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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

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 interprofessional 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.

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-to-voice interactions with others and that govern their display of

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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).

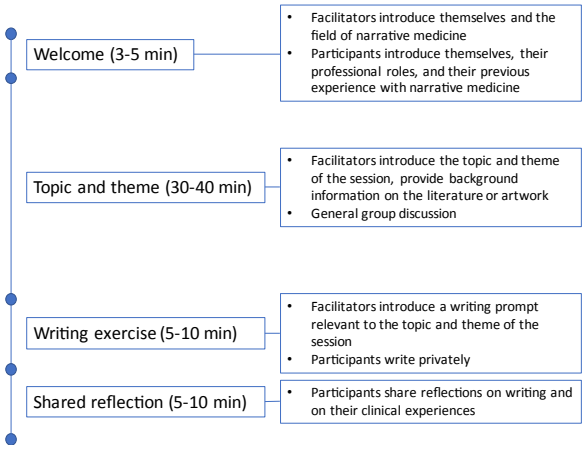

Figure 1. Structure of an AfterWards session.

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.

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