Three Things to Do With Stories: Using Literature in Medical, Health Professions, and Interprofessional Education

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Abstract

It would be unusual to find a current medical school administrator or faculty member who has not heard the phrase "literature and medicine" or who does not know that literature is taught in various forms—short stories, novels, poems, essays—at many points in the curriculum at U.S. medical schools. Yet the phrase is used in slippery if not elusive ways, with no clear referent common to all who use it. This article focuses on three theoretical and pedagogical uses for literature in medical, health professions, and interprofessional education: close reading, ethical or moral inquiry, and drawing illustrations. Summaries of these approaches are provided, followed by demonstrations of how they might work in the classroom by using the story "Blankets," by Native American writer Sherman Alexie.

Close reading requires reading slowly and carefully to enrich an initial encounter with a text. Ethical or moral inquiry turns to literary representations to challenge readers' assumptions and prejudices. Literature offers rich, provoking, and unusual depictions of common phenomena, so it can be used to draw illustrations. Although each approach can be used on its own, the authors argue that reading closely makes the other two approaches possible and meaningful because it shares with the diagnostic process many practices critical to skilled interprofessional caregiving: paying attention to details, gathering and reevaluating evidence, weighing competing interpretations. By modeling a close reading of a text, faculty can demonstrate how this skill, which courts rather than resists ambiguity, can assist students in making ethical and compassionate judgments.

I do not know which to prefer,
The beauty of inflections
Or the beauty of innuendoes,
The blackbird whistling
Or just after.

—Wallace Stevens[1]

It would be unusual to find a current medical school administrator or faculty member who has not heard the phrase "literature and medicine," or who does not know that literature is taught in various forms—short stories, novels, poems, essays—at many points in the curriculum at U.S. medical schools. Yet the phrase is used in slippery if not elusive ways, with no clear referent common to all who use it. Theoretically and pedagogically, literature and medicine is more than the sum of its two parts, and it is "enacted" differently across settings in medical education, health professions education, and interprofessional education.

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The field of literature and medicine formally began in 1972 with the decision by some visionary medical educators at the Pennsylvania State University College of Medicine to appoint Joanne Trautmann (Banks) as the first full-time PhD in literature at a U.S. medical school. Her eloquent theoretical contributions to the field[2–4] remain foundational and vibrant even as other literature scholars' work has deepened and enlarged the field. Among these scholars are Kathryn Hunter,[5] who wrote the groundbreaking *Doctors' Stories: The Narrative Structure of Medical Knowledge*; Anne Hudson Jones,[6–8] who cofounded *Literature and Medicine*, the premier journal in the field, and contributed as one of its key thinkers; Anne Hunsaker Hawkins,[9] who wrote *Reconstructing Illness: Studies in Pathography*, a theoretical study of first-person written accounts of illness; Rita Charon,[10,11] who is responsible for a vast compendium of work on the larger field of narrative medicine, in which the analysis of literary and other texts figures prominently; and many others who have produced articulate and persuasive rationales for the uses of literature in the education of physicians. Each of them provides a different perspective on the things to do with stories.

The purpose of this article is to provide medical educators with three theoretical and pedagogical uses for literature in medical education. We begin by providing summaries of these three approaches and end by demonstrating how they might work in the classroom by using the story "Blankets" by Native American writer Sherman Alexie.[12] There are, of course, as many approaches to a text as there are ways to look at a blackbird, but unlike Wallace Stevens, we have elected to limit our discussion to the three that are most relevant to medical education.

Three Things to Do With Stories

Read them closely

The most commonly cited theoretical approach to reading literature in medical education is what literary scholars call close reading. Joanne Trautmann provides the clearest articulation of the educational value close reading brings to the practice of medicine. In her 1982 article "The wonders of literature

in medical education" (arguably the theoretical crown jewel of literature and medicine pedagogy), she contends that "to teach a student to read in the fullest sense is to train him or her medically."[3] To read in the fullest sense, in other words, is to read closely. The introduction of basic literary elements, such as point of view, plot, imagery, setting, and narrative stance, to medical education has instrumental value to trainees, Trautmann argues, by supplying them with specific intellectual tools to use in the various aspects of caring for patients. She continues:

> To ask the medical student what is being said [in a story]—not at all an easy question when one must look at words in their personal and social contexts and when several things are being said at once—is to prepare him or her for the doctor–patient encounter.[3]

For Trautmann, when students practice the skills of close reading, a process that courts rather than resists ambiguity, they learn to respond imaginatively and critically to the vagaries that patients present to them.

