's psychological, emotional, spiritual, sexual, social and physical being. I learned that this model emerged from humanistic movements such as narrative medicine out of which RW practices in Med Ed were born. I was given a framework to understand both the trauma and the compassion we had experienced. My personal exigency for engaging with RW work and eventually this dissertation was named.

I fell in love with the work because from a professional level it provided an incredible and rare opportunity. I was shocked by the lack of conversation and collaboration between CS and RW work in Med Ed. Here was an entire field of writing taking place that had gone virtually unnoticed by CS despite the fact that the study and facilitation of writing practices of all kinds in any context is precisely what we do. This is not to say that CS scholars have been completely absent from conversations. For example, chapters within Charles Anderson and Marilyn MacCurdy's seminal edited anthology *Writing and Healing: Toward an Informed Practice* reference voices from narrative medicine. Similarly, CS scholar Kathleen M. Welch conducted an ethnographic study during a literature and medicine course emphasizing RW and engaged with related scholarship from Med Ed ("Interdisciplinary Communication"). Conversely, I have seen numerous references to Anderson and MacCurdy in Med Ed literature, and I was pleased

to find an article from medical educators Delese Wear and colleagues noting, “In spite of the widespread presence of reflective writing in the medical curriculum, educators have not yet mined the rich vein of composition studies . . . The theory and practice of this field can guide not only the way in which medical educators think about why, how, when, and where students are asked to write (versus merely discuss), but also the way in which writing is framed as an important part of the reflective process” (605). However, other than a few exceptions, communication has not been taking place. As Welch notes, “The single largest divide in academia is centered between humanistic and scientific disciplines” (*Resistance and Reflection* iii). Accordingly, I found another exigency for the work of this dissertation, which is to continue to bring CS into the dialogue so that we may contribute our unique specialization in the study and teaching of writing to this important work.

I fell in love with the writing taking place in Med Ed and the students themselves. It turned out that my practice of the previous three years, what I had thought of as “life writing,” was known as “reflective writing” in a healthcare context, writing that releases, processes, and bears witness the psychosocial aspects of experiences. Though I had worked with incredible students producing incredible writing in my decade of teaching, very rarely had I encountered writing of such vulnerable honesty, of such trauma, of such expression of purpose. It was not restrained by traditional academic conventions and forms of evaluation. It was not expected to result in a polished product though, ironically, it yielded some of the most fluent pieces of writing I had ever received from students. I learned of their histories with illness, with death, with abuse, with the births of their children, with leaving home for the first time. I learned of the traumas of medical

education, of the grueling hours, of the fierce competition, of the pressures of culpability to patients' lives and, hardest of all, deaths. I learned of their passion and excitement to pursue medicine, of their incredible dedication and drive. I came to know these students at an intimate level and both respected and empathized with them. Like myself, many of them were in pursuit of more than just a career with a good salary and social status. They had purpose and wanted to become humanitarian healers. Helping them do so provided another exigency for this dissertation.

Despite my love for the work, however, it was far from easy and, as I continued to design and facilitate projects, I became increasingly aware of gaps in my knowledge. Navigating through the instruction of highly vulnerable writing in a Med Ed context was an entirely different world than teaching undergraduate composition courses in the English department. Difficult questions arose. How should I respond to students who described severe struggles with mental illness or who were resistant and/or apathetic? How should I conduct group work in a manner that both honors students' feelings while also meeting the objective of nudging them into the vulnerability of a patient's perspective? How should I effectively implement projects when they were on the periphery of the curriculum (or disconnected altogether) and there was little to no time to scaffold the work with students? How should I justify the RW curriculum to the administration so that it would not be viewed as merely an extracurricular wellness exercise? So, while quite a bit of my experience teaching writing transferred over, and I have always been fairly adept at working intuitively, I also recognized that a firm theoretical and pedagogical foundation was needed in order for me to do my job effectively and, importantly, guide others at our institution who were involved with the

facilitation of RW. I turned first to Med Ed scholarship for answers and discovered that, while they have been diligent in exploring the exigency for the work (the *why*) and the results of the work (the *what*), the literature was lacking in the specifics of *how* to do it. I turned next to CS and made two discoveries. First, there is a significant body of scholarship on writing practices similar to RW in Med Ed, practices most often labeled as "writing and healing" or "trauma writing." The second discovery I made was that while my CS training had been fairly comprehensive, I knew very little about efforts in these areas, particularly more recent scholarship. Again, though this time for a more personal reason, I realized that acquiring and sharing related research from CS was an important exigency in that I needed this grounding for my professional identity.

Therefore, this dissertation is an honoring of the RW work with which I fell in love and movement toward responding to the exigencies I have identified. Early in the dissertating process, my mentors suggested that a great way to approach the project might be to "write the guide" I wish I had had when beginning my work with RW. This text is my effort toward that end.

In terms of structure for this introductory chapter, I begin by outlining the three RW projects from which the research of this dissertation emerged and the methods I employed in data analysis and production of scholarship. Following this move, I identify the gaps in practice revealed during the research process. Specifically, I note the shortage of detailed, pedagogical scholarship in the field of Med Ed regarding: 1) practices in providing feedback to RW; 2) the design and facilitation of vulnerable writing projects involving group work; and 3) the function and value of RW produced by writing groups during clinical training. Next, I outline the literature in Med Ed engaging with these areas

and note the field's overall shortage of detailed pedagogical practices (particularly of the variety that emerge from teacher research and student voices). In response to this pedagogical gap, I then turn to CS literature and introduce relevant research and conversations taking place within the field. Finally, I offer chapter summaries to provide an overview of research findings and how the data will be presented.

Background on the Projects

I developed and implemented three RW projects at the University of Nevada, Reno's School of Medicine in 2018-2019, the projects upon which this dissertation is built. Doing so was an effort toward performing my job more effectively, particularly as the university was interested in expanding the employment of psychosocial training, and an effort toward providing authentic research sites for my dissertation.[2] The first project, unlike the other two projects which I guided independently, was facilitated by a team of seven comprised of four medical educators with eclectic backgrounds, two second-year medical students, and myself, a writing professional. Following a face-to-face introduction to RW and several in-class writing sessions during orientation, the project involved assigning Year-One students RW prompts through our online platform for the duration of the academic year. The goal of the work was to provide students a compositional space in which they could explore the psychosocial realities of their training in order to help them process difficult experiences and develop/maintain empathy for others and self. Toward this end, we tailored a schedule for student

[2] Though, to offer my embodied truth, the primary reason I engaged with this work was because I believed in its value and wanted to share this type of writing experiences with students.

reflections based upon time periods involving potential stressors, major experiences, and significant transitions. With input from the team, I designed our prompts accordingly (there were a total of six). We also established a system for providing feedback that involved my collecting all sixty-seven of the students reflections, removing identifiable headings, distributing these to team members for anonymous reading and response, and then returning them to students with the responders' names identified.[3] One of my responsibilities throughout this process was also to organize RW team meetings to discuss objectives, prompts, timelines, and student reflections.

The second project I designed and implemented involved sixty-six second-year students writing and sharing illness narratives. This was inspired by narrative medicine pioneers Sayantani DasGupta and Rita Charon's work with illness narratives at Columbia University's Medical Center. The goals of this project were to: 1) situate students in a patient's perspective through the practice of vulnerability; 2) develop trust in teammates; and 3) move against the dualistic notion of the physician as a disembodied mind. In the first step, students were introduced to the project during an orientation session in which they discussed introductory readings, asked questions, and began the writing process through brainstorming activities. Following this, students wrote their illness narratives which, in this context, are defined as accounts of illness/injury experienced directly by the student or someone with whom they had a personal relationship (the primary guideline is that narratives must be about how the experience affected the student

[3] Quite a few students would intentionally identify themselves within their writing. A future study examining student desire (or lack of) for anonymity would be valuable toward helping RW facilitators effectively design writing projects

personally). Once the narratives were completed, we then met in groups ranging from seven to eight so that students could read their narratives aloud and receive feedback from group members. Once this process was completed, I responded to students individually and solicited feedback regarding their experience with the work.

The third and final RW project explored within this dissertation was likewise inspired by Rita Charon's work at Columbia, though, in this instance, it borrowed from the practice of having students in clinical training write "Parallel Charts," which is the practice of documenting the types of psychosocial thoughts and feelings arising during patient interaction that would be inappropriate to note in medical charts. Essentially, it is composing a "larger understanding" extending beyond the confines of a *bio*medical framework with the goal of helping students consider the psychosocial realities of patients *and* themselves. The iteration I designed involved eight third-year students who regularly wrote Parallel Charts regarding their interactions with patients, families/loved ones of patients, and other healthcare workers. Their writing ranged from stream-of-consciousness to essays to short stories with the only "rule" being that they honestly engage with the types of thoughts and feelings excluded from traditional Med Ed curriculum. We met as a group for a total of five sessions, during which time group members shared their writing and offered each other feedback on both how the pieces were crafted and the experiences described within the writing. As the facilitator, I organized the meetings, offered students feedback during the sharing sessions, and provided guidance through online communication.[4]

[4] I also shared my own reflections if time permitted, an act that would benefit from further exploration in future research.

Research Methodology

An observation I made early on in my work at the medical school was that my research orientation for research differed from several of my colleagues. Whereas their interest for examining RW was in testing predetermined hypotheses through quantitative tools, I was approaching the research process from a Grounded Theory orientation, a qualitative method which "allows theory to emerge from the data collected" and "emphasizes relationships between members of groups, as well as the relationships of groups to each other" (Nye 397). In other words, I wanted to perform the RW work in order to *discover* what emerged from the process and, accordingly, focus research on understanding, organizing, and labeling the emergent data. Furthermore, I wanted to do so in a manner that moved against what medical communication scholar Laura Ellingson notes as a tendency in healthcare research "to reflect social science norms that frame the researcher's personality, body, and other sources of subjectivity as irrelevant" (301). Toward this end, the work conducted throughout this dissertation relies upon thick, embodied, teacher research and the stories and lives of the students involved in order to allow for lived experiences to determine the pathway of knowledge production. Accordingly, I draw from CS approaches to research that position "experience as a source of knowledge" (Patsavas 205); narrativity as "a dominant form of rationality" (Spigelman 74); a theory of writing "as a way of being" as movement against Cartesian divide (Yagelski *Writing as a Way* 33); and approaches to conducting research that employ "story, testimony, observational anecdote, [and] informal analysis" as orientation toward "our humanistic roots as writers" (Bishop "Teaching Lives" 134). I also draw from Narrative Medicine scholar Rita Charon who posits that "narrative knowledge, by

looking closely at individual human beings grappling with the conditions of life, attempts to illuminate the universals of the human condition by revealing the particular" (*Honoring the Stories of Illness* 9). In terms of a specific method for data analysis, I employ nursing researchers Lorelli Nowell and colleagues' qualitative, six-phase approach to thematic analysis due to its veracity in "examining the perspectives of different research participants, highlighting similarities and differences, and generating unanticipated insights" through identification, analysis, organization, description, and presentation of emergent themes from the data (2). Finally, IRB approval was obtained for all three projects and, for protection on anonymity, I have employed pseudonyms for all participants.

Gaps in Practice Revealed During Research

As the year in which the studies took place progressed, and I continued to design and implement RW projects across the curriculum, many questions arose relating to *how* such delicate work should be conducted. Year One's online RW project, for example, generated a great deal of questions regarding how to effectively provide feedback. One of the earliest indicators of this gap was when I began to gather team members' responses to students and noticed radical differences in the orientation and structure of their feedback. It was clear that we had different conceptions of purpose and approach in responses, which begged numerous questions. First, and foremost, what was our purpose in responding to students within this context? If our objectives were to promote mental health and empathy through the act of writing, how would specific types of feedback work toward helping students with those goals? Along these lines, should we be commenting on the writing craft (how the piece was written in terms of language use,

organization, and style) and/or aspects of the content (the experiences and feelings they describe within their reflections)? Would it be callous to ignore a student's confession of severe depression and simply note language use? Conversely, would it be risky to speak to their issues and offer encouragement or guidance when we are not trained counselors? Should we be taking on the role of an advisor or, perhaps, just a listener?

To illustrate the complexity of the work, I received a reflection confessing to severe mental health issues and a history of self-harm when they arose. However, the writer did not express intent to self-harm and, therefore, did not put me in a mandatory reporter position. I wrote a two-page response and, later, was urged by a member of the team to have a face-to-face conversation with the student. In hindsight, I believe both these actions were mistakes, particularly the latter in that I violated our promise to the students that they could be honest in their writing without repercussion. How then could I have offered feedback in a way that honored the writer's experiences and vulnerability, guided their writing process, and provided them with appropriate resources without taking on the therapist mantle? A critical sub question was how much of ourselves is appropriate and useful to include in feedback? All of us responders had relevant *ethos* and experiences to offer and, in sharing of ourselves, we hoped to indicate active engagement with student writing and demonstrate our own willingness to be vulnerable. Yet, in including our stories, were we co-opting student texts? Were we crossing boundaries and imposing ourselves in potentially uncomfortable ways? In considering all of these questions, I realized I had been operating from an odd mixture of CS studies training, intuition, my history as a writing teacher, and my identity as a grieving man who was able to empathize with students' educational trauma and exposure to medical

violence. This does not mean that my feedback was poor—I received a lot of great responses from students—but it was risky in its potential threat to boundary violations and illustrated a gap in knowledge. Furthermore, as the writing professional of the team, I had a responsibility to guide other responders in addressing these same questions. Should we be basing feedback on a rubric? Should I be conducting trainings?

Year Two's illness narrative project, likewise, revealed multiple questions in terms of *how* to design and facilitate highly vulnerable writing projects involving group sharing. For example, unlike assignments in composition courses that are afforded days of scaffolding, I only had a single class to introduce the project and begin students on the writing process. What, I wondered, would be the best way to use our limited time? Should I assign readings to discuss? Should I assign them a prewriting prior to the first class? Should brainstorming activities be done individually or as a group in this context? How much time would be needed to explain the theoretical underpinnings of the work? I questioned the efficacy of heavy scaffolding for students already anxious about writing and overworked in general. Yet, I knew they needed guidance.

Exit surveys and verbal feedback revealed pedagogical questions regarding the writing process as well. For instance, despite the fact that the narratives were not graded and the psychosocial objectives of the project were explained, a fair number of students reported feeling high anxiety regarding "doing it right." This type of anxiety is counterproductive and raises the question of how best to mitigate this fear for students. Similarly, some students worried that employment of creative nonfiction writing techniques to give form and depth to their stories (i.e. creating dialogue for a childhood event in order to capture the essence of the experience) was dishonest even though,

unless an author has a photographic memory, recreating settings and conversations is often a necessity for illness narratives. How then should I have explained and prepared them for this aspect of the practice? Lastly, several students reported feeling emotional distress while writing about traumatic experiences. How and to what extent should I have introduced mental health issues and resources in preparation for this exigency? Clearly, listing the campus counseling center on the assignment sheet and suggesting that they quit writing on a topic if it was too emotionally difficult was insufficient.

Finally, student feedback, as well as my own observations on the sharing process, generated a fair number of pedagogical questions. For example, should students who are opposed to the project be required to participate? What are the best ways to respond to claims that sharing illness narratives is irrelevant and/or inappropriate for medical education (a shocking claim for this context)? Is sharing one's illness experience professionally risky? If so, can this risk be mitigated? A concern I did not expect was that some students felt that their narratives were not traumatic enough and, therefore, invalid. How should this issue be addressed? Similar to emotional distress while writing, some students also worried that the sharing process could be traumatizing. Accordingly, what is the best way to prepare them for work of this nature? Perhaps the most significant questions arose regarding how to facilitate the feedback process. Specifically, what types of feedback are appropriate for students to offer each other? What are the best methods for teaching them how to do so? And, how should a facilitator handle inappropriate feedback (i.e. too long, overly directive, insensitive, etc.)? Hopefully this extensive list of pedagogical gaps does not give the impression that the project was a failure. The opposite

is true despite some difficulties. However, to successfully facilitate projects of this nature, the questions posed above need to be addressed.

For Year Three's Parallel Charting group project, data from the experience of facilitating it, students' entrance and exit surveys, and the writing they produced revealed three categories of questions to which this dissertation responds. To begin, questions arose regarding logistics—*how* to best organize a group of this nature. For example, scheduling group sessions was quite challenging due to their chaotic schedules and even travel out of the area for different rotations. What, therefore, is the best approach for ensuring maximum attendance? Relatedly, due to difficulty with attendance at the end of the experience, we ended up meeting in smaller groups a couple of times, an experience several students noted they appreciated. This begs the question of what is an optimal group size and should groups subdivide at times? Likewise, how often should groups meet in order to foster writing habits and maintain group intimacy without overextending students' time? And, speaking to intimacy, what are the best methods for developing and maintaining group rapport?

A variety of curricular uncertainties likewise arose from the data. For example, students noted a desire to have prompts provided more frequently, something I had avoided in order to promote autonomy with topic selection. What, therefore, would be a good approach to including prompts in the curriculum and what types of prompts would be beneficial? Similarly, as students noted that they had difficulty gaining momentum with the writing process at times, I was reminded of the creative nonfiction writing exercises I had been exposed to in independent community writing groups in the past, typically at the end of a session. How might these look within a small RW group in a

Med Ed context? Lastly, how should the feedback process work between group members (including the facilitator)? I left it primarily unstructured, yet several students noted that it felt like sessions were sometimes rushed by the end as a result of earlier readers receiving lengthy feedback (or the group getting sidetracked by stories).

To conclude, as I will explore in the following section, there is a great deal of Med Ed scholarship on exigencies and outcomes of RW projects of this nature. My interest as a writing professional, particularly one who is searching for best teaching practices, is in *how* their writing functions (the rhetorical moves they make) toward achieving the purported outcomes.

Gaps in Reflective Writing Scholarship

Med Ed is not silent when it comes to pedagogical practices in RW. One can find, for example, mention of a variety of different writing projects taking place. Sayantani DasGupta and Rita Charon's work with illness narratives and second-year students, the project upon which our illness narrative project in chapter three is based, outlines the exigency and assignment schedule for their course. Rita Charon's concept of the Parallel Chart, which informs chapter four of this dissertation, delves into the details of her teaching process and includes student voices and a superb section on feedback (*Honoring the Stories* 158). Victor Sierpina and colleagues note an assignment in which students are sent to patients homes to gather stories (not "medical histories") as a way of bearing witness and connecting with community. J. Donald Boudreau and colleagues provide a detailed structure of a faculty development workshop for teaching RW practices that includes prompts, writing excerpts, and a general overview of the attendees' engagement. Maura Spiegel and Danielle Spencer provide a detailed account of a narrative medicine

course they teach, including student writing, reading suggestions, and a variety of prompts. And, Geoffrey Z. Liu and colleagues report on a RW workshop for third-year students, including the structure and prompts.

Similarly, there are voices in Med Ed discussing what I hear described in both our fields as the "the nuts and bolts" of teaching writing. For instance, Hedy Wald's article on a "practical approach" to guiding students in RW provides pragmatic tables and charts outlining structures grounded in narrative medicine for constructing field notes (she even has a "nuts and bolts" section). Shmuel Reis and colleagues explore the value of offering students feedback to their "field notes" and design a standardized rubric for guiding the process. Similarly, Hanke Dekker and colleagues explore the types of feedback characteristics that "stimulate students' reflective competence" (2). Nellie Hermann, in her rich exploration of teaching "creativity" to medical students, draws on assignments, handouts, and student writing to make a case for creative nonfiction work in medical training. Johanna Shapiro and colleagues examine both the writing and reading/listening phases of RW and explore the practice's ability to reach its pedagogical objectives from a variety of angles. Finally, though not exhaustively, Allan Peterkin's *Portfolio to Go* provides long lists of RW prompts (including a few example responses from students), which are categorically arranged to address different types of exigencies emerging from medical training.

Despite the presence of scholarship of this nature, a primary exigency driving my work is that the field of Med Ed, though producing valuable RW research, has a critical gap in their scholarship regarding: 1) the nuts and bolts of curricular design such as specifics on scaffolding exercises, course structure, and feedback; 2) thick teacher

researcher reports detailing teaching practices and psychosocial interactions with students (particularly complicated ones); and 3) hearing more directly from students' voices as they are the RW writers and the focus of this work. Admittedly, as my dissertation research progressed, and I continued to discover examples of Med Ed scholarship performing this type of research, the type of research for which CS advocates, I became anxious. Was I falsely identifying a gap in the field? Was I being unduly critical of the very community into which I was entering and respected? The answer is no on both counts. However, this answer requires explanation.

To begin, as Lindsay Holmgren and colleagues note, there are thousands of scholarly articles in medical humanities journals on the employment of narrative in medicine, many of which deal directly with writing in medical education (246). Therefore, the relatively small body of literature engaging directly with the type of pedagogical scholarship for which I advocate illustrates the existence of the gap. Second, while the scholarship I present above is doing valuable, pedagogical work and provides a basis for several of my projects, several of them still illustrate aspects of the gap. For instance, while Alan Peterkin's incredibly pragmatic text provides a wealth of useful RW prompts, short sample writings, and facilitation guidelines as a manual for pedagogical practice (the only text of this nature I have found in Med Ed), its limitations lie in the absence of case-studies and examples exploring the experiences of teachers and students including valuable accounts of the inevitable difficulties arising in RW work. Based on his orientation and writing, he seems like he would be an amazing teacher, and I want to hear his experiences. DasGupta and Charon's description of their illness narrative course, though providing important information regarding exigency and outcome, does not get

into the nuts and bolts of how they taught the writing. I want to know how they prepared students for the process, how the specifics of the assignments looked, how they offered feedback to students and what was included in their responses, and how group discussions were focused and facilitated. Sierpina and colleagues make note of what sounds like an incredible assignment in having students interview patients in their homes but only leave us with the concept. As a RW teacher, I would love to hear more so that I can replicate their work and contribute to the research chain. Liu and colleagues' workshop report, though detailed in step-by-step description of the process, is missing facilitator and student voices, an important component for readers to get a sense of the emotional truth of the experience and the lives involved. Even Shapiro and colleagues' "model of reflective writing and its uses in medical education," focusses upon the exigency for and outcomes of students' RW without providing a vision of how the writing process unfolded; we are told, not shown. In essence, to receive the kind of in-depth guidance that can be foundational for writing teachers, the "bigger picture" needs to be shared. Without the researcher's life, the scholarship, while efficient, feels disembodied in a context where the purpose is to unite mind with identity.

In terms of being unduly critical of the RW research produced within Med Ed, I believe there is a difference between critiquing the value of work and pointing out that there are areas that could use expansion. In other words, I am not discounting the importance of the RW work taking place within the field and there is much CS could learn from the approach in Med Ed to studying RW.[5] However, while RW scholarship in

[5] This could easily be an entirely different, highly valuable dissertation or book.

Med Ed offers insight into the exigency for RW and why this work does or does not meet its goals, *how* exactly it is taught and looks (including successes and failures) remains largely outside the scope of investigation. This gap is understandable as the vast majority of scholars researching RW in Med Ed are medical educators often trained in the hard and social-sciences, commonly psychologists and MDs, who examine the practice through social science methodologies. Furthermore, due to the fact that "[m]edical education is still by-and-large rooted in the positivist-empiricist model of knowledge" and "requires methods of analysis that are precise, logical, and systematic," medical humanities journals primarily publish articles adhering to scientific formats and which tend to be considerably shorter than scholarship on writing from other fields (Shapiro et al. 234). Again, I am not discounting the value of this type of scholarship (there have been many times where I appreciated the brevity and straightforward approach of research in Med Ed publications). I am, however, positing that there is a gap in the field when it comes to specifics of *how* RW is taught and how that process looks, a gap that limits the type of teacherly knowledge that is critical for building best practices as a field. In response, I believe that CS, in their teacher research approach to scholarship and dedicated focus upon writing practices, has contributions to make to RW research. Accordingly, I now turn to scholarship from CS to illustrate.

Composition Studies Responds to Gaps

Scholarship from CS speaks to the gaps emerging from the research projects and, as a result, provides voices to assist in areas in need of development within Med Ed scholarship. Before I begin my exploration of these voices, however, it is important to note a couple of things. First, since I critiqued a few pieces of Med Ed scholarship for the

absence of useful pedagogical information, it seems only fair to acknowledge that not all the scholarship I reference in this section is comprehensive in the manner for which I advocate. In other words, limitations in scope on writing pedagogy exist even within a writing specific discipline. Conversely, I also list some sources more than once to indicate that they are engaged with multiple areas covered in this review of literature. Second, while a large percentage of the scholarship I now review is employed within the dissertation, I include additional voices toward the goal of providing the resource I wish I had had when beginning my work with RW in Med Ed. Finally, while there are obvious contextual differences between writing instruction emerging from CS and the RW work taking place in Med Ed, much of the pedagogy is translatable if not directly transferable. I move now to four specific pedagogical areas studied in CS that speak to RW practices in Med Ed.

Invention Techniques

CS has a long history of scholarship exploring and sharing invention/prewriting techniques (i.e. freewriting, mapping, listing, outlining, journaling, memory reflections), which have been used since the 1960s as a first step in generating ideas and beginning the writing process (Belanoff et al.). This practice is covered in detail by variety of scholars in the field (Elbow *Writing Without Teachers* and *Writing with Power*, Murray, Campo, Hallet, Sudol). Reflective journaling techniques have also received attention (Stevens et al., Kroll, MacCurdy *The Mind's Eye*). One of the closest analogues to the reflective journaling I have seen mentioned in Med Ed literature is explored by Jeffery Berman and Jonathan Schiff in "Writing about Suicide," wherein students keep a journal of their psychosocial reactions to texts and discussions on mental health topics (reminiscent of

Parallel Charts). Lastly, Louise DeSalvo's text on independent writing and healing and Natalie Goldberg's work with life writing provide an array of short writing exercises for generating ideas and beginning the writing process.

Facilitating Vulnerable Writing

I now narrow my gaze to CS pedagogues working directly with writing contexts involving vulnerable writing as it is the most closely related to RW. To begin, Michelle Payne's seminal text on teaching writing to students who write about abuse and eating disorders (among other issues) provides an incredibly comprehensive exploration of working with narratives and lives of this nature. Jeffery Berman's texts *Risky Writing* and *Empathetic Teaching* are, likewise, comprehensive in terms of exploring *all* aspects of pedagogy involved with teaching vulnerable writing. Charles Anderson's "Suture, Stigma, and the Pages That Heal," which he co-authored with two students, explores the risks and rewards involved with writing and healing pedagogy in detail. Marian MacCurdy's *From the Mind's Eye* takes a unique approach to writing and healing in its focus upon pedagogy that engages sensory memory relating to trauma (a lot of good invention techniques are included). Wendy Chrisman's "The Ways We Disclose," Carole Deletiner's "Crossing Lines," and Lad Tobin's "Self-Disclosure as a Strategic Teaching Tool" explore the employment of self-disclosure within the writing classroom to encourage vulnerability in writing and as a reciprocal response to students' disclosures. Margaret Price's "Writing from Normal" explores concepts of "normalcy" and how disability is approached in the composition classroom through close examination of student writing and her teaching practices. Both Sally Chandler and Regina Paxton Foehr examine the use of writing to recognize and explore challenging emotions, particularly

fear, within a writing curriculum. William Banks' "Written through the Body" explores embodied approaches to writing and teaching composition as rejection of dualism. Finally, many CS scholars examine the divide between facilitating a therapeutic writing process and providing therapy (Anderson and MacCurdy "Introduction" in *Writing and Healing*, Bishop "Writing is/and Therapy," Read, DeBacher and Moore, Carello and Butler, Hynes, Morgan, Spear, Valentino).

Feedback Practices

Due to the fact that students submit vulnerable writing in CS courses whether or not it is solicited, how to respond to such writing has been a conversation in progress within the field for quite some time (Anderson, Hynes, Payne). And, though not every one of the following sources deals directly with responding to vulnerable writing, the principles discussed apply or are translatable. First, Nancy Sommers' "Responding to Student Writing" situates feedback as conversation aimed to aid writers' processes rather than evaluate. Similarly, Peter Elbow, in "Options for Responding to Student Writing," positions the responder as a "real reader" rather than evaluator in order to foster students' concept of themselves as "real writers." Donald Daiker explores students' apprehension with the feedback process and outlines the efficacy of providing praise. Kristen Getchell and Ann Amicucci focus on a cross-institutional peer review assignment and advocate for "the golden rule" in providing feedback. Joni Cole, in *Toxic Feedback*, explores feedback practices in writing groups and the ways a facilitator should guide the process (a very accessible read). Richard Straub's anthology *A Sourcebook for Responding to Student Writing* is a superb resource and features a variety of scholars commenting on feedback philosophies alongside examples of student writing and corresponding feedback. Maja

Wilson critiques the use of rubrics in standardizing feedback and suggests alternative approaches. Dana Ferris explores philosophies on providing feedback and delves into the nuts and bolts of the process such as structures and time spent per student. Kathleen Hynes examines "the emotional labor" of responding to personal writing and makes suggestions regarding preparation and support for instructors. Lynn Bloom discusses the difficult practice of responding to "ugly writing" involving elements of racism, violence, and misogyny. Lastly, Marilyn Valentino, Michelle Payne, and Jeffery Berman (in both his cited texts) explore the challenges, responsibilities, ethics, and best practices in responding to high risk writing and provide an excellent foundation for anyone facilitating vulnerable writing. However, in terms of responding to vulnerable writing, be prepared for a lack of concrete answers because, in many ways, avoiding concrete answers is the answer.

Curricular Design

This final section presents CS scholarship engaged with writing and healing orientations in terms of course design. All the following sources include student writing, so I do not mention it in every citation. To begin, Rachel Spear's "Wounded Healer Pedagogy" outlines a pedagogy promoting writing as an act of communicating trauma by using our wounds as a source of strength in healing and "bearing witness" to others. Guy Allen's "Language, Power, and Consciousness" comprehensively describes a course grounded in personal writing and includes writing exercises, assignment sequences, teaching experiences, a workshop format, and evaluations. Cathryn Molloy's "Multimodal Composing as Healing" details a course engaging with scholarship on "writing and healing" (including its critique) and provides students with the option of

either producing "writing and healing" narratives or more traditional academic exploration of the topic as a way to engage students without perceived forced vulnerability.[6] Peter and Maureen Goggin explore "teaching writing (during/about/on) trauma" by first establishing a theoretical understanding of trauma writing and then describing their pedagogical process of teaching these concepts in a composition course. Jerome Bump's "Teaching Emotional Literacy" examines several courses he taught involving "writing skills to communicate our emotions as well as our thoughts to others and to ourselves" and the complications with which he dealt regarding administrative complaints that he was crossing boundaries into therapy (318). Jacqueline Rinaldi's "Journeys Through Illness" reports on a ten-week workshop she ran for MS patients and includes the project structure, writing exercises and prompts, and the overall philosophy of the work. Marian MacCurdy's chapter "A Crisis of Listening," beyond providing a detailed pedagogical description of a course in trauma narratives, provides an excellent account of addressing issues with resistant, silent, and at-risk students (*The Mind's Eye*). Lastly, Kathleen Yancey's edited anthology *A Rhetoric of Reflection* is an extensive resource that investigates both the theoretical underpinnings of reflection and its pedagogical application in a variety of teaching contexts including course descriptions.

In short, I believe both fields could greatly benefit from collaboration in that our unique ways of knowing, when partnered, have the potential to create a stronger,

[6] Providing students with an alternative to composing personal narratives is worth considering for Med Ed curriculum and is explored in chapter three.

interdisciplinary understanding and practice of RW in Med Ed.[7] I now turn to chapter summaries.

Chapter Summaries

Chapter 2: Approaches in Providing Feedback to Reflective Writing in Medical Education

In chapter two, "Approaches in Providing Feedback to Reflective Writing in Medical Education," I introduce an online project in which first-year students composed RW throughout the academic year in response to six psychosocially orientated prompts and received feedback from a member of our RW team comprised of four medical educators, two second-year students, and myself, a writing professional. As providing effective feedback to vulnerable writing is one of the more challenging aspects of teaching writing for many teachers and, within the Med Ed context, underexplored, I report the results of a detailed analysis of 328 pieces of feedback given to correlated reflections as a means for determining what responders are doing with their feedback and how they go about doing so. Results reveal that responders employ three primary styles of feedback including "listening," "guiding," and "encouraging," what I term a "feedback framework." As a method for investigating the benefits and drawbacks of each approach within the "feedback framework," I present three student reflections and corresponding responses representative of the categories as a means to draw conclusions regarding the benefits and drawbacks of individual approaches. Ultimately, the investigation reveals

[7] Though it is outside the scope of this dissertation, the possibilities for RW courses embedded within the English department, particularly for pre-med and psychology majors, are intriguing and worth consideration.

that all three have specific values and deficits and that feedback choices must be contextually specific.

Chapter 3: Design and Facilitation of Reflective Writing Assignments: An Illness Narrative Case Study

In chapter three, "Design and Facilitation of Reflective Writing Assignments: An Illness Narrative Case Study," I investigate the exigency for and pedagogical facilitation of the composition of illness narratives through the lens of a second-year writing project in which sixty-six students produced and then, within a small group setting, shared personal illness narratives in order to consider the psychosocial realities of illness, adopt a patient perspective, and practice vulnerability in communication with colleagues. Grounded in entrance and exit surveys, students' writing, and facilitator notes, I organized my investigation around student anxieties relating to both the composition and sharing of vulnerable narratives and present facilitators with theoretical and pedagogical responses to these anxieties grounded in my teaching experience, CS, related fields engaged in writing and healing, and the voices of students who had transformative experiences. Overall, the study makes an argument for the value of composing illness narratives during medical training and serves as a useful resource for navigating the more difficult pedagogical aspects of vulnerable writing not frequently discussed in Med Ed literature such as how to respond to anxious students and help them avoid the risk of retraumatization.

