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Medical Memoirs as a Teaching Tool within Narrative Medicine

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Medical Memoirs as a Teaching Tool within Narrative Medicine

Gaines Thesis 2021-2022

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Table of Contents

Background … 1
Teaching Communication Skills in Healthcare Settings … 3
The Value of Medical Humanities … 4
Narrative Medicine and Medical Memoirs ... 9
The Culture of Medicine … 12
The Practice of Narrative Medicine … 14
Overview of this Thesis … 22

What Doctors Feel … 22
Brief Synopsis … 22
Close Reading … 25
Reflective Writing … 31
Application when Teaching Narrative Medicine … 38

Every Patient Tells a Story … 45
Brief Synopsis … 45
Close Reading … 48
Reflective Writing … 53
Application when Teaching Narrative Medicine … 60

When Breath Becomes Air … 68
Brief Synopsis … 68
Close Reading … 71
Reflective Writing … 77
Application when Teaching Narrative Medicine … 83

Discussion … 92

Conclusion … 99

Medical Memoirs Cited … 100

Full Works Cited … 101

Background:

I was born with unilateral microtia on my right side, leaving me partially deaf on that side. This meant that my family was in and out of different appointments when I was a kid, going to hearing screenings, speech therapy, and surgery consults among other things. Though I was young throughout most of the fundamental parts of what I consider to be my healthcare journey, my different healthcare teams always made sure I felt both included and acknowledged. During one of my main reconstructive surgeries, I took a Dora plush doll in with me, and the nurses and anesthesiologist dressed her up in matching bandages and scrubs to surprise me when I woke up. Small acts like this helped me to always feel included as I was shuffled in and out of different doctor's offices and hospitals. Once I got to high school, I decided I was interested in pursuing medicine and therefore began shadowing and seeking out clinical exposure. I quickly learned through these experiences that much of what I remember from my childhood is not necessarily representative of medicine as a whole.

As I have gotten older, I have learned to further value and appreciate the communication and attention that was prioritized throughout my care. While I remember all of my providers fondly and can recall instances of them asking about different components of my life in follow-up appointments, further clinical exposure has shown me the wide volume of patients many healthcare workers care for. I always felt important during my visits (and even now I know that my providers do still care about me), but working in a clinic has revealed that many physicians and healthcare professionals have thousands of patients under their care, and many of these personal details my doctors have remembered were likely remembered because of a note they had previously jotted down in my charts.

Both shadowing and working as a clinical research assistant have exposed the vast amount of behind-the-scenes work (conducting consults, teaching students, making phone calls, checking drug interactions, etc.) that most providers are responsible for, and this workload often culminates in a short amount of time physically spent with the patients themselves. This lack of time on top of the fact that much of America's healthcare system is hospital-centric (meaning that often health problems aren't addressed until patients present to the hospital with serious complications) often leads to a communication gap in healthcare which has the potential to negatively affect care. This gap in care emphasizes the need to focus on building communication skills while training medical students for their future careers. Afterall, improved communication skills equip students to seek out patient narratives, and a narrative medicine focus within healthcare works to humanize patients and ensures they are seen as a whole person rather than only a patient.

There are currently fifteen core competencies as defined by the Liaison Committee on Medical Education which are outlined as important for entering medical students. They are intended to create a more holistic applicant and are grouped into four different categories: interpersonal competencies, intrapersonal competencies, thinking and reasoning competencies, and science competencies. Medical schools themselves typically have core competencies of their own, generally focusing on scientific knowledge and clinical skills, but also including other key qualities related to comprehensive care (such as communication skills). Regardless of which competencies are deemed "core competencies", there is typically a biomedical, evidence-based focus within medicine, particularly once students begin their clinical training (typically occurring in the third year).

However, previous research has noted that communication skills are quickly becoming recognized as one of the most valuable competencies for medical students to master (Baig et al.). Historical trends suggest that communication is not a skill that can be effectively taught, but this has since been disproven (MacDonald-Wicks and Levett-Jones 2012). And though medical schools have found different ways to teach communication, Objective Structured Clinical Examinations (OSCE) and standardized patients (SP) have both been utilized by many schools to assess students' communication skills.

Teaching Communication Skills in Healthcare Settings

Communication is a two-way interaction during which information is being exchanged. It can have both verbal and non-verbal components but is typically considered effective if the message was understood by the receiving party as it was intended to be received. Effective communication is essential to medical students for a variety of reasons, including "enhanced patient satisfaction, patient safety, symptom resolution and improvements in functional and psychological status" (MacDonald-Wicks and Levett-Jones 2012). On the other hand, poor communication can lead to misinterpretation of a patient's symptoms/history or the omittance of information vital to treatment, both of which can have drastic consequences. It is therefore in the best interest of both the patient and the provider to seek effective communication in order to provide the best possible care.

Beyond needing good communication to simply ensure that providers accurately understand the patient's problems and needs, it's important for patients and providers to have good communication because this then allows them to form trusting relationships. Secure relationships are ultimately necessary in healthcare settings to create the trust and comfort needed by patients to confidently tell their story. Good communication therefore serves to create a safe space for both patients and providers, furthering empathy within the patient provider relationship.

And lastly, there is the idea of narrative competence as it may fall under the broader idea of physician competence in general. Physician competence is a term defined by the American Board of Medical Specialties (ABMS) and the Accreditation Council for Graduate Medical Education (ACGME). Physician competence is meant to refer to six different domains: medical knowledge, patient care, communication, practice-based learning, system-based practice, and interpersonal relationships. Narrative competence on the other hand refers more to the ability to listen to patient stories and seek out the unsaid meanings behind them, as well as the ability to go on to create a narrative or story that can be shared both with the patient themselves to help them understand what is going on, but that also can be shared with others involved in the patient's care. Narrative competence could then be suggested to fall under physician competence wither in reference to the domains of patient care, communication, or even interpersonal relationships. What is important to note here, however, is the idea of a competence, whether it be physician competence, narrative competence, or even structural competence, as an idea of something you can teach and something that can be perfected. These different objectives are then often worked into medical curriculum as boxes to be checked off in the training of future physicians.

The Value of Medical Humanities

Relatedly, much of medicine and the curriculum designed to support a future career in healthcare emphasize the symptomatic aspect of medicine and the idea that medicine has become a business. As the cost of healthcare increases and we see more patients need care, speed and efficiency become a requirement. A patient presents to the provider or place of service with a complaint, the physician evaluates and addresses said complaint, and the patient then returns to life as it was. And though an education focused around this model is important in ensuring that providers are capable of treating patients' illness, a focus on symptoms and disease alone often fails to acknowledge the patient as a person. This model then provides that a physician is primarily responsible for treating illness, not leaving much room for the humanities to intervene in the physician's role (Shapiro et al. 2009). This therefore brings to mind the question of what larger role medicine plays in society beyond simply acknowledging a complaint and treating it, if there even is a further role medicine as a domain should serve. There is for example the fact that healthcare systems have historically been responsible for oppressing particular groups in both the policies and practices that they have developed (Klugman et al. 2019). Would it then not be beneficial for medicine to introduce a health and social justice lens when teaching future physicians to acknowledge and address the inequities that medicine as a system of power has established throughout history. Furthermore, as our understanding of inequities in medicine continues to develop, it will be beneficial for medicine to continue growing and bettering in response. Both of these things can be more easily achieved through the medical humanities as they introduce new perspectives and ways of thinking,

Additionally, in considering the responsibility of medicine as a field not only to patients but also to society as a whole, it is necessary to look into doctors themselves since they often serve as agents for progressing and applying acts of medicine to the larger population. Even if it is decided that medicine as an academic discipline should not be held responsible for social and/or humanistic justice (though it is of my own personal belief that this is irresponsible and even unethical), doctors hold an agency that deem them more capable of enacting change and creating an impact on an individual's life through one-on-one interactions and communications. Afterall, medical progress has often involved unintended consequences or even human exploitation (Cole et al. 2014). One such example is that of J. Marion Sims, the “father of modern gynecology”. Though Sims developed many important tools and techniques related to women’s reproductive health that benefit us even today, he did so through using enslaved Black women as experimental subjects, operating on them without anesthesia or any sense of compassion. This is obviously unethical, and in many cases inhumane as well. Furthermore, most of the famous ethical medical cases in history rest at least partial responsibility on the doctor (or doctors) that established or encouraged the study (e.g. Tuskegee Syphilis Study, Willowbrook Hepatitis Studies, Jewish Chronic Disease Hospital Study, etc.), leading medical establishments to in turn establish ethical guidelines that future physicians must follow. Physicians and other medical professionals find themselves in positions of power, particularly when it comes to patient-provider relationships, so a *just* provider would find themselves continuously working to respect patients and their background, protecting the vulnerable, and also working towards a future that promotes more equal access and the pursuit of justice (Cole et al. 2014).

This seems to suggest that the roles of medicine and of doctor in society are distinct from each other seeing as the two groups have historically acted both separately and together, yet both can benefit from the medical humanities when implemented effectively. It is clear that in a typical biomedical model (particularly in a paternalistic model), physicians are responsible for applying their knowledge of the human body and related scientific processes to treating problems that arise relevant to one’s health. That said, the role of medicine and doctors as stakeholders in social justice expands beyond this, as medicine is largely responsible for acting as a necessary bridge between science and society as a whole (Working Party of the Royal College of Physicians 2005). Beyond being relied on to interpret disease, physicians often work with individuals during times of high emotional distress. The uncertainty, stress, and grief that can accompany many healthcare experiences place patients in a state of high vulnerability which physicians must be aware of and help individuals navigate. This along with the fact that many physicians are responsible for serving as a voice for those unable to advocate for themselves (e.g. children and those who are disadvantaged both socially and economically) suggests that doctors must do more than simply treat illness.

What then do the humanities do to help reach this role? Medicine and the humanities are similar in that they both focus on humans and the human condition. But whereas medicine and the sciences utilize an empirical approach to the human condition, the humanities often push for a creative and even analytical look instead. Medicine recognizes humans by the physical (and occasionally mental) aspect(s) of their body and by the way said body may function or dysfunction. The role of medicine is therefore usually to acknowledge deviation from normal, working to restore individuals to their typical selves through different types of treatment. Health and sickness are a large part of the human condition, and medicine therefore plays an important role in maintaining the human condition. What is necessary to note here is the distinction between disease and illness. Disease addresses the biomedical side of an experience, the science of what is happening to the body. Illness on the other hand is much more subjective and refers to the experiences one has alongside their disease. This is where the humanities come in. By only addressing disease we are dismissing an entire aspect of a patient’s experience, leaving them unfulfilled and ultimately uncared for. The humanities add a further dimension as they are meant to look at what it *means* to be human, and what it means to incorporate psychological and social information into treatment, rather than only biomedical facts (Cole et al. 2014). The medical humanities take this a step further however to also examine how we as humans interact with one another. Human purpose and interaction are explored in many different humanities fields including not only literature and history, but also disciplines like philosophy, ethics, art, and music. Looking at interactions in healthcare helps paint a picture of why exactly patients feel dismissed or streamlined; the medical humanities help providers to better understand their patients' experiences.

Furthermore, within medicine there is a distinct difference between the experience a physician has and the experience a patient has. While a clinical visit or hospital rounds are part of a typical day for physicians, illness experiences can be seen as the worst moment of patients' lives (Gupta 2011). This failure to see patients as human, rather than looking at them as a case or to-do list, in their moments of need may exhibit a neglectful approach to care (though it may also indicate physician burnout, another problem that will be addressed). Furthermore, there is a distinct difference between curing and healing. While treating an illness and curing the patient may cause a physician to feel as if they have done a job well-done, patients are still faced with the act of healing. And by recognizing patients as humans and meeting them at their experiences and emotions, physicians may help patients not only to be cured but also to begin healing. It could be said then that there are benefits to recognizing the parallel between the act of acknowledging stories and history (humanities) and the act of creating a better healing environment (medicine). And though science is important within medicine and the humanities are also important within medicine, including the medical humanities into practice works to create an interdisciplinary approach rather than only a multidisciplinary approach.

It is therefore beneficial to incorporate the medical humanities into medical curriculum because it helps to counteract the classic, biomedical approach in favor of promoting important humanitarian traits like empathy, responsibility, and self-reflection among others. The medical humanities are then meant to serve as a beneficial complement to a traditional biomedical focus, rather than as a replacement for any existing component. This more holistic approach acts to expand the role of medicine and physicians in society to create better advocates for patients.

Though more people are becoming familiar with the term “medical humanities”, many are unsure as to what exactly the term refers to (Campo 2005). And in fact it is often debated which fields are truly included under the broader term of medical humanities, but most people agree that the field as a whole is interdisciplinary and encompasses the humanities, the social sciences, as well as the arts (Batistatou et al. 2010). An important note to make here is that this interdisciplinary approach must then also be applied when training medical practitioners in order to clearly distinguish the medical humanities as a field from the health humanities as a whole. Health humanities in comparison to medical humanities focus more on the application of the arts and humanities to a wider variety of healthcare disciplines, including informal caretakers as well as patients themselves (Crawford et al. 2015). It is then this specific emphasis within the medical humanities on training medical professionals which keeps the field distinctive from the health humanities.

Narrative Medicine and Medical Memoirs

One discipline encompassed by the medical humanities is narrative medicine. Rita Charon, widely recognized as the founder of narrative medicine, describes it as a form of medicine which incorporates “narrative skills of recognizing, absorbing, interpreting, and being moved by the stories of illness” (Charon 2001). Teaching narrative medicine ultimately helps doctors to listen more closely to the stories patients tell, capturing not only the symptoms but a bigger picture of their overall life and health. Narrative competence is therefore said to not only make medicine more humane but also more effective (Charon 2001). Within narrative medicine there is a large variety of literature that an instructor can use to teach the relevant tools, including forms like poetry as well as both fiction and non-fiction work. Some programs also incorporate stories of illness as well as doctors' accounts, but this is not a standardized practice.

This starts the conversation of medical memoirs and the role they can play within healthcare. Medical memoirs are a subgenre of literature that have been rising in popularity in recent years (Coulehan 2011). They used to be focused more on the physician themselves and the various life lessons they have learned as a doctor but have since transitioned to instead be focused on particular patients as well as specific interactions with other doctors and colleagues (Coulehan 2011). This shift in itself has been credited with much of the genre's popularity as we see a transition from the idealized idea of medicine that much of popular culture promotes (through TV shows like *Grey's Anatomy* or *Scrubs*) to a more realistic view of medicine. This fascination regarding the culture surrounding medicine is largely attributed to the fact that medicine did use to be idealized or put up on a pedestal. Showing readers that doctors and other healthcare providers are ordinary people that readers can relate to while also giving a look inside this completely different world (that many don't have access to) creates a lot of interest around the different memoirs.

Within the subgenre of medical memoirs, there are several different themes (or tropes) that these books could be organized into. The first such distinction to consider is memoirs from different specialties. There are many well-known memoirs written about physicians who practice in the emergency room (Dr. Michele Harper's *The Beauty in Breaking*, Dr. Paul Seward's *Patient Care: Death and Life in the Emergency Room*, Dr. Frank Huyler's *White Hot Light: Twenty-Five Years in Emergency Medicine*), memoirs written by surgeons (Dr. Atul Gawande's *Complications*, Dr. Stephen Westaby's *Open Heart*, Dr. Henry Marsh's *Do No Harm*), and memoirs written by physicians (and other healthcare providers) who work in other specialties. These specialty-specific medical memoirs allow readers to focus in on different areas they are most interested in. While the excitement of the emergency room may entice one particular reader, the resilience of pediatrics may interest another. Moving outside of specialty-specific memoirs, some memoirs are written about different patient histories (such as Dr. Oliver Sacks' *The Man Who Mistook His Wife for a Hat*); some of these themed memoirs focus on explaining lessons learned from different patients while others simply share stories for people's interest. Other medical memoirs still focus on pathographies written by doctors, or doctor-as-patient (such as *My Voice* by Dr. Iztzhak Brook or Dr. Alvin Reiter's *Even Doctors Cry*). This specific type of medical memoirs adds a unique perspective because it often becomes a criticism of the medical field seeing as these physicians are gaining a new perspective of their patients. There are other medical tropes still, such as a literary focus on particular themes (emphasis on death, religion, advocacy, etc.), the regional/national differences of memoirs (such as rural-focused memoirs), and memoirs that feature different healthcare systems (universal healthcare versus single-payer) among other medical tropes.

In selecting the medical memoirs for this thesis in particular, I pulled from three different medical tropes. The first novel that will be discussed, Danielle Ofri's *What Doctors Feel*, would be categorized as a medical memoir focused on a particular theme, as the memoir focuses on the emotional side of medicine. The second novel, Lisa Sanders' *Every Patient Tells a Story*, is a patient history memoir. And the third novel, Paul Kalanithi's *When Breath Becomes Air*, is a physician pathography. Each of these three medical memoirs then offer a unique perspective on the culture of medicine as they approach it from different perspectives and intentions.

The Culture of Medicine

This focus on medical memoirs specifically then raises the question as to what role memoirs play in both one's identity formation and, on a larger scale, the culture of medicine. A memoir is at its most basic definition a narrative of the author's personal memories. One valuable aspect of memoirs then is that they create a shared intimacy, allowing one to learn more about the author through their writing (Williamson 2019). And by intentionally allowing someone else into sensitive aspects of one's life, especially during a time of particular vulnerability as illness often leaves us in a more exposed state, memoirs allow for an "empathetic witnessing" in which the reader becomes emotionally and intellectually invested in a person's story (Holmgren et al. 2011). The medical humanities and narrative medicine specifically can therefore be utilized to create a more intersectional understanding of who a patient is by utilizing the narratives that are so common to medicine in a way that allows students to better connect with the speaker (patient).

