



Using Narrative Medicine to Build Community Across the Health Professions and Foster Self-Care



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A B S T R A C T

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Narrative medicine is a multidisciplinary field of inquiry and practice based on the premise that medical care takes place in the context of stories: the stories patients tell their providers, the stories providers tell each other, and the stories providers tell themselves about the work they do. Research on physicians and medical students suggests that training in narrative medicine conveys benefits, such as improved communication skills, personal growth, and job satisfaction. The role of narrative medicine in inter-professional groups has been less explored. In 2014, we started an interprofessional narrative medicine program in the Children's Center of the Johns Hopkins Hospital called AfterWards. Through literature, art, and writing, we endeavored to nurture empathy, encourage reflective practice, and build community among a diverse group of health care providers: nurses, social workers, attending physicians, residents, fellows, and child life specialists. The program meets monthly and is open to all on a volunteer drop-in basis. After 18 months, we conducted interviews of a purposeful sample of our attendees for reasons of quality improvement and to assess the program's impact. Our findings suggest that narrative medicine might have unique benefits for interprofessional teams. In a hospital environment that is often hierarchical and siloed, attending a narrative medicine group reduces isolation among health care providers, makes them feel equally valued, and provides a platform to hear diverse perspectives. By moderating the stress that arises from the emotional labor of hospital work, narrative medicine may also enhance self-care. Here, we report on our program's structure, summarize findings from our qualitative study, and provide perspectives from two nursing participants.

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Background

In the late 20th century, a group of physicians, philosophers, and literary scholars at the Columbia University College of Physicians and Surgeons, led by internist and literary scholar Rita Charon, announced the formation of a new discipline called narrative medicine. In many ways, narrative medicine was an outgrowth of the literature and medicine and medical humanities courses that had existed in medical schools ever since the 1970s (Jones, 2013). Historically, physicians were expected to be both civilized and cultivated and appreciating literature fit into that mold. But Charon distinguished her field by positing that the study of narrative, as represented by reading great literature and writing narratives, was

more than a civilizing veneer: it was an essential clinical skill. The benefits associated with achieving what she terms “narrative competency” included enhanced empathy and reflection, increased sensitivity to emotional or cultural aspects of delivering care, and appreciation of the singular humanity of the individual patient (Charon, 2006). Narrative medicine would teach health care practitioners to tolerate uncertainty, appreciate multiple perspectives, and deliver care in a more ethical manner (Miller, Balmer, Hermann, Graham, & Charon, 2014). The focus of narrative medicine research has been primarily on physicians and medical students and not on how narrative practice might impact nurses or other members of a health care team (Barber & Moreno-Leguizamon, 2017).

Researchers have also left unexplored the question of whether narrative medicine may play a role in reducing the stress that arises from the emotional labor of hospital work. In 1983, sociologist Arlie Hochschild coined the term emotional labor to describe the kind of work people do in organizations that require face-to-face or voice-

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to-voice interactions with others and that govern their display of feeling (Hochschild, 2012). Since then, emotional labor has been a topic of some interest in nursing (Smith, 1992). It has been less explored among physicians, although the imperative for doctors to hide or disguise their true feelings has been enshrined for at least a century, ever since William Osler, the father of modern medicine, identified *aequanimitas*, or imperturbability and self-control in moments of adversity, demonstrated by control of one's facial nerves and muscles, as a physician's key characteristic (Bryan, 2006).

When outer expressions do not conform to inner feelings, emotional dissonance may arise, especially in emotionally challenging situations. Emotional dissonance is a leading contributor to burnout (Andela & Truchot, 2017), which is occurring at alarming rates among both physicians and nurses (Drybye et al., 2014; Erickson & Grove, 2007). Because reading, literature and writing personal narratives promote the kind of authentic, reflective experiences that lead to the expression of the true self, narrative medicine may play a role in alleviating the emotional dissonance that arises from hospital work (Dutton, 2003; Grandey, Foo, Groth, & Goodwin, 2012).