Chapter 4: Writing on the Periphery: Exploring the Function and Value of Reflective Writing During Clinical Training

In chapter four, "Writing on the Periphery: Exploring the Function and Value of Reflective Writing During Clinical Training," I explore an extracurricular writing group I facilitated comprised of eight third-year students involved in their clerk-ship training (also termed "rotations"). I begin by outlining the curricular framework for the group, noting areas for revision, and then introduce the results of my textual analysis of their writing, results that reveal students used our project as a space for catharsis of negative emotions, processing the uncertainty of medical education, and bearing witness to the plights of others and themselves toward the development of empathy. As a way to explore the function and value of these three categories, I then present and analyze samples of student writing through the lenses of CS, related fields such a trauma studies, and Med Ed. I conclude with an evaluation of the project's success, a discussion on the application of the categories—which comprise what I term "a manageable framework"—and the overarching argument that RW work should not be, as is often the case, relegated to the periphery as an extracurricular activity but, rather, be a readily available, credited, and encouraged option for students.

Chapter 5: Writing and Healing in Medical Education: A Four-Year Curriculum

In chapter five, "Writing and Healing in Medical Education: A Four-Year Curriculum," I present a RW curriculum for Med Ed grounded in the research explored in previous chapters. For Year One, in addition to a continuation of the online writing project outlined in chapter two, I recommend two projects including: "The Biography" for which students compose biographies of classmates after a series of writing exercises and interviews and "The Cadaver Lab," for which students write pre and post reflections regarding their psychosocial impressions of meeting their cadavers for the first time. For

Year Two, I likewise recommend two projects including: “The Home History,” for which students visit a patient in order to conduct an interview regarding the patient’s life story and write a narrative on what they learned and “The Illness Narrative” for which students write and share a story of an illness experience involving themselves or someone with whom they had a personal relationship (the project explored in chapter three). For years three and four, I recommend three assignment options, two of which they must complete within their last two years of education. The first, “The Parallel Charting Group,” is a revised version of the third-year writing group explored in chapter four and involves students maintaining a reflective journal in which they document their psychosocial impressions of patient interactions and then meet monthly to share writing with other group members. The second, “The Physician Interview,” has students conduct an interview with a physician of their choice and write an article presenting what they learned about the physicians’ lived experiences (not just “the data”) and reflecting upon the experience. The third choice, “Introduction to Narrative Medicine,” introduces students to narrative medicine through a series of readings and reflective responses that engage both the history and practices of the field, as well as examples of it in practice. I conclude the chapter with an argument on the importance of situating work of this nature as part of the core curriculum of Med Ed.

Now that I have introduced exigencies, research, and objectives, I turn to the heart of the dissertation beginning with an exploration of feedback approaches to RW in Med Ed. Just as an interesting exercise, while reading the student reflections within the following chapter, consider how you might respond to their writing both in terms of

"writing craft" and "content" and then compare your responses to those offered by our RW team members.

Chapter 2: Feedback Approaches to Reflective Writing in Medical Education

Unlike the other two reflective writing projects outlined in chapters three and four, which involve small group work, the online reflective writing work with our sixty-seven first-year students was a team effort. We were an eclectic group of seven comprised of two medical education (Med Ed) curriculum directors, two education-specialists who facilitate wellness projects at the medical school, two second-year students, and myself, a writing professional and Ph.D. candidate heading toward a career in writing and healing within medical education. This was the largest reflective writing (RW) effort taking place at the University of Nevada, Reno's School of Medicine in 2018-2019. Six times a year, we posted a prompt eliciting a piece of reflective writing from students exploring whatever psychosocial (relating to the intersections of one's psychological, emotional, spiritual, sexual, and social being) realities were currently surrounding their experiences. We also offered students the option of veering from the online prompts toward writing about whatever they wanted to express, a practice in alignment with writing and healing scholar Marian MacCurdy's recommendation that students "should not be forced to write on topics they do not wish to pursue, even if the instructor believes certain topics to be necessary to their growth as writers" ("From Trauma" 195). For instance, during orientation several students opted to write about their first week in school rather than their visit to the cadaver lab even though the latter was the focus of the prompt. So, while we emphasized honesty and vulnerability and the assigned prompts directly related to difficult issues in health-education training, we did

not force disclosure of any particular nature.[8] Once students uploaded their writing through our online platform, I de-identified their Word documents to allow for greater anonymity, distributed them amongst the other six team members for reading and response, and then returned feedback with the responders' names to the students.[9] Following the return of feedback, our team met to debrief.

During these debriefing sessions, we generally discussed a variety of areas such as whether or not the prompt succeeded in encouraging wellness-focused reflection, the professional and personal implications of the students' experiences and ideas, resources to recommend to students who were struggling, future prompt ideas, potential readings (for both students and ourselves), and our individual reactions to a few noteworthy reflections. After two-years of working together and ironing out many programmatic details, our system had increased in efficiency and received positive feedback from administration and students alike. Yet, despite this growth, exploration of how we responded to student reflections was conspicuously thin, a deficiency that is surprising considering the fact that the majority of our labor was spent in writing feedback. The question is why, when we covered so many other dimensions of our program, had this area remain primarily unaddressed?

The answer is two-part. When we first began offering feedback rather than simply giving students credit for their work, I turned to RW scholarship in Med Ed for guidance

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[8] Chapter three on the Illness Narrative Project explores concepts of forced disclosure in more depth.

[9] The practice of writers remaining anonymous to responders while responders' identities are provided to students was, in our team's opinion, the optimal way of establishing a safety net for students while allowing responders to include aspects of their identities in their feedback (see Burman & Schiff 294 for a CS argument in support of this).

on our responses in that as a newcomer to the field, I was anxious to get a feel for the tenor of their conversations and recommended practices. Furthermore, while I had certainly spent time responding to vulnerable writing within my English courses, the context of and impetus for writing in Med Ed is unique, and it seemed reasonable to begin with an exploration of their practices. In doing so, I discovered that there is limited scholarship on responding to student writing, something acknowledged within the field by scholars who write that, "While the literature has examples supporting the solicitation of reflective writing . . . this is not the case for structured individualized feedback to such reflective efforts. Even when such feedback exists, a rigorously developed, practical framework is to the best of our knowledge absent" (Reis et al. 258). Their response, a response in line with what scholarship exists in the field, was to develop a structured rubric as a way to guide and standardize feedback to student reflections. Accordingly, our team decided to adapt their rubric to our own context in an effort toward consistent feedback practices. This effort failed.

We discovered that no matter how we adjusted the rubric to meet individual prompts and programmatic expectations, it felt like fitting a square peg into a round hole. Our norming sessions resulted in radical deviation of assessment and response amongst team members due to the fact that reflections were often unstructured (and/or completely off prompt) and that our team members prioritized different aspects of writing and approached the process through the lens of individual disciplines and histories. Speaking to the difficulty of uniformity in responding to texts, reflection and response scholar Pat Belanoff writes, "[E]ven when we read identical texts, we do not reflect (on) them (back) the same way; each of us gives the text his or her own bend or twist. Each of us sees and

reports events in a slightly different way, for each of us is gazing at our surroundings as they are ‘fixed’ within our personal mirrors” (405). As a result, we felt our use of rubrics was more confining than generative and yielded formulaic feedback. CS scholar Maja Wilson sums up this perspective well when she writes, “The way that rubrics attempt to facilitate my responses to students—by asking me to choose from a menu of responses—troubles me, no matter how eloquent or seemingly comprehensive or conveniently tabbed that menu might be. The idea that we can standardize our responses to students' papers deserves serious examination, because language itself resists all but the most basic attempts at standardization” (63). With general agreement to this sentiment from the team, we put the use of rubrics for crafting feedback on an indefinite hold.

This brings me to the second reason why feedback remained primarily unexamined in our program for so long, a reason for which I shoulder responsibility. When our rubrics failed, our first step should have been to establish a regular practice of sharing our feedback with one another in an effort toward exploring individual approaches and the implications of those approaches. Furthermore, as the writing professional, it would have been useful for me to begin supplying the team with feedback-related scholarship. Unfortunately, some false assumptions, as well as gaps in my own knowledge, led to our feedback practices going largely unexamined. First, I made the assumption that team members would appreciate autonomy without considering that autonomy might feel more like a lack of guidance for responders not formally trained in writing instruction. Conversely, I made the assumption that my own feedback practices were solid because of my decade of experience teaching composition, an assumption that

did not truly consider the uniqueness of the writing context and compositional goals.[10] Second, while I had begun to delve into CS literature on writing and healing (perhaps, the closest analogue to RW in Med Ed), I had not gotten to the heart of the conversation regarding responding to vulnerable writing and, therefore, had yet to acquire a framework for making choices as a responder. In essence, we were missing guidance on a critical aspect of teaching reflective writing: how to effectively and safely respond to students' reflections.

The aim of this chapter is, therefore, to address these gaps through the type of feedback exploration and subsequent guidance we needed when developing our reflective writing program, the type of guidance finally in place for us several years later as a result of this research and the pragmatic framework that emerged from it. I go about doing so in several steps. I begin by presenting the data, outlining my method of analysis, and introducing the three primary types of feedback approaches to RW revealed by analysis: 1) a listening approach; 2) a guiding approach; and 3) an encouraging approach. Furthermore, I explain how each one of these three feedback techniques, which comprise what I term a "feedback framework," can be focused upon the craft of writing and/or the content addressed in the reflection. Next, I individually explore the function and value of each of the "feedback framework's" three approaches by presenting a student reflection and the correlating feedback from a team member before concluding the section with an

[10] Due to the problematic nature of analyzing one's own feedback, I do not explore my own responses to students in this chapter. This is, however, unfortunate in that my feedback takes heavy risks in terms of self-disclosure and, accordingly, illustrates the potential for both meaningful communication and burdening students through co-opting their reflections.

exploration of how and why the particular approach is being employed through the lens of textual analysis, CS scholarship, and responder perspectives on the work. I conclude the chapter by outlining a "feedback framework" workshop designed to offer the type of responder training our team needed at the start of our endeavor, a workshop format now being employed at our institution.

Ultimately, I argue that, in the fashion of much CS research on pedagogical approaches to providing feedback (particularly to vulnerable/risky writing), there is no universally "correct" approach for responding to RW in that each style and focus of response presents advantages and disadvantages and should be contextually orientated. Accordingly, the "feedback framework" I develop functions as an effective tool for consideration and understanding rather than prescription.[11]

Data and Method of Analysis

The body of data collected includes 328 student reflections from six writing assignments given during the 2018–2019 academic year, 328 pieces of correlated pieces of feedback from our team, and transcripts from interviews with individual team-members following the completion of the academic year. All activities were conducted with IRB approval (1296420-2). The overarching research questions I applied to the data analysis were: 1) what types of feedback are being offered to students? 2) what are the functions of these approaches? and 3) are they theoretically effective? As a way to investigate these questions, I investigated the data through a "thematic analysis"

[11] Perhaps a useful analogy is in how physicians respond to patients. While there are certainly wrong ways of going about it, the right ways are numerous and contextually dependent.

grounded in the six-phase methodological approach outlined in “Thematic Analysis: Striving to Meet the Trustworthiness Criteria” (Nowell et al.). In phase one, “familiarizing yourself with your data,” I reviewed the student reflections, team-member feedback, and interview transcripts while making notes on general themes and questions I encountered. Though I had no specific categorical labels at this point, it was apparent that team-members approached the practice of offering feedback quite differently from each other. In phase two, “generating initial codes,” I began labeling general themes and approaches relating to the feedback (i.e. “responder self-discloses,” “lengthy feedback,” “addresses imposter syndrome,” “offers advice,” etc.). In phase three, “searching for themes,” I identified the most prevalent categories emerging from the data and eliminated those grounded in responses related to the specifics of our curriculum (i.e. “discusses step tests”). In phase four, “reviewing themes,” I began to see that the function of their feedback was more relevant than the specific content about which they were commenting, particularly when considering the chapter's pedagogical orientation. A good example is that I became less interested in *what* team-members were disclosing in terms of the topic (i.e. their own history with “imposter syndrome”) and more interested in *why* they were choosing to disclose this information (i.e. to provide guidance). In phase five, “defining and naming themes,” I arrived at the three primary categories informing this chapter based upon the fact that they represented the main functions team-members seemed to be enacting with their feedback and served as an overarching lens for understanding the general orientation of their feedback. I also realized during this stage that within each of the three categories, their feedback was also subdivided based upon whether the feedback was addressing “writing craft” (how something was written) or

"content" (the subject matter of the reflection). Therefore, I decided upon an investigation of their feedback grounded in the three categories of "a listening approach," "a guiding approach," and "an encouraging approach," with the sub-themes of "writing craft" and "content" focused. Before turning to phase six, "producing the report" in which I investigate the practice, purpose, and risks/rewards of each category, I thought it useful to provide an introductory overview of the categories along with a caveat regarding the fluid nature of their identity.

To begin, much of our feedback is what I classify as "a listening approach" in that it reflects back students' language and ideas in order to establish a safe writing space situating the responder as an engaged "listener/reader" rather than an "evaluator." Although the concept of therapy frightens many writing teachers due to the mistaken conflation of "therapy" with the "facilitation of a therapeutic process," a good corollary for a "listening approach" is found in the types of non-judgmental responses and questions a therapist provides a client during a session. Common examples of this found amongst our teams' feedback include rephrasing what the student has written to demonstrate that the student has been heard and expressions of interest in order to solicit more information.

Next, a "guiding approach" as exhibited in techniques ranging from personal anecdote to explicit directives are commonly employed by team members as a way to provide direction. This practice mirrors the types of conversations that take place during office hours between a mentor and mentee. Common examples from our team include instances of self-disclosure intended to provide a model for how (and how not) to go about the educational process, advice regarding seeking outside resources for emotional

turmoil, and directives related to writing craft and academic challenges (i.e. where to focus energy).

Third, an "encouraging approach" can be found throughout nearly every instance of our team-members' feedback as a way to reaffirm decisions and bolster student confidence regarding academic performance and personal identity. A good analogy for this category is found in the types of conversations one might have with a friend who has been through similar struggles and expresses empathy and support. Common examples of this are words of encouragement for students who confessed to feeling overwhelmed, exhausted, confused, and apathetic. Similarly, compliments regarding how a piece was written were frequent.

Fourth, as noted above and of equal importance, for each one of these categories feedback is further classified as either addressing students' use of language in crafting their reflections or the content about which the students are writing. Common examples of "writing craft" feedback include comments rephrasing a student's language in order to indicate recognition of their approach in how they composed an idea (a listening approach), suggestions for providing more detail (a guiding approach), and praise of a writer's ability to capture an experience through detail (encouragement). Common "content" comments, on the other hand, reflect understanding/reception of the reality of an experience or a student's emotional state (a listening approach), urge that a student take some kind of action regarding their situation (a guiding approach), and provide identification and support to students through positive and affirming comments and anecdotes (encouragement). Awareness of these sub-categories is valuable in guiding responders toward considering the purpose of the reflection and the subsequent feedback

they provide. For instance, there may be a RW context in which a listening approach is needed regarding the content of the narrative, but guidance is helpful regarding the writing craft. The converse could likewise be true.

Finally, before turning to exploration of the categories, it is critical that I make two notes. First, while this chapter's categorical division provides responders with a "feedback framework" for making feedback choices, categories are fluid and not intended to indicate firm delineation. For example, comments classified as a listening approach often include elements of guidance and/or encouragement. Similarly, a comment that, for example, urges a student to keep moving forward because they are intelligent and deserve to be in medical school could be seen as both encouragement and guidance. This fluidity, however, is not a short coming. In the same way that a rubric runs the risk of affixing unique/abstract work into neat boxes for assessment, to employ these categories as firm demarcations misses their function as a framework for consideration and not absolute delineation. A good analogy is found in how CS classifies different pedagogical approaches. For example, while labeling a curriculum as feminist, Marxist, critical, or expressivist is useful for understanding the general orientation and purpose of a course, those labels are likewise fluid and rarely represent the entirety of an approach. In other words, if a reader of this chapter finds herself thinking, "Wait, couldn't that comment be classified as encouragement just as easily as guidance?" an important purpose is already being served in that she is considering the function of a comment and has a "feedback framework" for doing so regardless of her ultimate conclusion.

Second, and in alignment with the previous point, the purpose of this chapter is not to arrive at concrete policies regarding what feedback goals should be in a Med Ed

context. As tempting as such policies might be, I am in firm agreement with CS scholarship positing that providing good feedback is a function of understanding the rhetorical choices we make as they relate to individual contexts. In other words, it is essential that one consider what type of feedback best fits the particular assignment, the responder's personality, and, most importantly, the student's need. As feedback scholar Richard Straub notes, "By understanding the great variety of ways teachers can create themselves in their comments—the many ways teachers may be directive and facilitative—we will be more able to describe, reflect on, and develop our own responding practices and share our comments to better fit our teaching styles, our classroom goals, and the needs of our individual students" (*A Sourcebook* 148). Accordingly, this chapter's exploration is intended to help responders in understand the fluid identities and implications of their feedback and, resultingly, make the best possible choices in how they respond to students, choices that recognize the uniqueness of every communicative exchange taking place in our students' writing and our responses. I begin this exploration with "a listening approach" in providing feedback. For the protection of student and responder privacy, I have employed pseudonyms for everyone involved.

A Listening Approach in Responding to Reflective Writing

As a standard practice during orientation week, we conduct RW sessions with the incoming first-year class to introduce our program, launch students' writing practice, and expose them to published narratives from journals focused on creative non-fiction writing in medicine.[12] During the second session of the year in which this study was conducted,

[12] A great deal of RW fits into the creative non-fiction category due to its frequent employment of story.

our students provided interesting commentary on a narrative they had read by a fourth-year medical student who had become increasingly apathetic and disillusioned with his education and patient interactions. Quite a few responded with concern and argued that faculty at the author's institution should intervene. Others criticized the author's "bad attitude" and suggested he quit the program. One even attacked the text for being "poorly written" in its simplicity. It wasn't until the end that a young man commented, "I just figured he needed to get his feelings out and have someone listen to him. I mean, isn't that the point of reflective writing?" While this perspective is a touch simplistic in that students produce reflective writing for a variety of reasons and desire/require different types of responses, writers often do just need a listener. And, in many instances, being a listener for students is the best response we can offer, especially considering the fact that we are training them to be good listeners for their future patients. As a way to investigate being a listener to students' ideas through feedback, I turn to a reflection from Allan, a first-year student, and feedback from Mac, one of the education specialist team members whose style best exemplifies a listening approach.

An initial prompt asks students to reflect upon the experience of meeting their cadaver for the first time, often an emotionally charged experience. In response, Allan begins with an anecdote of his mother playfully chasing him and his sister around with a box of their grandfather's ashes in a type of "macabre" game. He explains, "To me, it was vaguely scary and invoked images of haunting ghosts. To her, it was her dad, still living on in small way, getting to know the grandchildren he had never met . . ." He then describes how he still sees individuals when looking at cadavers noting the "[t]he crystalline lens of their eyes, created when they were just babies in the womb" and "[t]he

fat of their abdomens, a relic of family dinners." Regarding his own cadaver, he writes, "I was okay until I saw the enlarged heart. Suddenly, I envisioned my own father. On my last trip home, I found his blood pressure pills painstakingly hidden in a tissue box. He didn't want to worry me because he knew that I was already nervous about school starting. When we hugged goodbye, I held on a little too long, listening for the sound of his heartbeat." Thoughts of his father, he explains, caused him to wonder if the cadaver's family had known about the heart condition, a question that triggered an intense emotional reaction: "And in the lab, hidden behind everyone else, I cried. I put my fingers in his aorta, parroted the names of all the structures when prompted, and I wept while I did it. This is not sustainable." Regarding this unsustainability, Allan explains his fear. "While some of us might be predisposed to too much emotional distance, it is the opposite for me . . . I will get caregiver's fatigue. I will imagine them, their families, their friends . . . I will mourn with them. And I will try to keep in mind that the cadavers would not want me to be so saddened by their bodies that I could not use them for the purpose they intended." Finally, after expressing gratitude for the cadaver's "gift of enormous magnitude," Allan concludes with, "I can tell already that I need to navigate the same path that so many others have walked before me: protecting myself while also maintaining compassion and empathy."

Mac responds:

> "Thank you for your great reflection. That is an interesting connection between a childhood experience and what you are entering into now. Seeing the relationship between the cadavers you are working on and the development of these bodies from childhood is a very interesting insight. Fascinating that

> something within the anatomy lab reminded you of your father. Did this prompt any particular emotions or thoughts of reaching out to your dad? I wish there was an opportunity to ask these questions of the family of the cadaver at this stage, I'm sure you are still left wondering. Such an emotional experience, touching the body parts with such a personal connection to the same body parts of a loved one. As you say it is not sustainable and you will experience caregiver's fatigue – what are some things you can do *now* in order to help process, cope, and work through all of these feelings? This sense of protecting oneself while maintaining empathy is so central to why we reflect and encourage reflective writing – how do you think these sorts of writing exercises will aid you in achieving this goal of supporting yourself in the right ways?"

Through examination of Mac's feedback to the content of Allan's reflection, we see two primary purposes for his employment of a listening approach. To begin, in using language that reflects back to Allan how his ideas are being personally received, Mac situates himself as a reader rather than an evaluator. As a result of his reframing, he gently indicates to Allan whether or not his ideas have been clearly communicated without the demanding critique often present in traditional feedback. As expressivist pioneer Peter Elbow notes, "When we give students our frankly acknowledged subjective reactions, we are treating them as writers: 'Here are my reactions: you decide what to do about them.' Furthermore, by treating students as writers, we help them learn to treat us as real readers instead of just sources of impersonal verdicts" ("Ranking" 201). In short, by presenting himself as a "real reader" rather than evaluator, Mac mitigates the pressure—what writing and healing researcher Marilyn Valentino describes as "threat of

condemnation or personal judgement" (5)—often felt by students when communicating ideas, particularly when their ideas are risky and/or vulnerable. In other words, by demonstrating that he is present and listening to the student without inserting critique other than the types of questions an interested reader might ask, he honors Allan's story as a fellow human and moves away from the stereotypical power dynamics often associated with feedback from a professional. In doing so, Mac models Krista Ratcliffe's concept of "rhetorical listening," an approach to communication that shifts from the patriarchal "*logos* that speaks but does not listen," and, instead, grounds itself in a feminist approach "based on a desire for an intersubjective receptivity, not mastery" (qtd. in Hindman 15). To illustrate, I return to Mac's feedback.

While acknowledging that all comments are somewhat evaluative due to the rhetorical nature of the exchange (Elbow "Options" 174), in employing a listening approach to feedback, Mac demonstrates his engagement as a responsive reader and avoids critique of Allan's ideas. For example, in response to Allan's childhood story introducing the theme of death and bodily remains, Mac employs the listening approach of a reader when he writes that he finds Allan's "insights" to be "interesting" and comments that the connection Allan draws between his father and the cadaver is "fascinating." Similarly, Mac's comments that he wishes Allan had an opportunity to ask the cadaver's family questions "at this stage" and that he's sure Allan still has questions is different than feedback I've seen offered to nearly identical student ponderances, feedback that informs students that more knowledge of their cadaver is not necessary and could even be detrimental. While the latter perspective may be true, Mac does not feel the need to correct Allan's thinking and, instead, validates the way he feels without outlining

his personal opinion on the matter. This type of listening approach can be especially effective for whose only previous exposure to writing instruction has likely involved exacting disciplinary expectations of what constitutes correct thinking, the result of which, as feedback scholar Donald Daiker posits, can be the creation of highly apprehensive writers (155). As CS feedback specialist Nancy Sommers notes, when students perceive "feedback as an invitation to contribute something of their own to an academic conversation, they do so because students imagine their instructors as readers waiting to learn from their contributions, not readers waiting to report what they've done wrong on a given paper" (255). Accordingly, in offering Allan his subjective reactions as a reader, Mac indicates that he views Allan as an authentic writer rather with something to contribute rather than a student in need of a grade evaluation and, therefore, protects him from academic scrutiny that could suspend his willingness to take risks in future communication.

Second, just as Mac's listening approach provides non-critical feedback in his employment of a reader's stance, it also provides feedback that is relatively free of advice indicating how Allan should address the concerns he expresses in his reflection (though, his final question regarding how Allan can use writing to support himself in the "right ways" feels less like a peer reader and more like a teacher subtly providing a directive). While, as we will explore in the next section, guidance can be highly effective and even desired at times, it can also be dangerous in that content-orientated directives risk violating our principle of offering students a space in which they may write without feeling like their disclosures will result in intervention of some kind, either in the form of feedback or even in the material world. Even educationally-orientated content advice

potentially silences students who are seeking exploration and catharsis through writing and not assistance (or even encouragement) from an unsolicited mentor. A listening approach, on the other hand, offers a reader's presence without taking on the mentor mantle and, therefore, encourages uninhibited composition. As disability studies scholar Margaret Price posits, "listening with" students as a way to "simply to try to understand where [they are] coming from" can be more "respectful" than directing students toward other ways of thinking and acting, even when the responder has greater experience ("Writing from Normal" 71). In essence, as our student noted during orientation, sometimes what a writer needs is to be heard more than guided.

Mac, who states that he does not have the *ethos* to give students advice on their medical school experiences, exemplifies a listening rather than directive approach. This is illustrated, for example, when he asks Allan if his experience has prompted "any particular emotions or thoughts of reaching out to [his] dad?" While Mac's question could be interpreted as subtle guidance, it is framed in the conversational manner of an active listener. A mentor's comment, on the other hand, might suggest that Allan communicate these thoughts with his father. Similarly, Allan's description of quietly weeping while handling the cadaver's body is emotionally charged and could easily have elicited an intervening comment from a different responder. I, for example, might have shared that I struggle every time I see a cancer patient but that talking to someone about it has helped greatly. Perhaps this response would be appreciated. However, it could just as easily risk imposing my own trauma and recovery experience and, as a result, provide an unsolicited, thinly disguised intervention. Mac's reply, on the other hand, employs a safer, listening technique when he writes, "Such an emotional experience, touching the

body parts with such a personal connection to the same body parts on a loved one." This simple response conveys that Allan has been heard and validates the intensity of the experience through an expression of reiteration of the message. As a result, Mac situates himself as being personally present without inappropriate identification or an attempt to direct Allan toward how he should deal with the heavy emotions emerging from the experience.

When it comes to employment of a listening approach in responding to writing craft in this example, Mac is primarily quiet. Like the majority of the team, he expresses concern over commenting on *how* writing is constructed as he feels he does not have "a critical lens" or "the language" for doing so. While this concern is understandable considering the lack of training provided to the team, it does not negate the fact that we are still teaching students how to communicate through writing even if we are not focused upon the production of a polished text. Toward achievement of this goal, a listening approach in providing writing craft feedback has some critical advantages worth noting.

First, when we listen by providing our reader responses to students' writing technique, we are not asserting that their writing is "correct" or "incorrect." Rather, we are noting how it was perceived by us as a reader, and, therefore, we are not providing the teacherly type of compositional feedback students so often fear. Even a comment expressing confusion as a reader (i.e. "When you described your mom chasing you around the room, I was quite curious as to how old you were") does so from the perspective of someone engaged with the text rather than someone evaluating the text.

Along these lines, another advantage of using a listening approach to comment on writing craft is that it requires no special vocabulary or training in English. As most Med Ed professionals are unlikely to have writing instruction backgrounds, an informal methodology for communicating with students on *how* they are writing is paramount—after all, despite lack of evaluation, we are teaching writing as a habitual practice and want students' proficiency to increase over time. Listening, in its reflective simplicity and indicated reader presence, offers just such a methodology. For example, a responder could comment, "Your use of descriptive phrases like 'the crystalline lens of their eyes' and 'the fat of their abdomens' painted such a vivid picture for me that I felt like I was there with you." The beauty of this type of a listening comment is that it provides useful, reflective feedback on the writing without the need for any type of formalized training or terminology.

Finally, listening comments on writing craft allow a responder to engage with an author's representation of an experience rather than the experience itself.[13] While it may seem cold to not directly respond to, for example, an author's struggle with depression, it can actually be quite liberating in that to comment on the writing's stylistic approach rather than the content allows for engagement with the representation of the experience but without the risks of unsolicited emotional engagement and/or unqualified guidance regarding the author's life. Though writing and healing scholar Jeffery Berman advocates for methods for empathetically providing feedback to content, he likewise notes the value

[13] Jo, the responder whose feedback we evaluate in the next section, employed this technique often by quoting directly from a student's reflection and then commenting on how the language use inspired different feelings in her.

of providing reflective comments on "an essay's 'surface truths'—its diction, grammar, syntax, punctuation, tone, and organization" in that doing so can "enable students to sharpen their writing skills" without the risk of "invalidat[ing]" their emotions (*Risky* 36-37). In offering feedback to Allan, for example, a listening to writing craft response could have been, "The way your reflection shifts between your father and the cadaver, jumping back and forth in time, created a deep feeling of connection between the two experiences for me in a way that it would not have had you written about them separately. I found this to be such beautiful and vulnerable writing; I am honored that you were willing to share it." While Mac does comment upon Allan's connection between the father and the cadaver, a more detailed comment on *how* Allan does this while also acknowledging the bravery of the text might have provided a stronger response in its acknowledgement of the efficacy of Allan's writing in conveying his message. And, in looking at Allan's text, there are many instances of strong writing that could have been acknowledged and, therefore, promoted.

Returning back to the notion of fluidity of categories in light of the concept of highlighting aspects of a text, in many ways, employing a listening approach regarding how a text is crafted is a form of subtle guidance in that a reader's attention indicates either success or need for clarification. However, the majority of the guidance our team provided to students is not so subtle, which, as we will explore in this next section, has its advantages and disadvantages.

A Guiding Approach in Responding to Reflective Writing

After coding the team's feedback, I was surprised to find that instances of offering guidance, particularly as related to the content of reflections, were more prevalent than

any other type of response.[14] Considering the vulnerable nature of many student reflections, I had expected to find more examples of listening and encouraging due to their gentler and safer approaches to response. Yet, this expectation did not consider the pragmatic value and, accordingly, appeal of providing guidance nor the fact that providing guidance is the primary approach to feedback within most academic writing contexts. Speaking to this, Sommers notes that while "affirmation is often the end result . . . constructive criticism, more than encouraging praise, often pushes students forward with their writing" and "reveals instructors' investments in their students' untapped potential" (251). Likewise, affirming the popularity of a guiding approach, Straub reports on a large-scale study examining undergraduate students' perceptions of feedback, noting that they "appreciated comments in the form of advice and explanation" more than any other and, accordingly, he warns that "we should not reject all directive styles of response any more than we should all adopt some standard facilitative style" (*A Sourcebook* 148). Similarly, the few examples of scholarship from Med Ed exploring concepts of feedback likewise endorse a guiding approach. In their article on "guided feedback" in response to RW, medical educators Hedy Wald and colleagues note that students "enthusiastically endorsed" feedback involving "concrete suggestions" and quote a student who wrote, "Sometimes the comments would push me to continue my reflections and take it to a deeper level . . . [o]ther times, comments were 'just what the doctor ordered' when it came to answering questions . . . that I've struggled with as a first-year medical student"

[14] Out of 328 pieces of feedback, 276 contained at least one comment I classified as overtly providing guidance. I did not count the indirect types of guidance found in encouraging and listening-orientated comments.

(832). Interestingly, this student's comments seem to reflect an appreciation for both writing craft and content-orientated guidance.

Accordingly, as we will explore in this section, while there are risks involved in providing guidance, the solution is not abandonment of the practice but, rather, gaining an understanding of how and why we are using it so that we can make the best possible decisions regarding its employment both in terms of responding to content and writing craft. As a way of working toward this understanding, I turn to a reflection from Marco on his anatomy lab experience and the feedback given him by Jo, one of our student responders. Specifically, I explore how she offers guidance on both the content of the experiences described in his writing and to his writing craft.

Marco begins with, "As we walked into the anatomy lab . . . I wondered if anyone else felt an immense amount of anxiety and bewilderment that we were about to handle cadavers." He then comments on the oddity of the word "cadaver," noting that "It's like we are dancing around any word that would associate this body with life . . . someone who walked this earth for years, had friends and family, and their own life story. Someone who felt the excitement of holding a newborn baby, the sorrow of losing a parent, or the anger of an unexpected hardship." At this point, his reflection expresses anxiety over his lack of experience with cadavers and the realization "that everyone had at least seen one during their anatomy classes in undergrad." Accordingly, he expresses concern that his classmates were "far better prepared" than him and that his "thoughts would shift from being disturbed that [they] were picking on a human's flesh, to confused why no one else seemed distressed, to worried that [he] was not behaving like a proper med student and needed to remain calm and collected." He concludes with, "Looking

back, I know my feelings were shared by others after our lecture on imposter syndrome. Just because I do not have as much experience in the anatomy lab does not mean I will not have success in medical school. I may have to work harder in the beginning to become comfortable with the cadavers, but I will excel if I just try my best. I think I will eventually become comfortable with dissection and handling these bodies. I just need to remember that they donated their bodies to science for a reason . . . for me to learn and to someday help another human being . . . I ~~hope to~~ will make their donation worth it."