Specific memoirs can be identified and utilized within curriculum or broader narrative medicine practices to connect different aspects of one's identity to their health and wellness. This allows an examination of the trickle-down effect that identifying characteristics (race, gender, disability) have on larger societal structures (social, political, economic, institutional), and in turn an analysis of what roles these structures have on one's well-being (Banner 2016). This reflects structural competency, or the idea that health inequities as well as the overall health system must be considered and evaluates in the context of institutions and social conditions, or structures (Metzl and Hansen 2014). By looking at structural contexts rather than just the patient as an individual, physicians are able to see how many different factors influence one's health, such as the aforementioned social and economic determinants.

Furthermore, by asking students to consider fundamental aspects of one's identity and to specifically consider them through the context of a memoir, you are in some ways beginning to develop an intervention against stigma towards different patient groups which is rooted in cultural competency, as a better understanding of different lifestyles and views can help providers to better understand different patient populations. This is again emphasized by the idea of structural competency, as structural competency asks physicians to consider the stigma against patients as created by institutions, markets, and health care delivery systems (Metzl and Hansen 2014). By considering how these forces (economic, physical, sociopolitical) impact patients differently, providers are able to better see how one patient's needs may differ from another's. And as the culture of medicine continues to seek a less paternalistic approach, it is becoming more and more important that providers have a basic understanding of the values and needs of different groups.

On another side of professional culture, many professions require sacrifice in terms of work-life balance, and medicine is no exception. Work-life balance is something that looks different for everyone, but typically involves seeking out a separation of the duties of your job from your responsibilities and interests outside of work. Poor work-life balance along with stressful training can have detrimental effects, including but not limited to, dissatisfaction, depression, and burnout (Saini 2016). Burnout is a specific type of stress commonly associated with a constant or overwhelming state of work, which leads individuals to experience both physical and emotional exhaustion. Careers in healthcare often require a decent amount of self-sacrifice, causing strains on one's physical and mental health as well as often affecting personal relationships. It also is not uncommon to deem medicine a workaholic profession (Rezvani et al. 2014), further contributing to the sacrificial culture.

Burnout and lack of balance is especially timely now considering the sacrifices that many healthcare professionals have had to make when facing the COVID-19 pandemic. This includes things like having to take on longer shifts and facing limited resources, but also occupational hazards due to COVID-19 exposure. A recent national cross-sectional survey study polled 42 different healthcare organizations and found that daily stress was rated high or very high by 30% of the respondents, 43% of respondents indicated work overload, and 49% were experience burnout (Prasad et al. 2021). Furthermore, it was noted that women were reporting higher stress levels (and other negative measures) than men, and Black and Latinx health professionals were reporting higher negative measures than white professionals. This goes to show not only the real time relevancy of burnout in medicine as we continue to work through a pandemic, but also that there are further inequities associated with the problem.

That said, the medical humanities have been researched as a resource used within training medical students to reduce burnout and improve overall mental health within healthcare (Mangione et al. 2018, Narayan et al. 2018, Wald et al. 2019). This is likely related to the fact that studying the medical humanities has been found to improve empathy and resilience, traits that have been noted as negatively correlated with academic burnout (Arntfield et al. 2013).

The Practice of Narrative Medicine

Narrative medicine holds variety not only in the types of writing being read and analyzed, but also in the methods being utilized. The two that this thesis will be focusing on specifically are close reading and reflective writing/parallel charting, as these are considered the most common narrative medicine techniques. Even within these two particular methods however, there are differences in how they can be implemented.

Close Reading

Close reading involves reading and rereading a passage or selection of writing and then reflecting on several different things. This includes, but is not limited to, looking at the feelings the reading provokes and what this says about you as a reader, studying the framing of the writing, analyzing how time is depicted, looking at the form of the writing, and finally summarizing the plot. In rereading the text, the reader is aiming not only to understand the text itself but also to understand how they as a particular reader interpret said text. The development of these skills is important for healthcare professional as it teaches them how to better listen to patients both with empathy and with an increased focus. It is important to note here that medical students spend much of their early training reviewing biomedical texts (whether in the form of powerpoints, textbooks, journal articles, or other formats). When reading these texts, it is often necessary for students to memorize vast amounts of information, aiming to simplify complex topics into shorter mnemonics and explanations. Close reading on the other hand requires students to pay attention to each slight detail in order to create a larger message and understanding of what is being conveyed. This is nearly the exact opposite of what is asked from students during their classic, biomedical lectures and courses, and may create initial discomfort or uncertainty.

However, it is necessary to develop these skills as the same attention to detail associated with close reading is often compared to the practice of active listening. Active listening involves complete attention on what the patient (or person in general) is saying with no interruptions. The listener also must look engaged in what the speaker is sharing. It has been previously noted that communication is an essential aspect of healthcare and improving the doctor-patient relationship, and so it must be acknowledged that communication goes beyond speaking and writing to also include listening. But beyond improving relationships themselves and therefore also increasing patient satisfaction, active listening also serves to improve healthcare outcomes (Haley at al. 2017). It will come as no surprise that many physicians have a large multitude of different responsibilities, and it can therefore be difficult to focus on one particular task. A refinement of close reading (and by extension, active listening) therefore helps physicians to better focus on not only patients with whom they are speaking, but also to focus on other providers who play a role in care. This narrowed focus helps to retain key information as well as avoid potential misinformation and misunderstandings that arise from poor communication.

This may prompt the question then, as to why practice close reading at all rather than focus directly on active listening itself? First it is important to note that previous research has found that by improving one's reading and writing skills their listening and acting skills are improved as well, and vice versa (Rasmussen and Goyal 2017). Because sharpening reading skills helps to better refine listening skills, students are learning the importance of transferable skills, which will help them to be more successful as a doctor and as a part of a healthcare team. Furthermore, narrative competence has been recognized (and will continue to be recognized) as a way to make medicine more effective as well as more humane. How then can we expect students to exceed at seeking out and understanding patients' narratives without first providing them with the skills necessary to succeed?

Close reading also helps students learn to analyze different components of writing, such as the context, form, and mood behind the stories. These are all important things for medical students to understand as they prepare to listen to and understand patients' stories. Though active listening prepares students to pay attention to someone when they are talking, process what is being said, and then respond in engaged way (thus helping patients to feel heard), close reading helps students to develop the skills they need to properly process these stories as active listening requires. By only focusing on active listening skills, students would fail to fully participate in a patient's story. In developing the ability to analyze and understand stories better, students are able to better navigate ambiguity and uncertainty, preparing them to form better relationships with patients and act with more empathy.

Reflective Writing

Reflective writing on the other hand is meant to serve as an active process in which students evaluate a situation incorporating not only what happened but also any emotions or biases associated with the event (Zannini 2018). This can be practiced in various ways, but one of the more common methods is parallel charting. Parallel charting is meant to accompany the typical chart notes but is meant to be written in plain language (rather than medical jargon) and is supposed to describe not only the visit itself but also how the said visit affected the provider. Research has shown that students who participate in parallel charting better understand their patients and develop better patient-provider relationships (Banfi et al. 2018). In addition to giving physicians and students a chance to reflect on their experiences and what they have learned from particular encounters, reflective writing also allows students to share their perspective and experiences with others.

Medical Students have an interesting perspective of healthcare considering that in many ways they serve as both outsiders and insiders within medicine. When they first start learning in clinical settings (often during their third year of medical school), students are far enough into their training to be seen as insiders by patients. At this stage medical students have started to learn what questions to ask and how to portray themselves, and they have the white coat and other tools that paint them as “doctors”. However, they may still be seen as outsiders to those that are much further along in their training. Medical students are still learning much of what it is to be a doctor, and therefore may not yet know many of the terms, expectations, or rituals associated with being a doctor. This dichotomy between roles and responsibilities as students transition from their role as an outsider to being an insider is addressed through professional socialization. Professional socialization involves internalizing the culture of a profession as well as identifying the values associated with a particular profession and then incorporating said values into behavior (Zarshenas et al., 2014). Professional socialization is vital to integrating students into a larger community of professionals and is necessary to create a culture of belonging (cite).

There are different techniques believed to help with professional socialization, but one in particular is the act of storytelling. This connects professional socialization back to reflective writing, as storytelling and reflective writing both involve reflecting on patient stories and seeing what can be learned from them. It could be determined then that reflective writing is a form of storytelling, which would suggest that reflective writing in turn serves to progress professional socialization. The act of reflective writing could therefore help medical students to feel more at place during a time of transition, as well as create better relationships not only among peers but also between students and their supervisors.

Impact on Medical Education

Looking at close reading/reflective writing skills and the various benefits that each holds then begs the question as to how specifically narrative medicine is additive to medical education as a whole. In the streamlining of care and the communication gap that accompanies this streamline, it is easy for one's personal narrative to slip between the cracks (Milota et al. 2019). Oftentimes patients' stories hold important information which leave the medical record incomplete when not included. Though information found in a patient’s chart may contribute quantitative data in determining diagnoses and/or treatment, the patient’s story serves as a source of complementary qualitative data which helps to complete the puzzle. Furthermore, incorporating patients’ stories creates a more holistic approach to care by pushing healthcare towards a more patient-centered approach. Listening to patients when they convey the different aspects of their healthcare journey not only fills in potential gaps in knowledge, but also humanizes the patient and their experiences, giving physicians a deeper insight into the patient’s situation.

It can then be suggested that an increased focus on narratives within medical education will prepare students to combine the biomedical, evidence-based focus of much of their education with the personal details and experiences found in patients’ individual stories to create a better picture of the situation. Only teaching students the science behind medicine leaves them unprepared and unable to address the sides of medicine where patients are forced to navigate loss and suffering. A focus on narrative medicine and narrative competence therefore better prepares physicians to sit down with a patient and navigate the illness alongside them.

Beyond however seeing a better approach to healthcare after incorporating more narrative medicine practices into medical curriculum, we would also see an increased presence of beneficial traits in students and doctors, such as empathy, better interpersonal skills, even professionalism (Huang et al. 2021). Furthermore, recognizing and seeking out patient’s narratives allows for a more authentic connection between physicians and patients (Charon 2001). And in creating a more authentic connection, patients are much more likely to feel heard by their providers, leading them to provide intimate details and ask difficult questions that they may have otherwise held back, in turn creating an environment of more effective care.

This all brings to question as to what narrative medicine uniquely contributes to medicine, as there are many fields and practices which help to make medical students “better people” through these more general traits like empathy and professionalization. In their piece looking at the medical humanities as a sum of parts, Jeremy Greene and David Jones explore the numerous contributions that history makes to medical education, looking at ideas such as how the burden of disease changes throughout time and how the role of physicians has changed over time (Greene and Jones 2017). Greene and Jones emphasize the fact that the different contributions they list in the piece *require* historical analysis. This then begs the question as to what issues instead *require* a literature or narrative medicine approach? By creating a list of particular contributions that literature and narrative medicine provide to healthcare and which other fields cannot also offer, it helps to illustrate the importance of these fields to medical education by showing that curriculum is incomplete without their presence.

In imitation of the Greene and Jones piece, I created the following list:

The Contributions of Literature to Medical Education

- Medicine involves treating patients of many cultural and social contexts. Literature, and more specifically memoirs, allow doctors to gain insight into other perspectives which they may not have easy access to.
- Physicians often have patients who won’t explicitly say everything about how they’re feeling or how they’re doing. It then becomes their responsibility to analyze what the patient is saying, but also what they are not saying. This is a skill taught in literature through learning to read beyond the text.

- Medical advances have relied on knowing about different advances and research, which is often shared through literature reviews.
- Medicine requires written documentation of many visits for liability reasons, whether this documentation be through clinical notes, reviews, and presentations to peers.
- Similarly, most of medical knowledge is cumulative. Without the written documentation of what has been done and worked in the past, we would not be able to continue advancing.
- Reading and writing can work to “simulate emotion” (Baños and Guardiola) which cannot always be gained from a typical medical textbook.

This is a list that can be built on and should be built on, in order to illustrate the many unique benefits that literature brings to healthcare where other fields cannot. Furthermore, as it currently stands, narratives are already abundant in healthcare. They’re seen not only in patient-provider relationships, but also in learning the stories of disease progression, in forming bonds between coworkers following the sharing of patients’ stories but also one’s own story, in expressing the urgency of situation and diseases to the public as a whole. Narratives are a large part of not only medicine, but many other professions and aspects of life because narratives convey humanity and establish significance.

And because narratives are so prevalent in both life as a whole and within healthcare, it only makes sense to teach students different techniques and tools which will improve their practice of narrative medicine techniques. By clearly defining the contributions that literature specifically brings to medical education, it then becomes the responsibility of medical schools to in turn incorporate literature into curriculum in order to fully prepare the next generation of doctors. If medical education is meant to prepare students to serve as competent physicians, it must do so in an interdisciplinary manner so that students are competent in all aspects of care.

Overview of this Thesis

The rest of this thesis serves to expand upon the idea of narrative medicine as an important tool within medical curriculum by arguing that medical memoirs themselves should be implemented when teaching narrative medicine. It does this by exploring three different medical memoirs using the narrative medicine techniques highlighted above (close reading and reflective writing) and then explaining how each could be functionally implemented. The three novels examined are *What Doctors Feel* by Danielle Ofri, *Every Patient Tells a Story* by Lisa Sanders, and *When Breath Becomes Air* by Paul Kalanithi. Each section will be accompanied by a brief synopsis of the book, followed by personal examples of how I used close reading and reflective writing skills with specific passages from the book. This will lead into a discussion of why this novel would be beneficial when teaching narrative medicine, with the paper concluding in a discussion of the advantages of incorporating medical memoirs as a genre into narrative medicine as well as the benefit of narrative medicine to medical education as a whole.

Memoir 1: *What Doctors Feel* by Danielle Ofri

Brief Synopsis

Danielle Ofri is a practicing primary-care internist at Bellevue Hospital in New York City. In addition to being a physician however, Ofri is also an essayist and editor. She writes independently for different publications (e.g. *New York Times* and *Slate Magazine)* but also was responsible for co-founding the *Bellevue Literary Review,* for which she still serves as the Editor-in-Chief. Ofri is well known for writing about medicine as well as the doctor-patient relationship, and has written a number of different books (eight as of now) about the culture of medicine.

In *What Doctors Feel*, Danielle Ofri reflects on emotions within medicine. Physicians are often expected to be close to emotionless – acting as a clean slate which can move from patient to patient offering objective care. However, this fails to recognize the full extent of physicians as people and disregards the role that emotions can play in interactions and treatment decisions. Throughout her book, Ofri looks at a number of different emotions (frustration, hope, despair, and empathy among others) and the effect that these emotions have not only on medical students but also on currently practicing physicians. She then takes it a step further to acknowledge how these emotions affect the care that physicians provide, as well as investigating how the act of physicians fully feeling emotions can impact the patient-provider relationship.

Ofri does this through seven chapters that serve as a combination of patient stories and research studies. What is interesting about the book though, is that though Danielle Ofri includes the stories of many patients throughout, there is one patient, Julia, who acts as a continuous storyline. Julia presents to the hospital needing a heart transplant because of her progressive cardiac disorder, but she faces many barriers because she is undocumented. Julia's story is broken up so that one part is told after each of the seven chapters, with the book structured to be "Chapter 1: …" followed by "Julia, part 1" and so on. In the afterword of the book, Ofri reflects on why she chose to incorporate Julia's story so thoroughly. She notes that not only is this a case that has had "profound and lasting effects" on her (Ofri 211) and therefore must be honored, but also that during the years of Julia's treatment Ofri experienced every emotion that was discussed throughout the book. Julia's story then goes to show how influential emotions can be in both a patient's experience and a physician's, as well as shows that emotions are a dynamic component of healthcare which will continue to fluctuate throughout time.

As mentioned, each section of Julia's story is preceded by a chapter that focuses on different emotions. The first two chapters focus on empathy, looking first at empathy itself and being honest with ourselves, then transitioning to how difficult it can be to not only develop but maintain empathy. Chapter 3 moves into an analysis of fear and stress and how overwhelming these emotions can be during training. Chapter 4 invokes a discussion on grief as well as the negative effects that can accompany the vast amount of death and sickness experienced throughout training. Chapter 5 looks at medical errors and the guilt and shame that accompany making a mistake. Here Ofri also focuses on the need for transparency in healthcare, exploring how in order to prevent future errors they first need to be discussed. Chapter 6 then discusses the disillusionment that many people face in medicine and how the resulting emotions (frustration, stress, burnout, etc.) can lead to really detrimental consequences (e.g. angry outbursts or substance abuse). Chapter 7 then concludes the book with a focus on malpractice and the negative/avoidant feelings surrounding them. Overall, each of these chapters work together to depict the different emotions felt by practitioners, most typically unspoken. Furthermore, each chapter acts as a call to action to not only discuss these emotions, but also to provide the resources needed to acknowledge and work on not only the emotions that physicians feel but also the repercussions associated with them.

Close Reading

Close reading can be challenging in that it requires selecting a particular passage which is then isolated from the rest of the text as a whole. When researching close reading techniques, I found that it was recommended to select a paragraph or two at most to analyze at a time because larger sections of a text could quickly become overwhelming. Once passages were selected, a similar approach was taken as in Rita Charon's "Close Reading" drill in *Narrative Medicine: Honoring the Stories of Illness.* This involves five components: plot, framing, form, temporal scaffolding, and desire. Plot is relatively self-explanatory, but framing involves looking both at what has been included in the text and what has been left out, as well as what the intended audience is. Form consists of the more technical and literary aspects of writing, elements like narrator, genre, use of metaphor, etc. Temporal scaffolding looks at time within a passage, considering both the tense of the writing as well as the actual duration of time that is passing. Lastly, desire addresses what feelings a reader has when reading the passage as well as what this may reveal about the reader (Belling 2006).

