# Close Reading and Creative Writing in Clinical Education: Teaching Attention, Representation, and Affiliation

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## Abstract

Medical educators increasingly have embraced literary and narrative means of pedagogy, such as the use of learning portfolios, reading works of literature, reflective writing, and creative writing, to teach interpersonal and reflective aspects of medicine. Outcomes studies of such pedagogies support the hypotheses that narrative training can deepen the clinician's attention to a patient and can help to establish the clinician's affiliation with patients, colleagues, teachers, and the self. In this article, the authors propose that creative writing in particular is useful in the making of the physician. Of the conceptual frameworks that explain why narrative training is helpful for clinicians, the authors focus on aesthetic theories to articulate the mechanisms through which creative and reflective writing may have dividends in medical training. These theories propose that accurate perception requires representation and that representation requires reception, providing a rationale for teaching clinicians and trainees how to represent what they perceive in their clinical work and how to read one another's writings. The authors then describe the narrative pedagogy used at the College of Physicians and Surgeons of Columbia University. Because faculty must read what their students write, they receive robust training in close reading. From this training emerged the Reading Guide for Reflective Writing, which has been useful to clinicians as they develop their skills as close readers. This institution-wide effort to teach close reading and creative writing aims to equip students and faculty with the prerequisites to provide attentive, empathic clinical care.

Clinicians and clinical educators are coming to recognize that narrative skills, such as reading, writing, and attending to the stories of illness, contribute to reflective practice. An appreciation of the narrative dimensions of illness and care, while always at least implied, has come to accompany the more technical aspects of diagnosis and treatment since Hippocratic times.[1,2] Multiple pedagogic approaches have arisen, increasingly since the 1990s, to encourage clinicians' use of literary and narrative practices in health care—reading medically inflected stories, keeping journals, writing reflective essays about health care experiences—to develop and maintain a clinically useful curiosity about patients and reflective self-awareness.[3–7] These practices appear across a wide range of health professions and the specialties within them.[8–11]

In this article, we review evidence from the literature that narrative training benefits clinicians. We then summarize several theoretical frameworks that suggest why this might be the case—psychological, developmental, humanizing, and aesthetic theories. Because our central concern is the role of creative writing in medical education, we focus mainly on the aesthetic theories. Following this rather detailed examination of some aspects of the aesthetics of perception, representation, and reception, we turn to our pedagogic practice at the College of Physicians and Surgeons of Columbia University where both students and faculty are deeply immersed in close reading and creative writing. (To call writing "creative" means not that it is fiction or fantasy but that it unleashes the curiosity and imagination of the writer, who may write in any style or genre. Reflective essays written in our clinical clerkships or portfolios, for example, are often as creative as the literary texts the students write and we read.) The Reading Guide for Reflective Writing is a pedagogic tool developed from our educational practice that has helped our faculty to become close readers (see the "Practice: A Model for Teaching Attention, Representation, and Affiliation" section later in this article for a description of the guide, and see Appendix 1 for the guide itself). It completes the circuit of asking very broad questions to guide daily practice, which in turn informs the very broad questions.

## Evidence: Whether Narrative Training Helps

To start at the destination, teaching reading, writing, reflection, or the humanities to clinicians and clinical trainees is done for one overarching reason: to improve the health care that they are able to provide to patients. The specific consequences of narrative training for the learner, such as self-awareness or well-being, may function as intermediate goals on the way to improving patient care. Yet, the ultimate goals of any clinical teaching method are (1) to strengthen the attention that the clinician is able to pay to the patient's situation so as to improve accuracy and permit empathy; and (2) to provide the patient with the clinician's knowledge,

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skills, power, and caring, shared through an effective patient–clinician affiliation, or committed partnership. Attention and affiliation may be considered the bedrock goals of clinical teaching.