Jo responds:

"Fantastic writing piece—I really admire your effort to tune into your own voice, even when that meant ignoring conventional grammar and writing 'rules.' Your voice is SO clear in every word you chose and all the pauses you took and the flow of the whole thing in general. Your deliberate strike through of 'hope to' in the final sentence—nice touch! I definitely smiled as I read your piece, as I can empathize with the emotions you expressed. I too hadn't had any prior experience with cadavers, and I'm absolutely certain you have fellow classmates that are of a similar experience level as you (even if they were unwilling to claim that publicly). I've found that my peers aren't often willing to admit to "lack of experience" or confusion or uncertainty, yet when I push myself to be vulnerable in these respects, I always find someone else (at least one other person) who feels the same as I. I feel like the underlying theme of your writing is something along those lines—it felt to me like you really wanted to key in on the "human-ness" of your cadaver but felt this pressure to conform to everyone else's behavior—I'd wager you are going to have similar experiences several times over the coming

> year [side note—externally appearing "calm and collected" is a skill you will acquire over the coming year, and everyone in your class will have a moment when they *freak* out . . . and I do mean literally everyone—even though you don't witness it, it happens in this pressure cooker that is medical school]. I encourage you to go read some of the biographies that your classmates posted in Canvas, and take note of the fact that no two biographies are the same . . . What does that say about everyone's level of experience? Someone who has experienced a cadaver before may not have other experiences/skills that will enable them to derive more from their time in the laboratory. I totally understand your thought pattern here—we all tend to look around us and often use (what we perceive as) others' experience level as a benchmark for our own successes and failures. I have never walked out of this kind of mental exercise renewed or invigorated by my own shortcomings (you?). Instead, I work really hard on comparing myself today to where I was yesterday. Am I stronger/smarter/more experienced than I was a year ago? You betcha—and you are too!"

A primary purpose of offering students guidance in this context is to assist them with their psychosocial journeys (i.e. burnout, text anxiety, and imposter syndrome) throughout Med Ed. Initially, this feedback approach troubled me as my training discourages proffering advice to students on how they navigate their lives for fear that we would be "playing therapist." Speaking to this, in her seminal article "Responding When a Life Depends on It: What to Write in the Margins When Students Self-Disclose," CS scholar Marilyn Valentino warns of the danger of feedback that attempts to "heal the patient, rushing to perform heart surgery when an accepting ear was all that was expected

. . . since we are not experts, we may slip into misinterpreting a need" (8). This concern has merit, particularly when responding to students grappling with high-risk dilemmas. Yet, while a responder must tread carefully and *always* consider whether or not their comments will be in students' best interest, to reject all content-orientated feedback, particularly within this context, mistakenly conflates therapy with mentorship and illustrates what Price describes as a high "level of anxiety that attends our efforts to keep the teaching/therapy divide intact" (*Mad at School* 50). In other words, for many writing instructors, there is so much fear of inappropriately acting as a therapist that they abandon the very type of communication that informs humanistic pedagogies.

To offer a personal example, during both my master's and doctoral training, I took teacher education courses. A master's course on instruction, in particular, was extremely valuable to me as the majority of us were first-time teachers and mildly terrified. A large part of the curriculum involved journaling about our teaching experiences and the feedback we received from the veteran teacher was multifaceted. First, she responded to *how* I'd written my journals, noting her appreciation for my use of dialogue in describing experiences. Second, and of greater importance to me, were here responses to questions and concerns I posed within the writing relating to both my interaction with students and my navigation through the emotional challenges of being a first-time graduate student. She provided gentle guidance always grounded in her own experiences and never framed it as an imperative. The value of this mentorship was immense for me as I needed an outlet for discussing the intersection of my life and the challenging work into which I was entering. In her research on responding to personal writing, rhetoric of emotions scholar Kathleen Hynes notes that when "balancing

empathy with instructional guidance" writing instructors should "be prepared . . . to respond emotionally as well as intellectually, even when this labor is not specified in their job descriptions or training" (84). Our RW work with first-year medical students is analogous so long as we frame our guidance as experiential anecdotes/suggestions and have the *ethos* to speak to their experiences. Jo's response to Marco provides a good model for how this type of content feedback can both function very well and pose risks.

For Jo, self-disclosing anecdotal experiences is frequently her foundation for offering guidance. In her interview, Jo states, "There is value to [students] hearing that another student went through the same emotions that they're going through. Validating them and normalizing them." We see this exemplified when she writes, "I too hadn't had any prior experience with cadavers" and then goes on to note that this is also true of many of Marco's cohorts. Through her own vulnerability and normalization of his feelings, she validates his struggles with imposter syndrome. Likewise, when Jo shares that she has also found her peers unwilling to be vulnerable but that she "always find[s] someone else . . . who feels the same as [her]," she offers Marco advice to seek out likeminded classmates without the need for a commanding imperative, employing what writing and healing scholar Jeffery Berman calls "a pedagogy of self-disclosure" wherein "teachers and students share aspects of their lives with each other" as a way to construct knowledge "that becomes part of an education for life" (*Empathetic* 22; 29). Similarly, Lad Tobin, a pioneer of expressivist pedagogy, posits that using self-disclosure in offering feedback is "particularly accessible . . . because it allows [him] to present fuller, more specific, and more colorful examples than [he] could if [he] were talking about someone else's experience" and that, "[w]hen done effectively, this sort of purposeful

self-disclosure does double duty because it also can help [ ] to establish [himself] as an approachable and non-intimidating presence" (203). We see this self-disclosure technique repeated near the end of Jo's response in her witty comment that she has never been "renewed or invigorated" by her own shortcomings, a comment she follows up with an indirect suggestion to avoid comparing one's self with others and, instead, use one's own experiences as a benchmark for examining future growth. In short, these examples illustrate how guidance can be effectively offered without overly directive statements.

The other type of content guidance Jo offers, guidance best classified as explicit advice rather than the implied advice of anecdotal self-disclosure, is riskier in its potential to co-opt Marco's reflection and, as a result, inhibit his future writing. In her interview, she mentions that she tries "to not 'should on students,' to not sound preachy" when offering advice. Yet, like many of us on the team, her tone shifts into absolutes in her "side note" which declares that "externally appearing 'calm and collected' is a skill [Marco] will acquire over the coming year, and everyone in [his] class *will* have a moment when they *freak out* " [emphasis in original]. While it's quite possible that Marco appreciated these comments, they run the risk of what Anderson and MacCurdy describe as teachers "tak[ing] over the stories substituting their own voices, experiences, politics, or values for those of the student" (9). Accordingly, in that she is telling Marco what *will* happen rather than explaining that this was her experience in the past, it is possible that Marco found the declarative certainty of her response off-putting. Another, albeit more complicated, example is found in her statement: "I encourage you to go read some of the biographies that your classmates posted in Canvas and take note of the fact that no two biographies are the same." While her use of "I encourage" is an effort to

temper the tone of her guidance, it does not change the fact that she is directly advising Marco toward specific action to deal with his anxiety, a directive that could feel like intervention and, as a result, threaten Marco's willingness to self-disclose in the future. However, I am absolutely not critiquing her engagement with the experiences he describes in his reflection. Had she focused solely upon his writing craft, she would have run the risk of having her feedback be seen as insensitive, as disregarding Marco's vulnerable disclosures. Rather, I am advocating that she continue her approach of offering guidance through the sharing of her own related experiences.

Finally, moving away from contextual feedback, Jo offers guidance on writing craft. Though there are feedback examples in Med Ed literature illustrating comments on students' writing craft, the primary emphasis is upon communication regarding the author's experiences rather than their process of learning how to convey those experiences as exemplified by medical educators Shmuel Reis and colleagues' focus on content-orientated responses in their article on developing feedback frameworks for RW (253). And while, as noted above, content-orientated guidance is highly valuable within this context, to offer guidance on ideas but not how those ideas are composed neglects what, as I have noted, should be an important practice in providing feedback to most RW. Afterall, without helping students learn *how* to construct meaning, their ability to translate their experiences into written language and, thus, reap the benefits of RW runs the risk of being stunted. As trauma writing scholar Michelle Payne notes, despite writing instructors' anxiety that commenting upon writing craft "may be interpreted as insensitivity to the emotional and often traumatic experience the content may describe," to ignore such aspects of writing instruction is to ignore "one of the objects of a writing

course—to teach such means of controlling one's language, defining the boundaries of communication, and making conscious choices about content" (xviii). Accordingly, our work must also involve guiding students toward the development of their writing craft so that they develop a proficiency that will serve their future writing practices.

Jo, more than any other team member (including myself), directly addresses writing craft in her feedback.[15] Specifically, a common theme in her guidance is for students to move away from the production of polished "correct" writing, guidance I find refreshing having taught freshman English for years. We see this illustrated when she praises Marco for "ignoring conventional grammar and writing 'rules,'" and, as a result, guides him toward freedom of expression without conventional restraints. This is appropriate direction when teaching writing as a way of grappling with challenging experiences in that concern over formulaic rules can be counterproductive and debilitating in this context. Similarly, her emphasis upon the value of Marco "tuning into his own voice" and the resulting clarity of his prose, validates the *way* he wrote his reflection and is in alignment with expressivist pedagogy, which emphasizes the importance of the writer finding her own voice and ideas through free-flowing writing techniques.[16] As a way to highlight why Jo finds his writing to be "SO clear," she makes note of "the pauses [he] took" and the general cadence of the reflection. In the same vein, her feedback on Marco's creative use of a strike-through offers a positive and specific

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[15] I was surprised to discover a disproportionate amount of content-orientated feedback in my responses compared to comments on writing craft; I believe this illustrates how easy it is to become caught up in the lives of our students and lose focus on the need for writing craft responses.

[16] The work of Peter Elbow, Donald Murray, and Wendy Bishop illustrate approaches toward teaching and producing this type of writing work.

response to his writing technique and, as a result, encourages such writing moves in the future. In general, Jo's impressive feedback illustrates how a guiding approach—both in response to content and the writing craft—can successfully function within a RW context. I would advise, however, that responders be wary of explicit directives when it comes to students' lives as the risks potentially outweigh the benefits.

An Encouraging Approach in Responding to Reflective Writing

When considering the points I wanted to make regarding employment of encouragement in responding to reflective writing, I realized I have often needed encouraging feedback in my own educational experience. At the moment, I appreciate encouragement on the writing process from people who have written a dissertation (writing craft feedback) *and* gone through the psychosocial challenges of the process (content oriented feedback). Regarding our medical students, both of these forms of encouragement are potentially important and appropriate considering the vulnerable nature of the experiences and questions with which they entrust us. Yet, like we see in any context in which feedback is offered to vulnerable writing, providing feedback regarding their writing craft *and* the experiences conveyed within their texts requires careful consideration of the appropriateness and ratio of these two types of responses. On one hand, in a context where the content is exploration of the intersection between lives and education, to limit our encouragement to how the writing conveys meaning runs the risk of seeming apathetic in a vulnerable exchange where we are not just analytical readers but fellow humans involved in meaningful communication. On the other hand, offering encouragement regarding content when what the writer desires is to be heard and/or guided in their writing process runs the risk of overstepping boundaries and

encroaching upon a space that is supposed to be safe for freedom of expression. Unfortunately, there are no boiler plate answers when it comes to responding to students (Payne XX) as all writer/responder interactions are unique and, as feedback scholar Joni Cole posits regarding the feedback process, we must "tailor [our] teaching to each student's needs and sensibilities" (146). Therefore, the following example is not meant to proffer concrete guidelines for how (or how not) encouragement should be employed. It is, rather, a model we can use to explore both positive and negative possibilities with the ultimate conclusion being that both types of encouragement are potentially effective and that every piece of writing to which we respond must be carefully considered before making decisions on the type and extent of encouragement we offer. I now turn to a reflection from Anna and a response from Gale, one of our two Med Ed curriculum administrators.

Anna begins with, "Yesterday I was planning to respond to the anatomy-lab prompt, but something came up this morning that has been weighing on my mind, and I feel like I need to say something about it." She goes on to describe how she missed an important activity for which she had signed up as a result of not seeing the notification on her tablet, an oversight she attributes to not being "great with technology." She writes, "I didn't show up like I was supposed to and I feel like an idiot. I guess it's maybe not that big of a mistake? But I inconvenienced people and took up a spot I know a lot of other people wanted and then messed it up and it's also just that it seems like such a stupid mistake to make and so early on in medical school. I feel like now I'm not starting off on the right foot . . . and like people will think if I can't even read an email right maybe I don't deserve to be here." She then relates how her boyfriend tried to reassure her and

that she knows he's right but that she is struggling to let it go. She writes, "I've cried about it like three times today which I know isn't healthy but it just keeps popping back into my head so that's why I finally thought writing about it instead of the prompt might help . . . I guess it's affecting me a lot because I thought I'd have a bit more time before I made . . . such a noticeable [mistake] which is so embarrassing." At this point, she returns to the struggle with imposter syndrome, noting, "Sometimes I'm worried I don't deserve to be here still, like somebody is going to realize they made a mistake and take away my admission. I've felt like [an imposter] so much in school and professional settings and I'm trying to work through it but clearly it's still a problem for me . . . I know so many people who applied who deserve to be here and didn't get in and somehow they chose me instead and I'm worried every time I mess up I'm letting myself and those people who didn't get in and the people who believed I was good enough to be here down." She concludes her reflection with, "And now I feel silly for writing all this because maybe you're judging me for being so neurotic about something that's maybe not that big a deal but I've resolved myself to submit these thoughts anyways because I think I need to work on being more open to sharing my true thoughts with others and not letting things fester inside . . . Also I'm sorry for the bad grammar and formatting but I think the only way for me to not stress about the time this takes is to save time by not going back and spending a bunch of time editing, and also someone pointed out to me that the more I edit my written thoughts the more they might become less authentic, so I'm trying out this style of writing this time."

Gale responds:

> "OMG, do not ever believe that we are judging you! I am so glad you chose to write about something that was causing you stress because this is exactly what reflective writing is designed to do. Making a mistake like you did the first week of orientation is definitely a very forgivable one, and I do not think it will be held against you by any of the other students here at UNR Med. To be very honest with you, I am 61 years old and have been working here for over 13 years and I still suffer from imposter syndrome at least a couple times every month. Especially, when I speak to med students since I am not a physician or a basic scientist. It was really hard for me during my first few years here. Being surrounded by all these very smart, highly motivated faculty and students every day made me feel very inadequate! I promise you will be fine, you just need to move on and be your best self every day. I am glad you have support from your boyfriend, and please feel free to come and talk to me anytime! My door is always open."

As noted above, one approach and purpose for the employment of encouragement in feedback is to address content thought the recognition of successes and/or attempt to assuage anxieties regarding students' journeys through medical school. Looking at Gale's overall feedback, there are many examples of her praising students' personal and academic successes they describe in their reflections. Likewise, in responding to reflections such as the one above, Gale states, "If I get a sense of helplessness or anxiety, I work on my response to be encouraging in a way to give hope and to share my personal experiences or experiences with past med students" so that "they know they have help." In this sense, her encouragement exemplifies the pedagogical philosophy espoused by

writing and healing pedagogues that "[t]eachers can . . . have an important therapeutic role without being therapists" in that she provides support without attempting to "fix" Anna (Berman *Empathetic* 26). In other words, to reemphasize this critical point, we can *facilitate* a therapeutic process *without being* a therapist. And, in an educational journey as intense as medical school—particularly, as rhetoric of medicine scholar Suzanne Poirier notes, one during which many students are transitioning in adulthood as well—contextual encouragement through feedback is a method for doing so in that it provides an affirming response to the work Anna has produced privately, work Anna could continue to do on her own even without feedback (2). We see Gale enacting this approach in the way she encouragingly responds to several of Anna's anxieties.

First, Gale offers encouragement in order to assuage Anna's fear regarding her emotional state. For instance, in response to Anna's fear that the reader may be "judging" her for "being so neurotic about something that's maybe not a big deal," Gale begins with reassurance that she will never be judged. Furthermore, Gale's employment of the text-talk acronym "OMG," promotes the rapport of an empathetic responder rather than an evaluator in order to indicate non-judgmental communication. In this sense, she provides encouragement regarding Anna's fear and, thus, validates the risk she took in her expression of it. Writing and spirituality scholar Regina Paxton Foehr posits that "[t]hrough confronting fears in writing, we accelerate the coping process, a process characterized by discovery of insight, not mere catharsis" (350). I would guess that Gale's encouragement in this example assists Anna in her "discovery of insight" in that her encouragement reframes many of Anna's anxieties and, thereby, aids her movement

beyond catharsis into a different perspective.[17] In terms of appropriateness of the response, the fact that Anna addresses the reader would seem to indicate that a direct response to the ideas she conveys is appropriate and even desired.

Likewise, Gale addresses Anna's specific fear regarding missing an introductory patient-care activity. In noting that "[m]aking a mistake like you did the first week of orientation is definitely a very forgivable one," she downplays the seriousness of Anna's absence without contradicting the reality of it as an error. Had Gale stated that it did not matter, her encouragement might have seemed disingenuous since it did matter (even if only to Anna). Yet, in expressing that it is "very forgivable," she is supportive and reassuring of the fact that, particularly early on, these types of mistakes are not a big deal. To offer a related example, just recently I forgot about a class I was supposed to be teaching—the first time that has ever happened in over a decade of teaching. My anxiety regarding this oversight was extreme until the block director extended me great empathy, pointing out that I was dealing with some heavy circumstances with both my educational and personal life. I believe that had Gale strictly addressed the writing and not extended Anna assurance and empathy, it would not have been in Anna's best interest as Gale, a seasoned administrator, has the appropriate *ethos* for offering reassurance in this context without "playing therapist."

Next, in response to Anna's anxiety with imposter syndrome, Gale employs the valuable, albeit sometimes risky, technique of providing encouragement through self-disclosure, a technique Berman notes encourages his students to do the same and,

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[17] Chapter four explores catharsis and reframing through writing.

thereby, "result[s] in a sharing of knowledge that becomes part of an education for life" (*Empathetic* 29). On the same note, in her seminal article on responding to vulnerable writing, CS scholar Carole Deletiner writes, "My feeling is that the students write for me, week after week, draft after draft, and I owe them something in return . . . I am saying, I am vulnerable too, and we are all in this enterprise together; I trust you with myself, with my words" (316). Gale illustrates this encouraging, pedagogical approach in her employment of self-disclosure in addressing Anna's anxiety that other students deserve to be in medical school more than her and that "every time [she] messes up," she's letting everyone down. In sharing that, despite her experience and long tenure, she still feels imposter syndrome regularly, Gale extends trust and encouragement to Anna. She is telling her, "You are not alone; even an administrator feels this type of insecurity." Through this form of encouragement, Gale relates as a fellow human and, therefore, decentralizes authority in her establishment as an ally to Anna.

Finally, following her self-disclosure, Gale shifts back into a more traditional mentor roll with statements like, "I promise you will be fine" and "please feel free to come and talk to me anytime! My door is always open." These encouraging statements would run a greater risk of feeling patronizing had they come from a different responder such as one of our students. Though I would still be cautious in offering absolutes even when coming from an experienced perspective and framed as encouragement, again, Gale's *ethos* as an experienced administrator in the program largely mitigates this risk. In other words, as noted earlier, there is not a fixed set of rules for everyone to follow and, in this particular exchange, what feels appropriate coming from Gale may not be as easily accepted from a peer.

Another approach and purpose for the employment of encouragement is to offer students encouraging feedback on their writing craft in order to foster compositional confidence and highlight successes—an identical practice as offering encouragement to content except that the focus is on writing rather than students' content relating to their educational journeys. CS has a long tradition of promoting the importance of encouraging feedback on writing craft (often termed "praise," though praise does not encompass encouragement offered to fears/anxieties) beginning with the expressivist movement in the 1960s. Many arguments toward this end exist such as that "[w]ell focused praise" of even minor successes promotes greater growth than highlighting failures in that it empowers writers (Elbow "Ranking" 202); because "writing about a growth-enhancing subject" is often deeply personal, "[a] teacher's warmth, genuineness, responsiveness, and acceptance are especially important" because to critique writing of this nature in the same manner as an academic paper runs the danger of silencing the student (Berman *Risky* 36); for students who are fearful of writing, offering praise allows them to "experience success" they may not have had in previous writing contexts (Daiker 157); and, an encouraging comment such as "great insights" demonstrates to students that we see them as writers "with things to say" even if they are still in early developmental stages as writers (Sommers 255). Perhaps my favorite argument is also the simplest. Cole suggests that writing teachers "remember [their] own feedback stories . . . the particular someones who have been instrumental in [their] writing li[ves]" and consider how "a few words of honest encouragement" inspired them to continue writing (110). I'm sure we can all attest to the truth of this as well the opposite experience (a huge "F" with the

comment “be creative on your own time” nearly caused me to drop my freshman composition course despite the fact that the instructor probably had a valid criticism).

Moving forward, I turn to toward encouragement in writing craft. Gale provides an example of this approach when she writes, “I am so glad you chose to write about something that was causing you stress because this is exactly what reflective writing is designed to do.” This comment validates Anna’s decision to focus her writing upon what was weighing on her and, thus, praises her choices as a writer. It is easy to imagine how Anna might have felt had Gale criticized her for not addressing the cadaver lab prompt rather than offering encouragement. However, in this particular piece of feedback, this is the only instance of encouragement on *how* the reflection is written despite several opportunities for doing so. Specifically, although Gale notes in her interview that she doesn’t “care how much [students] are grammatically correct when they’re sharing something,” she doesn’t respond to Anna’s statement, “Sorry for the bad grammar and formatting” but “someone pointed out to me that the more I edit my written thoughts the more they might become less authentic so I’m trying out this style of writing this time.” This is an optimal opportunity for Gale to offer Anna encouragement regarding this choice, especially as Anna is absolutely correct in her assessment of RW in the context. Additionally, Anna’s clarity of voice and willingness to share her “true thoughts with others and not let[ ] things fester inside” is, in my opinion, highly worthy of praise. However, to criticize Gale’s shortage of encouragement regarding writing craft would be unfair because, as described in the introduction, I offered no training on the importance and technique for doing so. Furthermore, the reality is that capturing all potentially helpful types of feedback within one response, particularly when time is limited, is rarely

realistic as my own efforts, those of the writing professional, would illustrate were we analyzing my feedback.

In the end, after exploring the individual approaches found in the data, I posit that offering encouragement provides just as valuable a feedback tool as listening and guidance in our responses. As Daiker notes, "Since positive reinforcement, or its lack, is so crucial to a student's level of writing apprehension . . . one way of reducing apprehension is by allowing students to experience success with writing. They will experience success, of course, whenever their writing is praised" (156). We want our students to not only learn how to write but to believe in their ability to do so. Furthermore, in a context where writing is being taught as a practice for fostering personal and professional wellness, providing encouragement for both the writing *and* the experiences about which they write is not only appropriate but paramount at times. After all, we are teaching and modeling humanistic communication for the provision of health-care, which includes understanding how *and* what comments are made.

Conclusion and Recommended Practices

It was both exhilarating and terrifying to realize that many of my opinions on how to offer safe, productive, and empathetic feedback were shifting as I gained more knowledge and wrote this chapter. It was exciting in that I saw ways to be engaged in both students' writing and their experiences without overstepping boundaries; it was terrifying in that I became aware of my past mistakes and the need for a fair amount revision of practice. Accordingly, the purpose of this chapter has been to provide a "feedback framework" for anyone engaged in this type of work. However, I must reiterate, that a framework for a process of making good feedback choices is different

than a predetermined set of criteria for offering responses to students as a rule. After all, while there are certainly wrong ways of responding to students, there are many right ways of going about the process, ways that are highly dependent upon writing context, the responder, and (most importantly) the student (Elbow "Ranking" 198). As Straub notes, we would do well "to develop a repertoire of responses—and learn to use different strategies for different students and different classroom situations" (*A Sourcebook* 149). Or similarly, Tobin posits that "[e]ffective teaching is so difficult to achieve and differences in personal styles and material conditions so profound, it seems wise to keep all reasonable options on the table" (205). Accordingly, as a way to offer a pragmatic exploration of such options, I now turn to my own revelations and revisions as generated by this research. Following this and as a way to conclude the chapter, I outline a "feedback framework" workshop I have begun to facilitate at our institution.

First, I've come to see listening in feedback as the safest approach in that allows for a reader to indicate that they are present and engaged without the risks of co-opting the writing. Specifically, it offers the writer the reactions of a reader rather than a critic with a red pen or a concerned mentor and, accordingly, provides a writing space that honors the freedom of expression without fear of intervention. The downside is that a listening approach when offered in excess can come across as distant or unresponsive to student needs both in terms of the writing and the content. Personally, I have begun to include more listening comments, particularly as they relate to how students have conveyed meaning through writing techniques. I find that in doing so, I am able to comment upon writing craft while also providing an attentive "ear" regarding the content.

In short, listening feedback has become a substitute for much of my experiential guidance.

When it comes to guidance, my perspectives and approaches have shifted more radically than in any other category. In looking at the data, I was troubled to see the extent of comments that, while typically worded gently, gave students directives for how they should go about approaching the content-based circumstances described in their reflections. Doing so runs a risk of violating our agreement to provide a writing space free (excepting safety concerns) of consequences and, accordingly, can easily silence students or even direct them down a risky path. Guidance conveyed through our own related experiences (or those of other students with whom we've worked), on the other hand, mitigates much of the risks stated above while still potentially aiding students in the fashion of a mentor. They also illustrate our own willingness to be vulnerable, an important act. Though providing explicit directives regarding *how* to go about writing reflectively is appropriate in that we are teaching student how to write, I still find that experiential guidance regarding our own writing processes to be more effective than telling a writer what to do, especially within a context where writing is being used as a tool for thinking and wellness, what CS scholar Robert Yagelski terms "writing as a way of being," rather than more traditional academic work (*Writing as a Way*). However, whether responding to content or writing craft, large quantities of experiential guidance run the risk of co-opting a reflection, an issue I came to recognize in my own feedback and have since addressed.

Third, my current perspective on encouragement is that it should consistently be interwoven throughout feedback. In terms of writing craft, while I am not advocating for

false encouragement—what Tobin describes as "unqualified praise" (201)—in that it does not necessarily aid the writer and is likely to be spotted, we should remember how we have felt when receiving encouragement for our writing and what that did for us regarding confidence and motivation to continue the practice. This is especially true for unconfident writers whose previous experience likely involved enduring heavy critique. Furthermore, regarding responding to the content of reflections, I have always felt gratitude (nearly a sense of relief) to receive encouragement when I am struggling with my life as it intersects with my education, particularly from someone who has been through similar experiences. In this sense, I plan to offer small pieces of encouragement whenever it is appropriate to do so.

Before turning to the "feedback framework" workshop, I want to briefly address a question that was posed to me by a colleague from the English department who asked whether or not the results and recommendations of this study were transferable for providing feedback to students in a first-year-composition (FYC) course. This is an important question but not one with a simple answer. Like considering when or when not to use elements of listening, guidance, and encouragement in feedback, whether or not the recommendations in this chapter broadly apply to the teaching of writing in general really depends upon the specific context, instructor, and student. The fact that the goals for RW in Med Ed (a tool for catharsis, processing, and witnessing) vary from those generally espoused for FYC (a critical thinking tool and preparation for academic writing) is an automatic indicator that feedback should be contoured to meet the overall goals/purposes of the writing. Furthermore, even within these individual writing contexts, the purposes likewise vary. An excellent illustration is found in my feedback to a

reflection from Amara, a clerkship student whose work I analyze in chapter four. When I first responded to her piece "Emptied," my comments were grounded in listening and encouraging approaches as my prime objective was to show her that she had been heard and that her writing was outstanding (the narrative still brings me to tears when I read it). The second time I provided feedback, however, it was in the context of her wanting to submit the piece for publication. With this shift in purpose and audience, my comments were primarily directive and writing craft orientated, particularly as I had already communicated to her on the affective power of her story. Likewise, my feedback to students in FYC has varied drastically depending on the type of assignment (personal essay vs. research essay) and individual student (new writer vs. experienced). Put as simply as possible, the three categories of feedback broadly apply to all writing contexts, but the ratio of their employment must be contextually grounded.

Finally, to conclude, I offer a "feedback framework" workshop template grounded in a pragmatic application of this chapter's conclusions. In doing so, I hope to provide training toward the effort of making the best possible choices when responding to reflections.

A "Feedback Framework" Workshop

Step 1: The facilitator begins by selecting one or two student reflections for participant review. Choice of texts should be carefully considered with an orientation toward examples offering a range of content themes and writing craft approaches. For instance, reflections that are literary, resistant, non-structured, apathetic, highly vulnerable, rote, intellectual, and inspiring are all useful models for practicing and sharing responses. If participants are already engaged in responding to student writing, one option is to have them self-select a reflection, de-identify the text, and email it to the facilitator for use at the workshop *if* this is not a violation of confidentiality. This approach decentralizes workshop authority and provides an authentic, pragmatic format.

Step 2: Reflections are then distributed to participants for reading and written response. Although the amount of time needed for this step will, of course, vary between responders, I recommend allotting no more than 15 minutes per reflection as an important practice in offering feedback is learning time management.[18] A time limit also aids in the workshop's ability to cover more than one reflection.

Step 3: In step three, the facilitator offers a brief presentation on listening, guiding, and encouraging, as well as the differences between content and writing craft focused comments. Ideally, this would involve a handout and/or PowerPoint presentation in conjunction with the solicitation of opinions from the participants regarding the risks and rewards of the different feedback styles. This step only needs to be performed once if multiple workshops will be conducted with the same group of participants.

Step 4: Next, using highlighters (or highlighting on a Word doc) have participants code their reflections for the three types of feedback while also noting if their comments are content or writing craft focused. Just as I discovered in my own coding efforts, comments can reflect more than one category. Let participants know that it is fine, even beneficial, to classify comments as belonging to more than one category and that these can be discussed.

Step 5: Once coding is complete, ask participants to note any comments about which they are uncertain. This could include comments that are difficult to classify and/or comments that, after reviewing their own feedback, they now question in terms of effectiveness or appropriateness. I suggest acknowledging that the purpose of this is not to highlight "mistakes" but, rather, to provide an opportunity for the group to discuss difficult feedback questions.

Step 6: At this point, each participant (who is willing) reads her reflection aloud while cohorts write observational notes regarding insights, questions, and/or comments. These notes, however, should be saved for the next step.

Step 7: Once everyone has read, begin a group discussion so that participants can exchange ideas regarding the advantages and disadvantages of different types of approaches to the specific reflection being discussed. Commenting on each other's feedback is acceptable—even beneficial—but should be done respectfully, particularly if it involves any type of critique. This discussion is also a good time to have participants consider how their individual personalities and relationships with students might affect their feedback choices. If participants have responded to more than one reflection, set a time limit for discussion on each reflection in order to assure that there is time to cover them all.

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[18] Richard Straub's chapter "Managing the Paper Load, Or Making Good Use of Time" in *The Practice of Response: Strategies for Commenting on Student Writing* is a valuable resource regarding time management.

Step 8: To conclude the "feedback framework" workshop, ask participants to write reflectively on the workshop for five to ten minutes (i.e. insights, concerns, goals for future practice). This step is designed to help them structure the experience in to a cohesive narrative and, therefore, solidify the knowledge and ideas they acquired from the workshop. Let them know that this reflection is for their own use and will not be shared at the group level.

Step 9: Later, after they have gotten the opportunity to put their feedback training into practice, email participants to ask if they have noticed any differences in how they are responding to students and if they have any feedback to offer regarding the workshop.

Nearly two years after our initial RW meeting, I gathered the team for a pilot version of the workshop outlined above. We were in the process of responding to end-of-the-year reflections, and it seemed a perfect time to fill the gap in feedback training that had emerged during the nascent stages of our program's development. We were all incredibly busy, so an hour was all the time I could manage to coordinate. Yet, it was enough for a pilot effort. As we listened to each other read our individual responses to the same student reflection and discussed the purposes and variations in approach, I sensed enthusiasm and, perhaps, even a touch of relief in the team, emotions with which I could identify. A systematic approach for exploring our approaches to offering feedback was long overdue. A "feedback framework" did not provide all the answers, but it did provide a way to consider how we might find and discuss them within individual contexts.

Chapter 3: Design and Facilitation of Reflective Writing Assignments: An Illness Narrative Case Study

Eight of us sit around a table in a sunny room overlooking the University of Nevada, Reno's campus while Andrew reads his illness narrative, a narrative describing an experience he had while running a search and rescue operation out at Pyramid Lake.[19] His team had spent most of the night searching for a missing fisherman, a veteran recently returned from Afghanistan, when Andrew halted the search for a few hours due to the improbability of his small, utterly exhausted team finding the man alive at night somewhere in the 188-square-miles of freezing water. When they resumed the search at dawn, they found him. Andrew reads:

> "[H]e was wearing a lifejacket, floating upright with his arms gently on the surface in the shape of a barrel with his head cocked back and his eyes up toward the sky. My first thoughts turned my stomach. Was he watching the stars over the lake as he froze to death, or was he watching the search light of our helicopter pass over him like a ghost while searching the shoreline nearby? . . . Michael survived a war but froze to death alone in a cold lake in the United States . . . I cannot know if Michael was still alive when we called off that search but the position of his head and eyes have always made me doubt my decision . . . Dead or alive we did him an injustice. We abandoned him . . . I had been on call for more than a week and worn thin from a string of long, draining missions prior to that night. Did I make that call because I was tired? Were we really out of

[19] For the protection of this student's privacy, a pseudonym has been used.

> options? Why couldn't we search all night and rotate a fresh crew in the morning? Being the team that shows up when you call 911 on your last resort, we didn't deserve to go home."

As he finishes reading his story, a story he had worried wouldn't carry "much impact" because it wasn't about his own illness, there is stunned silence. And then feedback pours out of classmates validating his conflicted emotions and praising the vulnerability and skill of his writing, feedback that generates a discussion on exhaustion and accountability in medicine. Afterward, conversations continue into the hallway, and one student stops and tells me that she feels closer to her classmates and that she hadn't truly considered how much her own illness experience had impacted her life until she'd written about it (one of those great teaching moments when the work and communication with students feels especially authentic and inspiring).