When looking specifically at *What Doctors Feel,* I wanted to incorporate text both from Ofri's didactic chapters as well as text from Julia's story. With Julia's experience being such a large part of the overall message of the book and also being so influential on Danielle Ofri's life, it would have felt wrong to only focus on the more academic chapters.

The first paragraph I chose to utilize for close reading was from Chapter 5, and focused on the shame that medical students may feel when rounding on patients. This section of the book was chosen largely because it goes back to the conversation of medical students as both insiders and outsiders, as well as the role shame plays in the process of professional socialization and cultivating that sense of belonging.

> Medical students are particularly prone to this overwhelming experience of shame. Being naïve and inadequately skilled when all those around you are busy saving lives is potently shameful, and unique to the field of medicine. As the lowest on the totem pole, many students feel forced to endure and even be party to imprudent things that senior doctors do. One student on rounds with a superior who made rude comments to patients commented that "all this I am part of. I would like to run back to the patients and explain." Another said, "I was ashamed because I thought the [patient] associated me with the doctor; I took the blame for his nastiness."
>
> Interestingly, many medical students found that they identified more with patients than with other members of the team. Despite wearing the white coats of the profession, they felt like outsiders in this world, similar to the feelings of many patients. The humiliation that patients endured resonated profoundly with the students. "We have to ask our patients to undress and touch them in a way they would never allow any other human being to do." Students observed doctors speaking callously to patients about sensitive subjects. Many of the diagnostic tests and treatments seemed to sap patients of their individuality and personhood. The students were ashamed to be part of a system that inflicted such injustices. (Ofri 132)

After rereading the two paragraphs a second time, I moved into the beforementioned five components of close reading. To begin with the plot, this passage looks at how medical students experience shame and humiliation, particularly earlier on in their training. Ofri incorporates several specific examples of experiences that have caused students to feel shame focusing not only on students’ own naivety in the field, but also the private and prodding aspect of medicine that they were now also associated with. In looking at framing, the passage was taken from *What Doctors Feel* which was published in 2013. At this point in time, the culture of medicine was often described as hierarchal, exclusive, and selfish rather than collaborative (Krupat et al., 2013). This attitude seems to be reflected in the plot of the passage. The writing seems to be aimed at a layman audience, as there is not an abundance of field-specific terminology and the writing explains the culture in a way that suggests it is written for someone who has not experienced the medical school experiences themselves, suggesting it was not specifically written for someone already in medicine.

Moving on to the form of the passage, it is nonfiction prose, specifically written as a memoir (as will be true for all of the writing covered in this paper). There is the use of metaphor in this passage when Ofri compared the experiences of medical students as them being lowest on the totem pole, suggesting they have no power of their own. This in turn goes back to the hierarchal culture of medicine as mentioned in the framing. Beyond genre and metaphor, it is also significant to note that this passage uses third-person objective as its narration. Third-person objective involves a neutral observer who unbiasedly reports the facts. Though this passage does briefly discuss the students’ emotions, it does so from a place of reporting and not a sense of all-knowing, leading to the narration being objective rather than omniscient.

Transitioning to the temporal scaffolding, the writing begins in present tense, but quickly moves into past tense where it remains the rest of the passage. Regarding the duration of time, this excerpt appears to cover a relatively short period. Though Ofri seems to be discussing students’ reactions to rounds in general which could therefore have presented over a duration of time, she still focuses on the beginning of students' training in her evaluation which limits the scope.

The last of the five components, desire, is inherently the most personal part of the close reading analysis. The first emotion I felt while reading this passage was unease. As someone who will be pursuing medicine soon myself it can be difficult to read about how, for a while, I will be at the bottom of the metaphorical ladder, potentially not able to contribute much else beyond brute manual labor. Beyond a feeling of unease however, I soon moved into a near disdain. Patients often come to the doctor frustrated, tired, in pain, scared, or even humiliated, and yet our healthcare system functions in a way that limits humanity, leading to the callous and unjust approach mentioned in the passage. It is frustrating to know that limitations in the system along with the large number of patients and responsibilities a physician has both lead to an often far from perfect experience for patients. As a reader, this unease and disdain may suggest that I do not respect the healthcare system as it stands. I hope though that these desires instead reveal that I am passionate about the humanity of medicine, and hope that we are able to find ways in the future to preserve it.

The second close reading passage I wished to examine is a passage from Julia's story. This excerpt followed Chapter 4 which looked at grief and the idea of death. It was noted in the introduction of this thesis that many patients experience grief, potentially positioning them in a state of high vulnerability. By acknowledging and normalizing the grief that physicians also may experience while taking care of their patients, they are better equipped to relate to their patients. This further prepares physicians to not only address patient's grief, but also to better protect their patients while in a state of vulnerability. In the passage below, Ofri is beginning to come to terms with her own grief.

> I realized that I simply wasn’t ready to contemplate Julia’s death. All these years of her good health had allowed the denial to nest within me, to the point that I had convinced myself that she would never die. I knew that her heart was doomed, but every month or two she’d appear in my clinic for an appointment, looking basically the same as the previous visit. Year in and year out. Facts on the ground, you might call it.
>
> It was like I had a relationship with the healthy, robust Julia, the one who wasn’t going to die, and like any creature of habit, I wasn’t prepared for when the relationship changed. But as the months wore on, I could no longer delude myself. That healthy Julia was fading before my eyes, aging and weakening in real time. (Ofri 122)

Beginning again with the plot, in this part of the novel the narrator is reflecting on a patient, Julia, she has grown close with. She is verbalizing the inner conflict between knowing that Julia will die, but not being ready to accept it. In looking at the framing, the book’s publishing date remains in 2013, but the passage is framed in a more personal light rather than the more clinical setting that much of the rest of the novel relies on. The intended audience again seems to be a layperson, but I would say that the aspects of the book which focus on Julia’s story are also geared towards other healthcare professionals (whereas the more didactic excerpts seem to not be as much) in that they likely have relatable experiences and patients of their own.

Moving on to the temporal scaffolding, this conflict seems like one that she would have had to return to several times throughout the years. Julia was a patient of Ofri’s for over eight years and though there were likely certain years or even months when Ofri saw Julia more often than others, the conflict of this passage seems to be long-term. Requiring the tense of the passage however, it mostly occurred in past tense though seems to transition to present tense with the realization at the end.

Looking now at form, the narrator has now taken a first person point of view in contrast to the previous third person narration style. The genre remains the same as nonfiction prose, but the switch to first person makes the memoir feel almost more authentic as readers now explicitly know how Ofri was feeling. Use of metaphor is seen again when Ofri refers to herself as a creature of habit because she wasn't ready to give up her existing perception of Julia. However, another idiom is seen in the phrase "facts on the ground". This one is less clear, as facts on the ground is typically used to refer to the reality of a situation rather than the abstract. But when Ofri used the phrase, it is still within the turmoil of her not being able to accept that Julia is indeed dying. This led me to believe that Ofri's use of the word was almost to convince herself of the situation, trying to pull herself back into the reality of the case.

Transitioning into the fifth component, desire, the passage makes me as a reader feel grief for Ofri. It is clear from even this short passage that she intimately cares for Julia and has grown to know her well over the years. Losing a patient, or even knowing you will in the future lose a patient, that you know that well has to feel similar to losing a friend in some regards. But beyond grief, this passage also sparks feelings of kinship. As someone who is not currently a doctor, there are plenty of scenes in the book that I cannot relate to as hard as I may try. But everyone understands what it is like to know one thing about a situation and yet desperately want to believe another. Including this part of her thought process in the novel therefore allows readers to connect with Ofri's experience, even if the reader's feelings are coming from a different situation entirely.

Reflective Writing

When teaching and practicing reflective writing, whether in a medical humanities context or in other settings, individuals often work from a prompt and/or are encouraged to reflect on an event that invoked a specific emotion or outcome. When reflecting on these various scenarios and experiences people write about their different thoughts and feelings, essentially evaluating how said experience has affected them. Medical memoirs themselves are therefore often a form of reflective writing as the author is looking back at different clinical experiences and assessing how these experiences made the author feel. Rather than engage in reflective writing myself, different passages were again pulled from the memoir where Ofri was practicing reflective writing. This then allows the passages to be analyzed as a model of reflective writing; a model that students can themselves later emulate in practicing reflective writing on their own. Her reflective writing was then analyzed on three different aspects: her description of what happened, her analysis of what happened (how she was feeling, why she acted certain ways, etc.), and the outcome of the event (why it mattered, what she learned, and what she would do differently).

The first passage of reflective writing was pulled from chapter 3, which focused on fear. In this particular passage, Ofri is discussing the first code that she was in charge of. I chose to include this excerpt because of connections that Ofri makes between fear and humanity. She points out during her reflection that fear is necessary in medicine because it reminds doctors of the fragility of patient’s lives, causing them to give patients the attention and care they need.

> The patient did all right in the end, or at least survived the code, which was pretty much what we considered success in the MICU. I slunk off after the patient stabilized, hoping to disappear myself in the sea of white coast shuffling off to conference or rounds

> or the ER. I was furious at myself for getting so paralyzed by fear that I could barely run the code. What had happened to all my training? All the codes I'd participated in? All the lectures and books I'd been learning from?
>
> What made me the angriest at myself, though, was that I'd actually gotten it right. It *was* hyperkalemia. The T waves absolutely had been peaked. I could have called it on the spot and been the model of a take-charge resident, as a medical consult running a code is supposed to be. But I couldn't get beyond my gripping fear—of the situation, of getting it wrong, of killing the patient, of looking like an idiot. (Ofri 67)

Beginning with the description of what is happening, leading into this excerpt Ofri was discussing her first code and how she forgot how to read a patient's EKG once it was handed to her. She had a hypothesis of what had happened, but was scared to voice her opinion in case she was wrong. A fellow then showed up and took control of the code since she was not able to take charge of the situation herself, but when he went to reprimand Ofri they realized they knew each other. As he continued directing people for the code, he came to the same conclusion about the diagnosis that Ofri had come to. In the end, the patient stabilized and everything was fine.

After describing what happened, Ofri went on to analyze the situation. It first began with fear, as fear is what kept her from acting during the code. Though she had plenty of related experience and training to help prepare her for this moment, the panic she felt prevented her from recalling the relevant information. Ofri explains this fear by discussing the potential implications of her actions, noting how if she was to do something wrong she could look bad in front of her colleagues or even harm (or kill) the patient. Beyond the initial fear she felt, she reflects on feelings of anger and frustration, particularly anger at her inability to act in the moment. This makes sense, as many people would feel anger at themselves when working through feelings of ineptitude, especially in such a high stakes situation. This would then reasonably be exacerbated by the fact that the person who took over the code was someone Ofri knew and had once trained alongside. The feeling of fear was then aggravated by the sense of shame and inadequacy. And finally, Ofri reflected on the fact that her analysis of the EKG had indeed been correct if she had only acted on her interpretation. The hindsight of knowing she would have been justified in acting on the peaked T waves led Ofri to almost feel worse, as she mentions what the alternative scenario *could* have looked like. She *could* have called the peaked T waves and given the appropriate directions for treatment, thus leading the team (and the patient) in a more efficient code. However, Ofri notes, she let her fear and doubt hold her back from confidently taking charge.

Ofri's analysis and reflection then led to the outcome of the event. And seeing as her writing of the incident is stretched throughout the chapter, the outcome is also spread out over several different stories. She first notes why it mattered, reflecting on the fact that though she thought by doing nothing she was choosing the least risky path of action, her lack of action would have killed the patient if the cardiology fellow hadn't shown up when he did (Ofri 74). Earlier in the chapter Ofri mentions a conversation with friends who work in business. When these friends picture their biggest fear, they think of losing money or losing their job. Doctors on the other hand must live with the fact that mistakes at their job can cause someone serious harm, ultimately even killing them if the mistake is bad enough. It is therefore important that doctors feel some semblance of fear as they often hold someone's life in their hands. At the same time though, they cannot allow the fear to become debilitating as it was for Ofri during her first code.

This leads into what she learned from the situation; though she was trying to do what she believed would be least harmful, by failing to act she was risking the patient's life. As a doctor, this is not a risk she can take after reaching a certain point of training. Her patients rely on her to take action, to acknowledge the fear they feel but then set it aside and move forward anyways. In conversing with other doctors Ofri has found that everyone feels fear, the question is how to use this fear in a beneficial way. She takes it a step further to explain how she has learned that fear is not only common, but is often necessary in order to keep doctors grounded in the reality of a situation and the weight of what it is they're being trusted to do.

This moves Ofri's analysis of the situation into what she would do differently in the future. She first acknowledges that though fear is something every doctor experiences at least time-to-time, there is no easy way to handle it. There's a delicate balance because some amount of fear is necessary in order to maintain a doctor's sense of humanity while caring for patients, but it needs to be diluted enough to allow the doctor to still take appropriate action. Ofri concludes then that in allowing her fear to paralyze her during her first code she was failing her patient. Ultimately she knew what to do when she looked at the EKG, she had just allowed her fear to prevent her from acting. In the future, she would not make the same mistake because she knew to act even when scared; at the end of the day she had no choice but to trust her training and knowledge.

The second passage of reflective writing was pulled from part six of Julia's story, following a chapter focused on the disillusionment that many people face once in medicine. This particular passage was chosen because it focuses on joy, a happier emotion in comparison to the others that had been featured. The stress and frustration that accompany disillusionment often lead to burnout, and it is moments like the one in the passage below that remind people why they work so hard to keep going, even when things may seem bleak.

> When I finally sat back down in my office to catch my breath, I realized that there were tears streaming down my cheeks. I was so overcome with joy that I hadn't even realized I was crying. Those tears that I'd held back for so long—they were finally here.
>
> …
>
> As the headiness of the morning gradually began to settle, I contemplated the rarity of joy in our profession. In the months that I attend on the wards, I watch the interns and residents enmeshed in caring for patients, ricocheting from frustration to fear to anger. There are certainly moments of pride, pleasure, even fun. But pure joy almost never comes up. (Ofri 171)

In this excerpt, Ofri has just found out that Julia received a heart after eight years of waiting for one. Ofri had talked to a lot of people about Julia's case over the years, from friends and family to her writing buddies and editors. When she says in the passage that she sat down in her office to catch her breath, it is because she had been running around telling people in the hospital and calling friends to let them know Julia's good news. After sitting she realizes that at some point she had started crying, and this realization led into a self-reflection on joy and the rarity of joy in the clinical setting.

This self-reflection leads to an analysis of Julia's situation and the many different emotions that Ofri felt throughout Julia's healthcare journey. The most obvious of which is the joy she was describing in this passage, but Ofri also experienced grief, fear, frustration, and exhaustion among others. In her writing she mentions that she had been holding back the tears for a long time, which makes the reader wonder whether she means she had been holding in her tears of joy for years as she anticipated a hopeful outcome for Julia, or whether she was referring to tears of sadness and anger that she had been holding on to for so long and now could finally let go of out of relief. In another part of the passage however she reflects on how tears of joy are a rare phenomenon in medicine, suggesting that they were indeed tears of joy. It makes sense that Ofri reacted this way as she had spent many years at this point taking care of and getting to know Julia. Other parts of Julia's story that were shared in the book hint at how close their relationship became as the years went by, such as when Julia knitted a cap for Ofri's new baby. Ofri got to know Julia's family, understanding how things would be for them when Julia's heart did eventually fail her. Its these things and many others that strengthened Ofri's joy upon hearing the news of the transplant.

In considering Ofri's reflection of Julia's story, the outcome of the "situation" in this case requires a different approach than the previous passage because this is not inherently a situation to learn from. Where the fear passage had a direct takeaway (you must act even when scared), this passage is more indirect. But in looking at why this passage mattered, it first is important because of the recognition of joy. Many people go into healthcare because of a passion for serving and caring for others. That said, there are many stressors and negatives associated with the job as well which leads to high rates of burnout. By finding the joy in these moments, one is more likely to feel as if their career is not only worth it, but also that their career and their work is rewarding. This is an essential step to keeping people engaged not only in healthcare, but in any job. This passage also mattered though because of the vulnerability Ofri shows. I think there is a perception in healthcare that doctors cannot show that cases affect them, but physicians are just as human as the patients they are treating. By talking about crying, even if they are tears of joy, Ofri's reflection is again bringing a sense of humanity back into healthcare by reminding readers that physicians are not immune to becoming emotionally invested.

Looking at what she learned from the situation and from her reflection of the situation, Ofri mentions in the passage that joy is rare in the day-to-day life of physicians. It seems that this is something she had not considered before, and though it is not directly stated, it can be implied that this moment renewed Ofri's passion for healthcare. And this is important, as the book noted a direct link between doctor's feelings and patient's improved incomes (Ofri 160). She mentions feeling proud of the hospital and its staff, feeling grateful for the donor and their family, and feeling indebted to Julia's family. Julia finally receiving a heart restored Ofri's faith in many different aspects of the healthcare system. Furthermore, it feels intentional that this part of Julia's story was included directly after a chapter focused on dissatisfaction, exhaustion, and problems with work-life balance. In juxtaposition-ing this expression of joy against a chapter focused on what is in many ways the opposite of joy, Ofri is showing that it is not all one or the other. There is a balance to the emotions that physicians feel just as there is a balance to the emotions that everyone else feels.

