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Pediatric Resident Perceptions of a Narrative Medicine Curriculum

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Abstract
Training residents to become humanistic physicians capable of empathy, compassionate communication, and holistic patient care is among our most important tasks as physician educators. Narrative medicine aims to foster those highly desirable characteristics, and previous studies have shown it to be successful in fostering self-reflection, emotional processing, and preventing burnout. We aimed to evaluate pediatric residents' perceptions of a novel narrative medicine curriculum. After the initiation of a longitudinal narrative medicine curriculum, focus groups were conducted with residents who participated in at least one narrative medicine session. The curriculum was viewed positively, and residents found the sessions to be helpful in developing empathy, offering a space for reflection, and introducing new perspectives. Challenges noted were perception of relevance, timing of sessions, and interpretation by non-native English-speaking residents. With attention to linguistics and thematic undertones, narrative medicine is a feasible, replicable, and accepted teaching modality for pediatric residents to foster empathy, process emotions, and participate in self-reflection.

Keywords Narrative Medicine · Resident · Medical Education · Pediatric

Introduction

Training residents to become humanistic physicians capable of empathy, compassionate communication, and holistic patient care is among our most important tasks as physician educators. Narrative medicine is a methodology capable of teaching residents how to "acknowledge, absorb, interpret, and act on the stories and plights of others" (Charon 2001, 1897). Narrative medicine sessions aim to foster humanism in physicians-in-training so they are "attentive, thoughtful, and well-nourished physicians who are more fully prepared to care for those who are sick" (Rosenberg and Vitez 2019, 1239). Residency programs in diverse specialties such as emergency medicine, internal medicine, psychiatry, general surgery, and

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obstetrics have employed or embraced narrative medicine within their residency curricula to mitigate burnout, train compassionate physicians, and shape professional identities (Caretta-Weyer 2019; Pearson, McTigue, and Tarpley 2008; Wesley, Hamer, and Karam 2018; Winkel 2016; Fenstermacher, Longley, and Amonoo 2021; Scott-Conner and Agarwal 2021).

Pediatric residents, like their peers training to care for adults, may benefit from a narrative medicine methodology (Diorio and Nowaczyk 2019; Hester and Tsai 2018). However, the utility of narrative medicine in pediatric residency education is underexplored (Vibert et al. 2022; Birigwa, Khedagi, and Katz 2017). One narrative medicine curriculum for pediatric trainees nurtured self-reflection and engagement (Birigwa, Khedagi, and Katz 2017). Another noted that narrative medicine sessions provided a fulfilling and meaningful forum for emotional processing and reflection for pediatric residents rotating in intensive care settings (Vibert et al. 2022). Narrative medicine sessions diminished burnout for fellows in pediatric intensive care (Becker and Dickerman 2021). Reflective writing, one component of narrative medicine, allowed pediatric trainees to question professional morals in the provision of neonatal care and separately aided pediatric trainees' engagement with ethical reasoning (Boss, Geller, and Donohue 2015; Moon et al. 2013). Whether or not pediatric residents perceive that a longitudinal narrative medicine curriculum can help them process and provide care for complex pediatric patients (DasGupta 2007; Nowaczyk 2012; Sands, Stanley, and Charon 2008) or form humanistic professional identities (Miller et al. 2014; Wald et al. 2015) is unknown.

International Medical Graduates (IMGs) are physicians who attend medical school outside of the United States and then seek training in US hospitals. They face a particular subset of challenges in US graduate medical education (Murillo Zepeda et al. 2022). Inclusive and equitable integration into the American healthcare system can be challenging for pediatric IMGs (Osta et al. 2017). Effective patient communication and navigating communication barriers are other common IMG challenges (Murillo Zepeda et al. 2022). Whether narrative medicine—which improves residents' use of salient and reflexive language in place of dehumanizing language (Collier, Gupta, and Vinson 2022) and promotes attentive, empathic clinical care through close reading of texts with associated reflective writing (Charon, Hermann, and Devlin 2016)—can effectively bridge these gaps for IMG residents is unknown.