I begin with a vignette because it paints a portrait of the identity of the reflective writing (RW) work we are doing at University of Nevada, Reno's School of Medicine and, accordingly, illustrates why this work is worth the risks and complications discussed within the chapter. Unfortunately, it does not provide a complete picture and neglects two areas of investigation that are essential for instructors embarking upon the process of teaching RW. First, as I discovered several years ago when first designing RW assignment sequences, while specific types of RW projects are outlined in medical education (Med Ed) literature, they offer little in the way of pedagogical description. In other words, the nuts and bolts of instruction works are frequently missing. An example of this gap is seen in narrative medicine pioneers Sayantani DasGupta and Rita Charon's article, "Personal Illness Narratives: Using Reflective Writing to Teach Empathy," the

article that inspired the illness narrative project explored within this chapter. While the two physicians do an *excellent* job defining and justifying illness narratives within Med Ed, their description of the pedagogy involved in the six-week illness narrative seminar they designed is limited to a few paragraphs providing basic information such as a list with a sentence description of each week's writing exercise, brief descriptions of student reactions to the course, and comments such as that students "read aloud from their work" (353). I recognize that detailed exploration of how the course was taught is outside the scope of the six-page article and, furthermore, these authors *do* produce the type of scholarship for which I am advocating. [20] Yet, this ease does not ease my disappointment at the absence of descriptions of readings, prewriting exercises, how class discussions were facilitated, how writing support was offered, and how students were guided in the sharing process. Furthermore, since having the opportunity to facilitate a six-week RW seminar was not an option I had, I was disappointed in the lack of discussion on how the process might be adapted to a shorter timeframe. These types of pedagogical gaps within RW literature are, unfortunately, common.

The second important gap in RW scholarship's pedagogical description is exploration of student concerns and curricular complications—when things do *not* go smoothly. While Med Ed literature grapples with the overall ethics and effectiveness of

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[20] Charon's edited anthology *The Principles and Practice of Narrative Medicine* is an excellent exception in that several chapters outline pedagogy and share student writing. It also provides valuable background on narrative medicine and its response to a dualistic, *bio*medical framework.

DasGupta and Hayhurst's *Stories of Illness and Healing: Women Write their Bodies* presents a feminist perspective on illness narratives through the presentation of reflections from a variety of women ranging from physicians to patients to caretakers.

RW, it neglects specific issues educators encounter within their classrooms and how they address those issues. Even a useful text such as psychiatrist and therapeutic writing specialist Dr. Allan Peterkin's *Portfolio to Go: 1000 + Writing Prompts and Provocations for Clinical Learners*, which provides pedagogical guidance in RW assignment design, stays primarily with lists and general suggestions for aiding writers and facilitating group work. In other words, we do not hear about students frightened by the writing process or who resent required participation in RW curriculum. For instance, DasGupta and Charon note students' negative reactions to the writing process such as feelings of "vulnerability, embarrassment, detachment, exposure, confusion, resentment, fear, and difficulty," but they do not cover why these feelings manifested (354). Questions of how to prevent and respond to such reactions are, likewise, absent. As an instructor engaged with vulnerable RW writing, I want to hear how others have navigated *specific* issues that inevitably arise when working with writing of this nature beyond general suggestions such as: "Ground-rules regarding strict confidentiality outside of the seminar, respect for others' experiences, and support must be established early and articulated often" (DasGupta and Charon 355). When a student expresses concern that s(he) might be having a PTSD reaction while writing a narrative, instructors need to have resources ready to provide support.

This chapter addresses these gaps through a study of an illness narrative project I designed and facilitated for medical students at my institution in order to contribute to the understanding of RW instruction in two ways. First, in examining how I designed the course *and* offering suggestions grounded in revisions I intend to perform in future iterations, I offer a thick description in order to provide the type of pedagogical details

needed for those embarking upon RW instruction. Additionally, the field of Composition Studies (CS) has long been engaged with writing assignment design and, accordingly, speaks to many of the same pedagogical issues and needs. Furthermore, while I acknowledge that the composition and sharing of illness narratives is a very specific type of RW work, the practices I explore are transferable/translatable to other RW curriculum in that core objectives and writing structures involved in RW tend to closely align in their efforts toward wellness and metacognition. Therefore, through exploration our illness narrative project and related CS scholarship, I hope to provide a template of sorts—not as a static "how to" manual for a specific assignment design but as a point of departure for effectively designing and implementing RW assignments in general.

The second purpose of this chapter is to consider and address student concerns that arose throughout the project. Because of the vulnerable and, at times, risky nature of RW in general, the exploration of their concerns is, like assignment design, germane to RW contexts outside of illness narrative work. In addition, CS has a wealth of scholarship exploring similar types of student concerns, which is also included in this chapter. And, while I must admit to some unease with situating concerns as one of the two focal points lest I paint a negative picture of RW, it offers a pragmatic gaze as successes have already been documented in Med Ed literature while troubleshooting has been afforded little attention. Accordingly, it is my hope that in engaging with student concerns, I provide a framework for the consideration of these types of issues.

To achieve these two goals, the chapter begins by outlining the project's pedagogical structure while also providing a general definition and purpose of illness narratives in Med Ed. Following this, I provide an overview of the data informing the

project and the methodology employed for its analysis. Next, I examine nine student concerns that arose during the process of writing and, after, during the process of sharing their illness narratives. Specifically, I present the voices of worried students and then respond to concerns from the differing perspectives of other students, my own experience as a RW instructor, and the voices of scholars, primarily from CS, speaking to the same issues. To conclude, I offer suggestions to aide with RW assignment design and the mitigation of student concerns. It is my hope that this overall structure provides a useful pedagogical template and problem-solving guide for those embarking upon this work.

The Illness Narrative Project Design

In the spring of 2019, I facilitated an illness narrative writing project with sixty-six second-year medical students during their Context of Patient Care (CPC) block, a block centered upon psychosocial aspects of healthcare.[21] All activities were conducted with IRB approval (1296420-2). While form and style varied, the focus of the illness narratives students were asked to write involved an accounting of serious illness/injury either experienced personally by the physician in training or alongside someone whose illness/injury affected them emotionally—typically, family or friends. Generally speaking, the goals of RW projects such as this one, as medical educators Johanna Shapiro and colleagues describe, are: 1) developing empathy for patients and one's self; 2) uncovering possible shame regarding illness; 3) uncovering biases and personal challenges; 4) exposing students to types of discomfort in communication they will

[21] In a healthcare context, "psychosocial" refers to issues surrounding the psychological, economic, social, sexual, and cultural identities of patients, physicians, and governing bodies.

encounter while providing health-care; 5) helping students avoid confusing their own narratives with those of patients; and 5) encouraging students to consider the bodily realities of illness beyond a *bio*medical framework. Or, as Charon and Dasgupta note, "If giving and receiving accounts of self are central events in health care, then the better equipped we all are to receive and express our accounts of the lived experiences of health and illness, the more accurate and, perhaps, more effective health care can be" ("Editor's Preface" ix). Accordingly, I designed the illness narrative project as means for exploring and practicing ways of understanding and interacting with illness that extend beyond the silencing limitations of a strictly *bio*medical framework.

Though our project was inspired by the aforementioned illness narrative work at Columbia, curricular limitations required that I modify their six-week structure (involving multiple writing assignments employing a range of genres) to composition of a single illness narrative with two sessions: one to introduce and brainstorm and the other for students to share their writing. I also drew on my years of experience as a university writing instructor in the field of CS. Accordingly, the project followed a structure I have employed in a variety of writing instruction contexts.

Prior to the first session, students were asked to read illness narratives from *Stories of Illness and Healing: Women Write their Bodies*, a local author, and one of my own pieces describing a troubling health-care interaction while caretaking for my late wife. The readings were chosen for their brevity, eclectic authorial backgrounds, and employment of different writing styles meant to provide students with a variety of potential approaches. While I debated the inclusion of my own piece, I ended up subscribing to first-year-writing researcher David Sudol's argument that it is not only

useful for students "to share their work with each other," but also for the instructor to "share [her/his] writing with the students" in order to see her/him "as a fellow writer, struggling with the same problem[s]" (242). Furthermore, in our specific context, I wanted to demonstrate vulnerability while acknowledging personal motivation for my investment in the project.

Ideally, the first session would have begun with group work surrounding the readings, but, due to the block's overcrowded schedule, we were only afforded 30 minutes, and I had to prioritize introductory activities. As many medical students are data and *ethos* orientated, I began with a ten-minute PowerPoint outlining the background, purpose, and effectiveness of illness narratives in medical education as illustrated through Med Ed research as way to provide a foundational understanding and foster students' willingness to engage in the work. At the conclusion of the PowerPoint, we transitioned into a brainstorming exercise that had students list illness experiences and, after, used filters such as circling narratives that felt unresolved or ones that led to shifts in perspectives as a means for narrowing possible topic selections. Once students settled on an experience to explore, I had them freewrite on the topic for five-minutes using techniques established by expressivist pioneer Peter Elbow and writing and healing scholar Marian MacCurdy, emphasizing that they were not locked into the topic and would not be sharing the freewrite with anyone.[22] Following this writing exercise, we reviewed the assignment sheet and used it as a spring-board for a discussion on questions

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[19] Elbow's *Writing Without Teachers* offers detailed suggestions for freewriting techniques, and MacCurdy's *The Mind's Eye: Image and Memory in Writing about Trauma* is heavily grounded in sensory-memory recall, and, therefore, provides useful strategies for employing the five senses in brainstorming activities.

and concerns regarding the project, a discussion, as I posit in the conclusion of the chapter, that needed more time. This concluded our first session.

The next step had students respond online and independently to a brief, three-question "pre-reflection" that inquired into their hopes and concerns regarding 1) writing an illness narrative, 2) sharing that illness narrative with their group, 3) and the type of feedback they would like from peers. I required that students complete this survey before submitting their illness narratives in order to give them a chance to reflect on the project prior to writing.

Once the pre-reflections were completed, students wrote their illness narratives, which ranged in length but were generally between 600 – 1500 words.[23] These narratives were then brought to group sessions consisting of seven or eight students where each student read their piece aloud and received peer feedback. I conducted eight of these sessions total. Following each session, I wrote individual students a response to their narratives and asked if they would be willing to give me a bit of feedback on the overall experience. Ideally, I would have required a post-reflection, but the amount of work already squeezed into a two-week time-period gave me pause. I had a total of 25 out of 66 students respond to the post-reflection request and one who came to speak with me in person.[24] Additionally, I had access to their course evaluations, which provided useful

[23] Outliers include a student who wrote a 300-word poem and another who wrote 2,500-word story, an impressive effort but one complicating time restraints during the sharing session.

[24] Based upon past experience, this response rate from medical students to an optional request is high. Their willingness to reply, I believe, reflects reciprocity for my efforts in responding to each of their narratives in detail.

data for this chapter as it was the space in which several disgruntled students communicated their concerns.

This chapter, which explores the project's pedagogy and related student concerns as a means of drawing broader conclusions for RW work, is grounded in five types of primary data derived from this work: 1) pre-reflections; 2) students' illness narratives; 3) researcher notes spanning the entirety of the project; 4) post-reflections; and 5) student evaluations of the project embedded within an evaluation of the CPC block as a whole (required by the university). Due to the shortage of pedagogical guidance in Med Ed literature regarding writing instruction, I decided to focus my gaze upon the data reflecting *how* the writing was taught and *how* its production and oral performance affected student perceptions/experiences rather than themes emerging from their writing itself. To do so, beneath a grounded theory overview, I employed thematic analysis grounded in Nowell and colleagues' six-phase methodological, the same approach used for chapter two.

In phase one, "familiarizing yourself with your data, I carefully reviewed student responses to the pre-reflection, post-reflection, and evaluation form and familiarized myself with the content. In addition, I wrote reflective notes regarding general impressions of the data and potential secondary data connections. In phase two, "generating initial codes," I read through the data several more times and labeled responses (e.g. "student fears peer judgement during session"). In phase three, "searching for themes," I created lists and diagrams of the recurrent responses found in the data as a method for identifying and filtering overarching themes. In phase four, "reviewing themes," I reviewed and coded the data using the emergent themes. In Phase five, I

considered the broader picture in terms of how the themes interrelated and could be organized to accurately reflect the data. This chapter, which is phase six, presents my findings.

Ultimately, I discovered that a number of students had concerns relating to both writing the illness narrative and sharing it. As a response, I place these concerns in conversation with alternative perspectives from their peers, my own experience, and scholars working with similar forms of writing. Through this exploration, I provide a more comprehensive picture of the pedagogical realities in play with work of this nature and, in doing so, I hope to help future instructors to both mitigate the risks and be prepared to respond to anxieties. It is also my hope to illuminate the value of this work—to posit why it is truly needed in Med Ed and worth the risks.

Concerns with the Writing Process

Concern with the writing process is, while not ubiquitous, perhaps even more common within the Med Ed student population than in a traditional composition classroom. I attribute this to two factors. First, because the majority of medical students emerge from STEM-based backgrounds, their experience with personal forms of writing is often limited (even non-existent). As a result, the genre(s) can feel foreign and generate anxiety regarding their ability to, in the words of several students, "do it right." Similarly, because traumatic memory is, as writing and healing pioneers Charles Anderson and Marilyn MacCurdy note, "not connected to the normal, linear flow of timebound memory" and *the facts* of an event are often murky, students also expressed concern over

their ability to "truthfully" write their stories (6).[25] Finally, the vulnerable nature of the RW work taking place with illness narratives is often emotionally challenging and, as a result, generated concerns among students about how the process of writing the narrative might affect them psychologically. This section explores these concerns.

Writing Concern #1: Doing it "Right"

One of the most common concerns expressed to me by students in the three years I've been teaching RW in Med Ed is that they are not "good" writers, and, therefore, will have difficulty "doing it right." Not surprisingly, this concern presented itself in the pre-reflection data. For example, several wrote disparaging remarks regarding their writing abilities such as: "I am not concerned about writing this thing other than the fact that I am not a great writer or storyteller"; "My writing is not perfect and desperately needs work"; and "I know my [writing] is not good, that's why I went into medicine!" Similarly, a student expressed anxiety over her compulsion to write correctly, noting that she has "a bad habit of rewriting every sentence until it is 'perfect.'" One student, to my surprise, told me that it took him seven-hours to write his 600-word narrative because he "sucks as a writer."

The students' concerns over being good writers and producing correct texts is understandable in light of their histories with what Robert Yagelski, a scholar engaged with research on alternative forms of writing in education, describes as "mainstream writing instruction" and its misplaced obsession "with textual form and adherence to convention" ("A Thousand" 8). I would venture that most writers, even those of us who

[25] The concept of "facts" relating to trauma is problematic and will be addressed in this chapter.

teach and produce it professionally, can relate to concern over our ability to "do it right." Yet, at the very foundation of our project (and RW in general) is a radically different philosophical approach to the purpose and process of writing, an approach Yagelski terms as "writing as a way of being" in which writing instruction is "focus[ed] on the *writer writing* rather than on the *writer's writing*" (*Writing as a Way* 9). Others in the field of CS agree, noting that when focus shifts away from textual production, writing is: "not simply a way of thinking but more fundamentally a way of acting" (Cooper 373), a way to "to try things out symbolically, so that we can make better decisions about what we value and do" (Warnock 51), and "a useful, personal, and productive activity, perhaps even as part of a therapeutic process of coming of age" (Bishop "Writing is/and "Therapy" 506). Likewise, narrative medicine professor David Hellerstein notes that the best student writing emerges when they realize that writing is "something they can *be* . . . a way of experiencing the world, of living in the world of medicine" rather than simply something they produce (274). In other words, the purpose for the compositional process lies in what the author gains and, as a result, enacts from the experience of writing. When students are able to accept the validity of this framework, anxiety to produce "good" and "correct" writing is mitigated.

Speaking to this perspective, several of my students lauded the compositional freedom of the illness narratives. One wrote, "I like that we don't have to worry about perfecting our writing. Instead, we get to let the words just flow out of us." Another student commented that he has "no concerns" with writing his narrative "since grammar, punctuation, etc. do not have to be perfect. This takes a lot of pressure off the writing process itself." Similarly, in a post-reflection, a young woman commented on the value of

writing that was not "super 'sciency' stuff" and that she "did not realize how much [she] could write in a short amount of time when [she] just wrote instead of thinking about writing." One of the most interesting comments I received was from a student who announced to the group that procrastination had actually helped him since he hadn't had much time to "fix" his narrative while writing, and, as a result, it was "probably more truthful."

I know from my own experience of writing throughout my wife's journey with terminal illness, the writing that felt most meaningful and honest to me (and, as feedback seemed to indicate, to my readers) emerged when I was able to let go of my concern over writing convention and, instead, allowed the writing to function as a tool for generating an understanding of events that had previously felt beyond my grasp. One of the most eloquent expressions of this concept comes from Leslie Marmon Silko who, in describing indigenous storytelling practices, writes, "Where I come from, the words most highly valued are those spoken from the heart, unpremeditated and unrehearsed . . . As with the web, the structure will emerge as it is made and you must simply listen and trust . . . that meaning will be made" (49). Put simply, a "writing as a way of being" framework offers freedom from product-orientated anxieties because all it takes to produce meaningful writing is willingness to accept that the process of writing is the point and not the resulting text and that meaning will be made as a result. When this perspective is at the foundation of RW, concern over "doing it right" becomes a matter of honesty and habit rather than the strict adherence to the structures valued in more traditional academic writing.

Writing Concern #2: Doing it "Truthfully"

From the start of the project, I emphasized the importance of honesty in their writing as foundational for the illness narratives since the process is about exploring and understanding events in their life and not crafting a text that is artistically pleasing. In response, several students expressed concerns regarding their ability to "truthfully" write their narratives because they could not remember specific details of their illness experience such as dialogue, images, and order of events. And, because they felt these details were necessary to compose an accurate account, gaps in memory became disruptive to their writing process. For example, one student in his post-reflection wrote, "There was no way I could remember what people were saying at the time and it didn't feel quite right to make up conversation like you suggested (no offense :D). But the story felt kind of flat without dialogue." Another wrote in her pre-reflection, "My concerns . . . are associated with fear that I may not remember the details of the event as well as I should . . .which may cause me to feel some shame given the fact that the event is something I often think about and feel has affected me significantly." Finally, one student noted, "I am concerned about altering the story, as my recall of the events becomes less and less clear . . . the actual memory is very chaotic and fractured and I have to be careful to not fill in blanks."

Regarding this anxiety, a camp of trauma theorists posits that due to the chaotic nature of how memories are formed during times of duress, trauma can never *truly be known* and, therefore, conveyed through writing other than to mourn and acknowledge the experience. Rhetorician Michael Bernard-Donals, for example, argues that the "rhetoric of disaster, founded on a displacement of knowledge rather than its production,

presents us with an impossible ethics: to remember that which we cannot possibly write as knowledge" (74). Reinforcing this sentiment, CS scholar Lynn Worsham posits that because a traumatic event is perceived and stored outside the parameters of "normal reality," the result is "the impossibility of constructing . . . an adequate representation of the event" beyond conveying "the fact it actually happened" (178). In other words, while this position does not reject a survivor's right to explore their experience through language, it does assert that the survivor cannot compose an accurate account of the experience because the knowledge required to do so is lost in the experience of trauma.

Bernard-Donals and Worsham's positions are rooted in the supposition that a *truthful* narrative must have fidelity to what Vietnam veteran and creative-nonfiction author Tim O'Brien terms as "happening-truth," which refers to the concrete details of an experience (171). The method, both pragmatic and philosophical in nature, for addressing concerns related to the difficulty (or impossibility) of portraying "happening-truth" is grounded in what is known as "story-truth," the idea of accurately portraying the deeper emotional truth of an experience through a subjective and malleable account. As O'Brien puts it when describing his use of creative license in recreating wartime scenes, "I want you to feel what I felt. I want you to know why story-truth is truer sometimes than happening-truth" (171). In much the same way a painter's subjective recreation of a scene can potentially convey a deeper emotional truth than a photograph, story-truth's freedom from strict adherence to happening-truth's details allows it to creatively probe at the essence of an event despite gaps in memory or complicated timelines. Accordingly, situating "happening-truth" as a non-negotiable prerequisite for honest narrative accounts—what rhetorician Barbara Couture describes as a fixation upon the false "belief

that truthful writing corresponds to a single concrete reality and that facts are disassociated from beliefs"—can actually stand in the way of a truthful portrayal in its positivistic restraints (qtd. in Bloom 104).

Those who work with writing and healing agree. However, rather than seeing the fragmented nature of trauma memories as evidence that trauma narratives can never be true, they position such narratives within a different form of truth, arguing that the notion of an objective truth is indicative of "platonic essentialism" (Johnson 106) and that trauma narratives need "techniques to reconstruct image" (MacCurdy "From Trauma" 172) in order to arrive at a deeper truth so that we may "develop a representation of the self that is congruent with the experience" and move away from cliché into story-truth (Anderson and MacCurdy 6). As community writing activist and poet Rosemary Winslow posits, our traumatic history "lives in preconceptual figuration, beyond language, and to 'see' its truth, we need imaging strategies that move us into its world; otherwise we cannot 'see' . . . its language-exceeding truth" (610). Others go as far as to state that it is *only* through the creative process of reconstructing our experiences "that trauma is made present" (Goggin and Goggin 31). Put simply, reconstructive efforts in composing one's trauma carry the potential to arrive at a more nuanced and honest truth—story-truth—than the restraints present in strict adherence to factual details—happening-truth.

"Story-truth" is *not*, however, an endorsement of *carte blanche* freedom in recounting events. For example, if my student who wrote about his history with a suicide attempt had changed the ending from acknowledgement of his continued struggles with depression to a recovery narrative in which he learned his lessons and moved on, it would

be dishonest both at the level of happening-truth and story-truth. However, if it turned out that the exact conversation within his narrative didn't take place but was included as a mechanism for portraying the relationship between him and his father, then "story-truth" has been maintained even if happening-truth isn't fully accurate. In fact, as O'Brien tells us, a dialogue would portray a more "truthful" account of the experience than a thin version in which a reader is given only a vague, colorless representation due to limited "happening-truth" memories. The fact that many of the illness narratives students wrote made use of detailed dialogue and description, including accounts from when they were young, illustrates some acceptance of story-truth as a legitimate approach.

To illustrate this point, I shared the following personal example of story-truth with my students. The day after my wife was diagnosed with brain cancer, I wrote about the experience as a way to process the incomprehensible news. I had been, of course, in a total state of shock when first hearing the diagnosis, and my ability to remember many of the specifics the next day were sketchy. Yet, I remembered the *feeling* of the details even if *specifics* were lost in the horror and confusion. In particular, I wrote of pulling over on the side of the road so my wife could vomit on a patch of grass. This was "happening-truth." In my story, however, I describe it as being in front of the Olive Garden and watching average-looking families stroll by on their way to eat pasta while we tried to comprehend the unfathomable hell we'd just entered. I do remember people staring at us, but I don't remember who they were or even where we were. My use of families in front of Olive Garden was intentional because it conveyed the radical disconnect between the world we were entering and the lives we had suddenly left behind. In this sense, the "story-truth" here is much closer to capturing the feeling of that moment than if I'd given

the "happening-truth" of: "we pulled over on the side of the road somewhere on the way home." This meta-story, I hoped, would help students understand this perspective on truth in narrative so that they would feel more freedom to get at the emotional truth of their experiences.

Writing Concern #3 – Avoiding/Taking Emotional Risks

It is not surprising that several students expressed concern regarding the emotional ramifications of composing a traumatic experience. Writing our stories is, in a sense, a rhetorical method for re-experiencing and confronting our histories, and when those histories are emotionally charged, risk is bound to be present. Furthermore, it is often our most traumatic stories that, as trauma theorist Dori Laub notes, we feel "an imperative need to *tell* and thus come to *know*" (77). Yet, these stories can also be the riskiest to us personally. To illustrate, one student noted that the event "eclipsing the other topics" and, therefore, what he "needed" to write, was also among the most distressing "memories he had to face." Similarly, a young woman wrote that "[t]he writing process was a bit difficult" for her because it was the first time she had "actively tried recalling all of the details of finding [her] dad" in a parking lot after he'd suffered a heart-attack. She told me after our session that the feelings had been so intense while writing that she'd reached out to her parents for support and cried on the phone. In his post-reflection, another student wrote, "I think recalling the event in vivid enough detail to write about it possibly brought up some of the trauma associated with it. I was staying at a lake house this past week and actually panicked a bit when I flipped a kayak. I believe this was due in part to having just re-exposed myself to my past near drowning." Despite his observational tone, he directly mentions a post-traumatic reaction to his

experience of writing trauma. Writing and healing advocates warn that reconstructing traumatic details "necessitates re-experiencing the emotions associated with the experience, something most survivors have carefully avoided just to cope with life. Once images start to come, so also do the feelings which have been suppressed" (MacCurdy "From Trauma" 172). As a result, there is risk of what writing researchers in mental-health fields sometimes refer to as "retraumatization" (Carello and Butler 156). These are legitimate concerns, which must be examined when facilitating writing and healing work.

Yet, to cast emotional risk in writing trauma as evidence for the exclusion of the practice is a misguided reaction that overlooks several critical points. First, though most students opted to relate emotionally charged experiences, they had complete autonomy in their topic selection other than the general requirement that it be a personally-orientated illness experience. In other words, students had the right, as several noted, to choose "a safe topic" with the simple purpose of "thinking about health in [their] own lives." Accordingly, every group had low-risks stories involving topics like a bout with the flu, an anxiety producing tick bite, and even over consumption of tacos in a foreign country (a great story!). Furthermore, I conveyed the same the advice Donald Murray, an expressivist pioneer in the field of CS, offers his writing students: "Drop this subject if it's causing you pain. If it feels good to write about this, go ahead, but if it doesn't, stop. You won't be penalized for starting a new subject" (128). This is an effective approach in that the risk of retraumatization is reduced because students have autonomy in deciding what they want to disclose.

Second, although this component of our project needed greater attention, students were informed of the potential emotional risks involved in writing their illness narratives

and provided with contact information for mental health resources. Since we facilitate what can be a therapeutic process but are not trained counselors, it is vital, as writing and healing scholar Valentino notes, that we "refer students to others with the expertise, experience, and resources to help," including "clinical psychologists, counselors, special needs/ADA coordinators, and social workers" (11). Furthermore, I believe it is our responsibility as instructors to have preestablished contact with at least one of these mental-health workers for guidance when concerns arise. In doing so, we provide students with a safety-net, which reduces the risk of retraumatization. And, considering the traumatic nature of the medical profession and the ironic stigma placed upon seeking help, it is important to assist students in learning to rely on mental-health resources.

One only has to consider aspects of training such as dissecting cadavers, examining patients while a panel of doctors stands behind a two-way mirror evaluating, taking written exams that will determine in one sitting whether or not a student fails the entire program, and spending grueling internship hours beneath challenging physicians to see that Med Ed is rife with emotional risk. As Suzanne Poirier, a literature and medicine scholar, notes, "Medical education, however well it produces skilled, competent physicians, is a treacherous undertaking for many people" (2). Yet, there is very little discussion of abandoning these practices as the educational value purportedly outweighs the risks. Similarly, the emotional risks should be, as Poirier posits, considered a vital "tool for maintaining, even developing, emotional wholeness—a skill that might be as important for young physicians to learn as drawing blood or tying sutures" (19). Based on their responses, a majority my students would agree. One student who thought she had dealt with the death of a sibling wrote that the writing process was essential "because

those traumatic experiences had been packed away" and she "needed to return to them and remember the details and unpack what [she] had gone through." Many other voices echoed her sentiment in their observations that writing their stories helped them move from "regurgitating facts" to feeling "connected with the content," foster "gratitude" for the healing in their lives, "see how the progression of time" shaped their perceptions of the experience, provide a space to "voice emotions" long suppressed, allow perspective on "how difficult the situation had been," "explain some of the stress and anxiety" involved, and, "focus on the positives of the situation and find peace."

Writing and healing pedagogues similarly celebrate the value of this emotionally risky writing. Rachel Spear, careful to note that a return to "a complete, coherent, heal*ed* self" is not the objective nor even possible, posits the value of trauma writing in "re-creating the self, reestablishing the subject into a new identity, a transformed self . . . with a (healing) purpose that transcends the trauma" (66). Anderson and MacCurdy argue that in composing our traumatic experiences, "we discover and rediscover them, move them out of the ephemeral . . . onto the more permanent surface of the page, where they can be considered, reconsidered, left, and taken up again" (7). Perhaps most significantly, Louise DeSalvo explains the therapeutic value of writing as meaningful: "By writing, we celebrate, too, our courage and survival. Engaging in writing . . . permits us to pass from numbness to feeling, from denial to acceptance, from conflict and chaos to order and resolution" (57). In other words, while no one is arguing that writing trauma is risk free, to reject such a valuable practice over this addressable concern is a major loss for programs attempting to instill humanistic approaches to the practice of medicine.

Concerns with the Sharing Component

Though not more important than the writing of illness narratives, the group-reflection sessions were the highest stake activity within this project, as group sharing often is. It's one thing to write about a traumatic event and another to sit amongst peers and read it aloud. Not surprisingly, therefore, this activity received both the greatest praise and criticism. While criticism can be disheartening, it offers valuable insight into concerns in need of a response. Students and facilitators need to understand *why* we are making time for the (often uncomfortable) process of sharing and responding to narratives. Accordingly, this section explores sharing concerns relating to 1) appropriateness, 2) forced vulnerability, 3) professional risk, 4) emotional legitimacy, 5) emotional safety, and, finally, 5) feedback.

Sharing Concern #1 – This Work is Inappropriate in a Med Ed Setting

There was concern that the group-reflection sessions were irrelevant to medical education and, therefore, inappropriate. As a student noted, "I don't need to expose myself . . . to my classmates to understand that having to expose yourself to your physician is a difficult task, just as a surgeon doesn't need to have had an appendectomy to be able to do one for their patient." Another posited that he did not "have time" for "training in something [he] already know[s] how to do." Here, the perceived lack of pragmatic value in sharing illness narratives is cited by students as evidence for its inappropriateness in Med Ed and, essentially, reflects the *bio*medical perspectives illustrated by the physicians depicted within the first two narratives in the introduction.

What these concerned students were not seeing is that the group-reflection sessions offer a forum for practicing communication surrounding psychosocial aspects of

illness in medicine and, as a result, provide valuable training. For example, the student's analogy that a surgeon need not receive an appendectomy to perform one is problematic in that a surgeon *does* need to practice the procedure in a controlled environment before operating independently. Similarly, one does not need to *have had* the illness in order to humanely process it with patients/peers, but s(he) should have had hands-on training on varying approaches to understanding and discussing the highly contextualized implications of illness. For this reason, some students commented on the value of sharing and hearing each other's narratives in "[b]eing able to talk through the different experiences and how [they've] coped with them" as practice for conversations they will likely have with patients and colleagues. We need our future physicians to be prepared for diversity in communication—to multifaceted ways of seeing illness—that, as CS scholars note, extend beyond the *bio*medical framework to "specific material conditions, lived experiences, positionalities, and/or standpoints" (Knoblauch 62) so that "students might ideally go on to approach work with vulnerable people in community settings with care and attention toward the complexity of personal accounts" (Molloy 139). Accordingly, I suspect claims of curricular irrelevancy are more reflective of a common anxiety with the psychosocial aspects of illness than in a clear assessment of the appropriateness of sharing narratives in Med Ed.

Sharing Concern #2: This Work is Forced Vulnerability

Similarly, there was concern that the sharing work was forced vulnerability and, as one student put it, "crossed a line and was not appropriate for an academic setting." Another wrote: "I ask that you all seriously consider whether this sort of activity is appropriate to subject us to. The majority of the illness stories we have are very intimate,

private moments in our lives. Requiring us to share . . . with our peers and faculty as part of required curriculum is completely invasive . . . unethical and inappropriate."

If, "forced vulnerability," includes requiring students to participate in a group activity outside of their comfort zones, then it is true that the writing forces vulnerability. This is not, however, without justification. As the development/maintenance of empathy is a core objective of the medical school, asking students to participate in the experience of sharing illness narratives positions them in the roll of the patient or the patient's loved one and, accordingly, is a reminder of the vulnerability of being in that position. This type of training, what Medical educators Delese Wear and colleagues term "a pedagogy of discomfort," is essential in its "contribut[ion] to reflective practice as a collective rather than an individual process, one that always gestures toward the often-disenfranchised 'other'" (607). And, as seen in student comments extolling the value of becoming more "comfortable discussing illness" with other "medical professionals, patients, and patients' loved ones," they recognized the value of stepping outside of their comfort zone "as an opportunity to access that empathetic part of [their] personality." In the end, while we *never* forced students to disclose any particular story, we did require that they participate in the group session as opting out of vulnerable conversations will not be an option they or their patients will have in the future.

Sharing Concern #3: This Work is Professionally Risky

Another related concern was that our group-reflection sessions were professionally risky and, therefore, questionable for the curriculum. One student stated, "This field does not reward weakness." Similarly, a student wrote, "I think self-disclosure of family members with mental illness will be bad for me in terms of both my reputation

and my career . . . It's not that I am ashamed . . . I am simply concerned about the stigma." In other words, even though students felt stigmatization over illness was unfair and an important issue to confront, they questioned the professional safety of the sharing personal illness experiences.

