Brooke Covington

Ars Media: A Toolkit for Narrative Medicine in Writing Classrooms

In the face of a world still reeling from the effects of the COVID-19 pandemic, teachers of creative nonfiction, narrative, and composition have a unique opportunity to infuse narrative medicine into writing curricula. Through training in critical reading and creative writing, narrative medicine (or health humanities, as it is sometimes called) is an approach to healthcare that values storytelling and creative expression as a means to improve care, promote healing, and empathize with the experience of illness. As James McAdams points out in the Fall 2020 issue of *Assay*, "literature and illness are inextricably linked" and we, as writing instructors, can teach students how creative writing functions "as both a therapeutic and reflective outlet" for making sense of the pandemic and its effects.

In this piece, I join McAdams in advocating for a turn to narrative medicine in approaches to writing instruction. Though I write primarily to those poised to inject narrative medicine into writing classrooms (even in our first-year composition courses), I do not forget those who might inject creative writing into their medical classrooms. Hopefully, both audiences will find value in my invitation to blend writing instruction with narrative medicine through critical reading and creative writing strategies. Such instruction has the potential to enrich student learning about not just writing or the COVID-19 pandemic, but also may provide a way to help students heal from the tragedies we individually and collectively experienced due to the pandemic. Certainly, if we learned anything from the past year, it is how vulnerable we all are to illness and how important it is to promote and prioritize healing.

The stakes are high. In his piece, McAdams explains that "when the pandemic is over, an entire generation of healthcare workers will have stories to tell, and it's our job as writers, professors, editors, and proofreaders to help them." I agree with McAdams, but I will add that it is our duty to help not just the healthcare workers who have stories to tell, but also those storytellers who enter our classrooms or live in our communities. As teachers of writing, we can support, nourish, and cultivate this urge to tell those stories—through this piece, I invite you to consider *how*.

This toolkit is organized by first, suggesting a few salient reasons for incorporating narrative medicine into writing courses. The following section then outlines the pedagogical pillars on which this toolkit was built, before describing the specific learning objectives of my narrative medicine course along with an overview of potential readings and writing prompts. The toolkit ends by offering some student testimony to the benefits of incorporating narrative medicine into writing courses.

Why should writing instructors consider narrative medicine? First, and as McAdams rightfully claims, reading and writing about illness can offer therapeutic effects for students grappling with the meaning of illness (Coret; Jones; Shapiro et al). But importantly, the study of illness narratives (both written by ourselves and others) can also raise students' critical awareness of cultural and structural inequities in healthcare (Banner; Saffran; Metzl and Petty)—an invaluable learning opportunity that will undoubtedly serve students as they progress into adulthood. Later in this essay, I will offer some strategies for incorporating a focus on the cultural and structural inequities present in U.S. healthcare systems.

Of course, it is also worth mentioning that a focus on narrative medicine in our writing courses may invite more diverse students to enroll in our courses, including students from STEM fields. The great beauty of blending narrative medicine with writing instruction is that these courses draw students with diverse interests and career goals. In any one course, I may find myself teaching to future physicians, teachers, scientists, hospital administrators, social workers, artists, politicians—and these interdisciplinary

classrooms often become a melting pot of potential change and influence in healthcare contexts. What better way to shift racist, sexist, ablest, heteronormative ideologies than by building coalitions of students equipped with the critical awareness to work against the grain in the institutions they will one day work? Eventually, these collectives will set research agendas, determine medical school admissions, create diagnostic tests and tools, write and deliver prescriptions—and even train future physicians. Investigating how we might incorporate narrative medicine into our classrooms is a potential investment in revolutionary change in the future. Moreover, these types of writing classrooms are an effort to ensure that students leave campus better prepared to engage with diverse populations in their future encounters with illness (either as care-giver or care-receiver—a title we will all invariably adopt for however long).

One last valuable reason for incorporating narrative medicine into our writing pedagogies is that such an approach exemplifies the kind of pedagogy built on radical empathy that Stephanie Guedet advocates. Building off Jake Stratman, Guedet suggests, "educators today need to imagine classroom spaces that not only argue for abstract ideas, or that perpetuate the notion that learning is solely an individualistic (and economic) enterprise, but that create opportunities to engage in ideas with real people, and that invite students to explore empathetic concern and perspective taking (26). Narrative medicine offers one outlet to do so.

Guedet describes her pedagogy of radical empathy as a classroom experience where students read and discussed stories by famous authors, but "they also told stories—stories about their lives that had meaningful connections to the stories from the authors we studied and from each other. Unlike in other discussion-based classrooms where students' personal anecdotes are met with barely disguised eye-rolls, our class was a space where stories were not only encouraged but honored." As will be made clear in the following section, the ability to honor—to bear witness to—the stories of others is a key feature of narrative medicine.

An Introduction to Narrative Medicine

Writing in 1995, Rita Charon (who holds an M.D. from Harvard and a Ph.D. in English from Columbia) and her colleagues offer early theorizations as to what literature can contribute to clinical practice, suggesting that a focused study of literature helps physicians to better understand the experiences of sick people while also revealing the power and implications of what clinicians do in caring for the sick ("Literature and Medicine" 600). The central aim within medical school's narrative medicine programs is to equip healthcare professionals with *narrative competence*, a specific skillset that values empathetic patient-centered care and the ability to bear witness to patients' stories as a central feature of the clinical encounter.