And in looking at what she would do differently following the outcome of this reflection, I don't know whether there necessarily is something that Ofri would do differently afterwards. However, she does seem to believe that the hospital needs to have more joy in the day-to-day, though this is not in her hands alone. She mentions further down on this same page the poem "Gaudeamus Igitur" written by John Stone, which discusses joy in the context of medicine. Ofri states that she tries to read it to her students as much as possible, showing her desire to also instill a sense of joy (even in the mundane) in her students as they work to become doctors themselves.

Application when Teaching Narrative Medicine

In looking at potential applications of the memoir *What Doctors Feel* to teaching narrative medicine to medical students, it's important to first revisit the points made earlier in this thesis regarding the contribution of narrative medicine to medical education as a whole (see "Impact on Medical Education"). There were four main themes explained, beginning with the fact that narrative medicine emphasizes a patient-centered approach and creates more holistic care for patients. And in doing this, narrative medicine also helps to prepare students to navigate illness and the healthcare journey alongside the patient. These first two points are reinforced by the fact that incorporating narrative medicine into medical education trains physicians to have increased empathy, better interpersonal skills, and improved professionalism, all of these things helping to create a more authentic connection with patients. And lastly, with narratives becoming a dominant feature of our culture, teaching narrative medicine to students prepares them to be more competent physicians. All four of these points will be addressed when discussing the applications of each medical memoir.

To begin, this particular memoir is beneficial within medical education because of its emphasis on physician's emotions, and the recognition that we have to acknowledge these emotions in order to provide care in a way that is healthy both for patients and for the providers. By addressing the emotions that physicians may feel (such as shame from the first close reading passage or fear from the first reflective writing passage), one is also addressing that physicians are real people. Inhibition of physician's emotions has a negative impact on both the physician themselves, but also on patients (Kerasidou and Horn 2016). In showing the different emotions physicians work through within their professional sphere, and showing the negative effects of ignoring these emotions, having medical students read *What Doctors Feel* helps to reduce the stigma associated with emotion in medicine, and shows how emotions can in fact be helpful to caring for patients.

This leads into the first theme of patient-centered care. Patient-centered care requires acknowledging patient values and partialities, and then using these individual preferences to guide the clinical care process. Creating this personalized care requires elements like transparency when sharing information with patients, prioritizing both physical comfort but also emotional well-being, and an emphasis on collaborative care among other things. By encouraging medical students to acknowledge and invest in their own emotions, an incorporation of *What Doctors Feel* into narrative medicine curriculum would help students to develop emotional intelligence within a clinical setting. This is important as improved emotional intelligence has been proposed as potentially having a beneficial effect on patient-centered care (Birks and Watt 2007), and improved emotional intelligence will also allow physicians to better understand patient perspectives.

When working to incorporate this idea of patient-centered care as taught through Ofri's memoir into narrative medicine curriculum, it would be best for teachers to choose one of the chapters' emotions and have students reflect on a time when they experienced the same emotion in a healthcare setting. For example, the first reflective writing prompt of this memoir focused on an instance of paralyzing fear. After having students read Ofri's story of her first code, they would then be asked to spend fifteen minutes writing about a time when they experienced fear in a clinical setting. For those who are earlier in their training and do not have as much exposure, this writing could also reference a time they felt fear while shadowing as an undergraduate. This writing can be in journal form, but bullets and general notes are fine as well. After the fifteen minutes of writing, students should be placed in small groups where they are able to read their writing out loud. As noted in the introduction’s contributions of literature to medical education, reading and writing can help to simulate emotion, giving students a further understanding of situations then they can gain from a typical biomedical textbook. Once a student finishes speaking about their particular experience, there should be a few minutes where the other students in the group are able to respond and reflect. Each group will continue until everyone has had a chance to speak, and then the session will complete with a debriefing led by the instructor. This debriefing should be focused on helping students develop better emotional intelligence, explaining how the selected emotion (in this case fear) can be positively used and managed.

Understanding patient perspectives then moves us into the second point, as a better understanding of patient perspectives makes it easier for physicians to help patients navigate their healthcare journey. Ofri’s incorporation of Julia’s narrative throughout the book shows how invested she was not only in Julia’s immediate care, but also in Julia’s story as a whole. This ties into the idea of preparing medical students to navigate illness and the healthcare journey alongside patients, as Ofri is clearly invested in Julia’s journey herself. When Julia gets good news, Ofri cries out of joy for her, and when Julia faces hardship and eventually death, Ofri grieves alongside her and her family. It is impossible for physicians to invest in every patient they see as deeply as Ofri invested in Julia, but in sharing her relationship with Julia with readers, Ofri teaches students about the connections that can be gained from fully showing up for patients.

In implementing this theme into curriculum, students would be asked to read a selected passage from one of the in-between chapters focused on Julia's story. Each of these chapters are only a few pages long, so the instructor could either assign the entire excerpt, or narrow it down to a particular paragraph(s) depending on the class's level of experience. Students would first read the selection without taking any notes. On their second read through, they would follow the same close reading drill illustrated in this thesis, analyzing the passage's plot, framing, form, temporal scaffolding, and desire. Once students had time to work on this, they would move into small groups and read the selection a third and final time before discussing their personal annotations. After this third reading, students should discuss each of the five elements, taking special note when people's analyses vastly differed. This specific activity helps students to learn to read beyond the text, a skill highlighted in the contributions of literature to medical education. By learning to notice more than is explicitly stated in the story itself, students will also learn to notice more about patients' stories than what they share, including elements like body language and noticing what topics are more sensitive for particular patients. And in gaining a better understanding of what patients are and are not saying, students are better equipped to navigate the experience alongside them.

The vulnerability of navigating healthcare and illness alongside patients then leads into the importance of authentically connecting with patients. Julia and Ofri's relationship was as fulfilling as it was because they learned to be honest and transparent with each other. Ofri had to learn how to have hard conversations with Julia (upon Julia's first discharge, Ofri couldn't bring herself to tell Julia the full story about her dying heart), and Julia had to tell Ofri the truth about how she was feeling, rather than try to hide her pain and fears behind denial or pride. By incorporating medical memoirs like this one into narrative medicine curriculum, it shows students that seeking out patient's memoirs and creating a safe space for patients to share them can help improve the patient-provider relationship. And in developing these relationships, physicians are further developing these interpersonal skills like verbal and nonverbal communication, listening skills, and patience.

Students will undoubtedly come across patients who are from either cultural or social contexts that the students themselves do not understand. Because of this, it is important that we make an effort to cultivate a sense of compassion in students surrounding patients of different backgrounds. By including diverse memoirs which incorporate many different experiences and walks of life, we can help students build cultural competency. Before officially beginning the next exercise, students should be given a few minutes to answer the question, "Do you believe that Julia, an undocumented Guatemalan immigrant, should have access to a heart transplant if she needs it?". This answer will not be shared with others. Students should then be provided with the pages of "Julia, part five". Attention should be specifically focused on paragraphs 6-8 (paragraph six beginning with "Julia was born in a tiny rural village" and paragraph 8 ending with "That she had retained her gentle, sweet nature". In the classroom this passage should first be read aloud, either by the teacher or by a student volunteer. After the passage has been read, students will be given fifteen minutes to answer the prompt, "After learning more about Julia's story, does it change your answer from before as to whether Julia should have access to a heart transplant?". At the end of these fifteen minutes, students will then be immediately given an additional fifteen minutes to answer the new prompt, "Describe a time when you came to understand something about the way someone behaves after learning something new about either their cultural or social background. This does not have to be in a healthcare setting, but can be. Other potential options are friends, classmates, coworkers, etc.". Once writing times for all of these prompts are complete, students should be given the opportunity to share their response to the second prompt, whether in partners, small groups, or a whole class discussion. There can be additional discussion about comparison between the two Julia prompts (transplant opinion before and after hearing some of Julia's story) if appropriate for the group dynamics. These discussions should help illustrate to students the first noted contribution of literature to medical education, the fact that literature and memoirs can help students to gain insight into perspectives that they otherwise may not have been exposed to. And it is this understanding which will help to develop patient-provider relationships, again strengthening the various interpersonal skills.

Developing interpersonal skills then leads to the fourth and final point, that narratives are all around us and that it therefore only makes sense to incorporate a study of narratives into medical school curriculum so that we are guaranteeing the greatest competence possible in future physicians. Narratives by nature are meant to reflect on particular emotions or circumstances, allowing for processing of events and the formation of connections between people and shared experiences. Developing narrative competence has also been found to improve professionalism and professional identity among students (Huang et al. 2021, Chu et al. 2020). And because it has been noted in some previous literature that helping students to develop a sense of professional identity is one of the main goals of medical school (Merton, Reader, and Kendall 2013), encouraging and teaching narrative medicine, which then leads to narrative competence, also helps to fulfill the responsibilities of a medical education.

This then leads into the final narrative medicine exercise for the first memoir, another close reading exercise. This one will focus on the same excerpt from page 132 that I highlighted in my own close reading analysis above, and there will again be three total read throughs. For the first read through the instructor will read the passage aloud while students listen without taking any notes. On their second read through, students should read the passage silently to themselves. During this second reading, students should take brief notes on how the passage makes them feel. And on the third and final reading, students should follow the same close reading drill illustrated in this thesis, analyzing the passage's plot, framing, form, temporal scaffolding, and desire. Once students have had sufficient time to complete the read throughs and close reading analysis, they should move into small groups and discuss their personal annotations, again taking special note when people's analyses vastly differed. Following group discussions, instructors should lead the full group through a debriefing focused on the different emotions that students may feel as they are navigating the transition into medicine. This specific activity then helps students to again see how reading and writing can simulate emotion, but this time in the context of students' development as future physicians rather than looking at how emotions have the potential to affect relationships with patients.

By sharing stories of different patients Ofri has seen as well as stories that other doctors have shared, *What Doctors Feel* takes the emotions and shared experiences of physicians and makes them public so that others can live through them as well. By incorporating this particular memoir into narrative medicine curriculum and into medical education as a whole, students gain a better understanding of the emotional side of medicine. Furthermore, acknowledging one's emotions leads to a better understanding of what effect these emotions can have on one's decision-making abilities. As seen in the first close reading passage, becoming overwhelmed by emotions can render physician's ability to rationalize useless. But failing to recognize emotions at all dehumanizes healthcare. It is therefore beneficial for students to study memoirs like *What Doctors Feel,* which not only help students (and others) to develop narrative competence, but also helps them to find the delicate balance between feeling too much and not feeling at all.

As Julia died, Ofri read part of Julia's story back to her. Ofri had shared Julia's story in other contexts besides this memoir afterall, whether it was in newspaper columns, interviews, or in her book *Medicine in Translation*. When Ofri came to Julia's hospital beside and found herself at a loss for words, she came to the conclusion that even when she couldn't find a way to speak to Julia, she could still give part of her story back to her. "Something about tracing the narrative of her life seemed like the right thing to offer at this closing moment. It was the only thing, really." (Ofri 207). Sharing patient narratives through medical memoirs like this one allows patients like Julia to in some ways reclaim their illness and to reclaim the role their illness plays (or has played) in their lives. But it also creates a form of closure for physicians through the recognition of shared experiences and the acceptance that emotion in healthcare is okay.

Memoir 2: Every Patient Tells a Story by Lisa Sanders

Brief Synopsis

Lisa Sanders works in the Primary Care Internal Medicine Residency Program at Yale, serving as a clinician educator. Beyond this role however, Sanders also writes a column in the *New York Times Magazine* (a popular column titled *Diagnosis*) as well as a column in the *New York Times* blog The Well (*Think Like a Doctor*). *Diagnosis* columns start with the description of a real case, presenting the symptoms that caused someone to either come into their doctor or to visit the ER. Sanders then goes on to discuss the process of coming to a diagnosis, but these cases are difficult and because of this the lead physician(s) typically miss something important to making the correct diagnosis. At this point someone more specialized is usually consulted and the medical mystery is eventually solved. This column started in 2002, and in 2010 Sanders published *Every Patient Tells a Story: Medical Mysteries and the Art of Diagnosis*, a book that serves as a collection of some of these more fascinating medical mysteries.

In writing this book, Sanders advocates for not only physician competence as defined by the ABMS and ACGME in the introduction, but also the need to truly listen to patients and their stories (as could be gathered from the title). This again emphasizes the idea of narrative competence as it may fall under the broader idea of physician competence. She includes a multitude of clinical stories, elaborating on how in many cases the diagnosis could have been made sooner if physicians had considered a specific detail the patients mentioned in their history. Beyond this however, Sanders advocates for the training and retraining of young and experienced physicians alike, arguing that testing of competence throughout one's career is essential to avoiding medical errors.

The book itself begins with an introduction and then is broken up into four different parts, with each part subdivided into chapters. The introduction discusses a patient, Barbara Lessing, who was rushed to the ICU when several weeks of feeling bad quickly spiraled into her being deathly ill with no one knowing the cause. Lessing's case was complicated and not progressing well, even after a number of different tests had been ordered. However, a specialist was called in, and was able to eventually diagnose Barbara after again collecting a patient history and conducting a physical exam before reviewing the chart itself. The introduction then goes to show readers how much can be at stake in diagnosing patients while also explaining the many different things that have to be considered. Part 1 then, "Every Patient Tells a Story", continues to discuss the diagnosis process as a whole, while also explaining the importance of stories in medicine. However, it also considers the patient's side of the process, looking at for example the importance of giving a patient's story back to them, both to help the patient understand the diagnosis (and the significance of said diagnosis) as well as to help the patient heal. Part 2, "High Touch", focuses on the physical exam. It goes on to explain how the physical exam is continuing to die out in medicine today, whether it be because of the limited amount of time most physicians have when seeing patients or because one may favor diagnostic tools like x-rays. Sanders presents many cases that were solved because of something noted during the physical exam as well as discusses how different components of the exam contribute to the diagnosis process. Part 2 was easily the longest part of the book, showing Sanders passion for patient's histories and the physical exam. Part 3, "High Tech", moves on to look at the different tests doctors may order to come to a diagnosis. Focusing primarily on Lyme disease, part 3 explains how the tests that are ordered play an important role in solving the diagnosis puzzle, because if tests results aren't consistent with the proposed diagnosis, it's likely that said diagnosis and treatment will not truly work. Part 4 of the book, "Limits of the Medical Mind", looked at the limitations we face as humans, considering diagnostic errors and physician bias. Because of this, different technological advances have been proposed in order to help combat some of these limitations. However, there are data collection and technical difficulties that arise as well, each of which are addressed in part 4.

Each of these four parts come together to emphasize the importance of humanity in medicine, both on the physician side and the patient side. In writing these different parts of the book, Sanders incorporated a great number of case studies as well as personal reflections regarding the healthcare system as it stands today, but she also included a good amount of relevant history and explanations of medical concepts. And within the case studies, Sanders balanced common diagnoses that were simply overlooked with more rare and complicated cases that physicians were unlikely to have seen before. However, it is important to note that the book was less focused on medical mysteries, and more meant to serve as an overview of different components of the diagnosis process. This allows it to both serve as a reminder of patient humanity and the value of communication for physician/healthcare audiences, as well as makes the diagnosis process more transparent for patients who may be confused or frustrated by experiences of their own.

Close Reading

In returning to close reading methodology, the same five components will be analyzed as earlier, looking at plot, framing, form, temporal scaffolding, and desire.

The first passage I chose to analyze is from early on in the memoir. From the patient perspective, it seems as if the most important process of the visit would be coming to a final, correct diagnosis. It is interesting then to come across this passage which suggests that it is almost more rewarding for physicians to see the working thought process then it would have been to immediately come to a correct diagnosis. This then comes back to the idea of narrative competence and the ability to craft an engaging narrative which depicts the diagnosis process.

> Getting the right diagnosis is, of course, what you always want—and will usually get on TV and in the movies. But doctors are hungry to hear how others think a case through. Translating the big, various, complicated, contradictory story of the human being who is sick into the spare, stripped-down, skeletal language of the patient in the bed, and then making that narrative reveal its conclusion—that is the essence of diagnosis. Like a great Hitchcock film, the revelation at the end is not nearly as interesting as the path that gets us there. (Sanders 27)

To begin with the plot, in the beginning of chapter two Sanders is describing a lecture she attended at a medical conference. The idea behind this particular lecture is that medical students from across the country had submitted complex diagnostic cases, and Dr. Faith Fitzgerald (a well-respected figure with diagnostic medicine) would be read each case and would take the audience through her thought process as she tried to figure the case out. As she worked through the first case, she eventually found herself stumped having missed a large brain tumor after skipping a head CT (she didn't think it would reveal any new information). However, Sanders was surprised that even when Dr. Fitzgerald missed the diagnosis, the audience still applauded her efforts. When she asked some of the individuals around her whether they were disappointed that Dr. Fitzgerald had failed to provide the correct diagnosis, they clarified that the appeal of the event was less about the final answer and more about observing the thought process behind the diagnosis.

Moving into the framing, *Every Patient Tells a Story* was published in 2010. Similarly to Ofri's memoir analysis, during this time medicine was seeing a cultural transition from a period of physician autonomy to more of a shared decision-making process. This increased accountability leads to part of the framing above, as physicians are eager to gain insight into how others ***see*** cases, as depicted through the audience's fascination in Dr. Fitzgerald's decision-making process. Through looking at what was included versus what was left out of this section of text, readers are able to see then that the big idea was not indeed about the diagnosis itself and the particular tests that were run, but instead in the problem-solving process and in the importance to diagnosis of finding the doctor's version of the patient's story. This suggests that the audience is less about laypersons (though the writing is accessible enough), and more geared towards other medical professionals, regardless of level of training as Sanders seems to be emphasizing the importance of this particular way of thinking and considering cases.