While I am deeply troubled by the notion of students being stigmatized for have experienced illness, this potential should not deter the group-reflection sessions. First, as one student noted, the risk is easily mitigated because they have the option to choose a story they "are comfortable sharing with others." Other than the basic orientation on personally involved illness experiences, students have absolute agency in topic selection. Second, our group work serves to normalize illness experiences and, as a result, confronts the very stigmatization that students fear. Michelle Payne, a scholar whose research has focused upon students writing about abuse, speaks to this when she posits that in sharing stories of trauma, a student "immediately changes the relationships with her teacher and peers because she has disturbed the default assumption that everyone is normal . . . and writes about normal subjects" (13). To illustrate, after a highly emotional group session involving a poem about an attempted suicide, a student remained behind and told me that while he was "not brave enough" to share his own story, he'd had a similar experience and felt relieved to know he was not alone.

Sharing Concern #4: My Narrative is Not Emotionally Valid

Quite a few students expressed anxiety over the *lack* of emotion and, therefore, legitimacy of their narratives. Specifically, they worried that their "'Illness' stor[ies] wouldn't be very powerful" in comparison with classmates' more "serious and/or long-term, complicated issues." One wrote, "People sometimes think, 'who am I to have an

illness narrative? I had a baby and now I'm sad and then you hear the person next to you talk about their sister dying. Now that's sad! . . . It's almost like you feel like you're going to be stacked up against other people's real sadness." One student's comment speaks to a potential origin of illegitimacy anxiety when he writes, "Unfortunately, the way this is set up it makes it feel as if it needs to be something 'big' or 'heavy' and hold a lot of weight."[26]

While understandable, anxiety over the lack of profundity in their narratives misses a couple of key perspectives that would be of benefit to students. First, it overlooks that for the individual, trauma of any kind can occupy center-stage and be life-changing. MacCurdy writes that "we cannot judge how 'traumatic' any particular experience may be for a given individual. What to one could be easily assimilated into life can for another become a defining life experience" ("From Trauma" 161). To illustrate, the student who worried that his story "wouldn't be very powerful" wrote about how, after receiving multiple concussions playing football, his fear of permanent brain injury drove him out of the sport and, interestingly, into medicine. Despite the fact that his story didn't involve the emotionally charged types of trauma described in some classmates' narratives, it was clear how monumental the concussions were for his life. Recognizing this concept, a student noted that "everyone has a story of suffering in their lives. Some have worse stories than others, but each story has shaped that individual in some way to make them who they are today." This is an important perspective for

[26] Although I assured them during the introductory sessions that all types of illness stories were welcome, it seems clear that we needed to discuss the value of *all* stories regardless of their intensity.

physicians to hold both for their own life journeys and the lives of the patients they will touch emotionally and literally.

Whether the story is about getting sick in a foreign country after eating a dozen tacos or about a younger brother who hung himself, there are important lessons about illness and its treatment to be learned in *every* story even if those lessons are not immediately apparent. As a student noted in a post-reflection, "[W]hat you think may be an inconsequential story about your life may be a view that someone's never experienced and may appreciate very much. Even if they're not aware they appreciate it yet, down the line they may be working with someone and realize, 'oh, that's what's going on in that person's life." In other words, because all illness narratives highlight human condition regardless of intensity, there is no such thing as an illegitimate story. This applies to both the medical students' personal experiences and the illness experiences they will hear from their future patients.

Concern #5: Sharing My Story Could be Traumatizing

On the opposite end of the spectrum, there was concern over the emotional intensity of sharing such deeply personal and traumatic narratives. For example, one student wrote, "I think that the hardest part for me will be reading it aloud because that seems to make it more emotional." Similarly, another expressed concern over "the possibility that s(he) may cry while sharing it because it's an ongoing thing." Indeed, tears were common for both readers and listeners. Taking a slightly different angle, a student expressed reservations that "some emotions that have not been really examined may come up during sharing," a reservation validated by the potential of retraumatization.

Undoubtedly, emotional risks come with writing illness narratives but the sharing process can also achieve the opposite of retraumatization as facing tough emotions prepares students for the emotional intensity of communication in their futures as physicians. As Spear notes in her article on teaching trauma narratives, when a person shares and processes their experiences with the group, they are "re-establishing the subject into a new identity . . . a new self with a (healing) purpose that transcends the trauma" (66). Similarly, a student wrote, "It wasn't until I read it and got [touching] feedback from my peers . . . that I allowed myself to sit with it again. I've been trying to train myself to 'get over it' . . . my whole life and . . . it was validating to hear others being supportive when I've been beating myself up about it being the same old, overused story of my life." Multiple students made similar comments regarding the value of sharing their stories in its ability to "show [them] that there are still aspects of this topic that [they] need to learn how to cope with better" and that it can generate "thoughts, comments, and perspectives that could serve to be therapeutic." So, while there is no denying the emotional intensity of group work, sharing and discussing experiences that, for many, have remained formless, often produces the opposite effect of retraumatization in its ability to help the author process traumatic events. As a result of this healing work, students will be better prepared to face the unavoidable, emotional distress they will face in their future as practicing physicians.

Sharing Concern #6: I'm Nervous I'll Receive Critical and/or Patronizing Feedback

Offering feedback in group sessions is tricky business because, as feedback researcher Joni Cole notes, "most writers are chasms of hypersensitivity" (17). This is especially true when it comes to sharing vulnerable narratives. Accordingly, how students

respond to each other can form the basis for whether the experience "transforms stories that have never been told into texts that bear witness to lived experience . . . encourage[ing] victims to become agents for personal and public healing" (Anderson and MacCurdy 16) or reaffirms negative feelings surrounding the trauma and the act of sharing. As a means for encouraging practices leading to the former, I turn to students' concerns and desires regarding feedback. Specifically, I examine them through the listening, guiding, and encouraging approaches of the "feedback framework" outlined in chapter two as a method for understanding and addressing concerns and desires.

Students expressed concern that they would be criticized rather than being heard. One wrote, "It is a vulnerable thing to share some of these stories, so I feel that criticism wouldn't be very beneficial . . . it is more about being heard rather than receiving feedback." Another noted, "I think [classmates] should just listen rather than trying to act like they understand my life." Both students reflect what Payne describes as an anxiety that feedback in response to vulnerable accounts demonstrates an "insensitivity to the emotional and often traumatic experience the content may describe" leading to "feel[ing] dismissed, silenced, or not listened to" (xvii). Essentially, they equate feedback with either criticism or misguided understanding and, as a result, prefer that classmates simply listen.

Students also worried about inappropriate guidance from classmates on how and what they describe in their narratives. One noted, "Critiquing my writing should be done by a professor if it is done at all . . . I also don't think you should critique someone's experience with illness; that just leads to making one feel like their reactions to . . . the situation are invalid." To affirm this concern, there was an instance where, after a student

read a narrative about frustration with physicians not believing the intensity of her back pain, a classmate began his feedback with, “If I were you, I would have . . .” While his ideas weren’t necessarily poor, the way he framed them felt prescriptive and carried an underlying implication he knew what would have been best. For many, advice is the last thing they want and as future physicians, this understanding will be valuable in communication with patients.

A third concern relates to misguided and/or disingenuous encouragement. For example, a student in his post-reflection noted that feedback he received from a classmate had felt patronizing: “Her comment implied that my growth came after the events I described instead of me already having strength at the time everything was unfolding. If she had said something like ‘I am impressed by your strength’ or ‘you must have some amazing coping skills’ instead of saying how much I ‘must have grown from the experience,’ I would have been completely fine.” Similarly, another wrote, “I don’t want disingenuous responses or the clichés we have been taught to say when [a patient] says something sad . . . At that point, it feels as though [my classmates] would be saying things to make themselves feel more comfortable, not me.” Essentially, students don’t want their experiences minimized and, as one put it, “handled” through false encouragement.

The three feedback concerns outlined provide valuable examples of the types of listening, guiding, and encouraging feedback to avoid. There are, however, effective feedback approaches that align with Anderson and MacCurdy’s goal of guiding the “complex, ambiguous, sometimes painful dialogue between self and other" into an “ongoing recursive process in which self and community challenge, affirm, serve, and

extend each other in the drama of personal and public history" (17). When applied skillfully, listening-orientated feedback provides a safe and compassionate approach for those who are not looking to offer or receive direct commentary. In agreement, quite a few students expressed desire for their classmates to "mainly just listen," "validate [their] experience," and "respect [them] while telling [their] story." There are a couple of ways to do this. First, as an insightful student suggested, "individual students can be asked if they want feedback" and, conversely, uncomfortable responders can "say something like, 'I don't know what to say, but I want you to know that I care about you and if you ever want to talk, I want to listen.'" Along the same lines, in his text on risky writing, Jeffery Berman suggests what he terms, "empathetic listening," in which responses reflect compassionate reception without "criticism, commentary, or advice" (*Empathic* 112). These responses are not direct commentary on the writing or the experience. An illustration of this occurred when a student, after her classmate shared a wrenching story about the death of a parent, simply stated, "I've known you for two-years now and had no idea you'd gone through this. I'm so honored you shared your story." Listening approaches demonstrating the author has been heard while avoiding direct feedback on the text are a safe bet in a challenging, communicative environment.

Second, when approached cautiously, providing guidance in feedback can be of great value and, as suggested by student comments, desirable. For example, several students expressed interest in feedback on where "the writing could be stronger," their "perspectives [were] clearly portrayed," and when they were "'showing' effectively and not just telling." One approach toward this goal is to offer what Elbow describes as "true" comments that illustrate the reader/listener's personal "reactions and frankly

acknowledge their subjectivity" rather than "comments that purport to be true in general" ("Ranking" 200). For example, more than one student prefaced feedback with statements like, "I'm no writing expert, but . . ." before continuing on to point out aspects they appreciated such as the cadence and "poetic language." Guidance in the form of questions is also effective. In her article on feedback practices, Dana Ferris notes that, "[Q]uestions are preferable to imperatives, as they are less directive and promote student autonomy" (8). Questions regarding timelines and characters within the story were common in our sessions and illustrated that clarity was needed without an explicit directive. Finally, students noted the value of receiving contextual guidance from classmates who are willing to self-disclose related experiences that "help you process events in a different way than you'd be able to do on your own." As one noted, "[I]f other classmates had similar life experiences and were willing to share, I think it would be quite supportive . . . I tend to learn a lot about life by just listening to others' individual life journeys." A wealth of CS scholarship supports the value of self-disclosure in feedback as a way to "help dismantle boundaries" (Banks 25), inspire writers to "connect and share" their own experiences (Chrisman 183), "establish [oneself] as an approachable and non-intimidating presence" (Tobin 203), and illustrate a shared vulnerability (Deletiner 316). In a nutshell, the type of guidance students desire is non-judgmental, inquisitive, and grounded in relationships—the exact type of communication we want our students to offer future patients.

Offering encouragement is a way of empathetically engaging beyond the limitations of simply listening and without many of the risks involved in guidance. As several students noted, "empathetic" and "compassionate" support of the author's

experience as “valid and actually appreciated” made sharing meaningful rather than intimidating. Speaking to this, Spear notes the value of compassionate feedback through “verbal affirmations, positive encouragements, and nurturing spirits” (72). Specifically, this means feedback grounded in empathetic observations rather than commentary meant to impose a moral onto the story. As one student wrote, “I’d rather hear, ‘that must’ve been awful to deal with’ versus comments that try to draw a positive spin on the situation.” This is valuable insight for communication with patients. Speaking from experience, attempts to “see the bright” side or downplay the severity of my wife and I’s situation felt disingenuous and dismissive, which is why empathy and shared vulnerability often worked better. Accordingly, beyond functioning as guidance, self-disclosure can also serve as encouragement. For example, after a young woman shared a narrative involving failed attempts to help a friend with addiction, a classmate responded with her own account of failure to help an alcoholic family member, a type of account that, as Melisa Goldthwaite asserts in an article on confessional writing, provides “complicity or identification” that lead “not to condemnation but to comprehension” (65). Regardless of the type of feedback approach students decide to employ when communicating with patients, emphasis should be on learning to receive and respond to stories of illness with mindfulness. To that end, I conclude with specific pedagogical suggestions derived from this study and designed to facilitate future illness narrative work.

Suggestions for Future Practice

One afternoon, I sat in a colleague’s office at the medical school and relayed my frustration with a particular reflection-session I’d had involving a highly resistant student

who said the project was unethical and a waste of time seconds before his classmate was about to read an extremely vulnerable narrative. While the student's negative comments were insensitive, my frustration was primarily self-directed in that I realized I could have done more to address concerns of this nature. My colleague's reply was insightful: "You are learning the hard-way so that others won't have to." Accordingly, I would like to conclude by briefly offering suggestions for project design. Although these suggestions emerge from the illness narrative project, they are generally translatable to broad range of RW pedagogy and, at minimum, highlight practices in need of consideration.

1) Time

Suggesting that more time is needed is like suggesting to someone that they obtain more wealth—easier said than done. Furthermore, I do not imply that time limitations should prevent the type of work explored in this chapter from taking place. As illustrated by Colleen Fogarty's article on 55-word illness narratives, even a single-session RW workshop can produce valuable work. Having said this, a great deal of the complications throughout our project could have been prevented had there been more time to explore the function of the work and prepare students for the writing and sharing processes. My recommendation is, therefore, that introductory sessions be given greater time than our project was afforded. This is especially true of RW work involving group sessions as students need training on how to protect their own boundaries and respond to each other appropriately.

2) Readings

Providing example texts and scholarship exploring the background and purpose of the RW work is valuable in that it presents an empirical position and illustrates that there

are many "correct" ways of producing illness narratives. In doing so, students are provided with both precedent and options regarding *what* stories they may want to compose and *how* they will do so. Furthermore, seeing examples from students, physicians, and patients demonstrates the value of vulnerability in writing and that the issues they face are not unique and shameful. Generally speaking, I suggest providing readings that exemplify writing styles/options and offer diverse analytical perspectives on the work. Furthermore, making time for group discussion on the readings gives students the chance to hear each other's perspectives and develop group rapport.

3) Safety Guidelines and Resources

Including mental-health resources in the syllabus is essential but, on its own, insufficient for the emotional risks inherent in composing and sharing an illness experience. I suggest discussions grounded in readings that take place at both the class-level and within smaller groups so that those who are uncomfortable sharing concerns with the class as a whole will be offered a less intimidating space for expression of their thoughts. The purpose here is to generate safety awareness prior to the work and provide resources for those who may need them. Another effective safety measure is to hold regular office hours to provide students with a private space to voice concerns without the scrutiny of classmates.[27] However, it is *essential* to remember that our role is facilitating a therapeutic process and not providing therapy (Payne 30; Valentino 5; Price 50; MacCurdy "From Trauma" 161). Toward this end, anything beyond offering mental-

[27] I plan to hold remote office hours using an instant message feature on our online platform. Despite its loss of face-to-face intimacy, I suspect the students will enjoy and use that feature more frequently than they might my in person office hours.

health resources, writing instruction, and/or an empathetic ear as a fellow human being is risky for the student, teacher, and overall integrity of the work. In maintaining appropriate boundaries, we provide a model for medical students who will be in the same position of offering mental-health assistance and resources while *not* acting as therapists.

4) Offering Choices

In some ways, I am hesitant to suggest providing alternative options for those who oppose RW training as it contradicts my earlier arguments that students should be engaged in this work regardless of their discomfort, a position held by many practitioners within Med Ed. While I agree with this philosophically, I have begun to reassess the value of requiring students to participate in more vulnerable types of RW when they are vehemently opposed. Spending a great deal of energy convincing students of the value of writing work they oppose is a waste of resources and can lead to neglect of students who need *and* desire that attention (Di Orio 83). Moreover, when group work is involved, resistant students can be disruptive to the sharing process in their intimidation of those who are invested in the work. Therefore, while being pushed out of their comfort zones is often an intentional aspect of RW work, the result might be unfair to other students. Consequently, I suggest the model outlined Cathryn Molloy's "Multimodal Composing as Healing" in which she offers students the opportunity to either compose their own trauma narratives *or* more traditional essays exploring the ethical and cultural implications of writing and healing. Even those who choose the alternative must consider what it means to compose and share trauma and are, therefore, engaged with the work of RW. In short, depending upon the nature of the RW assignment, it might be worthwhile to provide an alternative so long as it remains challenging and on-topic.

5) Brainstorming

Having explored student concerns with their ability to write the narrative "correctly" and CS' recommendations for prewriting techniques to ease writing anxieties, it seems evident that more generative writing activities would be beneficial. Specifically, I suggest guiding students through writing exercises designed to explore and retrieve sensory-memories (MacCurdy *The Mind's Eye*); acclimate them to freewriting as an effective form of discovery (Elbow *Writing Without*); gather and plan their intentions for the writing (DeSalvo); and help them practice different types of writing styles (Goldberg). Though an hour including class discussion would be preferable, it could be done in thirty minutes if approached in five to ten minute "mini-writing-exercises." Essentially, the goal is for students to leave the introductory session(s) with not only their topics chosen, but also a wealth of ideas from which to build their writing and an understanding of how to employ brainstorming techniques independently.

6) The Feedback Process

The brief overview of feedback techniques I offered students during the introductory session was inadequate as illustrated by their concerns and several instances of inappropriate comments. Furthermore, as a core purpose of this work is learning how to bear witness and delicately respond to accounts of illness, providing adequate training for navigating the feedback process should be a priority. Toward this goal, I offer several suggestions. First, as noted earlier, giving students the option to opt out of receiving and offering feedback demonstrates respect for their right to simply be heard, a valuable lesson in a field that prioritizes the physician's way of knowing over the potential knowledge of patient accounts. Second, I suggest orientating students toward the position

of being empathetic responders whose purpose is to validate the author's work rather than rather than criticize or intervene. As an approach, have students practice responding to one of the more vulnerable sample readings through the "feedback framework" consisting of listening, guiding, and encouraging and, once completed, guide them through a class discussion on how the different approaches worked. Doing so will encourage mindful feedback strategies grounded in the types of responses they would appreciate themselves—the responder "golden rule" (Getchell and Amicucci). Finally, while I commented on their narratives, I did not provide feedback on their feedback. In many ways, this might have been more valuable than the comments I offered them on their writing though a combination of the two would be ideal. Therefore, I suggest making note of how they respond to each other during the group work and providing them feedback on their feedback. These three moves should provide effective feedback training and, as a result, decrease instances of comments perceived to be inappropriate.

7) Post-Reflection

One student mentioned that he appreciated writing about the experience after the fact as a way to "consider what [he] got out of the assignment." Similarly, based upon their responses, students who chose to respond to my "post-reflection" questions grappled with their experiences and were able to draw conclusions. Regardless of whether post-reflection takes place verbally or compositionally, it seeks, as assessment researcher Kathlyn Yancey posits, "to *discover* what we know, what we have learned, and what we might understand" (*Reflection* 168). Like many other aspects of the illness narrative, learning to engage in post-reflection will also aide them as future physicians in its development of the habit of reflecting upon communication after the fact. Furthermore,

post-reflections are valuable for facilitators in that they provide documentation of where programmatic outcomes have been met and areas in need of revision. Accordingly, I suggest a required post-reflection for both students and facilitators to consider the educational value of the experience.

In the end, following the completion of the illness narrative project, I struggled with whether or not to send the students a letter that, in addition to thanking them for their work, also acknowledged areas I needed to revise in terms of pedagogy. Ultimately, following the vulnerability endorsed in RW work, I included admission of mistakes I made within the process. Several months later, a student came to my office to respond, and we spent some time discussing many of the issues outlined in this chapter. At the end of the conversation, which he graciously allowed me to record, he said, "You know [illness narrative work] is good, you know it's beneficial. Just look at the work we did. It may not be the end-all-be-all, but it's pretty clear that it helps people. At least a lot of people. But it's not easy." I appreciated this conclusion. There is clearly educational and psychological value in composing, sharing, and responding to reflective writing as illustrated by both scholarship and the meaningful and relevant work performed by the medical students. However, as our exploration of their concerns indicates, there are also legitimate risks and complications in need of attention and, often times, revision. It is not easy work. However, regardless of difficulty and the fact that not everyone will appreciate the process, our future physicians need a space to consider and practice how they approach the art of medicine beyond the *bio*medical perspective. When guided mindfully, writing and sharing about their experiences provides such a space.

Chapter 4: Writing on the Periphery: Exploring the Function and Value of Reflective Writing During Clinical Training

Research in Medical Education (Med Ed) has produced a vast body of scholarship critiquing the narrow focus upon the *bio*medical aspects of medical training and the traumatic conditions under which students who are beginning to work directly with patients face as a result of the subsequent neglect for their psychosocial needs (i.e. time for self-care and preparation for working with trauma). The consequence of this, what medical educators Michael Neumann and Avner Elizur describe as "an imbalance between the emphasis on a scientific and technological approach and a humane approach to health care" and the "dehumanization of the student," has been shown to lead to difficulty "integrating the personal and professional dimensions of life, handling resentment and anxiety during studies, and maintaining the developing social and emotional sensitivity" (714). Having read close to 2,000 student reflections over the course of the last three years, I can vouch for the frequency of these issues being raised within their writing, particularly from students who are engaged in the process of clinical training.

An increasing response to this imbalance and subsequent student traumatization has been the employment of reflective writing (RW) during the clinical-training phase, often facilitated in group settings as a means for engendering a model of medicine that is more humane for both the patient and the physician. One of the earliest and widespread models for this practice comes from narrative medicine founder Rita Charon's concept of "Parallel Charts." She provides students with these simple instructions:

> Every day, you write in the hospital chart about each of your patients. You know exactly what to write there and the form in which to write it. You write about your patient's current complaints, the results of the physical exam, laboratory findings, opinions of consultants, and the plan. If your patient dying of prostate cancer reminds you of your grandfather who died of that disease last summer, and each time you go into the patient's room you weep for your grandfather, you cannot write that in the hospital chart. We will not let you. And yet it has to be written somewhere. You write it in the parallel chart (*Honoring the Stories* 156).

While the design and facilitation of clinical RW groups vary across institutions, they generally work toward the same purpose of addressing dualism in medicine and the trauma students face as described by Neumann and Elizur. It was, therefore, in response to the same exigencies and grounded in approaches described within the literature such as Charon's Parallel Charts, that I designed and facilitated the clerkship writing project, which took place at the University of Nevada, Reno School of Medicine in the Spring of 2019, the project providing the data informing this chapter.

The work of this chapter is three-part. First, because Med Ed scholarship already argues that RW promotes wellness (Pennebaker and Seagal; Wald et al.), encourages professional and personal meta-cognizance (Boudreau and Fuks; Levine et al.), and develops empathy (DasGupta and Charon; Hatem and Rider)—areas that correlate to the three categories outlined in this chapter—the results of the data from the clerkship project validate and build upon these existing arguments. Second, despite the fact that these arguments are already present, Med Ed scholarship on the topics commonly focuses upon a single function of RW (i.e. Liu et al.) or, conversely, such extensive lists of functions

that in-depth exploration is limited (i.e. Shapiro et al.).[28] In response, this chapter's pragmatic, three-part categorical division of the data, what I refer to as a "manageable framework," provides a comprehensive enough gaze to be useful in designing pedagogy, assessing outcomes, and demonstrating the efficacy of RW in meeting program objectives while still maintaining a narrow enough focus to not be lost in a multitude of conversations. Finally, as noted throughout the dissertation, composition studies (CS) has been conspicuously absent in RW research in Med Ed. By generating an interdisciplinary discussion that includes voices from CS (and other fields grounded in writing research), this chapter provides a variety of perspectives that serve to strengthen our understanding of RW in Med Ed. In short, the work of this chapter is to validate and further explore the function and value of RW in clinical training through the lenses of a "manageable framework" emerging from the clerkship project data and interdisciplinary scholarship.

The structure for performing this work is straightforward. Following a project overview and description of data and analysis, I explore the function and value of each of the three categories: 1) catharsis of negative emotions in medical education; 2) processing uncertainty in medical education; and 3) bearing witness for the development of empathy. To do so, I first present and then analyze samples of their writing through the lenses of CS, related fields such a trauma studies, and Med Ed. I conclude with an evaluation of the project's success, a discussion on the application of the "manageable framework," and the overarching argument that RW work such as the clerkship project should not be,

[28] Both articles used for illustration here are excellent and conduct important research; they simply do not provide the kind of pragmatic, pedagogical framework this chapter offers.

as is often the case, relegated to the periphery as an extracurricular activity but, rather, be a readily available, credited, and encouraged option for students.

Clerkship Project Design

In December of 2018, I solicited eight volunteers from University of Nevada, Reno School of Medicine's third-year class to participate in an extracurricular RW group during the clerkship phase of their training, also referred to as "rotations," which occupies the majority of the academic year and involves hands-on work with patients in multiple specialties. They were to keep a reflective journal during the upcoming Spring semester of their clerkship experiences—journals that might touch upon aspects of patient interaction not appropriate for medical charts and the balance between personal life and medical training—and would be meeting monthly to share writing with each other. The eight available spaces were filled by an equal number of males and females. However, due to personal reasons, one male student had to withdraw early in the process. All activities were conducted with IRB approval (1345203-1) and pseudonyms are used within this chapter to protect student anonymity.

I communicated regularly with the group via email in order to encourage them to habitually write (I advocated that they devote a 15-minute time period daily for reflection), offer journaling tips, and make stylistic and genre suggestions for those who might be feeling stuck/stagnant with their writing. Beyond this structural guidance, I intentionally avoided providing thematic prompts because I wanted the themes of their writing to emerge from need/desire and, therefore, more accurately reflect exigency for the work. Furthermore, I felt that limited guidance would create an atmosphere of professionalism rather than that of "students with assignments." Interestingly, while this

approach did result in individual agency in topic selection and, therefore, illuminating data for this chapter, one suggestion for revision participants noted in an exit-survey was the inclusion of thematic guidance.[29]

For the group-work component, we met monthly for a total of five times with each meeting lasting between 1.5 and 2.5 hours. Meeting locations began at the university, but, after obtaining group approval, we switched to meeting at my house. Scheduling was incredibly difficult and required evening sessions, some of which not all participants were able to attend.[30] As a result of this late timing and a desire to promote group ease, I provided food for participants.[31] While structure varied, we generally began with roughly thirty-minutes of conversation and food before sitting in a loose circle in my living room. Each participant (myself included when time permitted) then read a reflection from their journals, after which other group members provided feedback on aspects of the writing and the experiences informing the writing. Perhaps the most challenging aspect of facilitating a group of this nature was allowing time for identification with each other's experiences while still keeping the group on track so that everyone received equal time to share and process their pieces.

The clerkship RW group produced a wealth of data including: 1) an entrance-survey (seven out of eight responded); 2) twenty-eight reflections; 3) detailed session

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[29] Though I am grateful for the veracity of the data as a result of compositional freedom, I agree with their critique and recommend providing optional prompts and genre exploration.

[30] For the last two sessions, we were down to below 50% of the group members due to rotations outside of the area. Several students commented that they enjoyed the smaller dynamic even though they liked all of their classmates.

[31] Though providing food is not a requirement for facilitating this type of work, the group agreed that it created a more intimate and fun dynamic.

notes; and 4) and an exit-survey (all responded, including the student who had to withdraw).[32] While all the data is rich, the scope of the chapter ultimately dictated that I focus my gaze upon a particular data set, which I decided would be the students' reflections, a decision influenced by two primary factors. First, despite frequent reports within Med Ed literature of RW taking place during clinical training, medical educators note that "[t]here have been a few previous attempts to analyze students' original work" (Rucker and Shapiro 391). A focus on their writing, therefore, addresses a research gap within the field of Medical Education. Furthermore, seeing the students' RW in action, in many ways, provides the best evidence for the value of this work in the sense of the classic writing adage "show don't tell." In other words, the authenticity and depth of their writing speaks for itself. Second, the entirety of this chapter could have easily focused upon the groupwork component of the project, particularly as the majority of the students cited it as their favorite aspect. However, due to my exploration of groupwork in chapter three, a focus upon the writing is the most pragmatic investigation for this dissertation.

Like the method of data analysis found in chapters two and three, I employed Nowell and colleagues' six-phase approach for conducting thematic analysis of the clerkship students' reflections and surveys. Other than the influence of knowing the exigency and purpose for the project, I entered this process with no preconceptions of what type of categorical division and chapter structures would emerge. In phase one, "familiarizing yourself with your data," I read through all materials and wrote notes at the end of the process, some of which included ideas regarding connections with secondary

[32] Not all reflections they wrote were collected.

data. In phase two, “generating initial codes,” I labeled texts with general descriptions on subject matter (i.e. “disapproval from attending physician,” “personal relationship suffers,” “appreciates nurses,” etc.), and rhetorical function (i.e. “venting,” “explaining,” “witnessing,” etc.). In phase three, “searching for themes,” I created lists that included the most common reoccurring themes from these two categories. In phase four, “reviewing themes,” I put aside categories related to subject matter and focused solely upon rhetorical function because, from a writing researcher perspective, what students were *doing* with their RW writing was more relevant than the specific subject matter in that the latter varies according to individual context but the function of the writing can be more broadly applied. To illustrate, while battling my wife’s insurance company regarding coverage for proton radiation, I used RW as a tool to vent my incredible frustration. Similarly, clerkship students used RW to vent frustration regarding patients engaged with self-harm. Although the subject matter differs, the function is the same and therefore provides the greatest insight for research on writing instruction.[33]

Phase five, “defining and naming themes,” was the most difficult in that the primary categories revealed by the data—“catharsis,” “processing,” and “bearing witness”—had issues with ambiguity. For example, “catharsis” relating to a difficult patient interaction could, technically, be classified as “bearing witness” in that a detailed account of the patient’s experience is given. Yet, bearing witness is typically associated with compassion and empathy and catharsis with release of negative energy (Shapiro et

[33] Were I researching the types of trauma found within RW in medical training rather than how writing addresses these traumas, then a focus upon the subject matter would be more appropriate. Johanna Shapiro’s "Stories Medical Students Tell” provides an excellent example of subject matter exploration.

al.). Similarly, the very translation of the details of an experience into language is a form of processing automatically and, therefore, describes most RW. Yet, there were instances where students were clearly processing rather than attempting to provide testimony or release energy. Therefore, while the three categories *felt* easily identifiable, I realized that they needed clearer boundaries were they to be useful. It was at this point that I decided to add modifiers describing the *affective* function of each category (i.e. connecting "empathy" with "bearing witness") to provide a more accurate, nuanced, and delineated framework. Furthermore, it was evident that all three categorical functions could be subdivided between a focus upon "others" and "self," an important broader gaze in that one purpose of RW in medical training is, beyond humanizing patients, to address the dualistic disembodiment of physicians, an issue not receiving enough attention in Med Ed literature (DasGupta 244). I now turn to phase six, "the presentation of data."

Catharsis of Negative Emotions in Medical Education

Without providing students an outlet for catharsis of some kind during medical training, negative emotions can remain unaddressed and potentially toxic for others and self. This is illustrated by the fact that, as the American Medical Student Association notes, medical students view engagement with mental health support as a sign of "weakness" and, yet, "encounter emotionally traumatic experiences every day" and are "three times more likely to commit suicide than the rest of the general population in their age range." Speaking to this, literature and medicine specialist Suzanne Poirier notes a serious failure in traditional curriculum to teach "standardized emotional training," the result of which can be the message to "avoid confronting and working through difficult emotions and relationships" (18). A few years ago, I shared a couple of excerpts from

some of my medical students' reflections at a trauma writing workshop I facilitated at an English conference, excerpts similar to the ones included in this chapter. An attendee asked me if I was concerned by the level of frustration and guilt expressed within the texts. My response was that what I found troubling was knowing that many students felt similarly and yet kept the emotions hidden, a concealment that reflects what Poirier describes as a common practice in Med Ed of pushing students toward becoming "the lone, self-sufficient, heroic physician" (15).[34] The training is too difficult and the work too traumatizing to neglect providing students with tools for addressing the difficult emotions that inevitably arise during the process.

One such tool is the use of RW for catharsis of negative emotions. Specifically, analysis of the clerkship reflections reveals that students employ RW as a space for two primary forms of catharsis. The first, what students commonly refer to as "venting," labels acts of writing that release frustration, anger, exhaustion, or any type of emotion that builds to the point of threatening to escape containment, typically negative emotions directed at *others*. Common instances of this I found in the data include release of emotions relating to being overworked, treated negatively by attending physicians, and working with difficult patients. The second type of catharsis I discovered, what is most accurately labeled as "confession," refers to the employment of catharsis as a tool for releasing emotions such as guilt, shame, and fear—
emotions focused upon *self*. This form of catharsis shows up most often as "confession" relating to feeling a lack of empathy, judging others hypocritically, and worrying that

[34] The veneration of the renegade, heroic physician is incredibly common in American television medical dramas as exemplified by the series *House M.D.*

they have harmed patients. Although these two forms of catharsis often work in tandem as illustrated by the reflections presented within this section, venting and confession are not inherently joined and have unique functions despite their common goal of helping students release negative emotions. Therefore, I explore them individually by presenting two student reflections with cathartic orientation and then assess the function and value of each type of catharsis through textual analysis and interdisciplinary scholarship. I turn now to writing from Luke and Anthony.

Luke's "What a Dumb SOB"

Luke begins his narrative with a description of how he was only a few hours from being off work on a Friday afternoon, his jeep already "loaded down for a weekend of bird hunting," when he was called to the ER reception area to assist with an "MI [heart-attack] en route." Describing the patient, he writes, "On [a gurney] laid a 380lb man, unkept, covered in his own shit. He smelled like a yeasty, booze filled ashtray that had been left in a filthy outhouse – someone special for sure. The man was yelling 'Fuck you! I'm fine! I've never had a heart problem! Still don't!' . . . As I watched this situation unfold, I found myself thinking 'What a dumb SOB.'" Despite the fact that the man had "passed out while driving . . . and struck another vehicle head on," and had a history of "alcohol related arrests and smoked at least 60-packs a year," the EMT's let him go when he refused treatment, an action earning them Luke's label: "what dumb SOBs!"