A growing bank of outcomes studies demonstrates the consequences of including literary and narrative work in clinical training and practice. Increased knowledge of individual patients is the dividend in such varied clinical settings as genetics counseling,[12] fetal cardiology,[13] surgical training for medical students,[14] and individual primary care practice.[15] These studies demonstrate that clinicians' narrative writing about individual patients helps them to understand something that previously was unclear or to generate fresh hypotheses about a patient. Increased patient-centered communication also was mentioned, at least by self-reporting participants, in studies of medical students at various levels of training.[16,17]

Of 18 studies included in a systematic review of teaching empathy to medical students,[18] 4 studies report an improvement in measureable empathy when using narrative interventions.[19–22] The capacity for reflection is an often-measured outcome of narrative training. Using different conceptions of reflection that cluster around self-awareness and the recollection of past actions, these studies report increased reflection among preclinical students, residents, and practicing physicians as a product of their narrative training.[6,23–25] Constructs that can be grouped as affiliation—including health care team effectiveness, cultural understanding of patients, partnering with individual patients, and affiliating with peer learners—are outcomes in studies of trainees and clinicians throughout the learning continuum.[26–31] Finally, many of these studies find that learners derive pleasure from their narrative work and are grateful for the chance to use their creativity in their clinical training.[26]

## Theory: Why Narrative Training Helps

A number of conceptual frameworks have been created to organize our thinking about why narrative training helps clinicians and clinical trainees. The most prominent conceptual approaches can be divided, roughly speaking, into four frameworks. The first, psychological/behavioral theories of reflection, focuses on the cognitive aspects of reflection, endorsing the practice of retrospective self-review and critical self-assessment, that culminate in making decisions about how to change one's behaviors when next faced with a similar situation.[32,33] The second, developmental theories of professional adult learning, maps some of the changes in values brought about by authentic learning and recommends changes in the adult learning setting that might enhance singular and transformative educational outcomes in addition to the more rote aspects of skills building and knowledge transfer.[34–36] The third, theories regarding the humanizing potentials of the humanities, proposes that the study of the humanities can introduce students to ways of knowing that allow them to recognize ethical dilemmas, to regard patients holistically, and to feel the emotions of compassion toward patients and themselves.[37,38] The fourth, aesthetic theories of creativity, proposes that literary and narrative approaches to clinical training increase curiosity, strengthen the use of the imagination, and develop the creative powers of the student to represent what is seen so as to deepen his or her very perception of that which is before the eyes.[39–43]

Each of these frameworks has guided productive research and spurred pedagogic discovery in clinical education worldwide. As authors of this article, we represent our colleagues from the College of Physicians and Surgeons of Columbia University, an institution with a robust connection to the Faculty of Arts and Sciences and a tradition of recognizing the arts and humanities as central to clinical learning. Like other medical educators, we rely on insights from all four of the conceptual frameworks outlined above. However, we find that the aesthetic theories of creativity highlight particular aspects of teaching and learning in medicine that otherwise would be obscure.[44] Thus, for the remainder of this article, we focus on this framework.

### Perception and representation

The capacity to perceive events or persons fully and to inspect one's perceptions for accuracy are prerequisites for delivering attentive and empathic clinical care. Teaching clinicians the skills of the close reading of literature, creative writing, and the viewing of fine arts can strengthen their habits of "close listening" or "slow looking," thereby improving their quality of perceptive attention.[45–49] Cognitive scientists and literary scholars teaching in clinical settings agree on this point.[50–54]

That which is perceived has to register on the perceiver—it has to be claimed, grasped, metabolized, even maybe understood, at least provisionally.[55] How do perceived things become knowable or even known to the perceiver? Those who study perception give us surprising answers. Philosopher Nelson Goodman[56] reminds us that, when we look at an object, we look at a version or construal of that object. He then goes on to write that "[i]n representing an object, we do not copy such a construal or interpretation—we *achieve* it." Writing, as one form of representation, allows an individual to achieve his or her perception. To write is not only to report or record but also to discover. Creative writers too numerous to count—including Flannery O'Connor, Edward Albee, E.M. Forster, William Faulkner, and Franz Kafka—claim that writing is simply how they come to know what they think. The writer—or the painter, composer, filmmaker—achieves, through representation, some aspect of what he or she has witnessed or imagined.

