

Since this is an essay about narrative, I thought it would be appropriate for me to begin with a story of my own, about how I came to understand my own professional journey. I am a pediatrician, and for the last ten years, I have been on the faculty at the USC Keck School of Medicine, where I direct the Introduction to Clinical Medicine (ICM) program. Before going to medical school, I was a pre-med English major in the days when such a concentration was frowned upon by advisors and admissions committees alike. My passion for literature, though, has always been about the power of stories to reveal meaning and to expand my understanding of the world beyond my own life's experiences. At the same time, the stories of my patients and their families (as well as those of the patients who share their lives with the Year I and II medical students whom I supervise in ICM) have sustained my passion for medicine.

When I had the opportunity to hear Rita Charon speak at a meeting several years ago, she was a practicing internist who was finishing her dissertation in English Literature at Columbia University. In the course of her remarks at a conference on Spirituality and Health, she referenced some of my favorite recent novels—Pat Barker's *Regeneration* trilogy and Michael Ondaatje's *The English Patient*—and I had one of those life-changing moments. Besides the kind of life change that goes along with a decision to return to school at the age of forty-something (taking the GRE subject test in English Literature some 25 years after reading *Beowulf*, doing MY homework with my kids at the dining room table, getting paged by the clinic while in graduate seminars), my real epiphany was the understanding that my relationship to stories was what fueled my

passion for both medicine and literature. And I came to believe that the work and study of medicine could be illuminated through a relationship with narrative methodology.

I would like to share some of the stories and lessons that have come out of our work at the Keck School of Medicine in narrative medicine, and specifically what we have learned about the implications for educating students in the domain of professionalism. What is it that happens when students are given the opportunity—the space, the forum, the time—to read and write in medical school? I am certain that it has a salutary effect on the development of professionalism. But how? And what aspects of professionalism are we talking about exactly? I will look at some of the recent discourse on professionalism education, especially the work of Herbert Swick, Thomas Inui, and others, as they have tried to define what we mean by professionalism and how we educate for it. Next, I will describe the narrative medicine curriculum at Keck, focusing mostly on our work with third year Family Medicine clerkship students. I will report on some of the stories our students have shared with us, and I'll share the themes that have emerged over the course of the past couple of years. I believe that these themes—pertaining to empathy, to uncertainty, to the process of medical education and training, to acknowledging medical errors—speak to the essential components of professional development that so many of us have been struggling to define and nurture—for the health of our students and for the health of our profession.

Ron Epstein writes about mindful practitioners, those who “attend in a nonjudgmental way to their own physical and mental processes during ordinary, everyday tasks.”¹ This kind of critical self-reflection, he says, allows for attentive listening, recognition of errors, and ultimately for compassionate and insightful care. He maintains

that mindlessness may account for lapses in professionalism and errors in judgment and technique. While mindfulness cannot be taught explicitly, he says that it can be modeled by mentors and cultivated in learners.

In his article, “Toward a Normative Definition of Medical Professionalism,” Dr. Herbert Swick identifies nine specific behaviors that physicians must exhibit if they are to meet their obligations to their patients, their communities and their profession.² It’s important, I think, to note that he comments on our profession’s danger of losing its “distinctive *voice* [emphasis mine],” as business, economic, and political interests dominate so much of the discussion of health care.³ He suggests that strengthening the practices of medical professionalism is one important way in which medicine can reclaim its unique voice. Dr. Swick’s definition focuses on the actual work and behaviors of physicians:

- Physicians subordinate their own interests to the interests of others.
- Physicians adhere to high ethical and moral standards.
- Physicians respond to societal needs, and their behaviors reflect a social contract with the communities served.
- Physicians evince core humanistic values, including honesty and integrity, caring and compassion, altruism and empathy, respect for others, and trustworthiness.
- Physicians exercise accountability for themselves and for their colleagues.
- Physicians demonstrate a continuing commitment to excellence.
- Physicians exhibit a commitment to scholarship and to advancing their field.
- Physicians deal with high levels of complexity and uncertainty.
- Physicians reflect upon their actions and decisions.⁴

I will reexamine these behaviors later when we look at the stories our students tell us.