Later, right before the end of Luke's shift, the man was brought back to the hospital after driving and passing out yet again, "this time T-Boning an SUV filled with a family." After performing CPR and then being asked to stay to continue helping, Luke describes being "pissed" because, beyond the harm he had caused others, "this man's

self-inflicted health conditions were cutting into [his] weekend." He writes, "Had [the patient] not smoked, not drank, ate right and exercised this all could have been avoided. How could you partake in such self-destructive behaviors and then expect to be taken care of? What a dumb SOB."

After a description of the ER treatment they provided, including bringing the man back from a flatline, Luke writes, "I finally got on the road about 10 pm . . . Hungry, I chowed down on a gas station burrito and a bag of pork rinds. Tired, stressed, and looking to relax, I chewed through damn near a whole can of Copenhagen . . . It was 1am by the time I got to camp. My buddy and I sat there bullshitting by the fire, smoking cigars and drinking ourselves into a stupor, crashing only as the sun was about to rise. Tired, hung over as hell and hacking up a lung, I was barely able to hike the next day. While I stopped to suck down my inhaler, I realized the irony of the whole situation. I was coping by engaging in the same self-destructive behaviors I resented my patient for the night before . . . There was a total disconnect. Worst of all . . . I was carrying less empathy. Hell, I wasn't just carrying less empathy—I was carrying none. What a dumb SOB."

Anthony's "Jaded"

Anthony begins by noting that being jaded "has gotten noticeably worse" throughout his year. He writes, "I understand bad things happen to good people and not all people are good and still need to have their diseases treated. My issue stems from people knowingly breaking themselves and expecting you to put them back together. I don't know if I have just watched enough good people die of diseases that they couldn't control that it burns me up to see people destroy themselves." After a brief discussion on

whether or not addiction is a disease, he continues, “I can feel my empathy quickly weaning with these patients. Like why the fuck are you our problem? Why are you taking up a bed from someone who is in pain from something they couldn’t control? Why should I care when you didn’t?”

At this point, he launches into a story about a “40-year-old female who has all but drank herself to death.” He writes, “She decided to do this. She decided to ruin her life over years. She decided to ignore pleas from family and loved ones to stop. And now she has the audacity to ask for aggressive treatments . . . Are you fucking serious??? Why??? There is no going back. There is no reversing the damage. It’s done. It’s over. All that’s left is saying goodbye.” Anthony, then questions his emotional reaction, wondering why “she makes [him] so angry.” As a way to explore this question, he decided to stay after work and spend some time with her. He writes, “We talked for hours. And then I spent the next evening with her and the next. She didn’t blame anyone. She only requests all measures because her loved ones want her to fight and she has let them down enough . . . She regrets it but what’s done is done.”

He concludes by noting that he “figured out why her and everyone like her pisses [him] off.” He writes, “I was one choice away from being her and everyone in that situation. I had forgotten my past since being in medical school. I had forgotten what I once was. I have forgotten that not that many years ago . . . I was the one laying in the hospital bed on death’s doorstep with tubes coming out of me. The bottom line is I have been projecting on this patient and patients like her that I have encountered. What I hate about her is what I hate about myself.”

The Function and Value of Catharsis as "Venting"

The need for catharsis of what medical educators Johanna Shapiro and colleagues characterize as "the 'uninvited guests' in training" such as feelings of "rage and despair" is great (240). The healthcare community in general has long recognized the value of this form of catharsis, what physicians Soul Mugerwa and John D Holden in their research on writing therapy describe as a "powerful therapeutic agent," for those working in traumatic medical contexts whether medical student, nurse, or physician (661). An MD friend of mine described a physician support group she attends in which members have a safe space to share about the difficult and traumatic aspects of their professional world. She explained that sometimes physicians just need a space to release frustration, to say what they're not supposed to say in professional settings.

Luke and Anthony's reflections perform the same work in their expressions of frustration with patients who are hospitalized as a result of self-harm behavior. Luke, for example, expresses feeling "pissed" about how the patient's "self-inflicted health conditions were cutting into [his] weekend." Similarly, his question, "How could you partake in such self-destructive behaviors and then expect to be taken care of?" sounds more like a rhetorical question meant to vent than one to be answered. In essence, he is incredulous that a patient would expect medical care when they have not cared for themselves, a sentiment I have heard from many in the field. Furthermore, the fact that the very title of his reflection is "What a Dumb SOB," an explicative label he applies to nearly everyone in the reflection (including himself), illustrates the extent of frustration he is venting, frustration professionalism dictates should not be directed openly at the patient.

Likewise, Anthony is brutality honest with his anger at the patient's "audacity to ask for aggressive treatments." His use of profanity is especially revealing of the intensity of his emotional state when he asks, "[W]hy the fuck are you our problem? Why are you taking up a bed from someone who is in pain from something they couldn't control? Why should I care when you didn't?"[35] Like Luke, his questions at this point in the narrative feel more like expressions of negative emotions than contemplation. Anthony's comments that "She decided to do this. She decided to ruin her life over years. She decided to ignore pleas from family and loved ones to stop" are likewise indictments of her behavior, of her identity, and illustrate that frustration is overriding his empathy. While understandable and common reactions, both Luke and Anthony clearly feel a great deal of negative emotions toward these self-harm patients.

Unfortunately, evidence suggests that when left unmitigated, negative emotions such as those experienced by Luke and Anthony often become displaced onto others. In her research on memoirs in medical education, Poirier notes frequent accounts of unaddressed negative emotions being directed at patients causing them to "suffer the effects of the students' or residents' anxiety or anger" even when the patients are not the original trigger for the emotions (19). Though both of these students are *incredibly* compassionate individuals, it is not hard to imagine their frustration being displaced onto the next patient, particularly the next self-harm patient. Speaking to this type of

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[35] During the many nights I spent in the hospital with my wife, the chief complaint I heard from the nurses with whom we interacted related to intoxicated patients who were placed in the oncology unit due to lack of space in the appropriate wards. I too admit to feelings of rage when these patients woke my wife up while screaming obscenities at the very people offering them medical treatment.

transference, literature and psychoanalysis scholar Mark Bracher, noting the similarities between traditional "talking cures" of therapy and "writing cures," argues for the value of written catharsis in that without it our "impulses and affects" too often find channels into the world "behind our back[s] . . . possibly with severe intensity and grotesque form" (147). Put simply, unaddressed negative emotions run the risk of harmfully leaking onto others. Accordingly, when students carthart these types of emotions through RW, it should not be seen as a reason for concern as the woman at the conference suggested but, rather, a healthy emotional practice with the potential to protect physician and patient alike.

The second form of catharsis taking place within these reflections, the one to which Luke and Anthony's texts ultimately arrive, is that of catharsis through confession, an act that allows the author to turn over self-directed negative feelings and reframe those emotions through a new perspective. In agreement, writing and healing scholar Emily Nye notes the therapeutic value of shifting challenging experiences and feelings from the "private to the public" as a way for those exposed to trauma to "unburden themselves" and "reconstruct . . . the events in their lives" toward transformative action (406).[36] In the context of medical education, it provides students the opportunity to confess aspects of their patient interactions about which they feel emotions such as shame, guilt, and fear and consider how they might reshape those feelings into greater self-awareness and goals for revision of future practices.

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[36] For future research, I would like to employ a mixed-method study employing a social-science orientated measurement tool such as the Jefferson Scale of Empathy as a means to assess outcomes and connect pedagogy with transformative action. This would provide a rich, interdisciplinary research approach.

In Luke and Anthony's cases, their confessional catharsis addresses guilt over the frustration and lack of empathy they felt for their self-harm patients and bravely notes the hypocrisy of their judgement. Luke, for example, ends his narrative with an interesting description of the variety of unhealthy behaviors in which he partakes within a relatively short time. In admitting to his poor eating habits (a gas station burrito and pork rinds), denial of rest (staying up all night), and substance abuse (chewing tobacco and getting drunk), he confesses to the same type of behaviors about which he harshly judged his patient. Furthermore, and perhaps most telling, in describing how he "stopped to suck down [his] inhaler" while "hung over as hell and hacking up a lung," he acknowledges that he has a preexisting medical condition and, yet, continues self-destructive behavior, the "irony" of which becomes clear to him in that moment. The realization of his own hypocrisy then triggers an understanding and subsequent confession that he is "carrying" a total lack of empathy for the patient.

Anthony's text, again reflecting the similarities between medical students' journeys, likewise confesses to hypocrisy though his is grounded in his history rather than current behavior. After spending time with the patient as a way to try and understand her perspective and his feelings, he arrives at the realization that he had "forgotten [his] past." Although he doesn't provide specifics of what had happened, the description of him "lying in the hospital bed on death's doorstep with tubes coming out of [him]" infers that he had participated in behavior leading to quite serious self-harm. Like Luke, he admits that the judgement he placed on the patient was hypocritical, and, in doing so, he unburdens himself of the guilt he had been carrying. Furthermore, in confessing that he has "been projecting . . . what [he] hates about [himself]" onto patients with self-harm

issues, he acknowledges inherent bias and his movement toward becoming "jaded," or, put differently, lacking empathy.

In making their perceived mistakes visible for consideration through writing, medical students not only unburden themselves of the heavy emotions they shoulder, they also provide enough objective distance between themselves and their self-depictions to render experiences and related emotions available for greater understanding and, as a result, the potential for transformative action. As writing and healing scholar Marian MacCurdy notes, "Writing requires construction of a persona—and the point of view—that is different from the protagonist," a practice that can result in clearer "understanding" and "agency" regarding one's difficult experiences and future changes (2). Looking at Luke and Anthony's narratives specifically, we see examples of this in that through confession of their biases and hypocrisy, they construct an interpretation of an event that allows them to, as CS scholar Jeffery Berman posits, "search for endings that will revise, reinterpret, or resolve difficult experiences" (*Empathic* 123). It is hard to imagine that either of these students will encounter similar contexts without at least considering the experiences they have documented within their stories. In this sense, the very act of translating the experience and resulting understanding into language is already transformative action, a type of amends if you will. Speaking to this, trauma writing scholar Jacqueline Rinaldi writes, "At the core of a therapeutic rhetoric is an assumption that any experience of failure is amenable to being reconstructed in a way that makes that failure tolerable, even beneficial according to a different set of values" (201). In essence, transcribing of one's mistakes through RW can not only help to unburden students of the

guilt and shame they have been carrying, but it also provides a tool for reframing mistakes into assets for future interactions.

Processing Uncertainty in Medical Education

The practice of medicine is full of uncertainty due to the variation of outcomes, lack of concrete answers, and the complexity of psychosocial contexts underpinning human interaction. As medical educators Maarit Nevalainen and colleagues note, "Uncertainty is a major cause of mental strain for medical students," particularly regarding "insecurity of professional skills, [one's] own credibility, facing the inexactness of medicine, fear of making mistakes, coping with responsibility, tolerating oneself as incomplete and accepting oneself as a good-enough doctor-to-be" (218), which can result in a "sense of dislocation, moral challenge, and threatened identity" (Shapiro "Stories" 51). Yet, despite this reality, a *bio*medical model of medical education does not provide students with tools to process the uncertainties inherent in their training. As medical educators Boudreau and Fuks posit, traditional training has focused solely upon questions grounded in the "basic sciences" as being "germane" and, as a result, has not helped students address difficult questions relating to the philosophical, ethical, and social ambiguities inherent in providing healthcare (330). Similarly, Poirier, in describing findings from her research on medical education memoirs, notes the tension "between the human need for certainty and the inherent uncertainty in the course of many illnesses" and the fact "that the one-sidedness of teaching mostly the scientific aspects of medicine is dangerous and often damaging, not only for its incompleteness but also for its failure to address students' own needs to grapple with the anxieties of medical uncertainty" (3). Put

simply, a traditional model of medical education fails to provide students with the needed tools for addressing uncertainty in their training.

One response to this gap has been the employment of RW in that, as narrative theorist Jerome Bruner notes, contemplating our experiences through writing "gives us a ready and supple means for dealing with the uncertain outcomes of our plans and anticipations" (28). Exemplifying this approach, the clerkship reflections reveal that students frequently use RW as a means for processing the ambiguities involved in their training. Specifically, they identify, question, and comment upon aspects of their training to which there are no clear answers, aspects relating to the people and practices within the medical system (others) and their own performances as medical students (self). As a result of their efforts, I posit that they not only broaden the exploration of uncertainties beyond a *bio*medical framework but that, in doing so, they develop a greater tolerance for uncertainty in medicine. To illustrate, I present two student reflections, analyze their function in identifying and addressing uncertainty relating to others and self, and conclude with an argument on the overall value of RW as "a feasible means of both expressing and dealing with uncertainty" (Nevalainen et al. 222). I now turn to writing from Beth and Andon.

Beth's "Teegan"

Beth begins her narrative by introducing the context in which Teegan, an 11-day-old baby girl, is brought to the hospital by two worried parents due to "being fussy" and "having a temperature of 100.4F." Beth, describes her reaction to the rationale for the girl's hospitalization: "It's not even a real fever—pssshh." As the story continues, the attending physician keeps Teegan in the hospital while waiting for a sepsis analysis and

has Beth perform rounds in the morning. Beth notes that, other than the a "mildly distended belly" and the parents' worry that Teegan was "gassy," the little girl "still looked healthy." It is at this point that Beth encounters a dilemma related to her medical training, noting, "There have been many times I've mentioned physical exam findings to attendings only to have them shrug their shoulders in annoyance or disregard, so the decision to speak up regarding patients is always met with a lengthy and nervous internal discourse. Teegan was stooling normally . . . so I thought the likelihood of any serious pathology was slim. Better not to make myself look foolish." A paragraph later, we learn that she made the incorrect choice after the attending physician reexamines Teegan in the afternoon. She writes, "Not only had [Teegan's] distention increased, but the physician noticed it immediately and asked why I hadn't said anything. Wrong call, apparently . . . Say something, attending doesn't seem to care. Don't say something, get burned."

In an ironic twist, after Teegan's belly condition is diagnosed as "malrotation" requiring abdominal surgery, a senior physician reviews the information and overturns the diagnosis, proclaiming that the infant is "just gassy," Beth's original assessment. She ends her narrative with, "I couldn't help but feel angry. I had failed to mention what would seem to be an important physical exam finding. The patient was subjected to a milieu of what seemed to be unnecessary testing. And now, I was more confused than ever. What is and isn't pertinent? Which incidental findings are important and which ones are not? When is it OK to ignore something and when is it not? And, these are the nuances I'm constantly trying to sift through. What if the patient actually had malrotation? If the attending hadn't caught the abdominal distention, and I continued to

ignore it, what would the outcome be? What's the difference between hypervigilance and intuition? Will I ever figure it out?"

Andon's "Neurology"

Andon begins his narrative with the reflective questions: "What is a man who cannot formulate and communicate a thought? What is a woman who cannot make decisions and simply just . . . exists?" He then introduces a discussion on the "palpable shift in mindset of medical treatment" he discovered within his neurology rotation, noting, "As beautiful and elegant as neurology was, it seemed like there was a terminality to every patient who was present." After explaining that, due to the poor prognosis inherent in brain injury and disease, "treatments are mainly targeted at symptomology at our current day in age," Andon notes the intense effect this reality "has on the physician and team over time" in their "understanding that a case is hopeless regardless of how well [one] responds." He writes, "You keep the person alive; yet, that person is 'dead.' They don't respond. The person is just an empty shell of who they once were. The 'spark' that made them who they are and what made their presence and imprint on time is gone. All that's left is an organism that barely functions to be."

At this point, his reflection shifts to an illustrative narrative about "a young woman in her mid-thirties presenting with stroke-like symptoms" who had just had a child a month earlier. After noting that the "rapid response team" was divided on whether "she was having a real stroke or if she was presenting with a conversion disorder," Andon describes their process of discussing the possibilities and the various tests they administer. The eventual conclusion is "a punch to the gut" for the team when they determine that she has two serious issues, one in the brain and one in the sinuses. He

writes, “Treat one pathology and your patient may die of hypoperfusion to the brain. Treat the other and your patient may die of intracranial hemorrhage.” The team has “a choice to make” and Andon, “remember[ing] a similar case,” makes a treatment suggestion. After being asked to “look up dosing” for his idea, he writes, “I quickly pulled it up and read it out loud, all the while questioning if my words were going to lead to the patient’s salvation or her ultimate demise.”

At the end of the shift, he describes how he and the other med students “high-fived as [they] left, each of [them] having played a crucial part to her presumable diagnosis and treatment. It was a success.” The next morning, despite their optimism, Andon learns the patient had permanently lost all brain function during the night. He writes, “I couldn’t help but feel guilty. Like I had destined her to this fate . . . I knew I had given the recommended guideline dosing for her situation and my attending assured me I was correct for the patient’s situation. Then why is it that regardless of our steps towards treating the patient correctly, her ultimate fate was brain death? I went home that day asking myself questions that I’m ashamed of expressing but feel must be said. What did I do right? What did I do wrong? What else could I have done to prevent her disease progression?” Andon concludes his reflection with, “She’s a mother of one month and a wife of several years; yet, she doesn’t know that. Not anymore . . . So, I ask myself, what have I done?”

The Function and Value of Processing Uncertainty in Medical Education

Now that we have born witness to Beth and Andon’s reflections, I turn my gaze to an exploration of how they function within this context. The use of RW as a tool for processing uncertainty is widely espoused within a variety of interdisciplinary fields

including CS and Med Ed. Specifically, the argument is that when students identify and grapple with uncertainty, they develop a more nuanced, psychosocial understanding of the ambiguous contexts through which they are navigating. For instance, CS scholar Jane Hindman notes that employing writing to explore "the gaps of the contradictory positions and emotions" creates a space where writers can gain greatest understanding in that it is in their "attempts to mediate those contradictions that [they] can best become aware of those sometimes invisible ideologies that discipline [them] and those social institutions which construct [them]" (105-106). Similarly, reflection and assessment scholar Kathleen Yancey notes that "reflection keyed to ambiguity is an active process in which students participate in a meaning-making ecology; in this ecology, reflection plays a primary role in their own knowledge making" and guides them in "assign[ing] causality, see[ing] multiple perspectives, and invoke[ing] multiple contexts" (*A Rhetoric* 152; *Reflection* 19). In other words, the function is in understanding the dynamics of the uncertainties rather than arriving at concrete answers, which, particularly in medicine, often do not exist.[37]

Beth's identification, questioning, and commenting upon uncertainties relating to the power dynamics of their training and the realities of providing healthcare—uncertainties relating to others—illustrate these points. To begin, her initial dismissal of Teegan's low-grade fever as unworthy of hospitalization identifies and comments upon the dubious matter of how seriously to take the reactions of "worried parents," an issue grounded in social and psychological considerations as much as *bio*medicine. Similarly,

[37] Sadly, due to the pandemic, we are experiencing uncertainty of this nature on a global scale.

when Beth reveals that her "lengthy and nervous internal discourse" regarding whether or not to "speak up" regarding the infant's stomach condition is based upon anxiety over how the attending physician will react to her observation, we learn that her uncertainty relates to the power dynamics and emotional consequences of making mistakes in training more than the severity of Teegan's symptoms. Finally, Beth's description of the attending physician's serious diagnosis being overturned by a senior physician who supports Beth's original assessment, beautifully illustrates that prognosis and treatment are not always clear-cut matters and heavily rely upon individual interpretation.

Andon, in the same manner, engages with uncertainty in medicine relating to *others*. His initial questions of: "What is a man who cannot formulate and communicate a thought? What is a woman who cannot make decisions and simply just exists?" are important ones with serious implications regarding the treatment of patients. Yet, they are not questions addressed by *bio*medicine. His exploration of the ramifications of working in a field where "you keep the person alive; yet, that person is 'dead'" is likewise clear engagement with ambiguity in medicine and the toll such nebulous delineations have upon practitioners. Finally, his portrayal of the rapid response team's debate over diagnosis and treatment, particularly as all their options carried serious ramifications, is telling of the intense uncertainty many physicians face on a regular basis as illustrated by his question: "[W]hy is it that regardless of our steps towards treating the patient correctly, her ultimate fate was brain death?" While *bio*medicine could offer a scientifically grounded answer, one Andon knows, his question is existentially based and seeks a different type of contemplation.

Shifting to processing of uncertainties relating to *self*, Beth's self-questioning provides several examples of how she uses writing as a tool to identify and consider confusing aspects of her performance as a medical student. For example, she contrasts her failure to mention "what would seem to be an important physical-exam finding" with the fact that the patient "was subjected to a milieu of what seemed to be unnecessary testing" as a result of what she correctly chose to ignore, noting that the ambiguity of what was the "right" versus "wrong" decision in this situation leaves her "more confused than ever." Essentially, her analysis indicates that there was no correct choice. Finally, the conclusion of her reflection probes at the confusing nature of becoming a physician with consideration of how one knows "the difference between hypervigilance and intuition" and if she will "ever figure it out." Again, these are examples of important questions that cannot be definitively answered.

Andon also employs RW to grapple with uncertainties regarding his performance as a medical student. For example, he questions whether or not his choice to speak up was "going to lead to the patient's salvation or her ultimate demise." From a *bio*medically based perspective, decisions of this nature are simply a matter of assessing the data. Yet, as Andon illustrates through his processing of the experience, the implications and responsibility of such choices are great and carry psychological ramifications that must be considered if one is going to preserve mental health. Like Beth (and again exemplifying the similarities between Med students' journeys), he ends his reflection with questions he is "ashamed of expressing" orientated toward self-analysis: "What did I do right? What did I do wrong?" and, the one that still makes me cry, "What have I done?" While a *bio*medical perspective could attempt to respond, ultimately

scientifically grounded answers do not seem to be what Andon seeks in the face of his uncertainty, particularly as he acknowledges that his treatment suggestion was literally textbook.

Ultimately, as the data suggests, students use of RW to process uncertainty in medical education is not geared toward discovery of concrete answers to ambiguous problems. Rather, the value of the practice lies in their naming and engaging with uncertainty, in their acquisition of a tool that explores ways of knowing outside a *bio*medical perspective. CS scholar Sally Chandler captures the essence of this argument well when she writes that "[reflective discourses] create ways to 'look around' inside of uncertainty without resolving it. Such discourses engage . . . creative multidimensional knowing not possible to articulate in the language of goal-directed logics driven by closure" (20). Though further research is needed on the long-term effects of this type of RW such as students' overall tolerance of ambiguity and decision making in the face of uncertainty, the data makes clear that they are using writing to engage with uncertainty from multifaceted perspectives, which is a step toward psychosocially orientated medical training.

Bearing Witness to Others and Self for the Development of Empathy

Few patients, physicians, medical educators, or medical students deny the importance of empathy in the practice of medicine as illustrated by the fact that The American Association of Medical Colleges, the Accreditation Council for Graduate Medical Education, training manuals, and trainees alike emphasize empathy as a critical component of medical education (Shapiro "Walking" 2). Yet, as researchers in medical education warn, mounting evidence demonstrates that, despite students' "idealism and a

genuine intention to serve those in need of help," empathy progressively declines throughout medical education, particularly during the third year of training (Hojat 1185). This decline is attributed to a variety of factors including an education that "promotes physicians' emotional detachment, affective distance, and clinical neutrality as emphasized through a focus on the science of medicine and a benign neglect of the art of patient care" (1188-89). Essentially, the loss of empathy is, in large part, attributed to a *bio*medical gaze, which fails to recognize the psychosocial realities of patients and physicians alike.

A modern response to this decline has been the employment of RW as a tool for "bearing witness," which, in this context, I refer to as the act of sharing testimony about medical experiences with the intention to honor those involved and illuminate the human condition. Illustrating this intervention, analysis of the clerkship data reveals that students frequently used RW to empathetically bear witness to their experiences with patients, caretakers, and colleagues. Although accounts of healthcare interactions are prevalent in a great deal of medically orientated RW, the categorical distinction I make here with "bearing witness" relates to the particular function the testimony serves. Specifically, while "catharsis" in my framework functions to unburden negative emotions and "processing" to identify and explore the uncertainties prevalent in medicine, "bearing witness" focusses upon descriptive accounts intended to recognize and, as a result, empathize with those described within the testimony. Furthermore, like the previous sections, I divide the analysis into subcategories relating to *others* and *self*. Within a medical education system that promotes empathy for others but too often ignores the reality of "physician bodies in the privileging of physician minds," this recognition of the

humanity of *all* parties involved is critical as physicians need to find empathy for themselves as care-providers facing trauma alongside their patients (DasGupta 244).

As a means to explore how acts of bearing witness perform this work, I present and then analyze two clerkship student reflections through the lenses of interdisciplinary scholarship and conclude with an argument for the efficacy of bearing witness in the development of empathy. I now turn to reflections from Parisa and Amara.

Parisa's "Passerby"

In her reflection "Passerby," Parisa, a 26-year-old Persian female, bears witness to an encounter with an at-risk man in the hospital where she worked.[38] She writes:

> I was so happy to be done! I'd finished earlier than I expected, and now I'd be able to make it to that cycling class at the gym. As I walked past the gift shop, I saw a man in a wheelchair sobbing as he faced an audience of large stuffed animals. He was not well put together; he looked unkempt, with poor hygiene. You've seen this person a thousand times. On the streets of North Virginia Street, on the corner of the I-80 off ramp, outside the 7/11. I walked past him and almost like a reflex stopped and looked back. He was staring at the five-foot-tall giraffe, a look of pure sorrow on his face. I turned back around and took a few more steps. I stopped. I looked. I turned. I stepped. I stopped. I looked. I turned. I stepped. I looked back again and saw a group of nurses pass by the gentleman. And then a family pass by. People walking past this person. Perhaps they were letting him grieve? Or perhaps, like me, they were thinking "I don't have the time or energy

[38] Due to the brevity of her reflection, I am able to include it in its entirety.

right now to stop and hear this guys' story." Yet I continued to stop and look back. I could feel the internal battle. Go talk to him. No, what if he doesn't want to be talked to? But what if he does? But *I* don't want to talk to him. Really, Parisa? This internal dialogue continued as I danced my dance down the hallway. Step, stop, look, turn, step, stop, look turn. I never found out what this man's story was. And every time I pass the zoo of stuffed animals by the Sierra gift shop, I am reminded of that.

Amara's "Emptied"

In her reflection "Emptied," Amara, a 25-year-old Indian female, tells the story of her first experience with an organ donation procedure. She begins with a description of waiting in the OR lobby for the procedure to begin when, as the donor is rolled in, the friendly "chatter" of the staff suddenly quiets. She writes, "It was Marvin. His last walk. On rounds we would say, '22-year-old with GSW to the head, self-inflicted. Waiting for organ donation.' In the real world that meant that Marvin had tried to commit suicide.[39] He had succeeded. Kind of. When he was brought in, he was brain dead, but we had to wait for his brain to herniate to pronounce it."

Amara then shifts her gaze to Marvin's family. She writes, "Behind his bed pushed by a nurse was his family. Ten people. His mother was beside herself. The child she had raised was going to his death. It was time for goodbye. As the family followed him to the door their devastation was on display . . . They were walking their baby to

[39] In her article on "personalizing the discourse of medicine," Kathleen M. Welch discusses the dangers of medical jargon dehumanizing patients, something Amara's reflection appears to recognize in this portion of text.

deaths door and there was nothing to do anymore." After observing that "tears filled the eyes of the bystanders" and "empathy flowed free in an area where the nurses and doctors usually kept their cool," Amara writes, "[E]ach member said their final goodbye. Marvin's grandmother leaned over to kiss him. They were handing him over to the doctors and nurses. The vultures waiting for his organs to save another human life. Somehow it still didn't seem fair."

At this point, Amara notes that she stood "in the cold OR . . . quietly hugging [herself]" as "the trauma nurse, the orchestrator of this whole ordeal, asked for a pause" and "[t]he eulogy started." She writes, "This time I couldn't hold my tears back. All of a sudden, the 22 y/o with GSW became a whole human. Loving rock and roll, playing with his animals, and seemingly happy. But there wasn't much time to linger on my emotions or feelings at loss of a patient and a human being. It was time for the harvest." After providing a few details on the specifics of the procedure, she writes, "The medical student in me was in awe. The beating heart trembled in the surgeon's hands . . . Marvin was gone. No time to waste or grieve, because the heart now belonged to a 42-year-old man a couple states away."

She concludes her narrative with, "Part of me felt exhilarated to see this miracle of medicine, but part of me just wanted to take a minute to grieve the loss of someone I had never spoken to . . . I thought about his family and how empty it must feel without him. At 4:45am, we finally walked out of the OR. Outside on the door was his high school graduation picture . . . He looked so innocent and happy, but who knew the chaos that had been inside his heart . . . [d]espite the near 24-hour shift, I didn't feel exhausted. All I felt was sad and empty."

When students bear witness to the plights and emotions of *others*, most often patients and patients' families within a medical context, they resist dualistic training and demonstrate that they *recognize* the suffering of those with whom they interact and provide care. In their article on promoting empathy during clinical clerkships, medical educators Jochanan Benbassat and Reuben Baumal define empathy as "a multiple-phase process" that involves: 1) "gaining insight into the patient's concerns, feelings and sources of distress; 2) "engagement" through "identification with these feelings"; 3) the development of compassion "produced by the distress of another person"; and a resulting 4) "desire to remove the cause of distress or at least to alleviate it" (833). Though further research would be needed to provide direct evidence that step four was reached, Parisa and Amara's reflections indicate engagement with the first three steps in that they bear witness to participants' experiences, identify the emotional states involved, and express compassion for the traumatic circumstances through which all parties involved are navigating.

For example, Parisa's vivid description of the man in the gift shop "sobbing," being in a wheel chair, and looking "unkempt" like the type of guy one sees by the "off-ramp" is important in that bears witness to humanistic details and, as a result, recognizes the man as emotionally distressed, disabled, and socioeconomically disadvantaged. In essence, she bears witnesses to the humanity of a person who, from what I've been told by nurses and physicians, is likely overlooked or even dreaded within a healthcare setting. While admittedly a subjective reaction, I found her mention of him "staring at the five-foot-tall giraffe, a look of pure sorrow on his face," to be a powerful and empathy-inducing sentence in that the stuffed animal speaks of innocence and his correlated tears

of loss. Parisa *sees* the man and testifies to his humanity and distress—though her ultimate lack of engagement with him is complicated, something I explore in a moment.

Turning to Amara's "Emptied," we see expressions of empathy for the patient and his family in her witnessing of the trauma they endure while saying a final goodbye to their child. For instance, Amara assigns agency and, therefore, humanity to an unresponsive patient in her description of Marvin as being on "his last walk."[40] This may seem insignificant, but in a pragmatic system where the "patient" has been designated "a body" for harvesting, it is notable. Perhaps the greatest expression of empathy for Marvin comes when, while looking at his photograph, it occurs to her that the innocence and happiness of the image does not capture "the chaos that had been inside his heart." This acknowledgement of the pain the young man who "love[ed] rock and roll, play[ed] with his animals, and seem[ed] happy" must have been suffering empathetically counters the judgement often cast upon patients engaged with self-harm, particularly suicide. Similarly, Amara's account also bears witness to the emotional horror, the "devastation on display," and the emptiness Marvin's family "must feel without him" while they say their "final goodbye." In particular, when Amara recognizes the mother's perspective that "[t]he child she had raised was going to his death," she captures a lifetime of relationship in a sentence. We are reminded that Marvin was once an innocent child, and the woman who raised and cared for him now has to watch him die as a result of suicide. The recognition here is profound and honors the trauma and grief experienced by Marvin's family. Amara demonstrates empathy.

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[40] The term "dead man walking" comes to mind with this description, which, for me as a reader, generated a visceral, emotional reaction that left me pondering the implications.

Though often more subtle, students' testimonies of their own roles and emotions likewise bear witness to the human condition within medical work and, as a result, engender empathy for *self*. Anthropologist Barbara Myerhoff in her work with elderly immigrants' production of oral and written accounts of their lives, notes that providing testimony of one's experiences is "reflective in the sense of showing ourselves to ourselves . . . arousing consciousness of ourselves as we see ourselves. As heroes in our dramas, we are made self-aware, conscious of our consciousness. At once actors and audience, we may then come into the fullness of our human capability" (qtd. in Heller 18). In essence, bearing witness to one's experiences through writing provides the author with a reflection of herself, which, in turn, offers the opportunity to view the events of her life through the eyes of a more objective, empathetic witness. Though neither Parisa nor Amara overtly express empathy for themselves in their writing, their self-depictions portray doctors in training who care, who are excited about the world of medicine, who are trying to do the right thing, and who are exposed to trauma and, as a result, suffer alongside their patients. In other words, they see themselves and recognize what they endure.

To illustrate, Parisa's description of being "so happy to be off work" and heading toward self-care is an acknowledgement of her own needs and state of mind and, accordingly, provides contextualization for her future choices regarding the man in the gift shop. Accordingly, when she describes her process of stopping, looking, turning, stepping, and repeating this pattern, it is easy to imagine an exhausted student torn between her drive toward altruism and the need for self-care including setting boundaries at work and taking care of her physical needs. Furthermore, her description of watching

others pass the man while she questions whether or not "they were letting him grieve" or simply did not have the time or energy, bears witness to her "inner battle" regarding the right thing to do and whether or not it was her responsibility to act. While, in the end, she does not intervene and, as a result, is haunted by the fact that she "never found out what this man's story was," the account she provides of her own exhaustion, turmoil, and desire to do the right thing provides an empathetic framework through which she may consider her decision regardless of her ultimate verdict.