### A rationale for writing and reading in medical school

Until a perception is captured in a representation, it is evanescent and unavailable for consideration by the perceiver and others. But, once form has been conferred on it—written, sculpted, painted, photographed, dramatized—the "immaterial" thing becomes "material" and can be communicated to oneself and to others.[57] Abstract expressionist Mark Rothko[58] suggests, in his magisterial *Artist's Reality*, that the poet's or the philosopher's "chief preoccupation, like the artist, is the expression in concrete form of their notions of reality. Like him, they deal with the verities of time and space, life and death, and the heights of exaltation as well as the depths of despair." Those who perceive the complex events and states of affairs evident in health care settings deal with these verities day in and day out, and yet their perceptions of reality might be unavailable to them without a habitual, dependable means of achieving them in a representation.

Rigorous training in the act of close reading and disciplined coaching in the craft of creative writing are powerful avenues to achieving perception, allowing one to inspect what he or she has perceived and to share that with others. In the training phase, learners have to strengthen their skills of representation. They have to learn the medium of writing or visually representing reality, at least well enough to capture that which they seek to preserve. Sometimes, trainees have to be encouraged simply to expand the mind to take in all of what is seen without preconceptions or wearing blinders. Creative training in clinical education does not have to start with writing about clinical matters. Instead, early on, learners must develop their creative and imaginative powers of discovery, vision, and representation.

If students are to write, these theories further suggest, they will need good readers. Henry James[59] writes in an essay on the novels of George Eliot that "the reader does quite half the labour." He draws attention here to the reader's duty to enter creatively into the scene, to do the complex work of recognizing what the creator might be doing, and to generate some provisional hypotheses regarding the meaning of the work. Aesthetic theorist and art collector Leo Stein,[60] brother of author Gertrude Stein, writes the same about visual art: "No object of composition, that is, no work of art, exists in the absence of a spectator." Representation is always a dialogue, in which the receiver of the work contributes a necessary response to the creator of the work. These observations about the role of the receiver help us to understand that the medical student who writes is owed a careful reading or hearing. We will return to the implications of this need for good readers later.

Through clinical training, we hope to transform our learners' perceptive attention—noticing things, being curious enough to look hard, being selflessly absorbed in what another tells, generating robust hypotheses—into a committed affiliation with a patient. Once one fully perceives a patient's situation by virtue of representing it, and once one donates one's own creative powers toward discovering it, one finds oneself in the patient's presence—absorbed, committed, newly aware of the complexity and potential meaning of that which is seen.[13,14,61–63] Recalling Nelson Goodman's assertion that one only has access to one's own version or construal of a perceived object, we must accept that there is no one or total version of anything perceived, including a clinical situation. What the clinician aspires to do is to represent accurately his or her own perception so as to consider it, compare it with others' versions, and come to some provisional and testable hypotheses about what the situation might be. This is why clinicians write notes in the medical chart, including about physical examination findings, formulations, assessments, and plans. And this is why our students grow as clinicians as they strengthen their powers of representation.

The goal of this work, ultimately, is for learners to achieve a state of attentive and empathic affiliation with a patient, born of their efforts to represent what they perceive, to seek the necessary perspectives beyond their own, to register that which is mysterious or unclear, to wonder about the mysterious, to ask questions about the unclear, to generate hypotheses about the patient's situation, and to test those hypotheses in the growing affiliation with the patient. Once learners can rely on their capacity to represent and then to consider what they perceive, they have at their disposal a most powerful and dependable tool to gain entry to the realities of patients and to offer themselves as partners in care.

## Practice: A Model for Teaching Attention, Representation, and Affiliation

The narrative components of the curriculum at the College of Physicians and Surgeons of Columbia University have grown in the past decades from elective courses in reading and writing to required narrative medicine seminars, required four-year-long writing portfolios for students, narrative medicine clinical electives, the option to complete the school's required scholarly project in narrative and social medicine, and graduate study in narrative medicine for faculty and students. Housestaff and faculty in all the health sciences professional schools are similarly exposed to narrative training in many clinical settings.[13,17,20,24,26,28,29,31,53,64]