Writing almost a decade later, James Terry and Edward Gogel[13] assert a similar justification for pursuing the study of literature and medicine. Such study, they argue, involves the improvement of critical-thinking skills that cultivate a "tolerance for the ambiguity of words and signs [and] the fleshing out of stories from fragments."[13] Comparing a physician's diagnostic hunches after a patient interview to a close reader's analysis of a poem, they suggest that the

> tension between the meaning of the whole and the analysis of the parts is what is particularly well illustrated by the process of interpreting a poem. When looking at a poem, we may shift from concern regarding its ultimate meaning to a focus on such things as its tone, its voice, its shape and presentation on the page, or its energy level.… In a similar fashion, we may look at patients to see how they "present": alert or lethargic, in apparent distress or apparent good health, and so on.[13]

Attention to detail, then, is equally important to the process of close reading as it is to the practice of medicine.

In her 1990 article "Literature and medicine: Traditions and innovations," Anne Hudson Jones[7] provides further articulation of these points, preferring to call close reading an "aesthetic" approach.[7] And like Terry and Gogel, Jones sees important similarities between closely reading literature and attending to a patient. She aptly points out that in addition to objective data—the labs, the history and physical findings—the "text" presented by a patient also "includes the patient's subjective symptoms and story" that can be more richly understood through interpretive skills similar to those used in literary inquiry.[7] Her statement of purpose for teaching literature in medical education is "unabashedly pragmatic: to make [students] better doctors … who will take better care of their patients and better care of themselves."[7] Jones, like Trautmann, argues that these interpretive skills are directly transferable to clinical work.

Model ethical or moral inquiry

The second thing to do with stories is to provide a model for ethical or moral inquiry. Again, Jones clearly explicates how this approach works, focusing on representational content, such as "Images of healers and their ethical dilemmas; works by physician–writers; and themes of illness and suffering, especially in narratives from the patient's point of view."[7] She and many others cite Robert Coles's[14] pioneering article in the *New England Journal of Medicine* as elucidating the questions raised to caregivers through literary inquiry, including "intense scrutiny of one's assumptions, one's expectations, one's values, one's life as it is being lived or as one hopes to live it." Terry and Gogel[13] similarly describe literature's value for supporting "the cultivation of empathy for the suffering; the puzzling over seemingly incommensurable values placed on human lives; the coming to terms with human frailty, failure, and morality." Readers may develop the ability to imagine the concrete ways that people unlike themselves struggle with their illnesses, their disadvantages, and their burdens, which in turn encourages them to pursue moral reflection and, ultimately, action. With the current emphasis on reflection in all health professions education, literature is a frequent vehicle for such activity.[15]

Draw out their illustrations

The third thing to do with stories is to look for rich, provoking, unusual, or remarkable illustrations of common phenomena. This approach is often omitted from theoretical or pedagogical discussions of literature and medicine, especially from scholars with formal training in the humanities, because it is seen as naively accepting a direct relationship between the thing represented and its representation. Susan Squier[16] uses the following example to make this very point, referring to a post on a literature and medicine listserv:

> An obstetrician–gynecologist, preparing a talk about fertility preservation in cancer patients, posted a request for literary works about living with cancer. The physician wanted to include some poetry about a patient's feelings of hope and about life after cancer treatment, or poetry from a physician's or nurse's point of view. This mimetic approach uses literature merely to illustrate a preselected point.

For Squier, the potential danger of such an approach is that these illustrations are too readily accepted as truth, rather than representations to be examined critically.