Program description

Early in 2014, we started an interprofessional program in narrative medicine in the Children's Center of the Johns Hopkins Hospital called AfterWards. Without funding or protected time for participants, we decided to hold sessions monthly on a voluntary drop-in basis. Scheduling presented particular difficulties. With attending doctors, nurses, residents, and others working different schedules and shifts, it was difficult to come up with a time that would be available to all. We settled on a 5:30 to 6:30 pm slot—"after wards"—in the hopes of capturing people either at the end or beginning of a shift.

Structuring our program presented additional challenges. Narrative medicine is far from monolithic, and approaches vary widely. We decided to model our program, with some modifications, on the format taught in narrative medicine workshops at Columbia University. Each AfterWards session consists of three parts: the discussion of a piece of literature or art with a medical theme, writing based on a prompt, and shared reflection (Figure 1). We have read, for example, W.H. Auden's poem "Surgical Ward" and talked about bearing witness to suffering. We interpret narrative broadly and include music, photography, film clips, painting, and sculpture because these forms of art tell stories. We have watched

Kendrick Lamar's music video "i" to talk about social pathologies and viewed paintings by Frida Kahlo to discuss coping with pain (Table 1).

Methods

After 18 months, we conducted a qualitative study of our program for the purposes of quality improvement and to better understand its impact. We sought a purposeful sample: that is, we sought participants from various professional groups, at different levels of training, who attended the program once or multiple times to capture diverse and deviant viewpoints. We chose a qualitative approach because we wanted to elucidate complex concepts that are not well described quantitatively, such as interprofessional relationships, the value our participants placed in their work as individuals and among teams, and the ways that narrative informed their practices. Our study protocol was reviewed and given exempt status by the Johns Hopkins Institutional Review Board.

Results

At the time that we conducted our study, 126 caregivers had attended AfterWards sessions, of which 32% were medical students, residents, or fellows; 29% were attending physicians; 12% were nurses or nursing students; 10% were social workers; 6% were child life specialists; and 11% were others, such as chaplains, administrators, and teachers. We administered semistructured interviews to 14 caregivers, some of whom had attended AfterWards only once, some as many as nine times, for an average of three times. Interviewees included three residents, three social workers, four attending physicians, one child life specialist, one fellow, and two nurses. Interviews lasted 31 min on average.

Building Community by Flattening the Hierarchy

Our participants particularly valued the interdisciplinary nature of AfterWards. They found in AfterWards a unique space in the hospital setting where diverse professionals can gather together and engage in broad open-ended conversations about their personal experiences and clinical practices. Art, literature, and writing level the playing field and set the tone across professions (e.g., between nurses and physicians) and levels of training (e.g., between residents and faculty). Normally, a child life specialist commented that she was not even allowed to sit at the same table as the doctors:

[W]e don't sit at the white table. So it was nice to like be at the table with them and not on like, you know, the outskirts of the room.

A resident noted that the program overturns the usual hierarchy that governs how people interact at work:

[W]e're coming to the table ... not necessarily as equals but like everyone coming with an opinion, in a structure where usually we're used to this hierarchical, like, you write the orders, and you do the orders, and you're the attending. So ... some of that, I think, gets minimized in that room.

It gives people insight into each other's roles on the team. As a nurse said:

[Y]ou get to know each other better when you do it like that. When you have social workers with physicians and chaplains and whoever, you get to like understand different people's point of views ... which I think is really important.

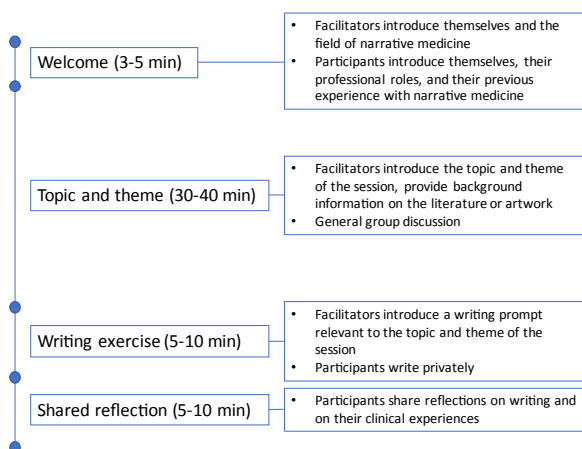


Figure 1. Structure of an AfterWards session.