We report on residents' perceptions of a longitudinal narrative medicine curriculum designed specifically for pediatric residents at a single institution with a large proportion of trainees who are not native English speakers. Readings chosen for our curriculum aimed to highlight either common clinical scenarios experienced by our pediatric patients and families or struggles in professional identity as a physician. The goal of this study was to describe pediatric residents' impressions of and responses to this narrative medicine curriculum and demonstrate narrative medicine as a feasible way to integrate humanistic training into pediatric resident education, especially for IMGs.

Methods

Narrative Medicine Curriculum

In April 2019, we began a longitudinal narrative medicine curriculum. Given the literature demonstrating the efficacy of narrative medicine as a teaching tool in graduate medical education, this curriculum was integrated into routine didactic education in which residents do not provide consent to participate. Conferences were held once every educational block during dedicated didactic times built into the residency program's curriculum. Due to the

COVID pandemic, conferences began virtually but transitioned to in-person discussions as pandemic restrictions relaxed. Didactic conferences were mandatory, and residents were expected to participate.

Conferences were facilitated by a trained pediatric attending (RF or RC). RF had training from the Director of Narrative Medicine at the Lewis Katz School of Medicine at Temple University and attended Columbia University's Narrative Medicine Basic Workshop Conferences and ongoing seminars with graduate students enrolled in Columbia's master's program. RC attended Columbia University's Narrative Medicine virtual seminars and was trained by the other faculty facilitator (RF).

Narrative Medicine relies on multiple conceptual frameworks in education, including psychological theory, the developmental theory of adult learning, the humanizing potential of humanities as a tool to promote reflection, and the aesthetic theory of creativity (Charon, Hermann, and Devlin 2016). Conferences followed the model used at other healthcare organizations (Rosenberg and Vitez 2019). Each conference began by reading aloud a short piece of literature or, in one instance, listening to an audio recording. Residents were asked to discuss each selection with techniques of close reading, including focusing on when/where the piece was set, how the piece made them feel, what they saw in each piece, and whose voice they heard. While prompts were employed to start the conversation, residents were given the freedom to guide the discussion to topics personally related to the source material. Residents were subsequently provided a prompt and given five to eight minutes to write reflectively. Finally, residents had opportunities to share their writing and offer comments on shared reflections. No resident was required to speak. Residents were not forced to write or required to read their reflections aloud.

Readings (Table 1) were selected by the faculty facilitators (RF and RC). Facilitators believed their selected readings would prompt discussion and reflection on common scenarios experienced by our pediatric patients and families or highlight struggles in professional identity formation. Some readings were taught in narrative medicine programs at other institutions (Rosenberg and Vitez 2019), some were in published narrative medicine curricula for residents (Winkel 2016), and some were selected de novo from the literary canon based on the facilitators' goals for discussion and reflection. An abolitionist pedagogy (Varman, Posley, and Christ 2022) was intrinsic to our narrative medicine sessions.

Qualitative Evaluation

The study involved a one-time participation of pediatric residents in a focus group. Participation in the focus group was voluntary. By signing up to participate in a focus group, residents were giving their consent to participate. To minimize coercion, an invitation to participate came from a single resident liaison (NG) who coordinated focus group participation on behalf of the faculty. The focus group interviews were conducted in person in a hospital conference room during lunchtime in place of regular resident conference didactics. Residents were offered lunch in exchange for their participation.

We conducted two focus groups with resident participants of the narrative medicine sessions. These focus groups occurred in March 2022, ensuring every resident had ample opportunity to attend at least one narrative medicine session.

An experienced, independent qualitative researcher utilized a discussion guide (Table 2) patterned off Arntfield's narrative medicine focus group questions (Arntfield et al. 2013). The researcher moderated the focus groups, audio-recorded these discussions with participant consent, and performed a thematic analysis. She had no prior relationship with