Amara's bearing witness to Marvin's death and his family's tremendous trauma is likewise grounded in empathetic testimony regarding her own perspective and emotional state. Her description, for example, of "hugging herself" in the "cold OR" and, "this time" being "unable to hold her tears back," paints a portrait of a young medical student thrust into an extremely traumatic experience, a student who, despite her efforts to remain in emotional control, is unable to stop the grief she feels for the young man and his family.[41] Similarly, her final statement that "all [she] felt was sad and empty" bears witness to her own second-hand trauma, which, as most medical providers and caretakers would attest, is often lost in the chaos of the primary trauma. This testimony is an act of empathy for self. Perhaps of equal importance to her recognition of the trauma she faces, the account of "the medical student in [her]" feeling "exhilarat[ion] to see this miracle of medicine" bears witness to her fascination and excitement with the work despite the inherent trauma. This is important testimony when one considers the guilt students often experience over feelings of excitement regarding the strictly biological components and

[41] I am reminded of Dr. Van Meter's empathetic display of emotion during my visit to her office.

procedures surrounding working with trauma. She documents her engagement without judgement and, as a result, extends empathy for feeling excitement in the midst of tragedy.

In a medical education system that often reinforces dualism, bearing witness to others *and* self honors all those involved in the trauma and, as a result, engenders empathy. As MacCurdy notes, "[T]he act of speaking or writing the trauma can have a beneficial effect for both the survivor and the witness. It can establish our common humanity, which is the primary antidote to trauma" (*The Mind's Eye* 185). Testimony such as was offered by Parisa and Amara exemplify this function well in its disruption of the physician/patient divide emerging from a *bio*medical framework. Put simply, it says "I see you. I see me. We are all humans with hopes and fears going through an intense experience. I empathize." And, though this chapter has not focused upon the group work involved with the clerkship project nor the proliferation of writing such as this entering the public, it is important to acknowledge that the fostering of empathy through bearing witness is not limited to just the immediate participants of the story.[42] Genocide researcher Stevan Weine notes that sharing testimony "strives to be consequential for the witness, the individual survivor, the collective of survivors, and other witnesses to this witnessing" (167). Accordingly, I believe that the type of empathy generated in accounts such as those explored in this section will: 1) aid medical students as they navigate through trauma and attempt to find a balance between dedication to patients and self-care; 2) provide their future patients with a better chance of being seen as suffering

[42] Amara recently informed me that her narrative "Emptied" is in press for a medical humanities journal.

humans rather than someone to "fix"; and 3) give those who read this type of testimony, whether healthy or ill, a greater understanding of what illness, trauma, and recovery mean. This is a *bio*psychosocial model of medicine.

Concluding Thoughts

If we return to Neumann and Elizur's concerns outlined in the beginning of the chapter that a dualistic system of training leads to students having difficulty with "resentment and anxiety," "integrating personal and professional dimensions of life," and developing/maintaining "social and emotional sensitivity," the reflections from the clerkship project illustrate that through compositional acts involving catharsis of negative emotions, processing uncertainty, and empathetically bearing witness students directly engaged with these issues. This does not, of course, imply that the issues with which the students grappled were solved (though it is a fortunate product at times). That is not the purpose of writing groups of this nature. The goal, rather, is that students develop a writing practice that will serve the psychosocial needs of their patients *and* themselves, a goal the data implies was met.

Feedback from the exit survey also supports the success of their efforts toward this end. Alluding to catharsis, a student wrote, "This whole thing is one big juggling act and at times I feel like I'm dropping every ball . . . [writing] offered such a safe space to express myself without the fear of judgement or punishment." Similarly, another commented, "[Writing] helped me deal with how I felt about patients in relation to my own experiences. It is important to consider how a patient makes you feel when they remind you of a friend or family." Relating to processing, a student noted, "I think writing helped to define the experience and showed me which interactions had the most

impact on me—sometimes unexpectedly so." Another wrote, "I feel like I gained perspective, not just through my experiences, but through others' as well. It was great to step out of our microcosms and just think about what we're doing in the positions we are in every day." Themes connecting to bearing witness and empathy likewise emerged in their feedback. One wrote, "Writing certainly helped me to realize how raw some of the emotional connections I had with patients were, both for me and them. I also gained a deeper appreciation of the vulnerability of patients and the amount of almost unearned trust they place in their providers. Truly a powerful thing to be respected." Another commented, "We don't always realize how a patient has impacted us in the moment. In the weeks and months as they cross our minds, we begin to realize their true mark. Writing about the patient interactions really helped me figure my true emotions and then file them into how they fit with me as a person and a doctor." Several students commented specifically on the empathetic value of our group work as well. One wrote, "The project has a lot of potential to create a feeling of unity and connection among classmates during times that are often lonely and isolating." Another observed, "At first, I was concerned about writing and sharing with peers. The fear of being vulnerable was holding me back. However, from the start of our first session it became comforting to share. All of a sudden, we were talking about similar experiences and processing together. This allowed for writing to become rawer." In short, all group members reported having a positive experience that aided them with the humanistic aspects of their medical training.

A successful pilot project, however, is just the beginning of the work needing to be done. Accordingly, a primary purpose of the "manageable framework" outlined in this

chapter is to engage with this work by providing RW facilitators an interdisciplinary lens for designing pedagogy, assessing outcomes, and demonstrating the efficacy of RW toward meeting program objectives. Regarding the first, contemplating the "manage framework" when designing writing prompts is useful in that one can consider the needs of a particular student population (i.e. a bearing witness orientated prompt for students working with cadavers). It is also useful for explaining to students the function and value of RW in straightforward terms when introducing writing assignments. Next, the "manageable framework" also provides a structure for considering and discussing *what* students are doing with their writing and *why*. Thinking in the terms of chapter two, for example, it provides valuable insight into both their writing craft (i.e. use of detailed descriptions of cadavers as bearing witness) and the content of their reflections (i.e. noticing correlations between heavy amounts of catharsis and specific curricular demands). Along these same lines, it could provide responders with focal points to highlight regarding function (i.e. "I really appreciate how you are using writing to address the uncertainty you feel on the oncology ward"). Finally, though not exhaustively, the "manageable framework" can be employed when proposing RW projects to administration. Considering that medical education is extremely outcomes-based, being able to directly correlate the function and value of writing curriculum with program objectives is essential for making the argument that this type of writing work is needed.

This brings me to my final point. While I am not positing that writing groups such as the clerkship project be forced upon students as resentment over requirement could be disruptive, they should be a readily available, encouraged component of the mainstream

curriculum—perhaps, one of several medical humanities options provided toward the fulfillment of training requirements.[43] In doing so, we acknowledge the importance of this type of work and make it realistic for students to participate. Guy Allen, a narrative specialist who works with medical students, writes, "We teach humanism and dodge its practice. We ask our students to study and understand meaning at the same time that we offer little opportunity for them to make original meaning" (287). The fact that I had multiple clerkship students approach me after I sent out the project invitation to express disappointment that they would like to be involved but had no extra time for extracurricular activities which earned zero credit speaks to this. If we are truly advocating for a psychosocial model of medical education, then perhaps it is time to pull writing groups such as our clerkship project in from the periphery, to recognize the function and value of this work as a fundamental tool for humanistic medical training.

[43] See chapter five for recommendations on how this could potentially function.

Chapter Five: Writing and Healing in Medical Education: A Four-Year Curriculum

In arriving to the end of this dissertation's theoretical and pedagogical exploration of three distinct reflective writing (RW) projects in medical education, I bring us to the translation and application of the knowledge gained from this research and translating it into practice for future RW facilitators. As noted throughout the dissertation, while medical education (Med Ed) has done an excellent job investigating *why* RW is employed and *what* the results of its employment indicate due to their social-sciences orientation, little attention has been afforded to *how* it is implemented and functions at an instructional level. This is problematic in that responding to exigency and arriving at programmatic objectives relies upon trained instruction and an understanding of students' writing processes. It is not surprising, therefore, that, despite composition studies' (CS) focus upon questions relating to the *how* of writing practices through teacher research and the voices of students, Med Ed has drawn very little from our field. In response, grounded in CS, my years of experience teaching university level writing, and strong curricular ideas within Med Ed in need of pedagogical description, I now offer a four-year curriculum as base upon which future RW facilitators may build and tailor RW curriculum. In doing so and keeping with the orientation of the dissertation as a whole, I provide the type of textual guide in my Writing and Healing in Medical Education curriculum I would have greatly appreciated in the beginning of my RW work as a teacher and program developer. As a result, it is my hope to improve the understanding and facilitation of this important work toward its goal of helping students provide more humane care for patients *and* themselves.

Now that I have noted the exigencies and foundations for the Writing and Healing curriculum—concepts covered in depth in chapter one—I would like to briefly review the key findings of the three projects explored within the body of the dissertation as they provide a foundation for many of the curricular ideas outlined within this proposal. To begin, chapter two, "Feedback Approaches to Reflective Writing in Medical Education," focuses its gaze on facilitator feedback to online reflections from first-year students and uncovers three emergent categories of "listening," "guiding," and "encouraging" styles of response, what I term a "feedback framework." Furthermore, it examines the benefits and drawbacks of each approach, ultimately arriving at the conclusion that all three have pros and cons and that feedback must be tailored to meet contextually specific needs.

Chapter three, "Design and Facilitation of Reflective Writing Assignments: An Illness Narrative Case Study," investigates the exigency for and pedagogical practice of composing illness narratives through the lens of a second-year writing project in which students produced and then shared personal illness narratives in order to consider the psychosocial realities of illness, adopt a patient perspective, and practice vulnerability in communication with colleagues. More specifically, I focus my gaze upon student anxieties relating to the composition and sharing of vulnerable narratives and present facilitators with theoretical and pedagogical responses to these anxieties grounded in my teaching experience, CS, related fields engaged in writing and healing, and the voices of students who had transformative experiences. This knowledge serves as a useful resource for navigating the more difficult pedagogical aspects of this work not frequently discussed in Med Ed literature such as student anxiety and retraumatization risk.

Lastly, chapter four, “Writing on the Periphery: Exploring the Function and Value of Reflective Writing During Clinical Training,” examines a small, third-year clerkship writing group, which reveals that students used our iteration of Rita Charon’s Parallel Charts as a space for catharsis of negative emotions, processing the uncertainty of medical education, and bearing witness to the plights of others and themselves for the development of empathy. While a multitude of subcategories relating to how and what they discuss in their writing exist, these general three delineations provide a “manageable framework” for understanding the function and value of the RW group work and considering how RW training for the clinical training stage of education should be implemented.

Before turning to the curriculum, it is important to note two things. First, while in-person sessions are preferable for many of the following assignments, with the exception of “Meet Your Cadaver,” which requires an in-person cadaver experience, all of them could be modified to an online platform. This is important in that, beyond the fact that clinical training often requires students to work out of the area, I am writing this chapter in quarantine due to the coronavirus and all education is currently distance learning, a reality that is, according to experts, unlikely to be contained to this single pandemic. Therefore, online learning may sadly be a requirement in the future. Second, the scope of this chapter simply does not allow for the presentation and development of multiple extracurricular projects such as faculty RW workshops, community-based writing groups in healthcare (for both physicians and patients), an online RW journal hosted by the medical school and run by students, and a four-year scholarly concentration in narrative medicine. Accordingly, the pedagogy I present, while extensive enough to inform a four-

year curriculum, should be thought of as a foundation but far from exhaustive both in terms of curricular possibilities and the spaces in which those possibilities could be hosted.

With these exigencies, contributing bodies of knowledge, and caveats in mind, I now turn to Year One's curriculum, which focusses upon the introduction of RW practices toward the goal of providing students a tool for processing the difficulties of medical education and a base upon which they can build future RW practices.

Year One: Introduction to Parallel Charting

In many ways, Year One is just as much an introduction and adjustment to the emotional and social aspects of medical training as it is the acquisition of *bio*medical information and procedure. As students begin to face high stakes examinations, grueling hours, competition over grades and training positions, and exposure to medical trauma, it is essential that we provide them with training for processing these experiences and feelings, the type of emotional training for which the scholarship we have examined in this dissertation calls. I propose a reflective writing (RW) curriculum grounded in the composition of Charon's "Parallel Charts," a journaling technique designed to cathart, process, and bear witness to the types of personal perceptions, emotions, reactions, and interactions involved with medical work that rarely make it into the academic realm of training. Although the concept of Parallel Charting traditionally involves RW on the topic of patient interactions (as illustrated with the clerkship charts), for first-year students in this context, their "first-patients" are cadavers, classmates, instructors, texts, training experiences, and, most importantly, themselves. This more precise RW designation is purposeful in that the curriculum gains transparency and scaffolds for the third-year entry

into clinical employment of the charting. Specifically, as medical educators note, getting students into the practice of examining experiences for the psychosocial realities (i.e. psychological, cultural, sexual, socioeconomic, ethical) paralleling the facts involved with their human interactions, "can assist learners and seasoned clinicians alike to integrate intense experiences into their professional persona, especially extremely emotional experiences" while building a foundation for the type of perceptive, empathetic gaze we want to engender (Fogarty 402).

To present this curriculum, I describe two foundational assignments designed to introduce Parallel Charting at the start of the year when students have greater availability for in-person sessions (orientation and the first few weeks after are optimal in that students are eager to begin their education and meet fellow students). Next, I present the basic structure for monthly Parallel Charting. I conclude with recommendations regarding the identity and function of the responder team, an important consideration in that how facilitators go about the feedback process can drastically affect students' reception and practice of the work.

The Biography

This introductory assignment is adapted from composition studies (CS) scholar Jeffery Berman's biographical writing sequence emphasizing "collaborative learning and multiple perspectives" (*Risky* 72-74). Employed in Med Ed, it also serves as an introduction to psychosocially orientated interviewing practices while giving students the chance to develop rapport with teammates (a multipurpose "ice-breaker"). In my experience, students generally find assignments of this nature to be *fun* and anxiety

relieving once they are underway.[44] To begin, in step one, students list a chronology of five (or more) formative events in their lives, which could include births, deaths, first loves, moments of epiphany, traumas, educational experiences, etc. In step two, a process for which I give them 20-30 minutes, they write a short paragraph for each event that includes both factual detail and psychosocial perspectives (i.e. what happened *and* how and why it affected them). It is important to emphasize that these are not polished paragraphs and are simply there to convey details of an experience. While the events necessarily emerge from the past, they should speak to the students' current identity and/or understanding of illness. In step three, students exchange their paragraphs with a classmate who, after reviewing them, then interviews the partner for additional information and jots down notes regarding overall impressions.[45] In step four, students write biographies for each other (roughly two pages double-spaced) and email a copy to their partner to review before the next class session.[46] In step five, the author reads her partner's biography aloud to a small group of four. Other than thanking the author and subject of the biography or asking non-evaluative questions, providing feedback—particularly guidance—should be discouraged as they have yet to been trained in the art.[47] In step six, students freewrite on the experience and then voluntarily share impressions

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[44] It is amazing how infrequently "fun" is emphasized in pedagogical scholarship despite the fact that the vast majority of learners, whether kindergartners or Med Ed faculty, appreciate curriculum that relies on engaging styles of learning such as games, multimedia presentations, and non-evaluated group activities.

[45] Ideally, this takes place in a 75-minute class or is divided into two shorter sessions.

[46] Due to the potentially vulnerable nature of the content, it is important to remind students that sensitivity is crucial *and* that students should not include any information they are uncomfortable having shared at a group level. See chapter three for recommendations on addressing anxieties relating to vulnerability.

[47] Chapter two focusses entirely on how to effectively respond.

with the class as a whole. This final discussion presents a good opportunity to debrief on the practice of Parallel Charting including what details they found to be the most consequential, how to respond effectively to classmates' stories in the future, and the availability of mental-health resources should writing trigger emotional distress.

The assignment to which I now turn, "Meet Your Cadaver," builds upon "The Biography" in that students have pre-established rapport with classmates, which, for some, provides emotional support for what can prove to be an intense experience. Likewise, they have been introduced to the practice of examining situations for details that extend into the psychosocial realm, which is the type of humanistic gaze we want them to employ in their work with cadavers.

Meet Your Cadaver

Med Ed scholarship on the psychological ramifications of cadavers as medical students' first patients is prevalent. As medical educator Douglas Reifler notes, "In the anatomy lab, students confront death, graphic details of the human body, and fatal body processes, often for the first time. They also begin to learn to handle shocking circumstances in a professional manner—or, rather, they begin to develop attitudes and demeanors that will eventually become a part of their identities as physicians" (1). His use of "or, rather" is telling in that indicates the potential for students to alternatively develop unprofessional perspectives on cadaver interaction (patients as a sum of their body parts). It stands to reason, therefore, that providing students with an opportunity to Parallel Chart on the psychosocial aspects of their work with cadavers is needed, particularly in its attention to the humanity of the "patient" and the student's own psychology. Here is an approach I have successfully employed:

In step one, students read several published reflections from physicians and medical students prior to the first session.[48] In step two, students divide into small groups during class to discuss their impressions of the readings and jot down notes to share with the class. In step three, following a class discussion on their reactions, they respond to a pre-reflection prompt such as:

> How do you anticipate you will react psychologically, emotionally, and physically to the experience of working with a cadaver? Are there any reactions you would deem unacceptable? What do you consider to be healthy reactions? What might be some dangers of thinking about a cadaver's life and identity? What might be some dangers of not considering a cadaver's life and identity? How might a healthy balance look?

In step four, we collect submissions prior to the students' introductory anatomy lab session, provide feedback (reflective and validating *not* correcting), and assign the following Parallel Chart to be completed after they meet their cadavers:

> What about your lab experience met your expectations and what did not? When responding, take into account the biological, psychological, and sociological aspects. How did this early exposure leave you feeling regarding future lab work?[49]

The final step in this assignment sequence is a class session in which they discuss their impressions of the experience and whether or not those impressions were in alignment

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[48] Ralph B. Freidin's "The First Cut" and Edward Beal's "One Last Gift" are good example readings. I also recommend providing a student example if available.

[49] An alternative prompt I have seen mentioned in Med Ed literature has students write a short, fictional biography of the cadaver based upon their observations during the lab

with their pre-reflection predictions. In my past experience, this dialogue proves beneficial in that students learn that they are not alone in their reactions regardless of whether they felt highly emotional or, conversely, nothing at all. It also reinforces the idea that the point of reflection is not coming up with the "right" answer but, rather, engaging with important questions.

While these two projects provide examples of Parallel Charting, they are extensive in terms of requiring class time and multiple pieces of writing. The assignments to which I now turn are more independent, habitual exercises designed to foster an autonomous writing practice for entry into clinical training and, eventually, the professional realm.

Introduction to Parallel Charting

The bulk of Year One's writing work involves monthly, online Parallel Charts grounded in timely exigencies and related readings. To offer an example, prior to their standardized patient interviews—a process in which they practice medical interviews with hired actors—students are provided with a short reflection from a professional physician on interviewing patients. Next, they are prompted to describe one positive and one negative interaction they have had with a healthcare provider followed by an exploration of the differences between the two interactions. In doing so, they are encouraged to shift out of a purely academic focus (i.e. checking off the correct boxes on the list of interview questions and procedures) into consideration of the humanistic aspects of medical interactions they find affirming (i.e. feeling seen and heard). Medical educators posit that this type of shift in focus promotes an "awareness of the patient's concerns" and, as a result, "produces a sequence of emotional engagement, compassion,

and an urge to help the patient" (Benbassat and Baumal 832). The beauty of Parallel Charting work such as this is that because we are training students *how* to process psychosocial aspects of their training rather than delivering specific content knowledge, the thematic possibilities for monthly reflections can be contoured to meet student needs. Whether exploring the balance between educational demands and personal relationships, compassion fatigue, imposter syndrome, physician liability, or even something like medical risk in the time of a global pandemic, Parallel Charting provides students a space to consider current issues in their training through a humanistic lens. Furthermore, it provides them with a reader who bears witness and responds, which can both offer encouragement and model empathetic listening. This brings me to my final point.

There are advantages and disadvantages of particular responder team dynamics. For example, facilitation by a single writing professional or medical educator with proper training provides more autonomy than a team and results in the facilitator communicating with *all* students involved, thereby establishing a more comprehensive rapport. The disadvantages are the extensive workload and lack of diversity in feedback provided to students. The advantages of a team, conversely, are that they provide: 1) students a range of *ethos* in feedback (including student responders from upper classes); 2) division of workload for responders; 3) feedback training for Med Ed professionals and students who may be new to the process; and 4) a group for processing how to respond to concerning writing. The disadvantages are that the possibility of poor feedback is increased, and organization of a team requires more planning. With this in mind, my recommendation

for responding to class of 70 is a team of six: one writing professional, two Med Ed faculty members, and three students.[50]

Before transitioning to pedagogy for Year Two, I want to note that the Parallel Charting practice also functions nicely for Year-Two students and could supplement (or even replace) the following curriculum in that prompts relating to the psychosocial aspects of illness can be employed as a means to explore the same themes. I mention this because, while I prefer the following projects for their insightful engagement in human interaction, I recognize that some programs may not have the resources to facilitate endeavors with the logistical requirements of "The Home History" and "The Illness Narrative."

Year Two: Exploring Illness

There are multiple exigencies informing Year-Two's RW curriculum. First, as outlined in chapter four, the documented of loss of empathy in the third year of medical training is extensive (Afghani et al., Hojat, Newton). Engaging second-year students in writing work designed to explore the psychosocial realities of illness is, therefore, a preemptive move against this loss in its ability to illuminate inherent biases and alternative beliefs regarding illness.[51] Second, because acquisition of professional communication skills is a foundational goal of Med Ed, these assignments' direct engagement with peers and patients within vulnerable contexts contributes to the

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[50] Our RW team started giving students the choice to opt out of feedback from student responders due to anonymity concerns expressed by several first-year students.

[51] For example, anger with people engaged in self-harm behavior is a common theme I have encountered in their RW and, when exposed, seems to surprise students in that they are not always aware the extent of their emotions regarding this issue.

development of the types of communicative competencies they will need in their professional journeys. Finally, having students bear witness to their own journeys through illness resists the *bio*medical perspective of the physician as disembodied mind and the patient as a sum of their biological parts (Sierpina et al. 626). As a result, assumptions and shame regarding illness are often unburdened, processed, and empathetically witnessed, functions highlighted by the "manageable framework" explored in chapter four. I now present the two projects comprising the Exploring Illness curriculum.

The Home History

To begin, The Home History is designed to take place first as we want students to bear witness to a patient's illness story prior to composing their own because it demonstrates that the work of telling and receiving meaningful stories takes place outside the university walls (not merely a "mental health" exercise). Furthermore, in having empathized with a patient's story first, it is our hope that students enter The Illness Narrative project with greater empathy for their own struggles with illness, which, from my experience teaching Med Ed, can be more challenging for students than finding empathy for patients.[52]

In terms of origin, The Home History is a blend of two RW projects taking place in hospital and community settings. First, in their article "Regaining Our Humanity Through Story," medical educators Victor S. Sierpina and colleagues describe sending students to the homes of patients to interview them "to just get their story, not a medical

[52] This discrepancy gestures to the disembodiment of physicians inherent in a *bio*medical framework.

history" as a way to increase "personalization of the provider-patient relationship" (626). Following the interview, students compose short stories attempting to portray what they learned in the interview in order to bear witness to the patient's experiences. Regretfully, other than mention of a grading rubric, this is the extent of the pedagogy supplied in the article. Second, after hearing about it from a mental-health professional at a local hospital, I learned of R.N. Sheila Brune's program "The Living History," in which employees and volunteers "interview patients and write a brief story giving bits of information on their life," a story that is then included in the patient's chart.[53] She notes, "Then all people who 'touch' the patient (in any way) read the story and find ways to 'make connections' on a different level." Based upon these two projects, here is the curriculum I propose for The Home History.

In step one, facilitators contact community partners who can make arrangements with patients interested in the project.[54] In step two, several weeks before the first class session, students are assigned example narratives (preferably produced within similar contexts), Sierpina and colleagues' article describing the purpose of the work, guidelines for conducting an empathetic interview, and a reading outlining approaches to writing creative nonfiction.[55] Regarding the latter, the purpose for teaching creative nonfiction craft is that it provides students with a greater range of techniques for accurately portraying experiences in language. For instance, understanding how to write dialogue

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[53] This is the most literal "Parallel Chart" practice I have encountered.
[54] A beauty of Med Ed is that these types of partnerships should already be established due to clerkships, internships, and residencies.
[55] I recommend excerpts from Tilar J. Mazzeo's *Writing Creative Nonfiction* as it is extremely comprehensive and available for free as a PDF online.

and allowing characters to speak for themselves carries more impact than a writer who simply tells the reader what conclusions to draw. Similarly, employment of rich, sensory details paints vivid pictures and provides readers with a richer reality than basic descriptions such as "the patient looked ill" (How does "ill" look? How does witnessing it feel?). As a result of creative nonfiction techniques in writing, the story has greater potential to be impactful.[56]

In step three, an orientation and training session is held in which: 1) the readings are discussed at small group and class levels; 2) the project is introduced and questions fielded, including addressing any anxieties students might have; 3) etiquette for being respectful in patients' homes or hospital rooms is discussed; and 4) small groups brainstorm on the types of interview questions they might ask and report back to the class (have a scribe note everyone's questions for a class document). The purpose behind having them generate their own interview questions, especially at a small group level where students feel more at liberty to be vocal, is that they often come up with unique questions the facilitator may not have thought of, and it gives them a sense of agency and autonomy in the process. They are the professionals.

In step four, students conduct the interview, which includes either a hospital *or* a home interview depending upon availability—ideally, these would be close to equal in number in order to provide a diverse range of experiences for the class to process. In step five, they compose the story. For this process, it is important to remind them that the purpose of the project is to bear witness to the patient's experience and not to create a

[56] If this assertion feels lacking in evidence, simply consider what types of narratives have been the most impactful to you.

literary masterpiece. In other words, though I always promote the importance of detail, help alleviate students' anxiety regarding how "well" the piece is crafted and guide them toward honesty. In step six, after students have had time to work on their stories, I recommend an online workshop during which time they can share their drafts with their groups and the facilitator in order to receive feedback. Though this process should not be heavily guided, it is useful to provide students with some basic questions to consider when providing feedback to their classmates.

In step six, they send the story to their interviewee, include it in the medical chart (as long as the interviewee is happy with the result), and submit it the facilitator. In step seven, students are guided to reflect upon the experience through a few open-ended questions on an exit-survey, an activity that, as reflection and assessment scholar Kathleen Yancey notes throughout *A Rhetoric of Reflection*, aids in the processing and transfer of acquired information. As is the case with the Illness Narrative Project I present next, The Home History provides the possibility for individual publication and/or an anthology of stories, which bolsters students' CVs and letters of recommendations, provides positive exposure for the medical school as engaging in humanistic training, and, for willing interviewees, bears witness and honor patients' life journeys.

The Illness Narrative

The composition of illness narratives in medical training has become a central project for many psychosocially orientated programs. Narrative medicine scholars Sayantani DasGupta and Marsha Hurst describe the function of this practice as exploring quintessential questions in healthcare such as how illness: 1) affects "our self-image, family relations, professional identity, sexuality, and spirituality"; 2) fits into our cultural

perceptions of health; 3) inspires transformative action and connects us with others; and 4) impacts the care we receive from our healthcare provides (3). Similarly, based upon her extensive research on illness narratives, literary studies scholar Ann Jurecic notes their potential to "reclaim patients' voices from the *bio*medical narratives imposed upon them by modern medicine," and "encourage medical practitioners to respond to the stories of suffering people with attention, respect, and understanding" (2-3). Grounded in the results of our project and CS scholarship, chapter three of this dissertation arrives at similar conclusions. Although some of the following information is review from chapter three, I provide a basic structure of the Illness Narrative Project for the pragmatic value of this chapter as a curricular resource.

In step one, prior to the first in-class session, students are asked to read illness narratives from a range of authors. I recommend selections from DasGupta and Hurst's *Stories of Illness and Healing,* the online narrative medicine journal *Pulse: Voices from the Heart of Medicine*, and student narratives if available. As suggested by CS scholars, I also recommend that the facilitator include a short narrative of her own as a demonstration of vulnerability and project investment (Deletiner 316). In step two, the class meets for 75-minutes to scaffold the project through several activities. To begin, small groups of four or five discuss the readings as a way to tease out approaches, themes, and potential issues. Next, groups report their impressions and generate a larger class discussion on the functions, value, and risks involved with the work. Again, I advocate for the small group work first because it provides a more intimate setting for students who might not normally contribute to the conversation while also promoting team work. Third, following a brief introduction to the logistics of the assignment and

fielding questions, students shift into a brainstorming exercise that has them list personal illness experiences (either their own or that of someone impactful in their life) and, after, circle the experiences that feel unresolved and/or have influenced their identity in some way.[57]

Before moving to the final brainstorming exercise, it is essential to convey two things to them. First, some people are going to write very intense illness narratives involving life changing events while others will portray less traumatic events (either by choice or because they have not experienced heavy trauma). This variance is desirable because one goal of the project is to realize that, regardless of extent, illness can be incredibly important to the individual (MacCurdy "From Trauma" 161). The other critical guidance is that, while we encourage risk taking and vulnerability, students should avoid topics that present potential psychological or professional harm.[58] Following this guidance, students freewrite without stopping for five minutes on one of their topics. I encourage them to draw on sensory memories as much as possible. The final step of the class session is to have a brief discussion on how to exercise self-care when writing vulnerable stories and provide students with a list of mental health resources.[59]

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[57] While I generally guide students away from stories involving patients with whom they have interacted in a professional capacity, this is not a set policy and, as exemplified in the introduction to chapter three, a patient interaction may have had a significant, emotional impact.

[58] In chapter three, I discuss the possibility of an alternative assignment for students who are absolutely resistant to writing and sharing an illness narrative. While I do not believe that permitting students to opt out of this assignment is ideal, the potential disruption resistant students pose to group work presents an overriding consideration.

[59] Ideally, this single meeting would be expanded into two hour-long long sessions, which would open up the possibility for longer discussions, more pre-writing, and a guest speaker from the counseling department on campus.

In step three, students write their illness narratives independently. If possible, I recommend increased office hours (instant messaging is an interesting alternative to in-person timings) during which students can discuss writing craft and/or content with the facilitator. Illness narratives should generally range between 600-1500 words for ease of sharing sessions. In step four, students read a document outlining the pros and cons of the three types of feedback discussed in chapter two (including how those techniques can be used to address both writing craft and content) and general guidelines on how to be a respectful participant during the sharing sessions. They then submit a brief reflection on 1) what they hope to gain from the process; 2) anxieties they might have regarding sharing and/or responding; 3) and the type of feedback (if any) they would prefer from classmates. Again, regardless of their responses, this reflective exercise generates mindfulness regarding the process. Facilitators should make note of any particularly intense responses and reach out to students to address individual anxieties and/or needs prior to the session. In step five, groups of four to eight students meet for sharing sessions ranging between 45 to 75 minutes depending upon group size and programmatic limitations.[60] Facilitators should be prepared to keep the sessions on track both in terms of time and appropriateness of feedback (facilitators should be cautious not to embarrasses/shame students) and remind students that they may opt out of receiving feedback. In step six, following the sharing sessions, students write a brief reflection to be submitted electronically on what they gained/appreciated from the experience and/or what they disliked/suggest for revision. In step seven, facilitators respond to each student

[60] I have found that ten minutes per student to both share and receive feedback is generally sufficient.

regarding their illness narratives and perspectives on the process. This feedback does not have to be extensive but should indicate that the student has been heard.[61]

Building off of the first-year's curriculum in which they created Parallel Charts documenting the psychosocial aspects of their introduction to medical education *and* Year Two's exploration of the psychosocial aspects of illness through interviewing patients and sharing illness narratives, I now turn to Year Three and Four's Humanizing Clinical Care curriculum, which engages with students' exciting, yet highly challenging, shift into direct patient care and exploration of professional specialties. Specifically, this curriculum focusses upon practices and acquisition of knowledge that directly translate into professional identity. Furthermore, I suggest that students be given the option to choose only *two* out of the three following projects to complete by the end of their fourth year in order to accommodate educational travel for rotations and autonomy of individual interests.

Years Three and Four: Humanizing Clinical Care

As outlined in chapter four, students in clinical training suddenly find themselves accountable to real patients (many of whom can be quite difficult), to attending physicians with demanding expectations, to grueling schedules allowing minimal time for self-care, and to continued testing that can result in failure from medical school in the event of poor performance. Unfortunately, as medical educators note, these pressures have been shown to result in "attrition of empathy and compassion of medical students as their education progresses" (Reis et al. 256). An increasingly common response to this

[61] For a single facilitator, this is an immense amount of labor but, in my experience, essential in its demonstration of bearing witness and reciprocity.

issue is the employment of RW as a professional tool for students to relieve the pressures and uncertainty of clinical training and bear witness to the lives of their patients *and* themselves. Victor Sierpina and colleagues put it well when they write, "Why is narrative an effective antidote to isolation, callousness, and numbness? Because it serves as a lifeline to experiencing our own humanity, as well as a bridge that connects us to others, breaking through barriers built by professional roles, judgments, biases, assumptions, stress, and time pressures" (630). The Humanizing Clinical Training curriculum I now propose, which includes the projects, "The Parallel Charting Group," "The Physician Interview," and "Introduction to Narrative Medicine," performs this work. Because students are often out of the area or accountable to sporadic schedules in their rotations, only The Parallel Charting Group (typically) requires physical presence. Furthermore, I suggest that they only need to choose *two* out of the three options to complete by the end of their fourth year in order to provide flexibility.