Table 1
Selected topics, themes, and writing prompts

Topic	Theme	Writing prompt
"The Man Who Planted Trees," film by Frédéric Back "The Doctor," painting by Sir Luke Fildes "Rehab," music video by Amy Winehouse	Gratitude Being present Resisting treatment	Write about a time you felt gratitude or hope in your clinical work Write about a time you felt particularly present for a patient Write about someone you know who has resisted treatment from his or her point of view
"Doctors Don't Do Poop" memoir by Theresa Brown "What the Doctor Said," poem by Raymond Carver	Valuing the work we do Delivering bad news	Write about someone whose work you value Write about a time you delivered bad news to a patient or a family

The result, an attending remarked, led to new insights in patient care: "I think that everybody's perspective is important. I think they add a tremendous amount. Often they see things that we don't see." The diversity of the program led many to a deepened appreciation of the complexity of their patients. In a child life specialist's words: "I think just the conversations are what stick with me the most, of just seeing a patient ... on multiple different levels." A social worker simply found listening to diverse viewpoints personally rewarding:

I find that with AfterWards, too, you know, being able to meet somebody that you never met and hear their voice, and hear how they're experiencing this particular event that we're going through is very powerful.

Gathering together to discuss art, literature, and writing, we learned, transformed how people on health care teams related to one another. "I think actually that's one of the great things about it," an attending physician concluded. "It is a community building exercise ... which is wonderful. I mean it's something that was missing I think here."

The result, our participants confirmed, is a deeper connection to each individual patient and a renewed commitment to family centered care. Narrative training, a nurse commented:

is like the epitome of family-centered care, I think, because you're ... really understanding the patient and the family and the social situation. And then just hearing a story and then being able to ... individualize each patient and their situation.

Self-Care

Many participants in our study reported difficulties expressing their feelings at work. An attending physician recognized that the presence of faculty had an intimidating effect on other members of the team: "People may not feel safe if there's too many faculty there to say some of the things." Describing her work environment, a social worker said, "I don't feel comfortable coming in and expressing my frustrations, or my concerns about things." A child life specialist spoke about how the work culture inhibited expression of thoughts and feelings:

I mean we are kind of exposed to the weirdest parts of life that you don't think you're ever going to be dealing with, and then you're expected to come back to work the next day or see the next patient and forget about that.

Work at the hospital is emotionally stressful, and the effort of managing emotions takes a toll. In a nurse's words:

Because if you don't, then I feel like you get burnt out. You got to let it out somehow, because you see things, and you hear things, and we're part of really high emotional, intense things.

The hectic, fast pace of hospital work, a social worker reported, did not give her time to process her emotions: "I need to plough through my day and get stuff done. And I can't worry right now about how this is affecting me."

In AfterWards, participants found the opportunity to reflect on their inner emotions. As a social worker reported:

And this is just a nice way to be able to step back and think, well, bigger picture, what's going on here, you know. For me it's like a little retreat, and way to focus on what's happening for me internally, because I don't, there are so many times where I am stressed out, but I don't have time to process that.

Another social worker found that narrative medicine provided participants with a safe space to express their thoughts and feelings:

I think this is one of the little gems that very few people know about, because I've seen people come in and be able to express themselves, and be able to share emotionally, and feel very safe doing it.

In a nurse's words:

So different people, it'll hit them in different ways. And you see different things, and I just feel like people being able to be open and vulnerable and like it being a safe space for us to talk about our practice in different forms, which I think is really important and really special about it.

Art, literature, and writing are key to creating a safe space where participants connect in valuable ways with themselves and others. "I like the idea that we use art," a social worker noted, "because I think art is an expression of the human spirit." A nurse found that the program promoted personal growth:

The people that I've been around at this group very much are interested in growing and learning more about something, art or literature or whatever the topic of the day is, or learning more about other people.