Table 1 Syllabus

Theme	Reading
Three Good Things	"Finding New Eyes" by Rachel Naomi Remin
Burdens of work	Excerpt from "The Things They Carried" by Tim O'Brien
Societal Upheaval	"I Am Waiting" by Lawrence Ferlinghetti
Academic Milestones	"The School Where I Studied" by Yehuda Amichai
Death and dying	"The Truth the Dead Know" by Anne Sexton
Self-Worth	"Now I Become Myself" by Mary Sarton
Shame	"Big Boy" by Dave Barry
Limit Setting	"My Last Day as a Surgeon" by Paul Kalanithi
Teen Health	Excerpt from "This is How You Lose Her" by Junot Diaz
Burnout	"Code Lavender" Seasons 3 Episode 1 Nocturnists Podcast
Self-Reflection	"No Apology: A Poemifesto" by Carmen Giménez Smith
Pediatric Cancer	"People Like that are the Only People Here" by Lorrie Moore
Toll of Global COVID Pandemic	"Survivors guilt of watching India Survivors Afar" by Rani Neutill
Business of Medicine	"The Billboard" by Rachel Kowalsky
Professional Identity	"The Work you do, the Person You Are" by Toni Morrison
Interpersonal Differences	"Where I'm From" by George Ella Lyon
LGBTQ Health	Excerpt from "A Quilt for David" by Steven Reigns
Managing Expectations	"Girl" by Jamaica Kincaid
Pain	"Pain Scale" by Eula Biss

the residency program or any of the residents enrolled, nor did she have a prior relationship with the faculty conducting this study. Given her impartiality, the focus groups were designed for her to run and analyze independently with the assistance of unbiased coding tools.

To analyze the data, the researcher used coding tools from the Reduct platform. Codes were assigned to key themes to systematically interpret, organize, and structure the data. She used an inductive approach to developing codes, where the codes emerged from the data.

The Einstein Healthcare Network Institutional Review Board approved this study and deemed participation in the focus groups to be minimal risk. Funding was provided by the Albert Einstein Society.

Results

Participant Characteristics *(Table 3)*

In the 2021–22 academic year, 30 residents were enrolled in our program and attended narrative medicine sessions. Of these 30 residents, 13 agreed to attend one focus group. Most participants were female, international medical graduates, and non-native English language speakers. Participants in the focus groups closely reflected the makeup of the residency program.

Table 2 Discussion Guide

Warm-up and Intros (10 min)

Objective: To establish the neutrality of the moderator, and to allow the moderator to begin to develop rapport with the group

- Welcome, guidelines, etc. (no wrong answers, equal airtime, etc.)
- Recording and confidentiality
- Verbal consent
- Respondent introduction

Incoming Expectations (15 min)

Objective: To understand the mindset of the residents who are participating prior to starting the program, in order to establish how expectations may or may not have been met by the actual experience

1. Let's start at the beginning. What did you think when you first heard about the Narrative Medicine program?
   a. Were you looking forward to participating? Why or why not?
2. What was your understanding of the goals of the program?
3. What were you hoping to get out of the program?
   a. Listen/probe for how participants were hoping participation might prepare them to care for their patients

Program Experience (25 min)

Objective: To understand the overall program experience and how it impacted the residents who participate; also, to compare the experience to expectations

1. Overall, how would you characterize your impressions of the Narrative Medicine curriculum?
   a. What did you like most?
   b. What if anything didn't you like?
2. How often did you attend these sessions?
   a. What influenced your decision/ability to attend?
3. How would you describe your participation in the sessions? For example, were you an active participant? Sitting back and taking it in? Why?
   a. How if at all do you think your participation impacted your overall experience with Narrative Medicine?
4. Thinking about your expectations for the program, how well were those expectations met? (or not?)
5. It looks like you read a variety of things. What stands out as particularly good or useful? Why?
   a. Probe for perceptions of the writing prompts
6. Were there any readings that you weren't as fond of? If so, what and why?
7. What moment during the curriculum most stands out to you? Why?
   a. How did that moment affect your impression of the Narrative medicine curriculum?

Program Impact (30 min)

Objective: To understand how participants will take away from the Narrative Medicine curriculum

1. Looking back, how if at all do you think the Narrative Medicine curriculum will influence your clinical work and care for patients?
2. And how will the curriculum/experience influence your growth as a medical provider?
3. What skills or tools (personally or professionally) did you gain by participating?
4. One of the goals of the curriculum is to improve communication. What do you think it means to you to be a good communicator, and how well did the Narrative Medicine curriculum impact your ability to be a good communicator?