The Parallel Charting Group

The Parallel Charting Group project combines the introductory charting work done by first-year students for releasing, processing, and bearing witness to psychosocial experiences in medical training and the small group work performed by second-year students during their illness narrative sharing sessions, which engages with vulnerable communication and alternative perspectives of illness. However, while this curriculum builds upon earlier RW work, because third and fourth-year students' education has advanced into clinical training, their writing necessarily focuses upon the experiences and emotions emerging from relationships with patients, families, and healthcare providers. Furthermore, unlike the single sessions involved with the illness narrative project, the

charting groups meet regularly in the manner of professional healthcare RW groups. Rita Charon, the founder of narrative medicine and originator of the Parallel Chart concept, describes her pedagogical process of facilitating Parallel Charting for students engaged in clinical training:

> [S]tudents are instructed to write, in ordinary language, about aspects of their patient's care that do not belong in the hospital chart but that must be written somewhere. Students write about their own attachment to patients, their being reminded by patients of family members, their own fears that are awakened by the care of sick patients. When they read to one another from their Parallel Charts, they make contact with dimensions of their colleagues that are generally hidden. Over short periods of time, they find themselves able to express ideas and sensations that add to what they know about patients and about themselves" (Charon "The Essential Role" 107).

Her authentic, straightforward curriculum presents an excellent model for adaptation to individual institutional contexts and specific group needs. The Parallel Charting Group I outline now illustrates this concept.

The first step is determining if the group will be a required part of the curriculum, voluntary, or something in between. Charon's work at Columbia is most often described as being imbedded within required curriculum whereas the clerkship group I facilitated and explore in chapter four was independent and voluntary. I like the idea of having the group as one of several options for training in the medical humanities, the model presented in this chapter. The reason behind this is that a resistant student can *easily* disrupt a group of this nature, a group that relies upon trust and support. In step two,

perhaps the most difficult step logistically, groups are formed and timings scheduled. Regarding the former, I recommend four to eight (absolute maximum) students with six being the optimal number in terms of diversity, intimacy, and time to share.[62] Groups meet once a month for a semester (roughly five meetings) and timings should be *preestablished* for the entirety of the project.[63] In step three, a pre-reflection having them explore their goals and anxieties (if any) for the project is assigned. These reflections are useful for mindful facilitation of the group, comparison with the post-reflection at the end of the project, and potential co-participatory research. Again, presenting students with the possibility of publishing their work is both exciting in terms of having their experiences and perspectives witnessed while improving their professional qualifications. Likewise, student publications provide universities with positive public exposure regarding their humanistic curriculum. Institutions such as Columbia, University of Arizona at Phoenix, University of California at San Francisco, University of California at Irvine, and Brown provide excellent examples of RW work being made visible through the publication of student voices.

In step four, the first prompt is provided through an online platform along with writing instructions, which should emphasize a couple of things. First, students should be encouraged to write habitually (I recommend ten minutes a day). As a writing teacher *and* a writer, I cannot emphasize the value of consistent writing practices enough—like

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[62] Groups could be formed according to individual students' schedules (use a survey to establish this), or for a group of students who already want to work together, they can self-form.

[63] The largest issue our group faced was difficulty arranging meetings due to our lack of preestablished timings.

exercise, it is a practice that must occur regularly for progress to take place. I also suggest that they not worry too much about producing polished pieces as lamenting over craft is one of the easiest ways to stifle authentic productivity. I do, however, suggest to them that they use sensory details and dialogue as much as possible when attempting to portray an experience—"show don't tell." I also encourage genre experimentation for those who enjoy writing craft and are looking develop their skills, particularly as playing with different styles of portraying experiences can help tease out alternative ways of knowing. For example, writing and healing scholar Marian MacCurdy notes that employment of the present tense in recounting traumatic experiences "enables [authors] to get back the details of the moments more readily" (*The Mind's Eye* 22).

In terms of prompts, I recommend providing several a month but only as suggestions for those who appreciate guidance.[64] As is the case with first-year students' Parallel Charting, these prompts can be tailored to address specific exigencies of their educational journeys. For instance, during an intense rotation involving severely injured and/or hostile patients (i.e. the emergency department), I might prompt students to: "Describe a time when you felt compassion for someone last week and a time when you had none to give. What made the difference?" Similarly, asking students to adopt different points of view can encourage critical thinking and empathy, both of which are core program objectives for most medical education institutions. To offer an unusual example, a colleague mentioned that he has students: "Write 500 words from the perspective of a virus."[65] Encouraging student to consider how they want their

[64] Alan Peterkin's *Portfolio to Go* is an excellent resource for prompt ideas.
[65] Frighteningly relevant at the time of this writing.

professions to unfold is also useful for their construction of a professional identity. I like the prompt: "Imagine you are at your retirement party after decades of practicing medicine. What would you want people to say about you?" Allowing students to craft prompts can be rewarding as well in that they have, of course, the best concept of what is happening in their world, and it provides prompts RW facilitators may employ in the future.

In step six, the group meets for an hour to two hours in a *comfortable* location to share writing. Each group member reads one to two charts depending on length and, after, receives a bit of feedback from group members.[66] To conclude the meeting, group members (including the facilitator) participate in a short writing exercise designed to generate ideas and maintain writing momentum. For example, creative nonfiction exercises such as playing with dialogue, sensory details, action scenes, memories, and genres provide students with writing craft instruction while also engaging in language play.[67] For example, I have used the prompt: "Describe a memorable interaction you had with a patient or colleague this week only using dialogue and action descriptions—in other words, no editorializing or employing heavy amounts of descriptive details." To reiterate, this practice, beyond being *fun*, teaches students greater control of language, which, in turn, improves their ability to translate personal experiences and perspectives into meaningful language. It also increases their chances at publication should they be

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[66] For the group explored in chapter four, asking the author questions and sharing related stories seemed to serve as the primary methods for indicating that they were listening and empathizing. It is also acceptable to opt out of feedback.

[67] As mentioned in chapter three, Natalie Goldberg's *Writing Down the Bones* is a great resource for creative nonfiction exercises.

interested in that avenue. In step seven, the facilitator provides individual students with a brief written response (I typically send emails) relating to their writing.

The next option in the Humanizing Clinical Care curriculum is the Physician Interview, an assignment that, like first-year's biography of a fellow student and second-year's interview of a patient, is focused upon interviewing skills and bearing witness to the perspectives and experiences of others.

The Physician Interview

This project, which involves students interviewing a physician of their choice and then writing an article presenting and reflecting upon the interview, is inspired by three sources. First, the American Association of Medical Colleges publishes an online project called "Inspiring Stories," which describes "journeys others have made from applicant to medical student to physician." The stories emerge from psychosocially orientated interview questions relating to early motivation to become a doctor, memorable experiences from medical school, management of stress, and impactful experiences while practicing medicine. A second influence is Kristin Yates' podcast "Imposter to Unstoppable," which, through live interviews, explores how "physicians have struggled with imposter syndrome but have thrived despite it." Finally, the Physician Interview builds off of a first-year composition assignment I have employed in which students interview a professional in the field of their choice and write a journalistic style article on the experience as a way to explore their interest in the field.

In alignment with these projects, The Physician Interview serves several valuable purposes. One goal of clinical training is to afford students the opportunity to explore various specialties in their search for, as they often term it, a "good fit." Accordingly, the

opportunity to interview a physician, particularly about less discussed aspects of a field, supports this objective. Similarly, in learning of successful physicians' insecurities and journeys through difficult circumstances, students' vision of what being a "successful doctor" is humanized and, therefore, helps to address imposter syndrome. Additionally, this project builds upon the psychosocially oriented interviewing skills developed in Year One's biography curriculum and second-year's patient interviews in its emphasis upon close attention to personal stories and humanistic communication. Finally, the Physician Interview provides students the opportunity to build relationships in the community, which is good for all parties involved including the university.

Turning to pedagogy, in step one, students are provided with example interviews and a list of interviewing guidelines.[68] In step two, a 60-minute class session is held to discuss the project requirements, readings, interview guidelines, who they may want to interview, and possible interview questions.[69] Again, to accommodate students who may not feel comfortable speaking in front of the entire class, I suggest small group work to cover the readings and interview questions followed by a whole class discussion on the ideas generated.[70] Additionally, groups should submit a list of their questions to be posted online as a resource. For the final five to seven minutes of the class, students freewrite on who they might interview, why, and what they anticipate learning. Though these

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[68] For the readings, both "Inspiring Stories" and "From Imposter to Unstoppable" provide relevant interview examples, and Lisa Ladd's "Interviewing Doctors: How to Get a Great Healthcare Story" provides a good template for basic interviewing guidelines.
[69] This step could take place online for those who cannot attend the session.
[70] I have found that wandering between groups is useful in that it provides them with personal attention and the chance to ask me questions. Furthermore, it gives me the opportunity to hear the ways in which different groups communicate.

freewrites are not collected, advise students to keep them for when they write their final texts as a piece of data from which they can quote and compare end results. In step three, students conduct interviews with a focus upon psychosocially orientated questions such as: "Was there ever an experience that really frightened you as a physician? Can you describe a moment when being a doctor brought you great joy? What would you do differently if you were starting your career over again?" Students should be encouraged to craft questions that have meaning to them and relate to the type of knowledge they hope to gain.[71] In step four, following the interview, students write the results. In many ways, this text is more akin to an article or essay than the RW they have done in the past and, as a result, may be challenging for some. It is important to emphasize, however, that there is not a single "right way" to write up the results, but that it should include four fundamental elements: 1) perspective into why this physician was chosen; 2) what the student expected to learn; 3) examples of stories and insights shared by the physician (the bulk of the text); and 4) what the student thinks/feels about the experience (i.e. did the experience change their minds about anything?). When it comes to writing interviews, I suggest that students write the experience as a chronological narrative (tell us the story) and in a manner that they would enjoy as a reader. In step five, the facilitator reads and responds to the texts. Typically, revision is not a part of RW work due to RW's nature as a healing and processing tool for self rather than an end product. However, in this instance, I recommend requesting revisions so that students ultimately produce a text that

[71] My question to Dr. Van Meter in the introduction regarding how she is able to do her work without experiencing heavy compassion fatigue provides a good example of the type of question that could be highly relevant.

can be shared with the physician and, possibly, published within a class anthology or an online RW journal.[72] It is important to note that issues with clarity of thought, organizational structure, and overall tone— what many in CS refer to as "global issues"—should always be addressed prior to issues with grammatical, mechanical, and stylistic choices—"local issues." Furthermore, I suggest that critique is couched gently and that positives aspects of the writing are highlighted (encouragement) in tandem with guidance. In essence, apply the golden rule to the feedback process.[73] I now turn to our third and final project option.

Introduction to Narrative Medicine

In many ways, Introduction to Narrative Medicine is a capstone for The Writing and Healing in Medical Education curriculum in that it offers a broad overview of narrative medicine extending beyond the RW focus the curriculum has embodied thus far. Through this overview, students are introduced to literary techniques for interpreting medical narratives (both written and spoken), conversations surrounding the field, and professional examples of narrative medicine put into practice. This is valuable in that it provides more advanced theoretical context to the writing and verbal communication work students have been practicing since Year One.

Specifically, students are guided through several areas of training. To begin, they explore the exigency for narrative medicine and its emergence from a variety of

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[72] Publication provides an excellent resource for future Physician Interview projects, and, as noted regarding the Home History and the Illness Narrative, positive exposure to the community for the student, physician, and university.

[73] See chapter two for specific guidance on how to provide these types of positive comments.

disciplines including medical humanities, literary studies, narratology, trauma studies, and, though seldomly acknowledged, expressivist movements in CS. In the same vein, they are exposed to current conversations and research surrounding the field, including the voices of critique (i.e. Woods). They also learn approaches to literary interpretation of medically orientated narratives, approaches emerging from narrative medicine founder Rita Charon's training as a PhD in literature and medical doctor. Charon and colleague Nellie Hermann summarize this interpretative gaze, what is termed "close reading," concisely:

> "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 (6).

Finally, students learn that the close reading techniques described above have pragmatic application for clinical settings as the practice of 1) "attention," which refers to the employment of interpretative frameworks in patient communication toward greater comprehension of meaning; 2) "representation," which can be verbal reframing of what the physician hears from a patient *or* written interpretations after the fact; and 3) "affiliation," which is the establishment of rapport, trust, empathy, and community as a result of this careful listening and reframing (Charon "Attention, Representation,

Affiliation"). I now turn to an outline of the pedagogy I propose for achieving these goals.

Due to the high possibility of students working rotations outside the local area and increased movement toward students' professional autonomy, this curriculum is designed to be implemented online. Accordingly, in step one, the facilitator organizes an online platform with multimedia capabilities in order to provide a space for delivering and receiving files and to facilitate written conversations (including instant messaging if possible). In step two, students read the project description and post a brief introduction of who they are (encourage humanistic details), what area of medicine they intend to pursue, and any questions/comments they have regarding the project requirements. This serves to both establish rapport and address a broad range of questions with the class, some of which students might not have considered. Sensitive questions/concerns may be emailed directly to the facilitator who may then choose to address the issue(s) on the discussion board or simply respond to the student personally depending upon the nature of the issue. In step three, following their submissions, the facilitator addresses their questions/concerns on the same discussion board. This communication provides a great opportunity for the facilitator to demonstrate active listening and empathetic professionalism through her responses.

In step four, the bulk of the project, students read and respond to two readings a month over the course of five months. In terms of readings, I have a few suggestions.[74]

[74] For monographs, I recommend short excerpts as the amount of time allotted for this project is insufficient for most students to read book length texts while attending to their other studies.

For background on the exigency and emergence of narrative medicine as a field, I suggest Rita Charon's *Narrative Medicine: Honoring the Stories of Illness* and Trisha Greenhalgh and Brian Hurwitz's "Narrative Based Medicine: Why Study Narrative?" For background on the history and function of bearing witness and composing illness, Arthur Frank's "The Voices that Accompany Me," Arthur Kleinman's *The Illness Narratives,* and Kathleen Conway's *Beyond Words* all provide accessible concepts and powerful examples. For research and discussion on the neuroscience and general health implications of the composition and reception of narratives, I recommend Alice Brand's "Healing and the Brain" and James Pennebaker and Janel Seagal's seminal "Forming a Story: The Health Benefits of Narrative." For the potential limitations of narrative medicine, Alan Peterkin's "Primum Non Nocere: On Accountability in Narrative-Based Medicine" and Angela Woods' "The Limits of Narrative" provide a comprehensive view. For medically orientated narratives to be used as examples of narrative medicine in practice, a few (of many) good options are Alice Munro's "Floating Bridge," Kay Redfield Jamison's *An Unquiet Mind*, Paul Kalanithi's *When Breath Becomes Air*, Christin Montross's *Body of Work: Meditations on Mortality from the Human Anatomy Lab*, and Sayantani DasGupta and Marsha Hurst's *Stories of Illness and Healing: Women Write their Bodies*. For films, I appreciate *Wit* and *Dallas Buyer's Club.* These are but a few of the immense amount of possibilities.

Regarding students' written responses, prompts are quite important and, as narrative medicine educators note, should include a mixture of narrative medicine's close reading analysis and creative possibilities calling on students to listen to "what they can find in themselves that is informative and useful" (Spiegel and Spencer 42). Essentially,

the idea is to craft prompts that both engage with narrative medicine's structural approaches to textual analysis *and* encourage creative reflection outside the boundaries of traditional academic orientation toward "correct" and non-personal critique. As a great deal of CS pedagogy posits, students tend to excel when their work has direct relevance to both their professional futures and personal lives. Toward this end, I suggest providing students with several prompt options for each reading, options that approach texts from different angles. Furthermore, rather than specific length requirements, emphasize quality and authenticity of response as length will vary greatly depending on the purpose and style of approach. Any issues with poor quality responses (i.e. lacking critical engagement and depth) can be addressed through professionally orientated and non-shaming feedback from the facilitator.[75] Another requirement for written responses is that at least once during the project, students need to submit a reading response on the discussion board. This may or may not be the same response they submit to the facilitator (I often encourage students to pose questions they believe might generate a good discussion). Similarly, at least once during the project, students need to respond to a classmate's posts on the discussion board. The idea of this practice is to develop diversity of perspective and to foster the identity of the project as a community of learners. In my experience, this is often students' favorite aspect of an online platform, particularly when discussions are timely and engaging.

In step five, at the duration of the project, students submit a single document with all ten of their reflections clearly organized and a cover letter exploring: 1) what (if

[75] Resistant students should be encouraged to voice their objections in conversation to the content of the articles.

anything) they appreciated about the project; 2) suggestions for revision; and 3) if they envision elements of narrative medicine transferring into their future practices as physicians. Emphasize that a "good" response is simply an honest and clearly explained response. In step six, the facilitator thoughtfully responds to students' cover letters and thanks them for their work.

This ends the pedagogical recommendations of the dissertation and, to reiterate, they should be viewed as a *template* upon which to build and contour pedagogy to meet individual programmatic and student needs. In other words, just as psychosocially orientated medicine moves away from static definitions of patient and physician identities, a psychosocially orientated curriculum should remain flexible and conscientious of the lives it touches.

Conclusion

"I needed to write, to express myself through written language not only so that others might hear me but so that I could hear myself."

~Gabor Mate

As I have illustrated throughout this dissertation, the exigencies for the practice of reflective writing (RW) in medical education are vast. For too long, the biomedical model of medicine has dehumanized patients and disembodied physicians, the result of which is often isolation, frustration, apathy, and suffering for all parties involved. Ask nearly any person in Western culture and they are likely to have a story supporting this claim. Similarly, for too long the psychological strains of medical education have gone underrecognized as evidenced by the high level of mental-health issues experienced by students and the periphery status training in self-care often holds. Ask nearly any physician in Western culture and they are likely to have a story supporting this claim.

Additionally, beyond these well-established exigencies, we have entered a time of unprecedented medical crisis and subsequent trauma due to a pandemic. There are currently refrigerated trucks parked outside hospitals because morgues cannot handle the amount of people dying from the coronavirus, and medical students are being prematurely rushed into residency programs to meet the rapidly increasing demand for physicians. As a result, healthcare workers are reporting feeling extreme duress due to the unprecedented exposure to continuous fatalities and the personal safety risks they are required to take daily. As one physician put it, "I'm certain we're going to see a lot of trauma syndromes because no-one is prepared for the kind of stresses that we're going to be under . . . [t]he risk factors are all there, not just a threat to life, but also in feelings of being unprotected and unsupported" (Wylie et al.). As tragic illustration, just last week

the news reported that a New York physician who, after recovering from coronavirus herself, committed suicide as a direct result of the trauma her and her colleagues faced while treating those suffering from the outbreak. On a personal level, the fact that I am having to apply the same emotional coping mechanisms I learned while taking care of my wife, also illustrates this fact. Touching has become dangerous and people are generally terrified. It is the last exigency I would have ever wanted for this work to be in demand, but we need our future physicians to be trained in psychosocially orientated practices more than ever. We need them healthy and empathetic for their patients *and* themselves.

Toward this end, I have demonstrated the efficacy of reflective writing (RW) in guiding students toward these goals, in shifting from a *bio*medical to a *bio*psychosocial model, in helping young physicians provide the type of care my wife and I received from Dr. Van Meter as portrayed in the introduction. Unfortunately, as illustrated throughout the dissertation, how to move from the exigencies for RW to the benefits outlined in medical education (Med Ed) scholarship has been primarily absent in the literature. Pedagogy tends to be a numbered chart or a footnote. Accordingly, essential questions and practices have remained unexplored in scholarly conversations, which not only sequesters knowledge within the confines of individual institutions but also leaves those embarking upon their journeys as RW teachers unsupported.

In response, through emergent data from thick teacher research and composition studies' (CS) extensive theoretical and pedagogical engagement with related writing practices, the work of this dissertation moved toward identifying and filling this pedagogical gap in several critical areas. First, despite the fact that providing feedback to vulnerable writing is one of the more important and challenging aspects of writing

instruction, I have shown that there is little guidance available in Med Ed literature and what does exist tends to reflect boilerplate practices. The "listening," "guiding," and "encouraging" approaches to feedback explored in chapter two, on the other hand, provide a detailed and valuable "feedback framework" for mindfully considering and crafting feedback and yet do so with the understanding that responses must be tailored to specific contextual needs. Next, I illustrated that, despite the fact that RW curriculum centered upon the composition and sharing of vulnerable narratives is bound to generate concern in some students, little attention has been given to this area in Med Ed scholarship. The research in chapter three responds by outlining student concerns relating to both the composition and sharing of vulnerable narratives and presents facilitators with theoretical and pedagogical responses grounded in my teaching experience, CS, and the voices of students who had transformative experiences.

A third critical gap in Med Ed literature outlined in this dissertation is the general lack of exploration on *how* students are reaching the established goals for RW work in Med Ed through their writing. Chapter four replies with an analysis of RW from a Parallel Charting group, which reveals that students use writing to cathart negative emotions, process uncertainty in medicine, and bear witness to the lives of others and self toward the development of empathy. These categories, what I term a "manageable framework," provide a useful lens for understanding, discussing, and guiding RW work. Finally, though specific RW assignments are mentioned and occasionally discussed in some detail in Med Ed literature, I demonstrated that they often lack the type of "nuts and bolts" depth instructors need to reproduce an iteration without reinventing the wheel. Chapter five addresses this gap by providing a comprehensive four-year RW curriculum

including: 1) underlying theories behind assignments and their sequencing; 2) methods for adapting curriculum to different contextual parameters; 3) related readings; 4) scaffolding activities; and 5) structures for the facilitation of the writing and sharing processes. To my knowledge, no other RW curriculum of this nature currently exists.

The process of researching and writing this dissertation also revealed a number of areas in need of further exploration and development. For example, there are numerous opportunities for RW to take place within community settings, particularly in connection community healthcare partners. For example, I can envision facilitating and mindfully researching small "writing and healing" groups with oncology patients and involving Year Four medical students who have demonstrated aptitude for work of this nature. This would, likewise, present an opportunity to explore concepts surrounding the divide between the facilitation of a therapeutic process and providing therapy, an area in need of attention. I can envision a variety of anthology projects as well. At the present moment, for instance, I am working with another medical school to solicit 55-word narratives from students and faculty on the impact of the coronavirus on their lives. Similarly, each time I have taught illness narratives there have been multiple students expressing interest in publishing their writing, which provides a great opportunity to collaborate on an anthology. I can envision the design and facilitation of undergraduate courses in RW for students on a healthcare track. This curriculum would generate a beautiful opportunity for collaboration between CS, Med Ed (including nursing), and social sciences. Following examples like University of Arizona College of Medicine's *Stories in Medicine* website, I can envision developing a website in which students, faculty, healthcare practitioners, and community members could publish reflections relating to the intersections of their

lives and medicine. Lastly, I can envision RW workshops and Parallel Charting groups for faculty members, which would provide an exciting opportunity for wellness work and training in the facilitation of RW. While this list is far from exhaustive, it illustrates the wealth of possibilities for future RW work. Furthermore, with the knowledge and frameworks developed within this dissertation, I believe this work will be greatly strengthened.

While I make no pretense that RW training in medical education is a fix-all for the exigencies I've explored throughout this dissertation, it is an incredibly pragmatic practice with a variety of important applications including its use as a tool for releasing and reframing negative emotions, for processing difficult and ambiguous aspects of training and medicine in general, and for witnessing medical experiences through humanistic lenses. It offers more than lectures on humanistic medicine and assigned readings on psychosocial dimensions of healthcare, though I am not discounting the value of these activities. It is action, connection, and voice. It is unification of emotion and cognition. It is, as CS scholar Robert Yagelski and medical educator Hellerstein note, a way of being in the world, which, in a medical context, moves toward humanization of patients and embodiment of physicians. Put simply, it supports healthy and compassionate medicine. Accordingly, if we are sincere in our advocacy of training students in a *bio*psychosocial model, it is time to bring RW in from the periphery and situate it as a core practice in medical education.

Afterword

I would like to present one final story as both a way to demonstrate the function and value of reflective writing and to honor my late wife, whose suffering and beauty are the reason the work of this dissertation exists. As you read, put the "manageable framework" to work. Consider how I employ catharsis of negative emotions through the naming of medical trauma and the small, yet emotionally large, confessions I make. Likewise, note how I process the uncertainty of living day to day life post illness, including financial turmoil over medical bills, and raising small children while buried in disbelief and grief over the loss of my life partner. Finally, observe my acts of bearing witness to self in the depiction and organization of my trauma into a cohesive narrative. Likewise, see how I bear witness to my wife, how I chronicle the little things that made her such a bright and beautiful soul, how I honor her suffering through recognition of the trauma she experienced, how I illustrate her humanity as a way to demonstrate the critical need for compassionate medical care from physicians. I leave you with "The Things She Left Behind" (Zytkoskee).

"The Things She Left Behind"

My wife Danae left behind a pair of black Adidas tennis shoes with pink trim that continues to sit on the front porch. They're far too big for my daughter but too small for either of Danae's sisters. I should move them; but I don't. Instead, I see them when I come home from work sitting next to the pumpkins the kids decorated with glitter—as if she were right inside. The sneakers get dusted by snow and still I leave them. No one comments on the lonely shoes. Perhaps they fear any words will fall short.

She left behind paperwork that continues to come to our address in her name.

Mostly bills as the people who matter are aware that she's gone. One day, I decide to call the half-dozen hospitals who want money from us—from me. The bills sit, growing like the cancer they represent, in a file cabinet that is covered with free stickers from sports equipment we bought together. I'm put on hold. I'm transferred. I talk to a woman who says that she cannot talk to me because I do not have power of attorney. "So," I ask, "then I'm not liable for these bills?" "Unfortunately, you are," she replies. "You can make a payment; I just can't tell you the amount or any other details. I suggest you contact your wife's insurance company directly." So, I do. They transfer me three times, disconnect me twice, and finally, after an hour and twenty minutes, a woman says, "I understand your situation sir, but I'll have to speak directly to your wife." I tell her something colder than I've ever said in my life. "Ma'am, I hope that you get to watch your husband or whoever the fuck you love slowly die!" Before she can respond, I hurl the phone against the wall where it breaks into pieces. Instantly, I feel stupid and helpless. Rather than calming down, I scream into a pillow and then throw a tantrum worthy of a two-year-old. Afterward, I dig around the garage until I find some old, dry tobacco and sit on the back porch smoking an awful tasting cigarette while listening to sad music.

She left behind the territory under the sink in the master bathroom. Really, the entire bathroom was her territory, but I've reclaimed a majority of the lost ground... except for under the sink. Crammed to nearly overflowing, it was too daunting a task until one day I put on loud music and got to work—and by "put on," I mean dialed up to house-rattling levels. She has space saving baskets overflowing with unfamiliar things. The first one I pull out has maybe twenty different nail polishes. In her last months, she

became obsessed with doing her nails and anyone else's who would let her; it was something she could do even in the hospital. I put them in a pile to give to family and friends. One sparkly, blue color catches my eye and I set it aside for my daughter. Does nail polish spoil, I wonder. All the emery boards go in the trash; they disturb me, especially remembering the infections she got on her feet towards the end, infections that I told her weren't gross when she cried about how disgusting her cute toes had become. Another basket contains hospital masks; these remind me of death. Into the trash they go. I discover a box filled with small vials of essential oils for aroma therapy, vials that proclaim healing potential for just about every ailment. A memory flashes through my mind of a mocking comment I'd made to her about "stupid hippie products." Why did I feel the need to put down on her excitement? Fuck. I keep sorting and find nail clippers, an eye lash curler, two hair driers, boxes of unused contact lenses, laxatives, an old toiletry kit from Emirates airlines, a Beanie Baby seal, and a Neti-Pot. Some of it I keep. Some of it I set aside for her mom and sisters. A lot goes in the trash. I feel pulled between a desire to keep it all and to throw it all away.

She left behind her preferences for little things. At the store, I grab Fuji apples because those are the kind she likes. This is not sentimentality. It's habit. Not until three months after she's gone do I grab Granny Smiths, carefully selecting each green apple and feeling a sinking in my stomach as I do. Likewise, when I dress my two-year-old daughter Arya one morning, Danae's good-humored criticism of my outfit choices echoes and I find myself deciding against a particular pair of leggings because "stripes and plaids don't belong in the same ensemble." I put on Buffy the Vampire Slayer one night when I can't find something to watch—this was always her go-to when we couldn't

decide on something. But when the character Angel utters some ridiculously moody line, she's not there to hear my teasing, to laugh and tell me, "I can't help it Matt! I love this show!" So I turn it off, the fun gone. And it goes like this. I wipe up water from the bathroom floor after my shower because it bugs her. The Alfredo sauce remains off the pizzas I bring home from Papa Murphy's because it makes her feel bloated. In the used bookstore, I automatically reach for a title from the *Outlander* series in case it's one she hasn't read. Fourteen-years of a shared, intimate life leaves deep patterns, like old familiar ruts on a country road, and I'm not really sure how "to be" without her.

She left behind the walk-in closet. Like the bathroom, the closet was her domain for the most part, and is filled with hat boxes, small treasure chests, plastic organizing drawers, shoe racks, and a wrapping station. To me, a wrapping station was just one of those "female things" that served as a place from which to steal scissors and tape when the need arose (an action that seriously pissed her off). Now, when my four-year-old boy Finn is invited to a birthday party, I scour the wrapping station and find themed gift bags and colorful tissue paper. Thank you, Danae! And rather than leaving the scissors and tape out, I carefully put them away—I want them handy for the next time. I also find myself saving gift bags that are given to the kids, thinking, "Hey, I bet I could use it later." In the past, I couldn't chuck them into the recycling bin fast enough.

She left behind boxes of carefully wrapped holiday decorations. It was always "clutter" in my mind and, if I was left in charge of putting it away, things got recklessly tossed into the garage (or even the trash if I could get away with it). This year, on January 5th, I tenderly pull Christmas ornaments off the increasingly flammable tree, carefully wrapping each one in tissue paper and packing them away for next year. Some of the

ornaments are new, gifts from friends and family at Danae's memorial service and some carry the energy of her loving stewardship. They are my responsibility now and I will not treat them with the same careless disregard as the ghost of my Christmas past. While I perform this task, it occurs to me that I used to consider it a "task" as well, not realizing that having her by my side, listening to music, chatting, and sharing in the holiday effort, was the real Christmas gift.

She left behind her words in different forms like beautiful ghosts, who exact tears from me even when I believe my reservoir to be dry. In a stack of old letters, I find a homemade birthday card she made for me out of a map of Paris. She writes, "Happy Birthday Matt! Life with you is an adventure and I look forward to many, many more years of exploring. I love you! Yours, D." Another night, I find the courage to open up my old Yahoo email account. There are close to a hundred emails from Danae spanning the first seven years of our marriage. The messages range from everyday life details to love letters like this one she sent to me while I was commercial fishing in Alaska: "My love, I miss you. I want to cuddle in your arms, kiss your sweet lips, hear your melodic voice in my ears. I want to talk about life and the thrills and woes that drop into my head and swim about at night. I want to roll over in the morning and put my arms around you and feel the warmth of your body heating me up…devouring me. Most of all, I want to see you, just look into your blue daisy eyes, clasp your hand in mine and walk along the water…Roy running ahead and then turning to see if we are still heading in the same direction. You are my love forever and for always . . . enjoy the fish and tundra. Yours, Danae."

She left behind her presence in home movies. Whereas her writing is mystical and

sentimental, the Danae caught on tape is usually laughing and telling stories that bubble over with valley-girl cheer. Arya likes one in particular and asks to see it regularly. It's a video taken at a family vacation, a clip I filmed without Danae's knowledge. She's telling my mom about her and my dad's experience killing time at a local karaoke bar. She's wearing a funny tie-died shirt and her hair, streaked with summer reds, is long. Voice teetering on laughter, she says, "This guy is older, wearing glasses, and is—I don't know—maybe sixty. And he gets up on the stage and is singing this song like, 'I stroke it to the east, I stroke it to the west, I stroke it to the girl I like the best,' and he's dancing all sexy, like doing all this kind of stuff." At this point in the movie, Danae jumps up and starts gyrating her hips in imitation. "I mean it was sooo hard for us not to laugh! And after the guy finished, the DJ's like, 'I don't know about east and west; but I got north and south down!'" As Danae and my mom crack up on the video, Arya laughs loudly too, her eyes glued to the computer screen, her little mouth forming smiles. She doesn't understand a thing from the video, but she likes seeing mommy, likes hearing mommy laugh. It tears my soul in half, but when she says, "again!" I start it over.

War journalist and filmmaker Sebastian Junger writes that for soldiers who have seen action, seen death, "It's coming home that's actually the trauma." They return to a place that no longer exists, to a world that moves forward without them. I am not a soldier and have heard arguments against the war analogy for cancer. But, war seems to be the only fitting analogy for the violence cancer inflicted upon our lives. I have seen incredible suffering, shrieking in pain, puking blood, lying naked on the floor in shit and urine after she fell on the way to the bathroom. I have seen maggots crawl out of her nostril after feasting on rotting tissue, the humiliation and horror unbearable for her. I

have watched dreams wither and fear spread like a virus. I have lived with the threat of death on a daily basis for prolonged periods of time. I watched the love of my life die on a hospital bed, blood trickling out of her eyes, her swollen, unmoving hand lifeless in mine. And, like some soldiers, I know what it means to find that home no longer exists, at least not in the way it did.

So, the kids and I rebuild, salvaging what we can and scavenging the rest. And some days I see that she's left behind immense love and two thriving children. Other days, I see that she's left behind a deeply wounded man with one foot in this life and one forever on the other side.

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