"Narrative competence," according to Charon, is "the competence that human beings use to absorb, interpret, and respond to stories" ("Narrative Medicine" 1897). To cultivate narrative competence, teachers and workshop facilitators lead participants through guided practices with close reading, active listening, and creative or reflective writing. Exercises aimed at narrative competence allow students to experiment with and locate meaning in not only the narratives of others but also their own narratives. Proponents of this approach argue that bearing witness to the stories of patients is one of the most crucial duties of the physician. As Charon explains, "If the physician cannot perform these narrative tasks, the patient might not tell the whole story, might not ask the most frightening questions, and might not feel heard. The resultant diagnostic workup might be unfocused and therefore more expensive than need be, the correct diagnosis might be missed, the clinical care might be marked by noncompliance and the search for another opinion, and the therapeutic relationship might be shallow and ineffective" ("Narrative Medicine" 1899). Healthcare practiced with narrative competence, then, reduces some of these risks by honoring the stories of patients *and* their caregivers as vital to the clinical encounter.

Initially, this approach to literature and medicine largely focused on cultivating narrative competence through the study of great works of literature. Eventually, the texts being studied in literature

and medicine programs expanded to include not only canonical literary works of fiction but many genres of both fiction and non-fiction written by authors from all walks of life. While much of the work emerging from narrative medicine teacher-scholars focuses on medical school classrooms, I believe that these tools can be useful in creative nonfiction and composition classrooms, especially since narrative medicine provides a mechanism through which students can use writing to make sense of a life marked by a global pandemic.

Indeed, narrative medicine—and the health humanities, more broadly—is welcoming to any learner interested in the human dimensions of illness. In my courses, I try to adopt a diverse set of readings and assignments that are geared toward helping students acquire not just narrative competence, but also the ability to think critically about the social, economic, and/or racial dimensions that produce unequal distributions of illnesses (and care) across health contexts, particularly in light of the COVID-19 pandemic.

Pedagogical Commitments

Before describing my approach to teaching writing through narrative medicine, I want to share some pedagogical commitments I adhere to in this type of course. All of the course materials I share here are informed by what Rebecca Tsevat and her colleagues call the "three pedagogical pillars" of health humanities curricula: narrative humility, structural competency, and engaged pedagogy. Indeed, I share these pedagogical commitments even for those uninterested in engaging with health humanities pedagogy simply because these are great pedagogical pillars to live by.

The first term, narrative humility, asks students (and practitioners) to "humble themselves when they receive the narratives of [others] and [to] recognize that those [individuals'] backgrounds and identities cannot be easily reduced and understood" (Tsevet 1463). Practicing humility as a writer, reader, and instructor is foundational to my approach. Sayantani DasGupta explains further that "narrative

humility acknowledges that…patients' stories are not objects that we can comprehend or master, but rather dynamic entities that we can approach and engage with" (980). Importantly, though, narrative humility, as a pedagogical pillar, "requires that educators not only treat the narratives of their students in a balanced, respectful manner but also that they reflect on their own power when eliciting such narratives" (Tsevet 1463). Tsevet and her colleges argue that such reflection is crucial in these kinds of encounters. Because students rely on instructors for grades, instructors must ensure that students feel comfortable with sharing their work and in choosing *not* to share their work.

The second term, structural competency, asks instructors to be "mindful of which stories are usually told and heard…and which are silenced or marginalized" (Tsevet 1464). In essence, structural competency aims to help students to better understand the ways in which health outcomes are linked to individualized structural factors (such as income, education, health insurance, and healthcare access) and to broader cultural, social, political, and economic factors (such as location, policy, systems of delivery, cultural bias, institutional racism). As a pedagogical pillar, though, structural competence also reminds instructors to practice sensitivity in the kinds of texts and writing exercises assigned so that, in addition to some of the foundational texts, less typical genres from historically marginalized authors are also included. Doing so helps students to feel that there is room in the classroom space for a range of voices and perspectives.

Though it comes last in the sequence, engaged pedagogy is the pillar I return to again and again in assessing my course materials and my performance as an instructor. Engaged pedagogy is practiced with careful attention to the students' well-being and security; this pillar is perhaps the most essential of all pillars in building the elusive safe classroom space we all hope to create and protect. Drawn primarily from bell hooks, engaged pedagogy is an approach to teaching wherein the instructor "makes herself vulnerable before her students to provide the proper environment in which they all may explore subjective, biased, and potentially emotional topics together" (Tsevet 1464). In following the tenets of engaged pedagogy, I

refuse to assign a writing prompt that I myself am unwilling to share with—and invite feedback from—the class. In this sense, I become not just a source of evaluation for my students, but also a co-learner. Admittedly, because I am in the position of the instructor, I can never be in as vulnerable of a position as my students, I try to diminish this hierarchy as much as possible by participating in multidirectional sharing and evaluation in the classroom.