Table 2 (continued)

5. The curriculum also seeks to "foster humanism" to prepare you to care for patients. How do you feel about that? How well did the curriculum achieve that goal?
Looking Ahead (10 min)
Objective: To identify ways to improve the curriculum going forward and collect any final thoughts from participants
1. Looking forward, should Einstein continue to offer the Narrative Medicine curriculum to residents? Why or why not?
2. What suggestions do you have for the team running the curriculum, to improve the experience for future participants?
3. Any other final thoughts or comments?

Table 3 Demographics

	Number of Participants = 13	Residency Program Overall = 30
Post-Graduate Year		
% PGY-1	15%	33%
% PGY-2,3,4	85%	66%
Gender		
% Male	31%	33%
% Female	69%	66%
Medical Degree		
% DO	8%	10%
% MD	92%	90%
Language		
% Non-native English Speaker	69%	63%
% Native English Speaker	31%	37%
Race		
% White	54%	57%
% Black/African decent	8%	7%
% Asian	30%	23%
% Mixed (more than one race)	8%	13%
Medical School		
% International Med School Graduate	92%	87%
% U.S. Med School Graduate	8%	13%

Residents' Perceptions of Narrative Medicine

Overall, residents' impressions of the narrative medicine program were positive. A majority noted both that they would like to continue participating and that the program should continue. Further, residents identified three substantial benefits: developing

empathy for fellow residents and other colleagues, exposure to new perspectives, and providing space to explore and process emotion.

Theme 1: Developing Empathy

Although these participants did not use the word *empathy* explicitly, they described a process of coming to see their colleagues as fellow humans with a complex set of experiences that shape who they are and how they behave in certain circumstances. This empathy was built during discussions of the reading material when participants shared their unique perspectives, allowing other participants to see them in a new light. Residents observed, "Especially people who are above you, it's hard to humanize them," "You see the deeper in the person," and "Understanding people makes it easier to communicate to them." As a result, some described feeling like they are better able to work with others as part of a team.

Theme 2: Exposure to New Perspectives

By reading stories and poems of people who differ from them, with diverse experiences, many participants developed a deeper understanding of others. For example, stories about the experiences of people of a different gender, sexuality, or nationality helped participants understand what colleagues or patients who are not like them might be thinking or experiencing. Some also valued this exposure simply because it was interesting and made them think in another way. As one resident noted, "Even if you don't connect with the topic at hand, it opens up your mind to things that other people might be experiencing."

Theme 3: Providing Ppace to Explore and Process Emotion

Some participants observed that the fast-paced hospital environment does not leave a lot of time to experience emotions, lending them to feel more like a "robot" than a person. These participants appreciated the opportunity to dig into more emotional topics and explore their own feelings, as highlighted by the following comment, "It takes me back to a particular patient that I connected with who died."

Challenges Identified by Residents

Residents also noted challenges to address in future programming.

Challenge 1: Participation of Non-Native English Speakers

Those participants who were not born in the US and did not speak English as their first language were daunted by some of the materials, both from a cultural content and language perspective. For example, some pointed out that attitudes toward gender, sexuality, or violence may be very different in their countries of origin, making it difficult to relate to the

material, as noted by one comment, "Like the poem about people … in the South [of the United States] … I didn't know what was going on."

Others found language to be the biggest challenge. While they felt very comfortable with day-to-day English, especially in the hospital setting, some pointed out that poetry may rely on more descriptive or antiquated language that presented more of an obstacle to connecting with the material.

Challenge 2: Perceptions of Relevance

A few participants tended to be more literal, struggling to relate non-medical content to their daily lives. One questioned, "It's part of our world, but how does this directly relate to how I'm taking care of patients today?" Other participants appreciated that while non-medical content could help them in some ways, they still failed to connect with it. Most participants were able to find some materials that they enjoyed, even if others fell flat for them.

Challenge 3: Timing of Emotional Topics

As one participant lamented, "It's a very heavy thing to have in the middle of your day," noting a difficulty in processing the material. While some participants were open to exploring more emotional content, they also found the timing of the noon discussion burdensome. Others were simply less interested in connecting with their peers on such a deep emotional level.