Another equally problematic aspect of this approach is that, as James Terry and Peter Williams[17] explain, "lesser works … are often taught in medical settings." "If there is only one work of literature," they point out, "about kidney dialysis or the lives of residents or whatever, that work—even if flawed—may be taught."[17] Often lost from such representations are the complexities and subtleties characteristic of well-crafted stories, the kinds of stories championed not only by Trautmann and Jones but also by numerous others. Still, we argue here that this "illustrative" approach has merit when it disrupts a student's assumptions, perceptions, and expectations about people in all their varieties. The concept of "enstrangement," akin to formalist critic Viktor Shklovsky's ideas about defamiliarization, holds a place in the curriculum for literature that rattles one's thinking, unsettling predictable responses to familiar objects, people, and places.[18] The illustrative approach, then, can be illuminating.

An Example of Three Things to Do With One Story

In the remainder of this article, we will illustrate how one story—"Blankets," by Native American writer Sherman Alexie—can be taught in three different ways depending on one's goals and orientation to using literature in

the medical, health professions, and interprofessional curriculum. Our objective is to provide practical approaches that can be replicated in various educational settings. And although we have identified three different things to do with stories—close reading, ethical inquiry, and illustration—the process of close reading makes the other two approaches not only possible but also meaningful. Therefore, we begin by introducing techniques for reading "Blankets" closely, followed by demonstrations of how the product of the initial close reading we performed lays the foundation for generating the ethical and illustrative interpretations that follow.

First, a synopsis of Alexie's story. "Blankets" takes place in an urban hospital where an elderly Native American man sits in a "recovery hallway" after a surgery that removed portions of both his feet because of the complications of alcoholism and diabetes. At his side is the man's adult son, who is also the story's narrator. The main action follows the son as he attempts to find a better blanket for his father, who cannot get warm using the flimsy blankets provided by the seemingly indifferent hospital staff. Throughout the story, the search for a proper blanket works as a metaphor for the narrator's internal struggle to accept the causes behind his father's poor health and to reconcile himself to caring for him; the search for the blanket also symbolizes the various ways that medicine fails to meet the most basic needs of patients. Another notable aspect of "Blankets" is that it begins after the surgeon has completed the amputations on the narrator's father, thereby providing medical readers with all that happens to a patient after the doctor has walked away.

Read it closely

Broadly, to read closely, one must read slowly and carefully. The process requires returning to a text after the initial encounter to deepen and broaden one's immediate interpretation of it by identifying elements that stand out, such as point of view, plot, and setting. By spending time thinking about the various ways that these elements make meaning, either individually or collectively, different interpretations of the text become possible. The process of close reading, of returning to a text after making an initial interpretation, has its analogue in clinical medicine. In the clinic, prejudgment often informs an initial interpretation of a patient, but to reach a correct diagnosis or the best diagnosis the clinician must return to the evidence (i.e., symptoms, patient's history, etc.) and ask new or different questions of it.

If one were to teach "Blankets" using a close reading approach, one of the several ways to start would be to record recurring words and images, particularly vivid or insightful sentences and passages, along with their location in the story. Jane Gallop,[19] who has written passionately about the value of this technique, says "[c]lose reading slows us down, stopping us at words, getting us to look around at the context of the words that stopped us, making us remember similar words and go back and look for them." When conducting a close reading discussion, faculty must remain open to readers' unexpected interpretations or observations and, when possible, draw attention to other examples in the text that support such interpretations. It is equally important to counter less substantiated interpretations by pointing out that they lack textual support. The goal here is not to dismiss readers' interpretations but, rather, to emphasize the importance of supporting their interpretations with a close reading of the textual evidence. Here again, an analogue to clinical practice exists: The process of remaining open to various readings of a patient's symptoms or history, the clinician, like the close reader, arrives at a more comprehensive diagnosis often after considering the important input of interprofessional colleagues.