In his 2003 report to the Association of American Medical Colleges (AAMC), entitled “A Flag in the Wind: Educating for Professionalism in Medicine,” Thomas Inui says that the major elements of what we mean by professionalism in medicine have been very well described in our literature. He suggests that the fact that there is such

congruence in these descriptions is due to our common understanding that a medical professional should embody the attributes of a “virtuous person.” He offers these additional “core observations” that resulted from his time spent as a scholar-in-residence researching the subject:

- *There is a gap between word and action in medical school:* “What the literature and rhetoric of medicine lacks is a clear recognition of the *gap* between these widely recognized manifestations of virtue in action and *what we actually do* in the circumstances in which we live our lives.”
- *This dissonance is often unrecognized or unacknowledged:* “We may be unconscious of some of this gap, but even when conscious we are silent or inarticulate about the dissonance and, in our silence, do not assist our students to understand our challenges when attempting to live up to our profession’s ideals.”
- *Students often model what is seen, not what is said:* “In the process of becoming medical professionals themselves, our students learn powerfully from the systems in which we work and what they see us do (the ‘hidden’ and ‘informal’ curriculum), not only from what they hear us say (the formal curriculum).”
- *Cynicism is pervasive in medical education:* “Under present circumstances, students become cynical about the profession of medicine—indeed, may see cynicism as intrinsic to medicine—because they see us ‘say one thing and do another.’”
- *Behavioral change is needed, at individual and institutional levels:* “Additional courses on ‘medical professionalism’ are unlikely to fundamentally alter this regrettable circumstance. Instead, we will actually have to change our behaviors, our institutions, and our selves.”
- *We must be explicitly mindful that professional formation is rooted in daily activities:* “The opportunities for change that will enhance the modeling of medical professionalism are myriad, but the most difficult challenge of all may be the need to understand—and to be explicitly mindful of, and articulate about—medical education as a special form of personal and professional formation that is rooted in the daily activities of individuals and groups in academic medical communities.”⁵

I will return to this last point, because I believe that this may be what happens when students and faculty come together to read and write and share their stories. We create a

space to acknowledge, indeed to honor, the daily work that informs this personal and professional formation.

The very form of Dr. Inui's report is narratively interesting. He tells a story in his introduction about observing how a mentor of his always stood outside the room of his patient before going in, holding the chart, but not perusing it. When he asked the physician what he was doing, the doctor answered, "nothing really." Dr. Inui suggests that his mentor was probably referring to the fact that he wasn't doing any active medical reasoning at that moment, but he was no doubt ignoring that process of centering himself that got him ready to engage with his patient.⁶ Because these "nothing really" kinds of activities comprise so much of the so-called hidden curriculum, and because they also represent opportunities to learn from, and to help us understand our actions, to recover our language and inform our teaching, he writes his report in what he calls a "hybrid" form. He juxtaposes his expository sections with stories from his own development as a physician, presenting these stories, as he says, without any moralizing overlay, but challenges his readers, if they wish, to figure out why each story goes with each section. He even offers three ways to read the report—through the expository text alone, through the stories alone, or as the juxtaposed narrative.

So, Dr. Swick and Dr. Inui write about some of the critical components of medical professionalism—the importance of virtue and empathy and high ethical standards, accountability, commitment to excellence, tolerance of uncertainty, and the need for reflection. And Dr. Inui makes the crucial point that we must make fundamental changes in our behaviors, our actions, if we are to embrace a truly effective way to educate our students for professionalism.

When we began to implement a narrative medicine curriculum at Keck, it was not solely, or even primarily, with the goal of professionalism education in mind. We had just completed a major curriculum revision, and we realized that many of our school's revitalized overall program goals required narrative competence, what Rita Charon defines as "the ability to acknowledge, absorb, interpret, and act on the stories and plights of others."⁷ Students must be able, say our program goals, to listen and communicate clearly with patients, families, and health care team members using effective verbal, non-verbal, and writing skills. They must be able to obtain and interpret a patient's story or history. They need to respond effectively to the many factors that influence health and disease, including the sociocultural, familial, psychological, and spiritual aspects of their patients' lives. They need to be able to identify alternatives in difficult ethical choices. And they must develop the capacity for self-awareness in their growth as professionals, reflecting on their limits, strengths, and vulnerabilities. Clearly, these objectives demand that students develop the capacity to recognize, interpret, and construct with narrative—they must be able to listen, to tell, to write, and finally to act therapeutically based on what they have absorbed. We recognized the need for an explicit curriculum for what we agreed were these core clinical, and yes, professional, skills.

