The Necessity of Narrative: Linking Literature and Health Care in Higher Education Curricula

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Abstract

As programs in medical humanities continue to emerge in the curricula of institutions of higher education, the most prominent thread connecting medical and humanities disciplines has been "narrative medicine," which is a prominent presence in numerous previously established programs across the United States, including Columbia, NYU, Oregon State, Baylor and Stanford Universities (to identify some of the most prominent programs in this rapidly expanding field). One consensus view emerges in unambiguous fashion from such a survey of programs and courses: the necessity of narrative to any program or course of study. Our paper will initially trace the rise of narrative as the sought skillset in such collaborative and trans-disciplinary programs, contextualizing our thoughts in innovative activities currently at work within and without the university. The subsequent sections of our paper establish the evolving nature of narrative as the spinal structure for medical humanities programs, identify potential weaknesses in current approaches, and explore a somewhat hidden dimension of narrative research emerging from neurological studies. The paper will close with collaborations and innovations designed to connect both internal programs to external entities, although the largest goal of our presentation is to stimulate response and subsequent discussion. As Arizona State University intensifies its relationship with the Mayo Clinic (Scottsdale), the trans-disciplinary element of narrative in all its dimensions has assumed the preliminary core for this collaboration and the projected collaboration of the College of Nursing & Health Innovation, the College of Health Solutions, and the Department of English.

Introduction

Between 2013 and 2015, medical education will undergo two significant shifts in the admissions process. First, the Medical College Admissions Test (MCAT) will change in 2015, the most significant overhaul since 1991 (Brenner, 2013). The MCAT includes two revised sections that evaluate competencies in the humanities and social science, and social and cultural determinants of health (Kirch, Mitchell, Ast, 2013). One of the signals for revision was the emphasis on the triple aim in health care systems: the provision of high-quality health care for individuals, improving population health, and reducing overall health care costs (Mahon, Henderson, Kirch, 2013). Team-based care, interprofessionalism, cultural competence, and communication are vital to the success of the triple aim. Integrating these concepts early helps solidify success, yet all medical schools are challenged with limitations in time, space and human resources (Mahon, Henderson, Kirch, 2013).

Second, in an effort to assess the overall preparation of medical school matriculants, the Association of American Medical Colleges (AAMC) recommended a shift to holistic admissions, or holistic review (Mahon, Henderson, Kirch, 2013). In 2013, there were 48,010 applicants to allopathic medical school in the U.S. Of those, 21,070 were accepted and 20,055 matriculated (AAMC, 2013). Given the breadth and depth of the changes in the applications and admissions processes, medical schools are pressured to identify future physicians who will best meet the needs of the U.S. patient population. Further challenging the traditional health care paradigm is the momentum to incorporate interprofessionalism, systems thinking, and patient safety and quality improvement. Through holistic review, medical schools may be more effective in evaluating candidate professionalism, communication and patient-physician interaction.

Another purpose of holistic review is to enhance population health through a more diverse health care pipeline (Mahon, Henderson, Kirch, 2013).

Narrative medicine integrates these competencies while enriching the experience for both the patient and (future) physician. Thus, modifications in the MCAT and holistic review serve as a sign for a shift in direction by governing boards and as a springboard for discussion on innovative curricular methods to better prepare medical and health professionals, to identify competencies necessary to prepare students for success in medicine and health professions, and to assess critically the importance of humanities within medical practices and for long-term health.

Integrating Humanities in Medicine

Narrative medicine can be used to integrate themes in medical humanities with professionalism, self-assessment, and patient safety and quality improvement. Narrative medicine illustrates the experience shared by a patient with his/her physician or health care provider (Charon, 2001). The narrative is a source of information, but also a method of establishing trust, intimacy, and reflection (Charon, 2001; Ofri, 2014). If established properly, the relationship leads to diagnostic and therapeutic breakthroughs; if not, the relationship may be viewed as transactional in nature and thus, not as rich or meaningful. Narrative relationships may also be shared between the physician-self, physician-colleague, and physician-public (Charon, 2001). Introducing concepts in narrative medicine within didactic coursework (i.e. medical ethics) but exploring other relationships throughout the medical education continuum provides medical educators the opportunity to continually revisit patient safety, professionalism and team-based practice (see Table 1).