A good way to begin a close reading of a story is to draw connections between its title and its content. In the case of "Blankets," this exercise is particularly useful because the word *blanket* appears repeatedly. Once readers have identified all of the places where the word blanket appears, consideration of what function blankets serve in the story, literally and symbolically, begins. To prompt readers to recognize the literal and symbolic and to begin developing their own tentative interpretation of them, faculty can draw attention to a particular use of *blanket* and then model a close reading of that instance. For example, when the story's narrator requests a second blanket because his father cannot get warm using the one provided to him, he does so not from a hospital room but from a "recovery hallway," where "[t]here was no privacy, not even a thin curtain."[12] The narrator guesses that this setup "made it easier for the nurses to monitor the postsurgical patients" and observes that it also leaves his father "exposed" along with "his decades of poor health and worse decisions."[12] On the one hand, the blanket serves a literal function by providing warmth. On the other, it provides symbolic cover or concealment for a patient who is exposed to the prying and judgmental eyes of others when he is at his most vulnerable.

By calling attention to a scene such as this one and by spending time drawing connections between the images it presents with the literal and symbolic uses of blankets, readers have an interpretive model for moving forward. The goal throughout the close reading exercise is to use the interpretations generated as a means to enrich, expand, and even problematize readers' contributions to the overall construction of meaning. Close reading discussions are invaluable in demonstrating how interpretation can be a collaborative process—that is, how working together can generate new and unexpected ways of seeing the same phenomenon. Readers can discuss the other elements of fiction: Why is the setting of "Blankets" critical to the way the story unfolds? What is the tone of the story? What words and phrases contribute to that tone? How do we come to know the characters through their talk and interactions with each other, and through their actions? Such a process offers a model for interprofessional health care teams, each specialty bringing to the patient's bedside their interpretation of the case and, most important, a willingness to modify and reimagine those interpretations on the basis of different readings of the same evidence by other members of the team.

Model ethical inquiry

Just as the practice of close reading is a valuable exercise for schooling readers in the importance of remaining open to different and even opposing interpretations of the same evidence, so too can the techniques it relies on be used to advance ethical inquiry. Gallop[19] argues

that when we don't read closely, we see not what is in front of us but, rather, what we expect to find. In other words, we read texts with prejudice, projecting meaning onto them based on our own cultural circumstances. Close reading, because it requires paying attention to language, to what is actually written (and said), can, Gallop continues, "shake up our preconceived notions."[19] Thus, a second thing stories can do, as Coles suggests above, is to invite self-scrutiny of readers' assumptions, expectations, and values. In the case of "Blankets," there is much going on related to care for the so-called "noncompliant" patient to which readers can turn for examining their own biases about such patients.

Because the search for an effective blanket for the narrator's father makes up the story's plot, readers might examine scenes in which the search itself meets impediments or challenges. Two parallel scenes in the story involve the same nurse, whom the narrator describes as "irritated" and "remote."[12] Here is the first scene:

> She was irritated. I understood. After all, how many thousands of times had she been asked for an extra blanket? She was a nurse, an educated woman, not a damn housekeeper. And it was never really about an extra blanket, they were asking for a time machine. And yes, she knew she was a health care provider, and she knew she was supposed to be compassionate, but my father, an alcoholic, diabetic Indian with terminally damaged kidneys, had just endured an incredibly expensive surgery for what? So he could ride his motorized wheelchair to the bar and win bets by showing off his disfigured foot? I know she didn't want to be cruel, but she believed there was a point when doctors should stop rescuing people from their own self-destructive impulses. And I couldn't disagree with her but I could ask for the most basic of comforts, couldn't I?[12]

In the second scene, which takes place after the narrator has finally found a good blanket, the nurse responds to a healing song the narrator and his father sing together.

> Our voices filled the recovery hallway. The sick and the healthy stopped to listen. The nurses, even the remote black one, unconsciously took a few steps toward us. The black nurse sighed and smiled. I smiled back. I knew what she was thinking. Sometimes, even after all of these years, she could still be surprised by her work. She still marveled at the infinite and ridiculous faith of other people.[12]

Because the nurse appears to give voice to the frustrations many health care providers experience, the first scene provides an opportunity for readers to add their personal beliefs and understandings surrounding the expenditure of resources and caregiver responsibility for noncompliant patients. Yet later, noting the nurse's sigh and smile when she hears the singing, one may consider how words like "surprised" and "marveled" square with "infinite and ridiculous faith," and how they fit with what is known about the patients to whom blankets are given and songs are sung.