We had always asked students to write reflectively in our Introduction to Clinical Medicine program, a program that for more than 35 years has placed medical students at the bedside of patients from the very first week of medical school. Groups of six students learn the art and science of medicine, going to the hospital each week with their instructor to speak with patients. I began to teach a literary ICM group, asking my own group to read fiction and poetry and essays, and to write as well, as they learned their interviewing

and physical examination skills. In a new course that was born with our new curriculum's implementation, Professionalism and the Practice of Medicine, or PPM, we ask students to write their autobiographies, to write about their culture of origin, to write from the perspective of another, and to write reflectively about their own growth and development several times during the course of their two years in PPM.

When we began the narrative medicine component of the Family Medicine clerkship, we called it "Reflection Skills Workshop: Reading, Writing, and Doctoring."

We wanted students to be able to:

- discuss the importance of point-of-view consideration, reflection, and self-examination as clinical skills that foster empathy, narrative competence, and effective practice.
- identify specific tools for their own reflective practice.
- seek information from their own preceptors about how they reflect on/process their practice experiences.
- apply these tools to their Family Medicine clerkship experience through journal entries to be submitted with their weekly reports.

In preparation for the two-hour seminar (which takes place on the last day of the week-long orientation to the clerkship), students read two stories, "The Girl with a Pimply Face," by William Carlos Williams, and "Baptism by Rotation," by Mikhail Bulgakov.⁸ We begin by getting in a circle, and my colleague, a family physician, tells the students a story that Gordon MacKenzie writes about in his book, *Orbiting the Giant Hairball: A Corporate Fool's Guide to Surviving with Grace*.⁹ When MacKenzie was invited to speak to elementary schoolchildren about sculpture, he would visit each grade level for discussion and demonstration of his craft. He introduced himself as an artist and asked who in his audience was also an artist. In the first grade, every child raised his or her hand. By second grade, only half the class admitted to such a designation. By sixth grade, perhaps one or two children timidly raised a hand.

With a nod to MacKenzie's belief that education "suppresses genius," we give students "permission" to reclaim their artistic selves and to exercise a bit of their creative muscle, and we then open a discussion of the stories they have read. Williams's story tells of the narrator-physician's house call on a Russian immigrant family, where he meets an infant with a severe congenital heart defect, her alcoholic mother, and the adolescent girl with whose straightforward toughness he is immediately taken. Bulgakov's tale concerns the terrifying experience of a young practitioner who is called out in the middle of the night to deliver a woman who presents with an obstetrical emergency. His education by the nurse mid-wife, his mad dash back to his room to read his textbook, and his subsequent experience of the confluence of book knowledge and practical knowledge, resonate powerfully with the students' own early clinical experiences.

After talking with the students about their responses to these stories—which are wonderful, by the way—it takes just a little while for them to feel safe enough to comment on their own dances with nurses who know so much more than they do, but come to them for orders, or on some of their own feelings of incredible ineptitude, or on the fact that Williams's narrator sounds like (horror of horrors!) he might be sexually attracted to this teenage girl. The students then take twenty minutes or so and write a reflection on a recent patient encounter, or, if they choose, a point of view piece from a patient's perspective. We reconvene to share these stories and then tell the students about their assignment to submit weekly journal entries, which they do on-line. These are to be at least a paragraph in length, and we ask, borrowing from Angeles Arrien and Dr. Rachel Naomi Remen, that they consider what inspired them, what surprised them, and what

touched their hearts, as they reflect on their week's experiences in Family Medicine.¹⁰

Finally, we charge them to submit a final project that can be a reflective essay, a short story, poetry, or even a piece of artwork, as long as it is accompanied by a narrative explication. These works are shared at the final clerkship wrap-up session.

Over the years, students have given me permission to share some of their seminar writing, their journal entries and their final narratives. I believe that the themes that emerge from this writing may speak to the kind of effective education for professionalism that Dr. Inui talks about. Kirsten, a future ER physician, wrote about a young man she cared for during her surgical clerkship. He was a C-1 quadriplegic following a motor vehicle accident, and he was her first patient on trauma surgery.