As reflected in the published research, the separation between medicine and the humanities recently bridged was actually an already established entrant into what became a broader split between the sciences and the humanities, with the former growing in complexity across the 19th Century (Simon 2012). By the opening of the 20th Century the former entanglements between the arts and humanities and medicine were unwoven through thorough professionalization and increased specialization, and this alienation of natural allies in the struggle to ease suffering and promote wellness across the 19th Century was famously articulated in C. P. Snow's "Two Cultures" lecture (1953). As also reflected in the published research, the new-found alignment between the humanities and medicine did not occur without considerable institutional resistance—as S. W. Bloom's summative history suggests (1988). As noted above, the shift in testing and credentialing alike have shifted to incorporate medical humanities generally and narrative practices particularly into their expectations for applicants to and outcomes for graduates training for medicine and healthcare professions (McManus 1995). However, as F. D. Lester argues, the presence of medical humanities programs within medical schools and in higher education curricula ought not be construed as perennial and should be viewed as "precarious" (Lester 2002).

The strength of Lester's analysis, which is organized around perennial questions, highlights one of the most crucial contributions that the humanities can bring to healthcare training and practice—a robust interrogative mode that operates within those who practice and is articulated to those receive care. This questioning mode is shared by both the humanities and the sciences, since both disciplines tend to embrace critical analysis as its primary methodological tool. Some questions operate intra-personally: "Where do I fit in the profession?" Some operate experimentally and theoretically: "What role does language play in health care?" Others address cultural conditions and social contexts for medicine: "What are the connections between gender and health care?" Still others ask therapeutic questions: "How does one tell real versus imaginary patient-provider bonding?" Given the energetic embrace of medical humanities programs since the 1970s, the query that directs our efforts at ASU remains, not surprisingly, remains: "What are the challenges to integrating/adopting elements of narrative medicine as the organizational principle while preserving its ability to operate in transdisciplinary way?"

Integrating Language and Medicine

Before turning to the varied ways that current curricula incorporate the humanities to cultivate analytic and narrative skills, two quick critical diversions (into the late-19th and early 21st centuries) seem justified to establish shared provenance for the humanities and medicine. First, consideration of Freud's fairly systematic creation of psychoanalytic method is appropriate, since his proposed path into a patient's *psyche* was through "narrative and interpretation" and the successful outcome of that foray was termed "the talking cure." The typical analytic scene is always one of instruction and can offer interesting prospects for the integration of language and medicine as the platform for enhanced communication, shared scrutiny of both diagnosis and symptoms of illness, and honed rhetorical and narrative skills. His published works, while often focused on important case studies (i.e. Dora or the Wolf Man), were just as often anthropological or artistic analyses or hermeneutic encounters with literary or religious works. For Freud, there is no treatment without dialogic exchange between analyst and analysand; for Freud, language is already deeply implicated in all relations, and discourse analysis often yields significant insights into subconscious and unconscious structures made manifest during discursive therapeutic sessions—with dream narratives serving, in his well-known construct, as "the royal road" to the unconscious (Freud 1899).

Freud's own dream was to establish psychoanalysis as a science in its own right, and linguistic constructions and interpretations were essential to the method. Of course, Freud was constructing his field in the last half of the 19th Century (*Interpretation of Dreams* published in 1899), yet more contemporary instrumental interventions have arrived at a similar recognition of the beneficial outcomes for cultivation of trans-sensory narrative experience. Neurological studies of elementary age children have found that "greater frontal and supramarginal gyrus (BA 40) activation in narrative comprehension at the age of 5-7 years old was associated with better word reading and reading comprehension scores at the age of 11" (Horwitz, Vannest, Holland 2013). Other researchers have confirmed the fundamental force narrative exerts in the creation of new and modification of existing neural networks, with one group "compar[ing] languages that differ maximally in their mode of expression yet share the same core linguistic properties in order to differentiate the stages of discourse production." The studies also discovered that "common neural architecture [is] extended [by narrative apprehension] beyond the classical language areas and included extrasylvian regions in both right and left hemispheres" (Braun, Guillemin, Hosey and Varga 2000). Both the psychoanalytic and neuroscientific enterprises have established "narrative" as a fundamental condition of the human, whether gauged experientially or experimentally, and this realization itself is articulated as interconnected experiential and experimental forms of narrative expression, which have helped shape curricular in the best-known programs in medical humanities and narrative medicine.