Looking now at form, as in the first memoir the writing is nonfiction prose in a memoir format. Sanders does use a simile in this passage, relating the diagnostic process to a Hitchcock film. Hitchcock is known for being extremely methodical in his cinematic vision, planning everything out ahead of time and clearly leading viewers through his intended thought process. Similarly, the interesting component of diagnosis in this particular passage is not in the actual disease or condition, but in the critical thinking component of following a physician's logic to reach it. And interestingly, the point of view almost seems to shift around a bit in this one passage. Sanders uses the term "you" almost suggesting a second person point of view (and therefore encouraging an audience of healthcare professionals), but she does not go on to further develop this point of view. She instead seems to toggle back and forth between first and third person. Though she explains different aspects of the process and of medicinal culture as a whole (utilizing third person), she also provides the logic and emotions behind her own thinking, giving readers first-person perspective as well.

This then leads us to the temporal scaffolding of the passage. This passage is written in present tense and is explaining the importance of these findings to the state of medicine today. However, though the application of these concepts is more during, the actual duration of time that is passing during this passage is really limited to Sanders's thought process as she sits in the conference lecture. This makes the duration of time quite short.

And lastly, looking at the desire of this passage, it first moved me as a reader to feel eager. A large motivation behind why I am personally pursuing medicine is because I enjoy the challenge of a good puzzle, and I love the satisfaction of all the different pieces finally coming together. This is largely what Sanders describes in this passage when she portrays doctors as hungry to hear the thought process (another metaphor) behind diagnosis. It is no secret that many individuals in medicine find joy in both the challenge and achievement of diagnostic problems, and this is something I look forward to as well. Beyond feeling eager however, I am also left a little bit surprised. Until this point, I have considered the final diagnosis to be the most important part of the healthcare experience, and I am sure many patients would agree as well. It is therefore interesting (and surprising) to see how on the healthcare side of things the process behind diagnosis can be just as important, and even more important, than the actual final diagnosis. These two desires then, eagerness and surprise, suggest that I still have a lot to learn about healthcare, as can be expected considering my exposure is still extremely limited up to this point.

Looking at a later section of the memoir, the second close reading passage is taken from Chapter 8. There is an interesting contrast between this passage and the first close reading passage, as this one suggests an inability to tolerate the unknown whereas the first passage seems more tolerant to it (and furthermore almost intrigued by the idea of approaching the unknown). This excerpt pulls away from the idea of narrative competence and focuses more so on the emotions we saw in Ofri's book prior.

> Nobody likes not knowing, but doctors, perhaps, find this state of being even more intolerable because it utterly thwarts their ability to alleviate suffering, which is often the fundamental motivation for their entire career. But a doctor's discomfort in the face of the unexplained can lead them astray. Rather than accepting a patient's symptoms as real, but unexplained, physicians all too often either dismiss the symptoms as unreal ("all in your head") or, alternatively, read too much into scanty evidence in an effort to banish uncertainty with a crisp diagnosis. Neither response serves patients. (Sanders 183)

Moving into the same process of analysis, one begins with the plot. This passage is pulled from Part 3 of the book during which the writing is focused on diagnostic tests, specifically looking at diagnosis of Lyme disease. It is looking at a study that was done in 1998 in which 200 patients were diagnosed with Lyme disease. Upon further investigation though, only 44 of these 200 patients actually had an active case of Lyme disease while another 40 patients had Post-Lyme Disease syndrome, leaving one wondering why the other 116 patients had been diagnosed. Upon further investigation, it was found that many of these patients had medically unexplained symptoms, which leads into the excerpt above. In an effort to have some answer to give patients even when the facts are not clearly lining up, some physicians may go with their next best guess.

Moving then into framing, seeing as how this book was published in 2010, there should have been some developments toward Lyme disease since then, but diagnosis is still extremely unreliable. However, it has now come to light that diagnosis is unreliable, which has led to Lyme disease now being included on the CDC’s list of notifiable diseases. At the time of publication however (particularly at the time of the study itself), it was not fully understood how unreliable diagnosis could be. This prevented physicians from understanding how detrimental it could be for patients to be diagnosed with the wrong disease, leading to the mentalities listed in the passage. This makes it feel as if the passage is aimed more towards laypeople and patients rather than medical professionals, as the passage is serving to explain (but not justify) why misdiagnosis is so common.

Examining the passage’s form, we again see nonfiction prose. The point of view however remains constant in third-person rather than jumping around as it did in the first passage. There also don’t seem to be any similes or metaphors used in this excerpt, potentially because the passage benefits from being straightforward with the audience rather than relying on similes or metaphors to make indirect comparisons. The temporal scaffolding is just as straight-forward as the form, there do not seem to be any artistic choices made related to the depiction of time in this passage. In fact, time seems almost irrelevant to this passage as it technically is set in present tense as it discusses why misdiagnosis occurs in medicine, but this fact that the passage is in present tense does not seem to add any particular significance to the message the author is conveying.

Lastly, transitioning into the desire of the piece, this passage left me frustrated. It is easy as a reader, an outsider, to read that a physician's discomfort can lead to inaccuracy and be frustrated by that. A common application of this is how when I was a kid, I was often prescribed antibiotics for sore throats, even when doctors were not entirely sure if I had strep. Rather than run extra tests to rule out other possibilities, it was easier to write an amoxicillin prescription and send me on my way. We now know that it's problematic to take antibiotics too often as it leads to bacterial and antibiotic resistance, but even now sometimes physicians will go ahead and assume strep in case of persistent sore throats. I know that a false strep diagnosis is much less severe than a false Lyme disease diagnosis. It does however go to show that many of us have some sort of experience with the occasional physician discomfort of unknown and the accompanying tendency to make assumptions, assumptions that may or may not harm us. And this can be frustrating.

Reflective Writing

Passages of Sanders' writing were then pulled to be analyzed as examples of reflective writing. This again helps medical students to understand the benefit of reflective writing as an educational tool that they then can utilize again, but with their own experiences. Both selected reflective writing excerpts were then analyzed using the same three aspects as with the first memoir: first the author’s description of what happened, then her analysis of what happened (how she was feeling, why she acted certain ways, etc.), and later the outcome of the event (why it mattered, what she learned, and what she would do differently). What makes Sanders’ writing slightly more difficult to analyze from a reflective writing perspective than Ofri’s writing was, however, is the fact that much of her book is filled with anecdotes from other physicians she knows, or with more general tidbits that reflect on physicians as a whole. This only meant however that the selection of passages had to be more intentional in order to make sure that the passage is indeed serving as a model of personal reflective writing for students.

The first reflective writing passage was pulled from chapter four which falls under part two of the book, “High Touch”. This chapter specifically is looking at the importance of the physical exam and how when done properly physical exams can help guide what tests the doctor does and doesn’t need to run. This particular passage was chosen because it reflects not only on the physician’s emotions, but also the patient’s. This is an important aspect of care, as a deeper understanding of patient’s feelings and experiences can help better equip physicians to fully be there for their patients.

> The experience of being ill can be like waking up in a foreign country. Life, as you formerly knew it, is put on hold while you travel through this other world as unknown as it is unexpected. When I see patients in the hospital or in my office who are suddenly, surprisingly ill, what they really want to know is “What is wrong with me?” They want a road map that will help them manage their new surroundings. The ability to give this unnerving and unfamiliar place a name, to know it–on some level—restores a

> measure of control, independent of whether that diagnosis comes attached to a cure. Because, even today, a diagnosis is frequently all a good doctor has to offer. (Sanders 58)

In this part of the book, Sanders is transitioning into a set of cases where each person's symptoms came on suddenly without any obvious explanation. Sanders is leading us into a story about a patient, Gayle, who woke up suddenly in the middle of the night with an excruciating back pain. Gayle previously did not have any glaring symptoms that made her think anything was wrong until she ended up in the hospital Sanders works at with the back pain and a new inability to move her legs.

When it comes to this part of the book, I would argue that the analysis of the situation is just as much about how Gayle felt as a patient as it is about how the doctors felt. Further into the passage as readers learn more about Gayle's case, it is obvious that she is scared from not knowing what is going on or what will become of the situation. She is given muscle relaxants when she first arrives which then help her to calm down. This makes sense because at this point her main problem (the unbearable back pain) had been resolved. It is soon after this though that the leg numbness develops, leading Gayle to again feel panicked and out of control. This back and forth of emotions is something I think many people have experienced themselves if they have ever been to the ER or been to multiple doctor consults for a reoccurring problem. Later on, the doctors end up (correctly) diagnosing Gayle with West Nile virus. This brings up new feelings as she feels comforted, but not necessarily reassured. This illustrates an important dichotomy within healthcare, where often "finding" the answers can lead patients to feel relieved yet just as concerned depending on the diagnosis. West Nile virus is not a nonchalant diagnosis and can be associated with many complications, so it makes sense that the diagnosis itself isn't reassuring. There is still a lot of unknown, even with an established diagnosis. However, Gayle's sense of comfort makes sense as well, as now she at least has something to go off of and something she can research to learn more about. This goes hand-in-hand with what Sanders states in the above quotation, about how even when the diagnosis does not have an obvious cure there is still a sense of semi-restored control simply because there is now a name associated with what's happening.

This then moves us into a reflection as to why this acknowledgement of a lack of control and the associated emotions matters in the first place. It is first important that healthcare providers recognize the many different complicated emotions a patient may feel during their care, as even the environment of being in a hospital or similar place can create anxiety for patients. Though taking care of patients and running various tests and medications is a normal part of day-to-day life for most providers, these moments can be some of the scarier or more stressful days of a patient's life (depending on the severity of the circumstances). And this anxiety is particularly heightened in situations when even the doctor is at first unsure as to what is going on. By acknowledging that these situations are "unnerving and unfamiliar" as Sanders states above, we are acknowledging that patients are "allowed" to feel scared and concerned during a time of confusion and unease. This affirmation of a patient's feelings can help them to feel more comfortable during a time of discomfort and may in turn make the waiting period slightly more bearable.

This analysis of what happened and in turn why it mattered leads into a reflection on what Sanders learned from the event. And though she practically explicitly says this at the end of the quoted passage above, it seems the most evident lesson is that patients often care just as much about the finality of a diagnosis in a time of uncertainty as they do about what will happen next. By recognizing how much turmoil is associated with the unknown aspect of a doctor's visit, physicians and other providers can try to make the process more accessible. This can look like many different things, whether it means explaining what a test is being conducted for, or even why one test is being ordered and another test is not. The act of waiting and complying with different orders without understanding what is going on can create just as much anxiety for patients as the illness itself does. By working with each patient to help ensure personal health literacy surrounding their visit, even a devastating visit or diagnosis can bring some sense of reassurance.

This then transitions into the second and final reflective writing passage. This one is pulled from the afterword of Sanders' book, where she is now reflecting on the end of life and the desire to know just exactly how it is someone died when their death was unexpected. Throughout the afterword Sanders discusses the death of her sister, Julie, and the peace Sanders was given by learning the (inconclusive) autopsy results and piecing together different aspects of Julie's life to reach a conclusion on what must have happened. I chose this particular excerpt to be the final passage because in the past Sanders hadn't understood why her patients' families were so hooked on wanting an answer as to what exactly had happened. But when Sanders found herself in a similar position, she was able to better understand the families' behaviors.

> It was a strangely familiar question. When patients of mine have died, their spouse or parent or child or friend would ask me this very question after I broke the news. In waiting rooms outside the emergency room or ICU, shocked, sad, crying—they would ask: Doctor, how did this happen? How did this person, so very alive not so long ago, die? I would do my best to answer, to pull together the strands of a devastating illness or

> collapse, but it seemed a peculiar question—as if an explanation could somehow soothe the jagged edges of loss. But it made sense to me now. I suddenly understood that terrible need to know how. (Sanders 240)

Here Sanders is discussing how the fact that her sister's death was so sudden and so unexpected left her shocked. Julie was relatively young (42), healthy, and had died so suddenly that she hadn't had time to call 911. And even as Sanders expresses being confused by the situation, the familiarity of it also stood out to her as she considered previous patients she had seen. Sanders noted how in the past she thought it was odd for patients' families to want to know in the midst of their grief what exactly it was that caused their loved one's death. She did not understand why families would become so fixated on what exactly had happened, likely thinking that the more you looked into the death the more difficult it may be to mourn their loss. But after now finding herself in the same situation, Sanders reacts the same way her patients' families had in the past, trying to piece together the answers behind what happened while in the middle of also grieving her sister's death.

In looking at how Sanders was feeling, it is clear she was devastated and frustrated both by her sister's death and the unknowing which surrounded it. This is logical because as was discussed earlier, the discomfort surrounding uncertainty creates a lot of anxiety for patients. And it only makes sense then that uncertainty surrounding cause of death would create discomfort and anxiety for families; a large part of the healing process is accepting what has happened and that cannot be done if it is not in fact fully understood what did happen. Later in the afterword an autopsy is conducted and even that remained inconclusive, again causing Sanders disappointment. However, Sanders' medical knowledge means that even a lack of cause of death on an autopsy indicates something (for example, she now knows it wasn’t due to a massive bleed). Sanders was then able to use this information along with the rest of her medical knowledge and what she knew of Julie’s life in order to put together her best guess as to what it is that happened. And once she was able to share this belief of what happened with the rest of her family, they were able to move on from the more clinical side of Julie’s death to instead focus on all that they love about her.

It is also evident in this passage that after having this experience Sanders now felt a sense of understanding and almost comradery with all the families she had seen before in the exact same situation. In the past she had been confused as to why families would get so caught up on knowing the diagnosis when no diagnosis could bring their loved ones back. As a doctor who handed out diagnoses all day every day, she didn’t understand the value that an answer could hold for families. But once she switched over to becoming a patient’s family member herself rather than just a physician, she gained a new perspective that changed how she felt about the situation. It is likely that this realization and sense of understanding also created a grief of its own for Sanders as she realizes in her own way what the families may have been going through. And though her experience is not the exact same (no two experiences ever are), Sanders does still gain a sense of connectedness to these families that she may not have had before.

It is important that Sanders gained this new perspective because it again showed how much weight a physician’s words and conversations can have. As noted in the other reflective writing passage reflection, even though these conversations are often just another day for the physician or other healthcare provider, a family member’s death is one of the worst days for the families. Being on the other side of things and understanding just how frustrating and devastating an unknown cause of death is, allows Sanders to be more empathetic in the future when she talks with other families who are in the same boat. Because even though she was able to connect her medical knowledge and ask the right questions to figure out Julie’s death for herself, most people do not have the same skill set or resources and rely on physicians to be both their guide and their comfort.

This leads into what Sanders learned from this particular event, with the answer being that everyone processes their grief in different ways. While some family members may find themselves pulling away and detaching in these situations, others will gain comfort from asking as many questions as possible to try to find all of the answers. It is only after knowing the full picture that they may feel it is okay to grieve. And understanding that people grieve and process situations in different ways helps providers to convey information that is most effective to families. Afterall, it is the responsibility of a competent physician to make sure that they are making information accessible for all patients, and in some situations that will mean making information accessible for family members as well.

Application when Teaching Narrative Medicine

As discussed in the first memoir’s application section, there are four main themes to be examined throughout each memoir’s application. These include: the importance of a patient-centered approach and more holistic care, the ability of providers to navigate illness and the healthcare journey alongside patients, the development of traits such as increased empathy and professionalism, and the importance of training competent physicians. When considering the specific benefits that *Every Patient Tells a Story* as a memoir can contribute towards these four themes, one should focus specifically on the book’s overarching theme of what the unknown looks like within medicine.

When we think of what “success” looks like within the healthcare field, one is likely to picture the correct diagnosis of disease or ailments ultimately followed by a cure. It is interesting then to consider that misdiagnosis not only occurs, but in turn occurs more often than most people realize. It is impossible to gauge exactly how many misdiagnoses occur, but previous literature has cited that an estimated 10-15% of all diagnoses are incorrect (Newman-Toker et al.). This is not to say that all misdiagnoses are unforgivable. When looking at the broader category of all misdiagnoses, one can first narrow these cases down to a list of misdiagnoses which caused harm in some way, then narrow it down to whether these harms were truly severe (did they create disability or death), and then narrow the list down one step further as to whether these severe harm-causing diagnoses were preventable. Regardless however of the severity of a misdiagnosis, we as a society are still uncomfortable with the idea of uncertainty, particularly within the context of our (or a loved one’s) health. It is this aversion to misdiagnosis which makes *Every Patient Tells a Story* relevant to healthcare today, particularly for medical students. It is after all earlier in one’s training when they are most likely to make diagnostic errors, particularly when it comes to diagnostic errors which could have been avoided.

Moving into the first theme, patient-centered care, patients themselves play a key role in the diagnosis process. A large amount of research focused on misdiagnosis follows clinical decision making (which does without a doubt play a role), but patient perspectives also play an important part in diagnosis. In seeking out and seriously contemplating patient’s concerns and frustrations, providers are more likely to catch details which may later become a key component of an individual’s diagnosis. How often do we hear someone describe their healthcare experiences by saying they felt dismissed or ignored about one thing or another? Oftentimes dismissal or arrogance in clinician behavior can lead patients and their families to feel as if they are not valued or as if their health is not being taken seriously, and this means that patients will be less likely to communicate important information in the future. Incorporating Sanders' book into medical curriculum can then help students to remember how common uncertainty can be within medicine and the dangerous implications it may have if not taken seriously.