Faculty ask students to write throughout the four years of medical school in required courses and clerkships. A poem or a paragraph from a novel is as likely as a case report to form the basis for discussion in a small-group seminar. We encourage students to read the text for its information, ambiguity, complexity, texture, and mood as well as for its plot. Students quickly come to know that they will be invited to respond to open-ended evocative writing prompts. Not restricting them to first-person realistic accounts of the things that happened to them in clinic or essay-question answers, we encourage students to try the genres of lyrical, fantastic, surreal, or experimental forms. We want to equip them with the wherewithal to express, to capture in some way, that which they, singularly, see. Our experience to date confirms our hypothesis that faculty encouraged to do creative work themselves will productively guide students toward creativity's discoveries.[65,66]

### Who reads what the medical student writes?

If reflective or creative writing is added to the medical school curriculum, those charged with reading what students write—their faculty—have to be equipped to read closely and carefully what is written. Clinicians may be relatively inexperienced in the tasks of close reading and commenting on others' creative writing. Although they may be avid readers of fiction and other forms of nontechnical writing, they may not have the training to articulate what a writer might be doing in a stretch of writing or to respond productively to that writer. We do not want our students to squander that which they might learn about their own ways of seeing things for want of skilled readers of their writing. So we have made a commitment to provide our students with trained close readers. With funding from the National Institutes of Health and the Josiah Macy, Jr. Foundation, we have hosted intensive weekly seminars for all medical school faculty who teach in the courses on interviewing, reflective practice, professional development, and the personal dimensions of health, illness, and health care.

A pedagogic tool that arose from these seminars is the Reading Guide for Reflective Writing (see Appendix 1) that outlines some of the basic narrative features of written texts. Such guides are common elements of the pedagogy

of creative writing and close reading in literary and writing settings. We chose categories of specific importance for clinical settings, used language accessible to those not trained in literary theory, and piloted a series of versions of the Reading Guide with extensive feedback from a variety of clinical learners. The Reading Guide reminds our readers to search for aspects of a written text—like sensory detail, perspective, genre, time, voice, metaphor, and plot—that may harbor meaning for both writer and reader. Many of the physicians who have used the Reading Guide over several years at Columbia and elsewhere have told us that they found it helpful in developing habits of close reading.

Not every text will display each of these elements of form, and typically one, or a few of the elements, alone account for the power or the meaning of the text. We instruct our readers to consider the elements, using the Reading Guide, as a means to open up the text to attention. Not unlike the kind of drill a radiologist might use in reading a chest x-ray—inspecting first the film's exposure, rotation, and inspiration and then studying in turn the bony structures, the mediastinum, and finally the lungs themselves—the reader of a student-written text might use the Reading Guide to note sensory details or their absence, the solitary or multiple perspectives represented, the genre and voice. The unpracticed reader might not wonder about the metaphors or diction of a text or explicitly notice the temporal scaffolding. These formal elements, we find, are the new veins of meaning for beginning close readers.

### How to respond to medical students' writing

Faculty certainly rely on clinical judgment and empathic responses in commenting on their students' writing.[67] In training them as close readers, we hope also to equip them with the means to respond to what their students do with words. We hope that they help their student–writers to realize what they have achieved in the writing discovery process, thereby providing a potentiating force to their more clinically focused readings. We are convinced that the physician/educator/reader can be attentive to both plot and form. The reader can certainly recognize the student's efforts in the realms of professional identity formation and the critical assessment of his or her own professional actions at the same time that the reader is attuned to the formal textual elements. We have found ourselves combining these approaches to our students' writing, fortifying the impact of our responses as readers.

We do not grade our students' writing, whether for its reflective capacity or its creative achievements. We are certainly interested in assessing the capacity of our students to imagine and depict what they themselves have seen or done, to think for themselves about their own actions and perceptions. But we have observed that the best way to achieve this goal is to read closely, to appreciate what the writer has captured in his or her form and how he or she has done so. Once the reader has attentively read the text, he or she then can convey to the writer, in person or with written comments, what the writer seems to have done with words. This in turn enables the writer to undergo motion—to be brought somewhere new in self-understanding—by virtue of this well-read writing.