David (not his real name) was very depressed and was struggling to come to terms with his diagnosis. Each time that I would visit him, he would plead with me, asking me to switch off his vent and kill him. He would tell me how scared he was, often with tears welling up in his eyes. I felt helpless and frustrated as I saw what he was going through. Every time we entered his room, we had to don a full gown and mask to protect him from infection. We must have seemed like a bunch of aliens, there to torture him by periodically suctioning out his airway. With that mask on, I couldn't even smile at David when I would go in to see him. Communication was very difficult. When he would try to speak it was very hard to make out the words and I largely had to rely on reading his lips. I would often misunderstand, and he would become very frustrated...I felt guilty every time I had to say "Sorry, I don't understand." I remember during one of my first visits he began to cry...I grabbed his hand, my natural instinct, but my stomach turned as it hit me that he couldn't even feel my hand holding his. I felt so useless. As a future doctor, my job was to try to make my patients better. Yet in this case, there was nothing I could do. He wanted me to kill him; that was a wish that I could not grant. He wanted to walk again one day, but there was no way that I could make this happen.

I remember feeling so ill at ease that I began to have the urge to avoid visiting him. This thought made me feel all the worse...I felt so incredibly selfish for wanting to avoid a patient just because his situation made me personally uncomfortable...after all, he was the one who had to deal with being a quadriplegic for the rest of his life, not me. I got past my urge to avoid David and continued visiting him until the time of his discharge. His state of mind improved considerably and he eventually began to come to terms with his diagnosis. On his

last day in the hospital he actually thanked me. He said that he really appreciated everything that I had done and that I had helped him through a very tough time.

I had thought that I was upsetting him each day when I came in and attempted to communicate with him...with my inhuman mask and my inability to understand all that he was saying. Yet, in spite of these problems and my powerlessness to end his suffering, I had managed to do something for my patient. Now I see that even when you feel as if you are failing as a doctor because you cannot fix your patients' problems, you may be helping them by simply caring.

Kirsten's narrative reflects the profound impact this patient had on her professional development. Imagine the courage it took for her to enter his room each day, a courage that is mirrored in the fortitude it took to share this piece of writing with her peers and with us. She learned in action, and helped her peers learn, about putting the needs of the patient first, even when she felt so awful and useless. Every day that she took care of this patient, she stared uncertainty in the face, and ultimately this young woman, eager to "fix things" some day in her chosen field of Emergency Medicine, learned that "simply caring" is a therapeutic act. When Dr. Inui speaks about the essential re-integration of personhood and professionalism, I believe that he's addressing this sort of acknowledgement that the self is the primary instrument available for healing.

Here is a journal entry that another student, *Kristen*, wrote.

My second week in family medicine ended well. I had three patients on Friday for whom I felt I actually made a difference. Solving their problems was simple, and in all three cases doing a good job was only a matter of being thorough. I made drawings of mornings and afternoons, suns and moons, lists of medications and when to take them, explained diabetes, explained the thyroid. Did some convincing, some negotiating.

The earlier part of the week was sad, though. I felt too often that we weren't really helping anyone significantly. Just scratching the surface. Hurriedly rushing through a full day of patients who didn't really understand their conditions, who weren't really getting better, and if they did, it was nothing WE helped them with. And all week, there was this dog in the lot in the back of the clinic. There are so many strays in South Central, you see them everywhere as you drive through the neighborhoods. This one took to our parking lot, but he was so sick, he had so

many open sores, mange, he wasn't neutered. Taking him home would have meant getting my dog sick too. So I fed him crackers all week. Never thinking he'd come back the next day, I didn't think to bring dog food. It killed me, the sadness of the patients in the front of the clinic, then walking outside for some air to the torn-up dog out back. Until Friday, the week was pretty hopeless; I felt like that was all I'd ever be able to do for anyone; just give them crackers.

Then Friday came, and a patient smiled after I drew her that picture with the suns and the moons. She said she needed a physical and hadn't had one in a while, and could I do it, would I still be here? Another patient, grumpy and silent, couldn't stop talking after I told her I'd been to her neighborhood in Managua. And still another patient told me that no doctor had attended to her in the way that I had. She grabbed my arm and looked at me squarely when she told me, to make sure I was really listening. And that was all it took for my hope to return."