Current Curricular Models

Time excludes the opportunity to survey the proliferation of such curricula, and we have opted to look briefly at three degree programs capable of directing the development of instructional links for our university's projected transdisciplinary medical humanities/narrative medicine program. These programs (and others not referenced here) provide elements that will impact our construction of a curriculum designed to address the growing need for expertise in narrative medicine as we enter a particularly energetic phase of collaboration with community partners, whether the Mayo Clinic in Scottsdale (where the English Department already has a palliative care program) or Hospice of the Valley (the direction for the next expansion of the department's efforts.

The practice and research supporting this instructional effort have established narrative medicine as the most common and important feature for the medical humanities, and the previously cited work of Rita Charon (Executive Director of the Narrative Medicine at the Columbia University Medical Center) sets the standard for the cultivation of "narrative competence" as a vehicle to "recognize, absorb, metabolize,

interpret, and be moved by stories of illness" and extends pedagogical for all healthcare professions, including "physicians, nurses, social workers, mental health professionals, chaplains, social workers [and] academics" (CUMC NM mission statement). The course of study for this MS program offers the most extended and extensive group of courses in our survey, ranging from the inaugural "Foundations in Narrative Medicine" (NMED K4020) through "Illness Narratives" (NMED K4025) and "Methods in Narrative Medicine" (NMED K4110) to "Writing Narrative Medicine" (NMED K4350).

While narrative medicine tends to be the most prominent technique to emerge from medical humanities programs, the focus on bioethics continues to define such programs as well (and most programs are structured around these two dimensions). The Program in Arts, Humanities, and Medicine at Stanford University, which awards the MD with sub-concentrations in any and all these disciplines, is the best known and in some ways the most 'open', since its two foundational courses—Medical Humanities and the Arts (INDE 212) and "Biomedical Ethics" (PEDS 251) lead into separate tracks, yet both paths to the sought degree (MD) use "cross-disciplinary methods" to achieve its sought end by exploring the stratified layers within medical and healthcare practices and "the moral, social, and humanistic dimensions of medicine and bioethical science" (Mission Statement).

While the two prior programs probe the relevance of the arts and humanities for those already within medical centers and schools, the last program (Baylor University's BA in Medical Humanities) will quite likely serve as the preliminary model for the initial efforts of ASU, since it is designed to prepare students for a wide range of opportunities in the field of healthcare by immersing them in "a truly transformational [interdisciplinary] education for students seeking careers in healthcare and the medical arts under the guidance of faculty . . . committed to compelling scholarship and dedicated to service" (Mission Statement). At the preliminary level, the degree plan identifies 18 "core courses" and requires 15 credit hours drawn from that core, and students can, upon completion of the core requirements, must complete an additional 15 credits drawn from a dizzying array of courses offered by 11 departments (although only six hours can be from one group of courses). The Baylor BA degree has flexibility of design, involves a wide range of disciplinary units involved in interdisciplinary studies, offers opportunities for student-driven concentrations to emerge in their studies, and even provides a path for an undergraduate minor.

Conclusion: Future Directions

Drawing upon the best practices from these programs, the evolving efforts at ASU seek to design an interdisciplinary curriculum positioned at the coincidence of changing health care innovations to provide opportunities for pre-medical and medical educators to enrich students' experiences by integrating humanities-based education into their studies and thereby better preparing them for the personal and professional challenges of medical practice. This is already reflected among physicians and health systems researchers, as the American College of Emergency Physicians and Health Affairs have added journal departments focused on the Medical Humanities.

Although interprofessional education and practice are gaining traction within all health care disciplines, implementing these curricula presents its own challenges within the academic health care setting, as cultural barriers, logistical challenges, and the need for human and financial resources compete for attention. By working across disciplines at Arizona State University (ASU) and with community partners and employers in health and health care, the College of Nursing & Health Innovation, the College of Health Solutions and the Department of English seek to drive change in health education, research, and policy. Arizona State University is thus at the forefront of developing innovative curricula to prepare future members of the health care team by providing students from multiple disciplines the opportunity to learn from, with, and about one another in order to improve patient outcomes and decrease costs. The goal for the emergent program on medical humanities is straightforward yet nonetheless challenging: the cultivation of analytic qualities within which to better interpret description of symptoms by ailing patients

and healthcare practitioners, and the development of discursive abilities to craft such narratives in an accessible yet precise narrative designed to foster enhanced communication throughout the occasion of medicine (at the nexus where suffering is articulated and its treatment is constructed).