For the first exercise based on this memoir, students should be asked to get into small groups and brainstorm times when they went to the doctor and did not feel as if their concerns were fully addressed. After they have had a few minutes to discuss, everyone should come together as a larger group to talk as a class. The group should discuss not only the incidents themselves, but also how they made the student feel as a patient and what it made the patients think of the provider. Ideally the group would create a list of key feelings associated with these experiences. Following the group discussion, the instructor would read aloud the above passage pulled from page 183 of Sanders' book. On this first reading students would only listen, not taking notes. Students would then read the passage again on their own, this time annotating the text in the context of eventually answering why a physician may dismiss their patients' concerns. Following this second reading, students should be given time (~15 minutes) to write and reflect on the juxtaposition between their previously discussed experiences as frustrated patients and their potential future experiences as physicians. After 15 minutes of writing, students will get back into their same small groups as before, where they will be given time to discuss their writing and identify any common thoughts or themes. The session will end with a debriefing from the instructor which focuses on communication with patients and how to make sure they feel heard during the diagnostic process.

And to ensure that patients feel authentically heard during their healthcare visit, providers must navigate the diagnostic experience alongside them. Throughout her book Sanders advocates for providers to really sit down and listen to their patients, claiming that an accurate and thorough patient history is key to true diagnostic progress. However, it can occasionally be difficult to navigate these journeys alongside the patient when the listener themself has not been in the same place. We see this as readers when Sanders is processing her sister's death. She did not previously understand why friends and families reacted the way they did when faced with a loved one's death, and it didn't make sense until she found herself in the same place looking for answers to the same questions. This goes to say that when it comes to medical uncertainty and the diagnosis process, it can be difficult for providers to authentically navigate the process alongside patients. It is important however for providers to be conscientious of this and their own experiences (shared or different) when responding to patients' questions and reactions. Afterall, a provider can be empathetic and compassionate in their response to patients, even when they lack personal understanding of how it may feel to be in a particular situation.

In looking at how narrative medicine can help medical students learn to respond empathetically even in the face of the unfamiliar and unknown, it is important to have students embrace different perspectives. The instructor will first read the first close reading passage above (from page 27 of Sanders book) which emphasizes that interest surrounding the diagnostic process is often focused more on the process of coming to a diagnosis rather than the diagnosis itself. This exercise will reinforce this idea of an interest in one's thinking process by having students write and interpret directions of their own. After reading the passage, each student should be given a bag of Legos and asked to build a structure which they do not show to anyone else in the room. They should not be given any further instructions at this point. After five minutes of building, students should now be instructed to spend 15 minutes writing directions on how to build their specific structure. After these 15 minutes have elapsed, students will take a picture of their structure, take it apart, and place the Legos along with their new written instructions back in the bag. At this point everyone will pair up, and then switch bags with their partner. Each person will then be given 15 minutes and told to try and recreate their partner's original structure going off of the written instructions in the bag. At the end of the 15 minutes, each person will pull up the photo they took of their original structure and show it to their partner, so that everyone can compare what they created to what they were supposed to end up with. Once students have had a few minutes to compare, everyone will come back together for a group discussion. During the discussion the instructor should have students talk about what they thought of the activity, which parts were easier or more difficult than they anticipated, and how this activity could apply to the diagnostic process. The conversation should ultimately be guided to discuss similarities between having to interpret someone else's Lego instructions to create an unknown structure and having to ask different questions to draft a patient's experiences and medical history into a possible diagnosis. Because the partner during the Lego activity may have approached the structure from a different perspective than whoever originally wrote the instructions, the final structure will likely look different for both people. Similarly, different providers may approach the diagnostic process differently. However, it is important that providers listen to their patients carefully in order to show patients that they are working to navigate the process alongside them.

And because this diagnostic process can be emotional and vulnerable, it is important that providers approach it with humility and compassion. This leads into the third theme of how important it is to develop authentic connections with patients through an emphasis on intra and interpersonal skills. One of the stories Sanders tells in her memoir is that of Gayle and Kathy. The two had just gotten back from a long-term camping trip when Gayle suddenly became extremely sick and had to be rushed to the ER. The first doctor they saw rushed through the physical exam and did not seem confident in his diagnosis, and so Gayle and Kathy did not feel confident in the care he provided. This led to them driving five hours when new symptoms developed to instead go to a hospital in their hometown, where they felt respected and taken care of. This is a clear example of how even in a case of emergency, if the provider does not make an effort to connect with patients and reassure them, they likely are not going to feel as if the care they received was good or even sufficient (and in this case it definitely was not). Incorporating medical memoirs into narrative medicine curriculum can show students concrete examples of the differences that interpersonal skills like patience and communication can make in a patient's care.

When working to convey this lesson to students, they should first be read the passage above from page 58 about giving patients a roadmap in times of uncertainty. This is the passage in *Every Patient Tells a Story* that leads into Gayle and Kathy's story. After hearing someone read the passage out loud, students should be given the excerpt from pages 59-60 that discuss the first ER visit, starting with the paragraph which begins, "They drove an hour through the back roads of West Virginia to Maryland…" and ending after the paragraph which begins, "They were at least five or six hours from the small Connecticut city…". Students should read this excerpt silently to themselves, and then be given 15 minutes to journal about any initial thoughts or reactions to the situation. After the 15 minutes have elapsed, students should get into small groups to discuss the passage and their feelings about what happened. After some time as a small group, everyone should come together as a class where the instructor can facilitate a conversation addressing at least the following questions: "Was the ER doctor really to blame in this situation?", "What could he have done differently to offer better care?", and "Should he have sent them home?”. At the end of the conversation, the instructor should lead the group in a debriefing focused on the importance of making patients feel heard, focusing on the fact that because Gayle and Kathy had a bad initial experience they did not return upon development of new symptoms. As future physicians, medical students will soon be responsible for forming the trusting patient-provider relationships that transparent care relies on.

This emphasis on interpersonal skills and authentic connection then leads into the fourth theme, a recognition of the reoccurring presence of narratives in medicine. *Every Patient Tells a Story* again strengthens this argument because much of Sanders’ writing focuses on how important a patient history is to determine the correct diagnosis. And in listening to patient history and teasing out different details of a patient’s life and prior experiences, providers are creating a narrative not only of that patient’s present disease but also a small glimpse into who they are as a person. This is important because as noted in the last memoir’s application, if narratives are a large part of clinical practice then it is important that future physicians feel comfortable seeking out and portraying them in order to ensure the training of competent physicians.

The last narrative medicine exercise for this memoir then is a close reading/reflective writing combined drill focused on patient histories as a story. Instructors will play for students a mock clinical history video in which a patient is being interviewed. If instructors need an example, they can refer to this video depicting a problem-focused standardized patient visit created by Kansas City University of Medicine and Biosciences (*https://www.youtube.com/watch?v=MzoeBJyVlE0*). Note that this video does include osteopathic practices. Otherwise, instructors can use whatever video they think will be the most effective. On the first run through of the video, students will focus on the clinical things they have been taught to look for. After this first pass has been completed however, instructors will play the video again and ask students to practice parallel charting in which students take extra notes on the side of the chart expressing their own personal thoughts and reactions on the things the patient is saying. After these two different views are complete, students should be asked to journal for 10 minutes on the differences between the two different "charts" (clinical versus parallel) and the way they complement each other to create a more detailed story. After these 10 minutes are complete, students should get into groups and discuss their thoughts, taking specific note of where their parallel charting differs. After small group discussion, the instructor should lead a full group discussion in how looking at the same story from different perspectives (e.g. standard clinical history versus provider's reactions in this case) can cause us to catch details that we may have previously missed. Once the full-class conversation has ended, students should be given the second close reading passage from above (pulled from Sanders 183) and asked how they can connect the message of this passage to the previous discussion. Instructors should facilitate this conversation so that students see that though it is important to consider narratives from different perspectives, it also does not serve patients to unnecessarily misinterpret symptoms. Patient histories must then be used as a complement to other steps of the diagnostic process, not the be-all and end-all of diagnosis.

Through sharing stories of different medical mysteries, both ones that Sanders had seen and ones that had been passed on to her, *Every Patient Tells a Story* is able to illustrate how important patients themselves are to the diagnostic process. And by incorporating this memoir into narrative medicine curriculum, it shows students that even if they have perfected the various biomedical and technical competencies, without listening to patients' stories you may not have all the information you need for an accurate diagnosis. But beyond acknowledging the presence of narratives, it is also important for physicians and future physicians to recognize that there will be times when they must face the unknown. Whether this be through seemingly unclear diagnoses or uncertainty in how to approach a particular situation or question, students may not always immediately have an answer. And it is this ability to acknowledge and explore uncertainty that narrative medicine hopes to cultivate.

However, nothing is more paradoxical than the simultaneous switch between certainty and uncertainty surrounding one's own mortality. Though we logically know that everyone must eventually die, most people have no idea of when or how they will do so. This is a moral dilemma we explored earlier in this particular memoir when looking at Sanders' obsession surrounding the potential causes of her sister's death, but also something that many people reflect on at some point in their day to day lives prior to anyone they know or love dying. When someone is receiving care for terminal illness there is often a bit less uncertainty as patients may have a general idea of prognosis, but even then there is a lot that remains unknown both in regard to how exactly the disease will progress, but also what this means for a person and their current life as is. And it is this fascination surrounding mortality and its effects on one's personal values that leads into the third and final memoir of this thesis.

Memoir 3: *When Breath Becomes Air* by Paul Kalanithi

Brief Synopsis

Paul Kalanithi graduated from medical school in 2007, after which he returned to Stanford (his undergraduate institution) to complete both his neurosurgery residency as well as a postdoctoral fellowship in neuroscience. Ten years into his neurosurgery training, Kalanithi was diagnosed with stage IV metastatic lung cancer while working as a chief resident. Following diagnosis, he continued his medical training and kept working to finish his residency, spent time with his family (his wife and their new baby girl), and took up writing. He first wrote an op-ed titled "How Long Have I Got Left?" which published in *The New York Times*. Following the op-ed, he began a manuscript in the form of a Word document on his computer. Diagnosed in May 2013, Kalanithi died in March 2015 at the age of 37. His wife, Dr. Lucy Kalanithi, started meeting with Paul's agent and editor to figure out how she could take the manuscript and turn it into a published book. After spending a significant amount of time with the work, even supplementing in other work Paul had previously done in order to tie things together more completely, Lucy wrote the epilogue and the book was officially published as *When Breath Becomes Air.*

This book is different from the previous two in that Dr. Paul Kalanithi is able to share the perspective of both the physician and the patient. *When Breath Becomes Air* is an autobiographical memoir focused on Kalanithi's thought process of working through what the diagnosis means for his training and his career, but also on a wider scale what it means for him as a person. Throughout the book he takes readers through his personal journey of learning to live with the uncertainty of not knowing what is coming next and navigating how to find purpose for yourself when many of the things that used to hold part of who you are no longer are able to define you. Kalanithi first studied literature and philosophy before medicine, researching mortality and all of the questions associated with it: what it means to be human, how do we make sense of our lives, and what brings our lives value even in the face of mortality. His writing in this book then merges his early-career focus on mortality and the philosophy surrounding it with his work in neurosurgery.

The book’s structure consists of a foreword written by Abraham Verghese (a physician writer himself), Paul Kalanithi’s writing, and an epilogue written by Lucy Kalanithi. Following a brief prologue, the main section of the book is broken up into two different parts, the first one titled “In Perfect Health I Begin” and the second titled “Cease Not Till Death”. As could potentially be assumed from these two titles, the first half focuses more on Kalanithi’s early life: his childhood, family, early interests, and career training. The second half on the other hand focuses on Kalanithi’s life post-diagnosis, looking at his last months and his ability to process the cancer.

Each of these two parts is then divided into sections, rather than chapters. Part 1 has three sections, the first focused specifically on his childhood during which he claims he would never be a doctor like his father as he reflected on his father’s absence during Paul’s childhood. The second section focused on Kalanithi’s experience with literature: his undergraduate and graduate degree in literature, his thesis on Walt Whitman, and his ultimate realization that in order to truly study the body/mind connection he would need to study medicine. The third and final section of part 1 transitions into Paul’s decision post-medical school to go into neurosurgery, which Kalanithi believed was the only way to truly understand the relationship between one’s brain and their personality/identity.

The second part of the book was divided into four sections, the first of which takes readers to the time immediately following Kalanithi’s diagnosis. Readers are also introduced here to Paul’s oncologist. Section two explores a time during which Paul’s condition has stabilized and he begins to struggle with reidentifying his “normal”. Section 3 moves into a new set of scans and Paul’s realization that he must at last leave neurosurgery. Section 4 of part 2, the final section of the memoir, revolves around Kalanithi's chemotherapy but also the birth of his daughter, Cady. Paul's part of the book then ends with a message to Cady.

I chose to include this memoir as one of the three not only because of the unique perspective of Paul Kalanithi as both a physician and a patient, but also because of Kalanithi's passion for narrative medicine. Though Kalanithi never identified himself as a narrative medicine scholar, his passion in combining literature/philosophy with science and medicine shows an informal involvement in the field. And beyond this subtle endorsement again of incorporating the academic humanities into medicine, *When Breath Becomes Air* has the ability to remind medical students of what it means to see patients as human.

Close Reading

Just as with the first two memoirs, the same five components of plot, framing, form, temporal scaffolding, and desire will be analyzed while practicing close reading.

The first close reading passage is from section 3 of part 1, during which Kalanithi is talking about his first year as a Stanford resident. This passage was chosen specifically because it is pre-diagnosis, so Kalanithi is reflecting on his experiences in medicine without yet having an intensive patient perspective to reflect on as well. However, because this passage is specifically focused on the first year of residency, it is particularly relevant for medical students as they will soon be moving into this phase of life.

> At moments, the weight of it all became palpable. It was in the air, the stress and misery. Normally, you breathed it in, without noticing it. But some days, like a humid muggy day, it had a suffocating weight of its own. Some days this is how it felt when I

> was in the hospital: trapped in an endless jungle summer, wet with sweat, the rain of tears of the families of the dying pouring down. (Kalanithi 78)

Looking at the context of this quote, Kalanithi had been talking about his first year of residency after he and Lucy graduated from medical school and moved to California. He shares a story about the first patient he had ever lost, Mrs. Harvey. When she died it took an emotional toll on Kalanithi, but it also was his self-declared turning point for seeing patients as people rather than only paperwork. Following this anecdote, he moves into a list of a few other people he saw die during his first year. It is after this list that he writes the above quote about death and the weight associated with it, but also about the almost unbearable stress tied to residency. These patients were the first ones for which Kalanithi felt responsible. In his second year he gained more responsibility still and became much more used to (though never comfortable with) the idea of death. But the first year felt overwhelming in its own unique way.

When Breath Becomes Air was published in 2016, but most of it was written in the years leading up to Kalanithi's death. Because this is so close in publication year to the other two memoirs, there is not much of a culture difference between the various books. There is however the fact that this particular memoir looks more at the culture of death within medicine while the other two took a broader approach in describing many different patient encounters they had heard or seen across their professional lives. And we see this refined focus on death and mortality even before Kalanithi is faced with his own mortality. Looking then at what was included in this particular passage, it seems intentional that he focused specifically on families of the dying in this excerpt rather than mourning families in general. And though he does not explicitly state this in the passage, his alternation between devastation and nonchalance in facing patients' deaths almost seems to foreshadow his eventual back and forth when processing his own diagnosis in the future. This suggests that even though the audience seems to be pictured as the general public, in ways Paul also was writing for himself and to help himself process his own experiences as he navigated both his training and his life as a whole.

As with the first two memoirs, Kalanithi relies on nonfiction prose stylized as a memoir. Much of the first passage consists of a metaphor describing the hospital as a jungle. Similarly to how we may picture a jungle as loud, bright, humid, and potentially overwhelming, Kalanithi reminisces on feeling trapped in the hospital. He takes the metaphor a step further in comparing families' tears to rain in the jungle, implying that just as the jungle is characterized by rain the hospital is often pictured as a sad place and associated with death. Transitioning then from figurative language into the passage's point of view, though Kalanithi mentions "you" briefly, the passage relies on first person point of view. He is discussing the way he personally felt during this this time of his life, which may at first seem to suggest an audience of those in healthcare related fields, but instead seems to broaden the audience since Kalanithi describes the experience in a way that everyone could relate to in one way or the other (even if only superficially).

Considering then the temporal scaffolding of this first passage, Kalanithi writes in past tense. And though the passage could be applied to any part of his time in the medical field, it is clear that he is specifically referring to the duration of his first year in residency, as the weight of death he talks about has become heavier only now that he has increased responsibility as a resident. However, it does seem to refer to all of Kalanithi's first year rather than a specific, shorter duration.

Concluding with desire, this passage first creates almost a sense of dread for me. Though I look forward to a future career in healthcare and know that I will have to deal with death and loss just as everyone before me did, the weight that Kalanithi speaks of makes me more apprehensive. I am an empathetic person and sometimes tend to internalize the emotions of those around me. This is what the line saying the "rain of tears of the families of the dying pouring down" reminds me of, because it seems as if Kalanithi was also affected by the emotions of those around him. Beyond feeling apprehensive however, I also feel almost a sense of appreciation when reading this passage. Many people who write or share about medicine seem to glamorize their experience, even when it comes to the negative things they endured. To have Kalanithi instead acknowledge and also embrace these harder days is nice because it feels as if he is giving a more authentic explanation of his experiences as a resident. These conflicting feelings though of dread but also appreciation show again how complex medicine can be, as many experiences can almost be juxtapositioned against themselves depending on the different perspectives one takes when analyzing. This is why it can be useful to complete multiple readings of an excerpt when practicing close reading techniques.