Kristen's narrative is structured so that the metaphor of the mangy dog provides the central image, the hopelessness and sense of futility that this narrator faces in the daily practice of medicine amidst poverty and chronic disease. And yet she's told us from the beginning that the story turns out well, and in her final paragraph, she is hopeful once again, thanks to the patient who makes her look and listen. Even as it overwhelms her, the community she serves (complete with its hungry, dirty dog) ultimately demands her responsiveness and rekindles her hope.

Carey chose to do a drawing as her final project and here is the accompanying narrative.

I imagine my patient looking out at me through beer goggles: the lens of his alcohol addiction, recent Ativan doses and detoxification. He must perceive me to be fuzzy and far away and hard to hear. It isn't any wonder that we never connect, that he keeps leaving the hospital for another drink, that he has a host of unresolved medical problems – he had shrouded himself from people and help.

I remember waiting outside that shroud; in the demanding, clanging, and very sober hospital room, filled with eight other patients who listened as I raised my voice first to communicate, then in frustration. I felt myself becoming angry. This patient doesn't answer my questions. He makes me feel uncomfortable asking if I'm married. He keeps moving his hands into the sterile field when we attempt to start an IV. He has Hepatitis C, so I am concerned for my own safety as he jerks his leg and bats at my hand during the procedure. He stares at the sheets when I

tell him that I want to talk about the seriousness of his alcoholism. He offers no response.

He gives me no opportunity to see his humanity, his character, his personality. I'm left with a body in a bed, a man stuporous with alcohol and Ativan: someone easy to ignore and avoid.

Inside his cocoon it must be quiet. Is it peaceful? Probably lonely. Sick. Sad. I wonder if he cries sometimes in there. He must be lonely - wrapping himself so completely with alcohol, I doubt that many people can come close. Considering beer goggles reminds me that there is a person inside this body. I have to trust that he is in there. And who knows? With kindness and patience, he may show himself.

Carey's perspectival vision, here represented both graphically and narratively, allows her to remember her patient's humanity. We know we can't truly care for the patient unless we find a way to take on his or her perspective, and Carey's representation of her artistic path to empathy had a powerful effect on her classmates and on her teachers, and ultimately on our larger community through its display in our newly endowed faculty and student art gallery.

One more story, this time Adler's, is about a mistake. Adler wrote about taking care of an adolescent patient during his family medicine rotation, a fifteen-year-old boy with low-grade fever, chest pain and difficulty breathing. The patient's affect and demeanor suggested the possibility of drug use, and Adler appropriately sought further history from the young man with the patient's mother excused from the exam room. His preceptor agreed to Adler's suggestion to obtain a toxicology screen despite the teenager's denial of substance use, and this was ordered along with a chest x-ray and other blood work. Here are Adler's words.

The next day the blood test results showed no evidence of illicit drugs. I was a bit surprised when I read the results. With Manuel's (not his real name) history of nervousness, anxiety, and his demeanor during the examination, I thought that drug use would be the cause for his condition. A few minutes later, Dr. L called

me into his office. The chest x-ray had returned from the radiologist and showed that Manuel had signs of a pulmonary infiltrate that had caused effusion and collapse of the left lower lobe of his lung. He asked the nurse to call Manuel's family to have him brought to the clinic as soon as possible so we could admit him to the hospital. With a humbled and low voice I thanked Dr. L and stepped outside the office. I stood in the hallway for a few minutes and closed my eyes. Why did I not detect the collapsed lung when I examined Manuel last night? Why didn't I perform a complete pulmonary examination? If I picked it up last night we could have sent the patient to the hospital a day earlier. And why was I so certain that the answer was drug use rather than community-acquired pneumonia? Was it because the patient is a fifteen-year-old Hispanic male? Would I have thought differently if Manuel was of a different ethnicity? Was I even really listening to what he had to say? Or did I just dismiss his responses because of my initial perception of him? Was I good "doctor" for Manuel?

Again, Adler displayed tremendous courage to share a story about mistakes and erroneous perceptions. His writing, which he submitted initially as a journal entry, and then turned in, in a longer version as his final narrative reflection, demonstrates his formative relationship with the professional behaviors of accountability, commitment to excellence, and the ability to reflect honestly on one's actions and decisions.