Reference List

Boudreau, J. D. and A. Fuks, "The Humanities in Medical Education: Ways of Knowing, Doing, and Being." *Journal of Medical Humanities* (2014).

A. R. Braun, A. Guillemin, L. Hosey and M. Varga, "The neural organization of discourse: An $H_2{}^{15}O$-PET study of narrative production in English and American sign-language," *Brain* 124.10 (2001): 2028-2044.

Baylor University BA in Medical Humanities: http://baylor.edu/medical_humanities

Brenner C. "Rethinking Premedical and Health Professional Curricula in Light of MCAT 2015." *Journal of Chemical Education* (2013); 90:807-812.

Columbia University Medical Center Program in Narrative Medicine, "Mission Statement," http://www.narrativemedicine.org

Charon R. "Narrative Medicine: A Model for Empathy, Reflection, Profession, and Trust." *JAMA* (2001) 286 (15):1897-1902. doi:10.1001/jama.286.15.1897.

Evans, M. and D. Greaves, "Exploring the Medical Humanities: A New Journal Will Explore a New Conception of Medicine, *British Medical Journal* 319 (1999): 1216.

Evans, M. and D. Greaves, "Should Medical Humanities be a Multidisciplinary or an Interdisciplinary Study? Research on Interdisciplinarity is Essential for the Future of Medical Humanities," *Medical Humanities* 30 (2004): 1-4.

Freud, Sigmund. *The Interpretation of Dreams*. Oxford: Oxford UP, 2008.

Groopman, G., *The Anatomy of Hope: How People Prevail in the Face of Illness.* New York: Random House, 2004.

Hawkins, A. H. and M. C. McEntyre. *Teaching Literature and Medicine*. New York: Modern Language Association, 2000.

Horwitz, H., Vannest JJ, and Holland, SK, "Overlapping neural circuitry for narrative comprehension and proficient reading in children and adolescents," *Neuropsychologia* 51.13 (2013): 2651-62.

Kuper, A., "Literature and Medicine: A Problem of Assessment," *Academic Medicine* 81.10 (2006): S128-S137.

Lester, F. D. "The Precarious Position of the Medical Humanities in the Medical School Curricula," *Academic Medicine* 77 (2002): 320-22.

Mahon, K. E., M. K. Henderson and D. G. Kirch. "Selecting Tomorrow's Physicians: The Key to Future Health Care Workforce." *Academic Medicine* (2013) 88.12: 1806-1811.

McManus, I.C. "Humanity and the Medical Humanities," *Lancet* 346 (1995): 1143-45.

Ofri, D. "The Physical Exam as Refuge". July 10, 2014. http://well.blogs.nytimes.com/2014/07/10/the-physical-exam-as-refuge/?_php=true&_type=blogs&_php=true&_type=blogs&smid=fb-share&_r=1

Parsons, A. and C. Hooker, "Dignity and Narrative Medicine," *Bioethical Inquiry* 7 (2010): 345-351.

Ryan, J. and R. Hammer, "The Practical Application of Narrative Medicine at Mayo Clinic: Imagining the Scaffold of a Worthy House," *Culture, Medicine, and Psychiatry* 37 (2013): 670-680.

Shem, Samuel. *The House of God*. New York: Bantam Doubleday Dell, 2010.

Simon, H. K. "Medicine and the Humanities: Joining Two Cultures. *The American Journal of Medicine* 125.11: 1144-5.

Snow, C. P. "Two Cultures." http://s-f-walker.org.uk/pubsebooks/2cultures/Rede-lecture-2-cultures.pdf

Stanford University Program in Arts, Humanities & Medicine: http://nioethics.stanford.edu/arts/OtherPrograms.html

Table 1. Medical humanities in the medical curriculum

Relationship domain	**Curriculum phase**	**Example(s)**
Physician-patient	Undergraduate	Simulated patient encounters, to include patient feedback (error disclosure, difficult patient conversations)
	Graduate	Patient evaluation data, clinical rotations
Physician-self	Undergraduate	Reflective journals
	Graduate	Case studies (patient engagement, advocacy, service)
Physician-colleague	Undergraduate	Interprofessional role play
	Graduate	Interprofessional journal club (systems change, care coordination, accountability)
Physician-public	Undergraduate	Identify and explain your state practice guidelines
	Graduate	Case studies in breaches in professionalism

Adapted from Charon, 2001