The second close reading passage on the other hand was chosen from section one of part two, a point right after Kalanithi's diagnosis when he is trying to come to terms with what it means for his future. These two passages offer a good juxtaposition for students to see, a look first at the weight of being responsible for others' lives for the first time versus now the weight of having to navigate one's own life during times of uncertainty. This also serves to partially connect the second close reading passage to the themes of uncertainty seen before in Sanders' memoir.

> One chapter of my life seemed to have ended; perhaps the whole book was closing. Instead of being the pastoral figure aiding a life transition, I found myself the sheep, lost and confused. Severe illness wasn't life-altering, it was life-shattering. It felt less like an epiphany—a piercing burst of light, illuminating What Really Matters—and more like someone had just firebombed the path forward. Now I would have to work around it. (Kalanithi 120)

When Kalanithi wrote the passage above, he had just looked at his CT images and was seeing for the first time that the cancer had invaded multiple organ systems. Whereas his symptoms had been annoying and frustrating but still manageable before, they now were going to change his entire life as he knew it. He spent the night in the hospital and was starting to rethink all of his future plans, including his time as a neurosurgery resident. And in considering more tangible effects than the course of his career, Paul and his wife Lucy began discussing things like refinancing their mortgage and the fact that Lucy should later remarry. Amid the grieving and "restructuring" Kalanithi was attempting to do however, he also briefly met his oncologist, Emma. While the passage above first describes a feeling of being lost and confused as a sheep would, Emma comes in and begins to offer a path forward which focuses on and encourages Kalanithi's own morals and values (leading to Kalanithi "working around" the just destroyed path).

Considering the framing of this passage, though the book was published in 2016 Kalanithi likely wrote this particular part in late 2013 or early 2014, soon after his diagnosis. Even now in 2022 non-small cell lung cancer does not have an optimistic 5-year survival rate. That said, there have been many advancements in FDA approved drugs since Kalanithi was originally diagnosed, drugs that he would not have had access to during his treatment. It is interesting then to look at his sense of being lost as described in the above passage and wonder if he would have felt the same had he been diagnosed now, debating whether the discovery and approval of new drugs would bring comfort or only more hesitancy/uneasiness. The audience here would then be the same as in the first passage, written for both the general public as well as for Kalanithi himself.

This passage is still written as nonfiction prose and again heavily relies on metaphors throughout. Kalanithi begins this passage by comparing his life to a book, but quickly moves on to instead compare himself to a lost sheep. This transition from book to sheep serves to take control out of Kalanithi's hands (control coming from the idea of a particular chapter of his life ending and him moving into a new phase of life of his own accord) and instead say that Kalanithi does not have control over the situation after all. However, he also uses metaphor when referring to his diagnosis as a fireball, a change that has completely altered his perception of the future. And though this is nothing new as Kalanithi relies on metaphor throughout his entire memoir, there is a difference between this passage and the first in that this one is fully in first person whereas the first passage seemed to rely on both first person and third person.

This passage is again in past tense, though the last line seems to suggest that there will be a shift in tense coming soon after this passage ends. The exact time this excerpt refers to is harder to determine because Kalanithi's attitude toward his cancer fluctuated throughout his diagnosis. Though there were periods of time when he seemed more accepting of the situation and more sure of how to navigate it, these points of near clarity would often be followed by some form of update or conversation that changed his outlook and/or made things more confusing for him once again. That said, when the middle part of the passage compared learning of severe illness to feeling like being firebombed, it refers to a more immediate temporal scaffolding as it specifically focuses on Kalanithi's initial reaction to his diagnosis.

Concluding with desire, this passage first makes me as a reader feel more connected to Kalanithi. Though many of us will never have to deal with terminal illness, everyone has had at least one life transition that has left them with no idea of how to proceed. In these situations we often wish to have someone else there that can answer these questions for us, leading us through the uncertainty just as Kalanithi's referred to pastoral figure would. Beyond this more intimate connection with Kalanithi as a character however, this passage also caused me to feel hurt for him. He had gone through all of this extensive training to end up in a particular place he envisioned for himself and with this new diagnosis he now has had this specific vision of the future essentially taken away. This is something that would hurt anyone who has worked hard for something, whether it be something career-related, relationship-oriented, etc. And after receiving the diagnosis Kalanithi had his entire future altered, rather than just his perceived perception for how one part of his life would turn out. This is something that would frustrate and upset anyone, yet he ends the passage with resilience in that even though everything he knows has been taken from him, he will now find a new way around it.

Reflective Writing

Just as with the close reading section, the reflective writing analysis for this memoir will utilize the same methodology as the first two memoirs. Two different passages of Kalanithi's writing have been pulled with the intention again that these paragraphs will act as a model of Kalanithi practicing reflective writing. And seeing as how this memoir is in ways more personal than the other two since it does include Kalanithi's reflections on his own healthcare journey, these passages are a great reflective writing example for students.

This first reflective writing passage is pulled from section 2 of part 1 of the book, soon after Kalanithi realized he'd need a medical education in order to fully understand the connection between the mind and body. This passage was specifically chosen to analyze however in order to illustrate the apathy that is sometimes cultivated in medical students during the earlier part of their training, intentional or not.

> "Early on, when I made a long, quick cut through my donor's diaphragm in order to ease finding the splenic artery, our proctor was both livid and horrified. Not because I had destroyed an important structure or misunderstood a key concept or ruined a future dissection but because I had seemed so cavalier about it. The look on his face, the inability to vocalize his sadness, taught me more about medicine than any lecture I would ever attend." (Kalanithi 50)

Here Kalanithi is describing his experience working in the cadaver lab as a medical student. He starts off by making jokes with his friends when recounting his training, telling stories about how particular classmates had acted during dissections. In a sense Kalanithi was dehumanizing his peers in an attempt to make the dissections seems more "normal" to anyone who was not involved in medicine themselves. Kalanithi quickly realized however that though he may other his classmates in conversations with friends, he is actually quite similar to them in the way he approached dissection. Kalanithi discussed how ahead of time he thought dissections would be nauseating, but how it all felt relatively normal to him once he got into the room. This is illustrated in this passage where he himself did not hesitate to cut through the donor's diaphragm, not faltering until noting his proctor's reaction. His anatomy professor had instructed him to do so after all, and when you become used to following your instructor's directions each day, the sanctity of dissection is almost lost.

Before Kalanithi registers his proctor's reaction, it is clear that he feels dismissive of the situation. The diaphragm is nothing more than an obstacle to him, something he needs to get rid of so that he can reach the splenic artery (what he is meant to be focusing on). Because he and his classmates have spent several weeks in the anatomy lab at this point, he had gotten used to navigating different parts of the cadaver body, cutting and breaking various body parts as he worked. This makes sense because as we spend more time in an environment, we acclimate to it. Students are even instructed to cover the donors' faces in order to further detach themselves from the cadavers' previous humanity. It is easy then to forget that the object you are dissecting was previously a person.

The presence of a proctor then, someone who was an insider to medicine but an outsider to Kalanithi's experiences of learning anatomy, acted to jar Kalanithi from this sense of apathy. Because the proctor was not someone who spent each day working on the cadaver, they were able to still see the body as sacred and worthy of respect. Seeing the proctor's response to Kalanithi's convenient cut made Kalanithi realize that the habits he had developed may have been efficient, but were not necessarily in the field of medicine's best interest. This realization seems to have made him feel almost defensive (in the next part of the passage he explains to the proctor that this is how he had been instructed to dissect), but also seems to have humbled him. He has been reminded that this cadaver is more than just a test or teaching tool, but someone who had a whole life of their own prior to being on that table.

This leads then into what Kalanithi learned from the particular event. Cadavers are essential to teaching medical students anatomy, and have led to a better understanding of medicine for all medical professionals. Because of this, many medical schools now take precautions to ensure that these bodies are treated with dignity and respect. Some schools even hold funeral ceremonies for the cadavers in order to honor the lives of those who are now helping advance medicine. By setting time aside specifically for honoring donors and the lives they may have lived, schools are working to again humanize dissections while also instilling altruistic morals in future doctors (Ghosh 2017). No one can blame Kalanithi for following the techniques his professors instructed him to use, his instructor was in many ways responsible for ensuring that he approached dissection in the "correct" way (whether we consider correctness from the standpoint of anatomical preciseness or from a morality perspective). Though Kalanithi was originally taught to approach dissection from an efficiency standpoint, he seems to have learned from his proctor's response to not lose sight of the humanity of his patients, whether said patients are still alive or not.

The second reflective writing passage then is taken from section 2 of part 2 of the book, during which Kalanithi is working to come to terms with his own diagnosis. He has realized at this point that because he has limited time left, he must start choosing which things he values most. I chose this as the final analyzed passage for the memoir because this is where we really start to see Kalanithi's unique perspective as not only a patient, but as a patient with terminal illness. Though many of us as readers can relate to different conversations about illness, less of us understand what it is like to navigate terminal illness.

> “The tricky part of illness is that, as you go through it, your values are constantly changing. You try to figure out what matters to you, and then you keep figuring it out. It felt like someone had taken away my credit card and I was having to learn how to budget. You may decide you want to spend your time working as a neurosurgeon, but two months later, you may feel differently. Two months after that, you may want to learn to play the saxophone or devote yourself to the church. Death may be a one-time event, but living with terminal illness is a process.” (Kalanithi 160-161)

Beginning with what is happening, Kalanithi is having to decide whether he wants to finish his neurosurgery residency now that he knows about the brain tumor. During the time which this passage is written about, he was continuing to operate and see patients, and had been doing so with good surgical outcomes. At the same time however, he recognized that his values could change at any moment and he may decide that surgery is no longer of value to him in comparison to things like family or different hobbies he has pursued. We see this sense of unknowing in the passage when Kalanithi compared it to having his credit card taken away. In spending the rest of his life prior thinking he still had many years to come, he had never had to consider what the best use of his time is. Everything instead could be allocated to various life phases: time to focus on career, time to focus on family, time to focus on the things you enjoy. Now that he had that reliable future taken away though (or his credit card taken away), he had to relearn how to budget his remaining time.

Thinking then about how this change in perspective would affect Kalanithi’s life, it is likely that beyond feeling confused/conflicted he also would have felt sad about everything going on. Before his diagnosis he had his whole life in front of him, and now he is forced to sacrifice much of what he had planned (formally and informally) for himself. Furthermore, he would likely be sad about a range of different things. Firstly, he had just spent countless years of his life training to becoming a neurosurgeon. Now that this particular future has been taken away from him, one could expect that he would of course be upset to have trained so long only to barely finish his residency, but also upset because he then has to question whether he would have chosen the same grueling career path had he known that he only had ~40 years to live.

And beyond any bitterness he may feel surrounding his career, Kalanithi also likely mourned his future family. At the time of diagnosis he was already married to his wife Lucy, who later went on to write the epilogue of his book. It must have devastated him though to know that his future with her was now put on a timeline, just as they both were nearing a more relaxed and reliable point in their respective medical careers. And beyond his relationship with Lucy, we also see Kalanithi navigate the dilemma of whether he and Lucy should try to have a child or not, and what that would mean not only for Lucy's life after he passed but also for the child's. This was likely a frustrating situation for Kalanithi because there is no certain way he could (or even should) proceed.

Which leads into the fact that Kalanithi likely felt as frustrated as he did sad. He mentions in this passage that it was a process and that values were constantly changing. Throughout his diagnostic process he never fully knew what would come next because one week the tumor would be receding and his symptoms would be manageable, whereas another week there could be a new tumor and a new round of treatment. This uncertainty in what is coming next makes it even more difficult to determine what matters to you, because you're not fully sure of the context in which you're living. And since Kalanithi is a doctor, he is used to navigating these conversations with his patients, not navigating them himself.

This all goes to say that no one would blame Kalanithi for not being sure of what to do next in his life. And sure enough, his oncologist worked with him to ensure that if he did want to keep operating they would manage his symptoms as much as possible, but that if he wanted to stop working that would be okay too. She refused to discuss survival curves with him as well, encouraging him to focus on the present moment rather than constantly calculating what could or couldn't happen. Though it took a while, Kalanithi eventually came to realize that it was okay to not know what is coming next and that relatedly it is okay for his priorities and values to change as time goes on. We see this when he eventually decided to stop seeing patients and ultimately stop operating all together, and again when he and Lucy decided to go ahead with having a baby. And even later, Kalanithi had to learn how to let go of his traditional role as doctor and let his oncologist start making some of the decisions for him. In navigating these new spaces and letting go of his preconceived notions of what his life would look like, Kalanithi was able to spend his final years focused on the things that matter most to him.

Application when Teaching Narrative Medicine

As with each of the first two memoirs, the potential application of *When Breath Becomes Air* focuses on four different main themes: patient-centered care, navigating illness alongside patients, developing professionalism, and ensuring competence in future physicians. Each of these will again be briefly elaborated on as it relates to this particular memoir, and then a narrative medicine exercise will be paired alongside the theme. This will result in four final narrative medicine exercises for this memoir.

And because Kalanithi offers a unique insight into the patient perspective as someone who unexpectedly transitioned into the patient role himself, he is able to offer a different perspective on patient-centered care and navigating illness than the first two memoirs were able to. However, he also incorporates a deeper analysis of mortality because of his early career interests in literature and philosophy and this specialized focus allows him to potentially advocate for a different approach to professionalism. Finally, Kalanithi's passion for writing and literature may make it easier to apply certain aspects of his writing to theoretical narrative medicine exercises. Outside of these reasons however, *When Breath Becomes Air* is an important memoir for medical students to read because it helps students gain perspective on the fact that medicine and their career cannot be everything to them, because nothing is ever guaranteed.

This moves things into the first theme of patient-centered care. Because Kalanithi was first a physician and then later a patient, he had to quickly learn how to navigate two different sides of healthcare (sometimes both at once). Studying this particular memoir reminds students that anyone can be a patient, and it can happen to someone at any time in their life. And because all patients have their own levels of knowledge and unique previous experiences, when considering patient-centered care each patient will have to be approached and treated slightly differently. Part of good care is ensuring you are properly meeting a patient's needs, and more specifically meeting them wherever they are in this specific phase of their life. Patient-centered care by definition requires active participation of patients to ensure that treatment is aligned with their personal morals and needs. This leads into the ideas of patient education and health literacy. Patient education refers to the provision (by physicians and/or other providers) of information and support which is meant to help patients understand their health or illness and also learn to manage their health through establishing their own healthy habits. Health literacy on the other hand is the degree to which a patient is able to obtain but also understand information related to their health, ideally using said information to make informed decisions. High health literacy is ultimately the end goal of patient education, and patient-centered care has been shown to improve both the facilitation of patient education as well as increase a patient's health literacy (Altin and Stock 2016). And because every patient will come in with a different level of health literacy (Kalanithi as a neurosurgery resident for example would be in a completely different place than someone who had never heard of an oncologist), it is important that providers implement patient-centered care whenever possible.

In order to implement patient-centered care into narrative medicine curriculum in a way most relevant to Kalanithi's experience, students will practice close reading techniques themselves. This first exercise will focus on the same close reading passage I had pulled and analyzed from page 120 above (the second close reading passage). The instructor (or a student volunteer) will first read the passage aloud while everyone else listens without taking notes. The students will then be asked to read the passage silently to themselves a second time, this time taking notes on their initial reaction to the passage. After the second reading, students should be given 15-20 minutes to take general notes about the five close reading components above: plot, framing, form, temporal scaffolding, and desire. Once students have had adequate time to analyze the passage, they should get into small groups and discuss their annotations with each other. After discussion has slowed, the instructor should ask students to now discuss whether they think learning of the diagnosis would be different for Kalanithi than it would be for another patient because of Kalanithi's background in healthcare. If yes, why? If no, what makes his experience similar to every other patient? After enough time has passed for discussion, the instructor should lead the class in a debriefing focused on how patients have their own unique needs and what this means for patient-centered care.

Transitioning now into an examination of the patient's journey and this process of learning how to navigate their new diagnosis, physicians are responsible for helping patients to approach the process in whatever way will be the best possible for that particular patient. We see this clearly in *When Breath Becomes Air* as Kalanithi's oncologist, Emma, helps him to decide which treatment options are a best fit for him and his perceived lifestyle (for example, prioritizing a treatment plan that will allow him to continue operating). Similarly, Emma refuses to share survival rates or unnecessary prognostics with Kalanithi because she doesn't think these will be beneficial to his healthcare journey. She does however meet with him regularly, listen to his concerns and cares, and eventually offers to make decisions for him if he decides he has reached a point where he wants to only be a patient, not a doctor. Emma could have just as easily gave Kalanithi a treatment plan and a number to contact for emergencies and sent him on his way. But instead she was intentional in creating an open and safe relationship so that he felt comfortable coming to her and communicating his needs.

Similarly, in training future physicians it is important that they are also prepared to help their future patients determine what is most important to them. Afterall when considering different treatment options, patients will have their own specific needs and preferences depending on their personal morals and values. And in learning how to help others determine the morals that are most important to them, students must first learn to do it themselves. This exercise will therefore walk students through an example process of refining one's personal morals while also incorporating narrative medicine practices. Students will first be read the second reflective writing passage above talking about one's values changing (pulled from pages 160-161). This can be read to the class either by the instructor or by a student volunteer. After hearing the passage read a first time, students will be given five minutes to journal any values that are currently important to them. Students should not be given any additional guidance at this time. After the five minutes have passed, students should be placed in small groups and asked to share whatever they are comfortable with in their groups.