Challenge 4: Participation

Conferences that led to engaged dialogue and conversation were viewed as the most beneficial. However, participants noted several challenges to developing that engagement. The participants voiced a desire for more time to prepare for discussion. During the study timeframe, virtual conferences hindered full participation as there was often little to no discussion among the participants.

Discussion

Pediatric trainees who attended our focus groups noted this longitudinal narrative medicine curriculum was well-received. The curriculum fostered professional identity, improved cultural awareness among peers, helped integrate IMGs into the diverse perspectives and experiences of their patients, and nurtured teamwork.

Our pediatric residents affirmed what a systematic review of narrative medicine methodology affirms: narrative medicine is an effective tool for encouraging empathy formation in graduate medical education (Milota, van Thiel, and van Delden 2019). By exposing residents to voices they may not otherwise hear (voices of authors) and the voices of their peers' responses to those voices, residents confronted diverse perspectives. The sessions also raised awareness of patients' stories and encouraged reflective habits through reflective writing and attention to detail through close reading, all of which combined to cultivate empathic physicians (Charon 2001).

A strength of this study lies in the diversity of our residency program. To effectively teach empathy to a mix of IMGs and American-born pediatric residents, including many

who are non-native English speakers, is challenging. That narrative medicine provided a methodology to do this for a diverse group of trainees captures the power of narrative medicine as a tool in graduate medical education. Abolition medicine (Iwai, Khan, and DasGupta 2020) teaches us that American graduate medical education interventions need not start with white, American-born trainees to be deemed effective.

Healthcare professionals are quickly learning that understanding their patients' personal stories is vital to their care. As social justice, the social determinants of health, and trauma-informed care become vital to address the health and well-being of patients, narrative medicine sessions are a feasible forum for residents to learn communication techniques to incorporate those topics into their care. As noted by one resident, these sessions can "open your mind to things other people experience." That is the core of empathy.

Inclusive and equitable integration into the healthcare system for IMGs is an important and challenging educational need in US graduate medical education (Murillo Zepeda et al. 2022). Our narrative medicine curriculum incorporated topics germane to American pediatric healthcare. Residents affirmed that part of their empathic development included awareness of the perspectives of peers globally (i.e., discrimination faced in home countries, violence, the toll of COVID globally), promoting empathy for peers, as well as perspectives of patients, thereby promoting empathy for patients. Building a team of trainees from differing backgrounds with mutual respect and understanding is critical for patient safety and medical team functionality.

As highlighted by the focus group participants, narrative medicine sessions can assist emotional processing in the provision of healthcare. Narrative medicine utilizes both self-reflection (Murphy, Franz, and Schlaerth 2018) and group discussion (Harolds 2019) as modalities to process the emotional toll of patient care. Emotionality is challenging to teach in graduate medical education (Shapiro 2013). Narrative medicine is not therapy, but it can be therapeutic and provide a forum to discuss emotions evoked in the provision of patient care. There is no one right way or singular method to support physicians' ability to cope with witnessing children's trauma, suffering, death, and dying. Witnessing suffering should never become simple, and narrative medicine is one manner to help physicians grapple with all we witness (Charon 2017). That our residents believe narrative medicine can provide this as one forum within their training aligns with the intent that a longitudinal narrative medicine curriculum can foster this aspect of professional identity formation.

With a deliberative and concentrated choice of narrative medicine materials, these sessions can be another tool to assist residency program leaders in facilitating discussion and processing of difficult experiences for residents who may experience unhealthy emotions affecting their personal safety and care.

Pediatric residents believe humanism is a core component of pediatric training (Pu, Bachrach, and Blankenburg 2022). While narrative medicine is only one way to provide humanistic instruction for pediatric resident physicians, it appears to be successful in its goal. While case-based simulations can also foster this type of professional development (Kesselheim et al. 2010), narrative medicine can engage adult learners with more than one modality geared toward humanistic instruction.