What do students say about being asked to read and write like this in medical school? In the interest of full disclosure, I will tell you that in almost every cohort of clerkship students, there are one or two students who don't buy this at all.

- "This session is not a good use of my time at this stage of my education...I would prefer to either attend lectures that give me information I will be able to use in the clinic, or failing that, I'd prefer to leave earlier to have time to study."
- "Seemed a little tree hugging for me."

But student evaluations overall have been remarkably positive. From 2003 to 2005, more than 90% of students rated the reflection skills workshop as "good" to "excellent" when asked to consider how useful it was in enhancing their perspectives about some of the guiding principles of Family Medicine (Patient Advocacy, Systems-based Care and

Psychosocial Care). With regard to the wrap-up session, 88% indicated that this end-of-clerkship session was “somewhat” or “highly” valuable.

And in their own words:

- “I really appreciated the opportunity to reflect rather than react, which is what I had been doing all year.”
- “Inspiring”
- “Just what medical school needs.”
- “Enjoyed engaging my creative side.”
- “I thought it was really cool the stories that I heard from other students...”
- “As usual, the family medicine department sets itself apart from the others by looking at the bigger picture of medicine.”
- “We need this.”
- “This workshop was excellent. It helped me digest many issues I could not before talk about that I had faced on other clerkships. I think we should have something similar on each clerkship.”
- “Just being able to sit down and share how we feel after a year of such painful and depressing experiences was so helpful... We are expected to shoulder these emotions that so few people in our lives can really relate to... we are paralyzed with the fear of navigating the clerkship year and trying to survive... I would really like to thank you for offering us the opportunity to unload these emotions.”

So what do these stories, and the many, many other wonderful stories that space doesn't allow me to share, tell us about educating for professionalism? We learned a lot over the past few years of this curriculum, and I want to consider some of what our students have taught us. First of all, we've built a community where third year students can reconnect with their peers and with mentors. And the fact that it takes place during a required clerkship means that there is institutionalization of this particular form of a developing professional community. Creating the space to reflect in the classroom normalizes the fraught experiences of the clinical years, offers an opportunity for patient follow-up (many times students will read what they write in the seminar, and their classmates will be able to tell them what happened with that particular patient after they left the service); this safe space allows for the sharing of stories of pain, and suffering,

and joy. By creating the space to reflect in writing, we allow students to discover meaning away from the busy-ness of clinical life, and to acknowledge their emotional responses as catalysts to growth, and not as impediments to training.

Every six weeks as I read their final projects in preparation for the clerkship wrap-up session, I jot down the themes that emerge from students' writing. This is the way I currently frame my thinking about the narratives that students write.

They write about:

- the process of medical education/training—what the process does to them, their feelings of ineptitude, and of the joy of their emerging confidence; students speak of their fear that they are “losing [their] capacity for empathy.”
- relationships—the physician-patient relationship, the preceptor-student relationship, relationships with patients, relationship-building, family dynamics (reflections about their own families as they observe their patients/families). They speak about what they learn about themselves from patients, and about the kind of intimacy and involvement with patients they see on the part of the passionately engaged physician.
- the art of listening—the recognition that the chief complaint is often not the only, or even the most significant, of the patient's concerns.
- ethics—issues of confidentiality, physicians' relationships with the pharmaceutical industry, HMO/insurance issues, rationing, and insufficient time with patients.
- medical error—what to do with their own mistakes, and with what they observe on the wards and in the clinics.
- uncertainty—they reflect again and again on this ever-present dilemma.
- clinical care issues—pain management, the prevalence of obesity, the nature of the out-patient setting, and the fast pace of clinical practice.
- spirituality—praying with patients, examining their own spirituality in the face of what they encounter in their patients' lives.
- what it means to be a family physician—continuity, advocacy, the chronic care model, prevention, participation in others' lives, the complexity of family medicine, and the messiness of human experience.

And don't these themes comprise some of the key components of what we mean when we talk about professionalism education? Doesn't "accountability for themselves and for their colleagues" begin with the kind of honest discussion about shared experiences in clinical care and reflecting on their relationships with patients and with each other? Doesn't a "continuing commitment to excellence" require ongoing examination of the process of their own medical education? Much has been written about the narrative path to empathy, and the students' stories and artwork speak eloquently to this important domain of professional development.¹¹ "Physicians deal with high levels of complexity and uncertainty," and narrative writing and discussion in community are powerful tools in processing this complexity, especially when students are still in the early stages of acquiring a basic fund of knowledge. And if physicians must reflect upon their actions and decisions to improve their knowledge and skills, and to bring balance to their personal and professional lives, don't they need an explicit time and space and forum to do this? And shouldn't they witness their teachers and mentors engaged in the same process?