After 10-15 minutes of small group discussion, students will be led through the following exercise to help them further develop a list of their core values. There will be three different reflective prompts, and after each one students should be given 10 minutes to journal. The first prompt students should be asked is who it is they admire. Beyond only writing names of people however, they should also be asked to journal about what it is about these particular people that the student admires. This can be specific things the person has done, traits and qualities they possess, or anything else that the student thinks is important to note. After the 10 minutes have elapsed, students will be asked to reflect on times when they have decided to take action about something. This is meant to reflect on times that students have stood up for something (or someone), but if students think of other examples of taking action that is acceptable too. In brainstorming these different events, students should also reflect on the different feelings associated with the event, what specifically motivated them to take action, and what happened as a result. After these 10 minutes have elapsed, students will be led through the final prompt: times when they feel most at home/most authentic. This prompt is slightly more multifaceted, so students should be given more time to journal if the instructor thinks it would be beneficial. Students should be asked to journal here both about times when they felt uncomfortable and out of place, but also times when they felt comfortable and authentic. For the uncomfortable situations, students should elaborate on what was happening, who they were with, and how they felt. The same questions should be addressed when journaling about comfortable situations.

At the conclusion of these three prompts, instructors should take time to lead a class discussion on how these prompts help illustrate one's values. The first prompt, looking at admirable people, helps students to determine what it is they value through seeing common traits in people they look up to. The second prompt helps students see core values by showing what types of situations provoke them to take action. And the third prompt depicts one's personal values by showing students that comfortable situations can be indicative of alignment with your values while uncomfortable situations can show that something about the situation is clashing with your values. At the end of this exercise, students should be given a list of example core values and beliefs and asked to later narrow the list down to five or so core values that are most important to them. These should be values they already have, not values they wish to eventually emulate. In completing this exercise and refining a list of personal core values, students will be better prepared to help future patients refine their own core values by helping patient walk through similar thought exercises themselves (who do you admire, what provokes action, where are you comfortable, etc.).

When considering now what it means to be professional or exhibit professionalism, we often think of traits such as good communication or dressing neatly and modestly. It may spark thoughts of someone who is reliable and who holds themselves accountable for their actions. In the context of medicine, professionalism should also bring to mind someone who has a good foundation of clinical knowledge and adequate reasoning skills. But it should also provoke conversations about empathy and interpersonal skills, a desire to fully listen to a patient and their needs. Beyond dressing nicely or knowing the most common symptoms of a particular diagnosis, professionalism in medicine relies on helping patients heal. And though medicine often focuses on the physical aspect of healing, the mental, emotional, and psychological components play just as much of a role. It is important then that in considering professionalism, providers hear patients and work to figure out in turn what they can and should do for them to best help them. Professionalism does not start and end with the present patient encounter. But rather it begins far before then through creating a welcoming and safe environment for patients prior to their appointment and extends after the visit in ensuring that patients feel as if they can come back or reach out if they have any questions or concerns. Beyond even the scope of a patient visit however, professionalism also applies to physician training and the different habits and tendencies they are taught to practice, whether explicitly or implicitly.

One such example is seen in the first reflective writing passage above where Kalanithi is discussing his experience dissecting a cadaver. During my analysis of the passage, I briefly mentioned that some schools hold different ceremonies to recognize the lives of donors and honor the sacrifice they made to the future of science through donating their bodies to medicine. Though cadavers do not fit our traditional idea of what it means to be a patient, they still are being cared for and examined by future providers. Therefore it only makes sense that in training future physicians to be empathetic and professional, students also should be taught to respect the donors they are learning from. In a way, these donors are patients as well even if they may not fit our traditional idea of patients. The narrative medicine exercise for this theme reflects this idea of donors as patients by having students first reflect on their own previous experiences with cadavers and then brainstorm ways in which they can illustrate the humanity of cadavers. Note, if the students you are working with do not work with cadavers (whether through prosection or dissection), this exercise should be skipped.

First, students should be read the first reflective writing passage above (pulled from page 50). Students should then be put into small groups and asked to discuss their reactions to the passage, specifically discussing what it is they think Kalanithi learned from this encounter. After a few minutes of discussion, the instructor should facilitate a conversation on the humanity of patients and the fact that these cadavers were once people too, as well as the fact that they left lives and families behind. This conversation should also tie in Kalanithi's writing and the fact that losing sight of the donor as a person caused him to approach dissection differently. After this discussion, students should be given time to journal on their experiences working with cadavers and any feelings they have had during these experiences. Similarly, students should be asked to reflect on whether the class discussion has changed any of their preconceived notions of the cadavers they are (or were) working with. After this period of journaling, students should be asked to get into small groups and brainstorm ways that they could recognize and celebrate the humanity of the cadavers. If they are struggling to get started instructors can share a few ideas that other institutions have utilized, such as donor appreciation ceremonies, where they would read letters they wrote to donors and/or their families or read poems they had written. After brainstorming ideas in groups, students should be given time and asked to now creatively express their experiences with dissection/prosection. These reflections can take the form of a poem or short story, but also could be a drawing, sculpture, etc. Ideally these would be done outside of class on the student's own time, but would be brought back to class to share in groups on a later date. Once these creative projects have been shared, students should be given time to debrief and discuss their experiences.

Learning to recognize the humanity of cadavers helps students to see again how central narratives are to medicine. Afterall, most of the recognition of a donor's humanity is linked to their previous life and who they were before donating their body to medicine. When dissecting, students may note different scars or medical traits that indicate operations, conditions, or accidents prior to death. These things all go to form stories of who the donor was during their life. However, we also see narratives through *When Breath Becomes Air* because the entire memoir revolves around Kalanithi's experience as a patient and how he learned to face and navigate his own mortality. By having students study memoirs like this one, they can see the centrality and importance of narratives to medicine, including at times the relevance of their own stories.

Beyond simply the centrality of narratives and their ability to humanize patients, seeking out narratives in healthcare also helps providers to feel more competent by making medicine more bearable. For the final narrative medicine exercise, students should be read aloud the first close reading passage pulled from page 78. After listening to the passage, students should be asked to journal about a time they have felt overwhelmed since starting medical school. They should be asked to journal specifically about a time they were overwhelmed while working in the hospital or in a healthcare setting, but if students have not yet progressed enough to spend time in these settings they can discuss a different incident. However, they should be writing about something beyond the normal stress associated with mastering coursework. After 10-15 minutes of journaling, students should get into small groups to discuss their entries. Once all students have had a chance to share, the instructor should lead a class discussion on how it felt to share these incidents and hear about moments that were overwhelming to others. Ideally, students will feel a sense of comfort in knowing that other students have also had similar feelings of stress or overwhelmingness. And in seeing another aspect of narratives in medicine (being their own personal narratives alongside classmate's), students will see a different model of narrative competence.

Studying *When Breath Becomes Air* forces students to spend time considering not only mortality, but also their own personal values and what is most important to them. And in briefly including his own experiences as a medical student, Kalanithi's work potentially helps to start bridging the gap we often between patients and providers. Afterall, those these are two distinct roles, they do still overlap. We see this through Kalanithi in *When Breath Becomes Air*, but also in *What Doctors Feel* where we are reminded of the humanity of providers when looking at the many different emotions that physicians have been taught to ignore but should actually acknowledge. And we see it again in *Every Patient Tells a Story* when looking at the importance of creating a safe place for patients to fully share their own narratives, and how these narratives improve success of diagnosis. *When Breath Becomes Air* then serves as a final reminder of the value of a patient's story, showing what we stand to gain when we give patients an authentic chance to have a voice.

Discussion

Narrative medicine is a valuable complement to today's medical curriculum and can be further strengthened by expanding narrative medicine curriculum to include analysis of medical memoirs. This paper chose three different medical memoirs to begin illustrating the subgenre's potential contributions, *What Doctors Feel* by Danielle Ofri, *Every Patient Tells a Story* by Lisa Sanders, and *When Breath Becomes Air* by Paul Kalanithi. Each of these memoirs are beneficial in that they establish three distinct themes which are unique but also interrelated. Ofri's memoir creates a conversations about emotions and what it can mean as providers to recognize and honor them. Sanders' memoir then moves into a discussion of the unknown and what uncertainty looks like in various aspects of healthcare. And Kalanithi uses his memoir to focus on the idea of mortality.

Though these are three unique and personal focuses, it isn't hard to see how emotions, uncertainty, and mortality could be intertwined within healthcare. Afterall there are a lot of emotions associated with uncertainty, whether it be fear on a patient's side, frustration from a physician, confusion after symptoms are not adding up, devastation when it seems like no one has a good answer. And on the other hand, the presence of emotions in healthcare can create uncertainty of their own. We see this especially now during the COVID-19 pandemic when many physicians and providers are now facing an unprecedented level of burnout, burnout which many organizations and hospitals are unprepared to address. And many of these emotions (fear, frustration, confusion, devastation) are seen again when we consider mortality, whether it be our own or someone else's we care about. Beyond emotions though there is also the fact that mortality itself is associated with uncertainty, not only the uncertainty of what is coming next but also uncertainty as to how one should restructure their life when faced with their own mortality. These three themes continue to overlap and intertwine in a number of ways that would be interesting to analyze from a medical training perspective, but it is important at the same time to recognize the unique contributions that each memoir makes as its own distinct piece.

The three memoirs were originally chosen simply because each resonated with me as a reader. I believed that they conveyed important messages for both physicians and the wider healthcare community, and some aspects of each seemed to be written with a public audience in mind. What is interesting in comparing the three now though is first that they were all written relatively close together, each being published between 2010 and 2016. This period reflects both the growing popularity of medical memoirs in today's culture as introduced in the background of this thesis, as well as the trend of increasing transparency within healthcare as we continue to move away from a paternalistic healthcare model. Additionally, there is a clear distinction between Sanders' and Ofri's works where they are positioned as physicians, versus Kalanithi's memoir where though he is introduced as a physician he is primarily viewed as patient. This difference in speaker stood out to me even more than just the simple contrast in roles because much of society depicts men as physicians and women as other healthcare professionals (i.e. nurses or physician associates). It was nice then to analyze memoirs in which this dichotomy was almost switched, as most of the medical memoirs I have read throughout undergrad have indeed been written by men.

What these three memoirs all have in common however, beyond their similarity in timeline, is their emphasis on narratives and the role that stories can play in medicine and in someone's life. The beginning of the thesis focused on the idea of narrative competence, or the capability to listen to and interpret patient stories as well as ability to create and share patient's stories in a way that is understandable to patients while also beneficial to others involved in care. Narrative competence means one has mastered the process of hearing and understanding stories as well as the process of telling stories. And though this concept of narrative competence is important, it can be dangerous to approach stories with the idea of mastery. Afterall, mastery paints pictures of a content-oriented learning rather than a process-oriented one. Ultimately, stories and narratives are unique to the person telling them, and will never be fully understood by those who are listening. Even if we have heard a similar story many times over, a patient's story is still in some ways unique to that individual person. We must be aware that a story is not simply a fact to be memorized, that stories develop and can be engaged with. Every story holds its own idiosyncrasies and motivations, things that make it specific to that particular individual.

This suggests than that instead of expecting students to reach narrative competence, we should lead them towards narrative humility.

Where narrative competence relies on the mastery of stories, narrative humility recognizes stories as a dynamic relationship between the speaker and audience. A patient's story first belongs to them, and it is only through **their** sharing of **their** personal story that providers can come to even begin understanding what the patient is going through. This does not go to say that the audience does not play a part in the story, as narrative humility says that we as listeners have a responsibility to evaluate: "our own role in the story, our expectations of the story, our responsibilities to the story, and our identifications with the story" (DasGupta 2008). Here DasGupta reflects on the fact that oftentimes a story we hear will remind us of other stories we've come into contact with. And because narrative humility relies on the story creating a dynamic relationship, the audience must engage in self-reflection otherwise the experience remains shallow and insincere. This allows the conversation to become two-sided which can help mediate the feelings of vulnerability often associated with sharing your story with someone else. Because providers are in turn engaging with the patient's story and helping guide it through conversation, the experience becomes less like an interrogation and more like a relationship.

We see this arc from competence to humility in other areas as well. In this thesis in particular, we see it as a shift from seeking cultural competence to training cultural humility and a shift from structural competence to structural humility. Cultural humility relies on the idea of continuously learning from patients (or people in general) about their personal ideas and beliefs, while also remaining aware of one's own culture and how it may affect your opinions or reactions. Structural humility on the other hand requires physicians to acknowledge when they are unsure of how to address or resolve a particular structural issue, and instead work with others in the community who are better equipped to help. Both of these ideas then reflect the same idea from narrative humility of never truly mastering a topic even when educated, but rather being in a lifelong process of learning.

What is interesting to consider here though, particularly in the case of cultural competence and humility, is that narrative humility could allow for avoidance of the "othering" that cultural competency sometimes creates. Because cultural competency relies on the idea of learning how to navigate unfamiliar cultural practices or beliefs, it establishes patients as something different while also uniform. These patients are labeled unlike the provider, but homogenous in that all patients from a particular culture must be the same. By instead transitioning to the idea of narrative humility, the idea of "other" is celebrated as unique rather than stereotyped. It is still beneficial for providers to have at least a general understanding of different cultures, but regardless of culture patients still have their own personal story to tell. Furthermore, narrative humility encompasses differences in religion, gender, socioeconomic classes, and more, rather than only cultural differences.

The main point of the discussion then is this transition from competence to humility and how a shift in focus can improve the way we approach both education models and general career development. However, this can be taken a step further to emphasize the importance of narrative humility not only as a step up from narrative competence, but also as a potential replacement for empathy. I believe empathy has become somewhat of a buzzword in healthcare, but also in society as a whole. And though it is an important concept, it also is an idea that could be more effective if refined. Empathy by definition refers to being able to sense and understand someone else's feelings, relying on a second-person approach. This then means that empathy relies on one's own lived experiences and identities and will be easier as well as more effective in some situations than others. Narrative humility on the other hand relies on the understanding that the patient’s story belongs to the patient. And though as a listener we can try to understand it and relate to it, at the end of the day it is still the patient’s story. This also approaches a power dynamic in medicine where empathy places power in the provider’s hands as they determine to what degree they can invest in the patient’s experience. With narrative humility however, providers are recognizing that patients have ownership of their narrative and their experiences simply because it is theirs’s. Because empathy is subjective and yet becoming increasingly popular, narrative humility could be a suitable replacement as healthcare continues to progress and (hopefully) become more patient-centered.

A good place to end the discussion is with an acknowledgement of the limitations I faced while working on this thesis. The largest of which is the fact that though this thesis focuses on application of medical memoirs to medical school curriculums, I am writing as an undergraduate student. This means that I do not have the perspective nor experience necessary to determine what is truly “valuable” for future medical students. As someone who is going into medicine and has spent time studying the humanities I can point out traits and lessons that I think could be important for future physicians to develop, but ultimately I hold many different biases that I may or may not be aware of. In a real-life application of medical memoirs within narrative medicine, the instructors or physicians would be tasked with choosing their own narratives to analyze and their own passages to center exercises around. I provided many examples of drills in this thesis that I believe could be implemented within a classroom setting, but that is not to say someone with further training will agree with the passages I pulled, the exercises I developed alongside them, nor my personal interpretation of passages. And though this is a necessary limitation to acknowledge, one must also recognize that because much of narrative medicine is personal and intimate, differences in style or opinion is to be expected. However, instructors should select memoirs/exercises that specifically address the different skills or lessons they wish to develop in students. These may be similar to the ones I chose (emotions, uncertainty, and mortality), but they may not.

Relatedly, when considering potential limitations of this work, it is also important to evaluate the limitations of medical memoirs as a subgenre. While preparing to write this thesis I read many different medical memoirs, drafting a list of 15-20 that I worked my way through over a summer. As I began reading different ones however, I found a reccurring arc in physicians' stories where they would describe their training as long and tedious and barely survivable. They told different stories of the horrible things they had endured and how they almost quit at one point or another, incorporating humor at some points but not always. As the memoirs came to an end, they concluded with a happy anecdote of how great their life has become and how the gruesome years of training were worth it. Many of these memoirs paint a bleak medical training as a necessary evil, a mere steppingstone for every future provider to endure. Personally though, I don't believe that this is a healthy or even necessary picture to paint for the next generation of physicians. I believe that we should work to made medicine more accessible and more accommodating, so that not only are we training competent physicians but also physicians who are happy and resistant to burnout and immense mental/emotional stress. Because of this, I believe that educators have to be careful in choosing which medical memoirs to use within their own narrative medicine curriculum. The three that I chose all taught me valuable lessons about healthcare and what it means to be a physician, but they did so without also demoralizing trainees and encouraging poor work-life balance. And though there are many physician memoirs which do have good messages even while promoting a less than healthy lifestyle (intentionally or not), these memoirs would potentially be more effective as a book students choose to read for fun during their free time rather than incorporated into narrative medicine.

Conclusion

Medical memoirs have a lot to contribute to the training of future physicians, particularly when implemented alongside narrative medicine techniques such as close reading and reflective writhing. A narrative medicine-focused analysis of each of the three medical memoirs therefore cultivates more successful providers through an increased focus on patient-centered care, the process of navigating illness alongside patients, professionalism, and physician competence (later reworked to the idea of humility). Furthermore, the memoirs chosen for this thesis introduced three memoir-specific themes relevant to the future of medicine: *What Doctors Feel* started a conversation on the relevance of emotions to medicine, *Every Patient Tells a Story* illustrated the role of uncertainty, and *When Breath Becomes Air* highlighted mortality. Each of these topics are often avoided in medicine, but shouldn't be if we want to ensure we are fully preparing students for a future in healthcare. An increased focus on the medical humanities and narrative medicine specifically can help address this gap.

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