Draw out its illustrations

The use of literature as illustration is often the most common reason stories appear in medical, health professions, and interprofessional education, as we pointed out earlier. Whether depicting a physician, nurse, or other caregiver struggling with professional doubt; a patient responding to a significant illness; or a family coming to terms with the loss of a loved one, literature offers educators rich illustrations of the personal dimensions of health and illness to illuminate its more profound aspects for students. Although this approach is the most common, we have saved it for last because we wanted to first demonstrate how the practice of close reading opens up a text for a greater appreciation of the ways that it makes meaning. Just as that practice supports moral inquiry, leading to a greater appreciation of the ethical nuances of caregiving, so too can close reading make a straightforward illustration into an opportunity for questioning how students see their patients and themselves.

To draw out a story's illustrations, readers may be prompted to look for as many different illustrations of particular phenomena as they can find. Here, as with close reading, paying attention to repetition is a useful first step. Does the story rely on a recurring image to represent a particular aspect of a character's experience? Conversely, are there absences in the story that make the representations of those same aspects seem suspect? The key is to encourage readers to read critically what is illustrated, to question their initial interpretations. The two scenes from "Blankets" cited earlier offer a clear demonstration of the possible meanings a single illustration may contain.

One could start drawing out the implications these two scenes provide by asking students to focus on the contrasting forms of care they present. In the first, the nurse's frustration is motivated by the belief that resources, including her time, are wasted on patients who will not take responsibility for their own health; in the second scene, she witnesses a form of caring that does not rely on traditional medicine. From here, students might consider how the narrator makes it clear that the song provides only a temporary solution. He even admits the song will not "prevent [his] father from drinking a bottle of vodka as soon as he could sit up in bed," that it will not in fact solve any of his father's health problems. But for those who stop to listen to it, the song unites "the sick and healthy."[12] The improvement in the father's health from the medicine, like that of the healing song, is temporary. But the second scene also represents a ritual and, as such, illustrates the ability of rituals to produce a kind of healing that reaches beyond the physical.

As an illustration, these scenes provide insights that students may draw from when they begin caring for patients. But these same scenes also offer readers who pay attention to how the illustration is actually presented opportunities to see it more comprehensively—surely a skill worth honing. The nurse's reactions in both scenes are actually presented by the narrator, the patient's son. He claims to know what she thinks, but she never actually articulates the judgments he attributes to her. Rather, her apparent irritation at the request for a blanket is his. He knows his father will continue to abuse alcohol, that he will not change his self-destructive ways. Suddenly, the illustration becomes illuminating. It highlights how conflicted caregivers can become when tending to their loved ones. The narrator, like so many caretakers of such patients, knows his efforts are temporary, but they provide "the most basic of comforts" nonetheless.[12] By reading the illustration closely, it shifts from a picture of a frustrated nurse to a representation of the complexities of health care that challenge clinicians, patients, and caregivers alike.

Conclusion

We chose to limit our discussion to these three approaches because we see them not only as useful in medical,

health professions, and interprofessional education but also as accessible to educators whose formal training is not in literature. Still, any of these settings would benefit greatly from a credentialed literature scholar who could provide the kind of ongoing professional development for faculty without such training who nonetheless use literature in their teaching. As we have shown, reading closely shares with the diagnostic process many of the same practices critical to skilled caregiving that relies on interprofessionalism: paying attention to details, the gathering and reevaluation of evidence, and the weighing of competing interpretations. By beginning with a close reading of a text, faculty can demonstrate for students how this skill, which courts rather than resists ambiguity, can assist them in making ethical and compassionate judgments and can aid them in drawing insights from illustrative cases that lead to more comprehensive care in the future.

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