Limitations and Caveats

Designed as a descriptive qualitative study at a single institution involving one pediatric residency program, other residency programs will have to determine for themselves how to translate our programming for their trainees. While a majority of pediatric resident trainees

nationally are female, as they were in our residency program, a majority are not IMGs. While all residents (and physicians) can benefit from reading, writing, and discussing viewpoints, perspectives, and stories authored by those different from themselves, narrative medicine sessions with a more homogeneous group of primarily American-born trainees may draw out different themes utilizing the same or similar readings. This manuscript intended to show narrative medicine as a feasible tool for pediatric trainees, not to present a singular, all-purpose narrative medicine curriculum for pediatric graduate medical education.

While it is plausible both detractors and enthusiasts of the narrative medicine program were equally likely to attend a focus group, selection bias may play a role in influencing the results, as those most dedicated and eager to share their opinions may have been overrepresented. Further, while all residents participated in the curriculum lessons, less than half volunteered to attend a focus group. Lastly, thematic analysis was undertaken by one researcher, and qualitative analysis by Reduct software. Analysis by other experts may have found differing themes and analyses.

While a narrative medicine curriculum seems to be a feasible and well-accepted teaching modality for pediatric residents, it must be taught by skilled facilitators. Narrative medicine preceptors must be able to critically assess the appropriateness of presented material based on the diverse makeup of their audience. Based on the participant's life experience and social knowledge base, care may need to be taken in how and why the material is discussed. As noted by the focus group participants, it seems to be vital that narrative medicine materials are personally meaningful to them. At a minimum, it may be important to explore how the material is personally meaningful if this is not intuitive.

IMGs noted discomfort with poetry presented for discussion and reflection. Poetry is intentionally opaque. While printed language in any one poem may not be any more difficult to process than conversational English, poetry relies on literary devices, such as metaphors and manipulation of phonics, that may be difficult to decipher for non-native English speakers. Because poetry is the most condensed and emotionally laden genre of literature, nurturing residents' discomfort with poetry can help them push through internal discomfort when facing high-stakes or uncomfortable situations related to patient care. Challenging residents to grow in the face of this internal discomfort with the form of poetry through skilled narrative medicine facilitation may or may not be a worthwhile goal for facilitators.

While narrative medicine provides a forum to process emotional reactions to providing clinical care, the topics discussed during the session may cause emotional discomfort, and these sessions are not a substitute for formal mental health services and support. Facilitators must be mindful of those possibilities, have the time to address them, and have further resources available if necessary. Further, depending on the residents' clinical schedule and experience, a facilitator must be willing and able to quickly adjust the session for more appropriate topic discussions.

Next Steps and Future Research

This study cements the authors' belief that narrative medicine is a feasible and value-added component of pediatric resident education. The residents themselves suggested these lessons should continue. Authors plan to focus on examining works with less complex linguistics and themes without forgoing poetry altogether to ensure that non-native English-speaking residents are more able to participate and on choosing topics addressing a variety

of emotions, including those that bring calm, happiness, and confidence, and they urge similar programs to do the same. Ensuring that all sessions are in-person is an attainable goal. These minor adjustments will guarantee success with no modification to teaching methodology and/or overall objectives of fostering humanism, heightening professional identity, and improving resident-patient communication.

This study affirms that expanding narrative medicine throughout pediatric graduate medical education is both feasible and worthwhile. A natural next step would be to expand narrative medicine to a cohort of larger pediatric residency programs with both IMG and American-born trainees. Qualitative analysis of a larger sample of trainees could help further integrate narrative medicine into pediatric training.

Narrative medicine sessions provide a complement to resident lessons focused on pathophysiology, diagnosis, and management of specific medical problems as they anchor these medical problems into a larger context. They also provide a complement to other wellness programming.

Conclusion

Narrative medicine sessions remain a feasible and replicable way to help pediatric trainees develop into well-rounded, empathic pediatricians. Attention to the linguistics and thematic undertones of chosen narratives allows for diverse and deep discussions, fosters empathy, and enables the processing of emotions related to patient care. Integrating narrative medicine into residency didactics assists residents in their professional identity formation so they may provide holistic, humanistic pediatric care.

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Declarations

Competing Interests The authors have no competing interests to declare relevant to the content of the article.

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