A physician–reader skilled in close reading might say to a student something like, "I notice that the distance between the teller of this story and the patient in the story seems to shrink from paragraph to paragraph." Or the reader might say, "This sentence here is convoluted and very hard to follow—I wonder was something in it hard for you to say?" Or, "This paragraph reads to me like a prayer. Do you think you were praying for something? Who might you have been praying to?" Instead of responding to a writer at the level of affect, clinical judgment, or critique—"I'm so sorry that happened to you," or "Maybe it was congestive heart failure," or "What do you think the attending should have done instead?"—these readers are responding directly to the creative act itself. The text written by the student mediates the process of teaching and learning. Teacher and learner meet on the triangulating surface of the text. This frees the teacher from a judging stance and the student from a defensive stance. Unlike a therapeutic session or topical seminar, the matter at hand is not only what the student feels or knows but also what he or she creates.

Shifting the attention from student to work subtly and powerfully expands the nature of the lessons the student can learn about the self, ranging from the student's emotional and cognitive experience to his or her very notions, in concrete terms, of reality. As a result of this close reading, (1) the writer accrues some skills of craft, thereby becoming more and more able to represent complex situations and, as a result, to perceive them; (2) the reader does not intrude on the writer's interior reality as if claiming authority but, instead, suggests that it is visible and, perhaps, sharable, becoming affiliated company on the writer's search for meaning; and (3) the writer is helped to discover what he or she has done with words, for the writer, until ably read, does not know what has emerged from the self in words.

Our students, when asked to write creatively, are offered an otherwise rare opportunity to recognize aspects of their consciousness that typically lie outside of their awareness. Because we have written ourselves, have subjected our own writing to close reading by others, and have insisted that our faculty–learners do so too, we all have experienced the realization that close reading routinely reveals things to the writer that were unperceived before the reading. This is the power of writing.

## Conclusions

We have embarked on an institution-wide effort to teach close reading and creative writing at the College of Physicians and Surgeons of Columbia University, informed in part by aesthetic theories of creativity, so as to equip students and faculty with the prerequisites to provide attentive, empathic clinical care. The Reading Guide is one pedagogic tool that has helped our faculty to develop the skills needed for close reading and responding to their students' writing. This work has taught us that (1) faculty members themselves must develop skills in reading and writing and have readers for what they write, (2) a writer is needed to guide this process, and (3) a change in institutional culture is needed to permit and encourage creative work among students and faculty. That our institution has come to value and endorse the teaching and exercise of creativity as a critical aspect of its clinical enterprise is both the strength of the work described here and a limitation to its generalizability.

Work currently underway assesses the capacity of our physician–educators to become attentive readers for their students' writing and to become more skilled writers themselves. The required College of Physicians and Surgeons portfolio provides robust grounds for the evaluation of both the development of faculty members' reading skills and the consequences for the student–writers. Ultimately, we may find that these narrative skills will alter not only our students' and colleagues' learning and teaching habits but also their clinical practices. Future research will focus on the clinical consequences of narrative training for clinicians, students, and patients.

We think that our attention to the creative and formal dimensions of what medical students write will harvest important dividends for the students, for those they write about, and for those who do their best to teach them.

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## Appendix 1

**The College of Physicians and Surgeons of Columbia University Reading Guide for Reflective Practice**

**1. Observation**

Signs of perceiving—seeing, hearing, smelling, touching. Details, descriptions, sensory aspects of the scenes.

**2. Perspective**

Were multiple perspectives represented, explored, guessed at? How were these perspectives conveyed?

**3. Form**

What is the genre—story, poem, play, screenplay, parable, cautionary tale, ghost story, black comedy? Notice any use of metaphor or imagery. Describe the temporal structure of the text—are events told in chronological order, in reverse, in chaotic sequence? Are there allusions to other stories or texts? Are there inserted texts (like quotations, letters, substories)? What is the diction—formal, breezy, bureaucratic, scientific?

**4. Voice**

Whose voice tells the story? Is the narrative told in a first-person, second-person, or third-person voice? Is the teller near or far, intimate or remote? Can you feel the teller's presence as you read? Is the telling self-aware?

**5. Mood**

What is the mood of the text? What mood does reading it leave you in?

**6. Motion**

What does the story do? Does the teller seem to move from the beginning to the end? Does the story bring you somewhere in its course?