Narrative medicine, we have learned, can help alleviate the emotional dissonance of hospital work. AfterWards gives our participants an opportunity to reflect, openly express thoughts and feelings, create meaningful connections with others, and achieve personal growth—all important aspects of self-care. It leads providers to reconnect with the meaning and value of the work they do. As a resident reported:

The concept of feeling relaxed when I leave, is like this, just like a bigger, a sense of a bigger purpose ... not just as a resident, but like this happens to be the job that I do, but, um, then I'm just like a person in the world who can do good things.

Conclusions and next steps

Our findings demonstrate that narrative medicine can play a role in building community among diverse health care providers and promoting self-care. Our results are limited by the small size of our sample, the self-selected nature of our AfterWards participants (as the program is voluntary), and the lack of a comparator group. In future studies, applying a mixed-methods approach by adding quantitative measures of burnout, empathy, and emotional dissonance, would be helpful, as would be evaluating narrative medicine programs like AfterWards at other hospitals.

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Sidebar 1

Amanda Mein, MSN, MEd, RN, Nursing Student

As nurses, we spend a lot of time with patients. A LOT. This time allows us to perform vital assessments and alert the care team to subtle changes in the patient's condition. Great nurses thoroughly assess physical conditions while listening to the patient's story about who he is and what he values. The husband, uncle, cat-loving, beach-walking, and vegetarian patient is a person. Every month, AfterWards reminds health care providers that a patient has more than his illness, that he has a story which, if we take time to listen and understand, should impact his care.

Recently, I cared for a young man whose cancer was defeating every treatment attempt. He expressed to me his fears about dying and what that experience would entail. What would happen? What if he signed do not resuscitate papers and then changed his mind? What if he could no longer tell us his wishes? What if his family disagreed with his decisions? I was a nursing student, and he was the first patient to ask me such pointed questions. I was terrified of saying the wrong thing. So although I cared for and continually assessed his physical needs, I also told him something I knew would help him focus on something joyful: that I would do everything I could to help him enjoy a bowl of watermelon.

I had met this patient about 6 weeks prior during a separate admission. With narrative medicine in mind, I try to learn personal information about my patients so I can understand their story and how their diagnosis really impacts their lives. Pain, nausea, fever—we anticipate and try to alleviate these with every patient. But when we know the person with whom we are working, we can help them feel more human during a health crisis. We can give wedding dress opinions, talk about rebuilding cars, and provide a stationary bike for daily exercise. When we understand a person's values and learn their stories, we become better care providers who are able to look beyond the disease and see a person.

In the case of this particular patient, he loved food. He and his grandmother love spending time together in the kitchen: seafood and sauerkraut are two favorites to cook. The young man took great delight in sharing with me his favorite recipes and

encouraging me to spend more time in the kitchen. So when he was readmitted and afraid, we did not focus on his disease. His cancer was powerful, but it was not him. While I assessed his physical condition, I asked what he planned to eat as soon as we had his pain under control. The rest of the night we made cold watermelon our new goal.

Sidebar 2

Emily Hoppe, MSN, PMHNP-BC, Nurse Practitioner

Before becoming a nurse practitioner, I had a wonderful job as a staff nurse on an inpatient unit for children with intellectual disabilities and autism spectrum disorders who were experiencing severe behavioral problems. The nurses on the unit love the patients, who would stay with us for about 6 months. We would come back from the floor to the nurses' station to share stories of how a patient had tried to make us laugh or told us off. Sharing these stories helped us reflect on our patients' lived experience, strengthened our bonds with one another, and enriched the experience of providing care.

Now I work as a psychiatric-mental health nurse practitioner in an outpatient clinic. I continue to feel connected to patients' stories, but I miss the camaraderie of the nurses' station. At AfterWards, I have found that camaraderie again. We share stories of providing care and find fellowship in our shared experiences as clinicians. We also explore art, music, and literature as an integral part of who we and our patients are as human beings.

At AfterWards, we have the opportunity to examine *how* we see, hear, and experience patient encounters. By doing this, we push ourselves to a deeper practice of observation, perception, and connection.

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