Again, from our students we hear this--

- "The wrap-up session was the only time in the clinical year that we ever got the chance to share our experiences and to learn collectively from them... [we're] expected to move on every six weeks as though the people we saw and the lives we touched did not have an effect on us. I really benefited from the experience and am grateful that someone allowed us to speak in an organized setting."
- I just wanted to say thanks for opening this rotation to self-expression. If only we could have more dialogue about how it feels to be a physician it would teach us to be more conscious of ourselves and the way we influence the world. Hearing the other students' voices reminds me of our oneness and common struggles which helps me, because I frequently feel I am so different from most of the other medical students. Keep up the good work.

In her essay on narrative medicine, Dr. Charon reminds us that “to profess is a narrative act.” She says, “Perhaps the most effective methods to strengthen professionalism in medicine are to endow physicians with the competence required to fulfill their narrative duties toward one another: to envision the stories of science, to teach individual students responsibly, to give and accept collegial oversight, and to kindle and enforce the intersubjective kinship bonds among health care professionals. Only when physicians have the narrative skills to recognize medicine’s ideals, swear to one another to be governed by them, and hold one another accountable to them can they live up to the profession to serve as physicians.”¹²

I want to return to Dr. Inui’s final observation about professionalism education: “[Our] most difficult challenge [is to be] mindful of, and articulate about—medical education as a special form of personal and professional formation that is rooted in the daily activities of individuals and groups in academic medical communities.”¹³ That’s what’s happening when we create the space and time in the formal curriculum to recognize and honor this unique, communal, and life-long weaving of the threads of professional development. When students share these stories, they hear from each other and from us, their teachers, about others’ struggles with the same issues. Their stories remind us of our own vulnerability, our own efforts to reclaim our idealism, to cope with uncertainty, or with overwhelming sadness or fatigue, etc. I am inspired by their stories of courage, and I feel compelled to reflect—with them—on my own path to the lessons they are learning, that indeed, reflective practitioners remain committed to learning and relearning over a professional lifetime. We effectively change our actions, our very selves

through this narrative process. And I agree with Dr. Inui when he says that this is the critical component of educating for professionalism.

¹ Epstein, Ronald, MD. Mindful Practice. *JAMA* 1999, 282 (9): 833-839.

² Swick, Herbert, MD. Toward a Normative Definition of Medical Professionalism. *Academic Medicine* 2000, 75 (6): 612-616.

³ Ibid, 613.

⁴ Ibid, 614-615.

⁵ Inui, Thomas S. A Flag in the Wind: Educating for Professionalism in Medicine. Association of American Medical Colleges, 2003.

⁶ Ibid, 5.

⁷ Charon, Rita, MD, PhD. Narrative Medicine: A Model for Empathy, Reflection, Profession, and Trust. *JAMA* 2001, 286 (15): 1897-1902.

⁸ Both of these stories are anthologized in *On Doctoring: Stories, Poems, Essays*, edited by Richard Reynolds and John Stone (New York: Simon and Schuster, 2001), which all U.S. medical students receive at the White Coat Ceremony as they begin the first year of medical school.

⁹ MacKenzie, Gordon. *Orbiting the Giant Hairball: A Corporate Fool's Guide to Surviving with Grace*, New York: Viking Penguin, 1996.

¹⁰ Arrien, Angeles and Remen, Rachel Naomi, Journal Exercise, © Institute for the Study of Health and Illness (ISHI) at Commonweal, 1993, <http://www.commonweal.org/ishi/>

¹¹ Charon, Rita, MD. The Narrative Road to Empathy, in *Empathy and the Practice of Medicine*, ed. Howard Spiro, et al, Yale University, 1993.

¹² Charon, Rita, MD, PhD. Narrative Medicine: A Model for Empathy, Reflection, Profession, and Trust. *JAMA* 2001, 286 (15): 1897-1902.

¹³ Inui, 5.

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