Attention to each of these pillars helps remind me to destabilize traditional narratives that leave little room for stories from diverse populations and to draw from texts outside of what has become canonical. That said, this is work that never ends and there are still many ways in which I myself need to diversify my course materials. Yes, I do still assign works that have been overly privileged in the health humanities—we practice closely reading Charlotte Perkins Gilman's "The Yellow Wallpaper," Nathanial Hawthorne's "The Birthmark," and Ernest Hemingway's "Indian Camp" (to name a few). But I try to diversify these selections by including BIPOC authors and other creative minds who experiment in different kinds of genres. In the next section, I will describe some of the reading and writing exercises we use to achieve the course's learning objectives.

The following sections describe some of the course materials I utilized in two different undergraduate writing courses at my previous institution. The first course, titled "Literature, Medicine, and Culture," and the second, titled "Narrative Medicine," each satisfy requirements in both the English Department's curriculum and in the Medicine and Society minor offered at my prior institution. Housed in the Department of Science, Technology, and Society (STS), the Medicine and Society minor allows students to "examine medicine, disease, and health through the perspectives of social science, history, literature, and philosophy." To do so, the minor brings together instructors and undergraduates from many different disciplines across campus—in any given class, students from STEM fields, the social sciences, or the humanities may be present, with the numbers skewed slightly in my courses towards the sciences. Most

of the students enrolled are upperclassmen, since these courses are upper-level courses that carry prerequisites.

Learning Objectives

This piece draws most heavily on the Narrative Medicine course. I begin by outlining the learning objectives for the course, then I discuss the portfolio project we pursued over the course of the semester and the readings we engaged with to support that effort. First, the learning objectives for the course included:

1. To introduce students to the theories and practices of narrative medicine and develop narrative competencies by closely reading literature that addresses illness and healing.
2. To engage with writing and other forms of creative expression meant to imbue students with narrative humility and empathy.
3. To cultivate the capacity to recognize, absorb, interpret, and be moved by stories of others across a range of genres and media.
4. To investigate multiple perspectives on medicine, health, and illness through narrative lenses and formulate informed opinions on complex healthcare issues.
5. To understand how identities, values, ethics, cultures, and structures shape social meanings of disease and suffering and the delivery of care.

Portfolio Assignment

Based on these course learning objectives, I build the course materials. For our assignments, I take a portfolio approach, meaning that the "final examination" in the course consists of a Narrative Medicine ePortfolio, where students compile all the writing they have completed in the course in an organized ePortfolio using Google Drive. Early in the semester, students are placed in writing groups of 4-5

students, and they receive feedback on their work from their writing group members and me—they are graded both on the quality of their initial drafts and their written feedback to their fellow writing group members. By the end of the semester, each entry in the portfolio must include the initial draft, the feedback they received on that draft, and a revised version of their first draft (but may also include any subsequent revisions). Each entry is also accompanied by a short reflection, where students reflect on their process in whatever way is meaningful to them. The portfolio, then, ends with a 2-3-page conclusion, where students discuss what they learned from completing the semester-long assignment.

I use the first day of class to describe this portfolio assignment in detail—and I return to this description again and again over the course of the semester so that students understand how important it is to work on the portfolio early and often throughout the semester. At midterm, I ask to see a draft of the first few entries to avoid (as much as possible) too much procrastination from the students.

Foundational Readings

To address our first learning objective, we begin the semester by laying the foundation for what narrative medicine is and why it matters (according to foundational texts from authors like Anne Hudson Jones, Rita Charon, Sayantani DasGupta, and others). From that foundation (which answers *why* it is valuable to study narrative medicine), we attempt to put the principles and practices of narrative competence to work by engaging closely with a range of texts. At least a week is spent providing a crash course in close reading, using either the Close Reading Guide provided by Charon in her seminal work *Narrative Medicine: Honoring the Stories of Illness*, or by introducing the students to narratology (through the works of Mieke Bal or Monika Fludernik). We then practice close reading using short stories like Jamaica Kincaid's "Girl" or Sylvia Plath's "Lady Lazarus."

One exercise I enjoy (both as a writer and as a reader) is to assign Alice Munro's short story "Floating Bridge." After spending a class analyzing the story, the corresponding writing prompt asks

students to write about the experience of being on a floating bridge. Some students, of course, take the assignment literally—but I encourage students to explore this prompt in creative and expressive ways. The results are usually varied and interesting. This is also a fairly low-stakes assignment that gets students comfortable working with writing groups prior to addressing more difficult topics like illness and inequity.

Once we have some foundational knowledge of narrative medicine and have practiced close reading and creative writing, I shift to stories that address the human dimension of health and illness. Importantly, I try to frame each reading with contemporary issues in healthcare—often by pairing literary works with journal articles, news articles, or case studies. Doing so helps students to better recognize some of the cultural or structural inequities addressed in these texts but also raises the stakes for many students because they come to realize that the meanings derived from a short story (potentially published decades ago) continue to have relevance even today.

Just as important as cultivating the narrative competency to unpack the implications for these texts is raising awareness to (and writing about) the cultural and structural inequalities made visible between the lines of these texts. To focus our attention on these concerns, we often engage with the presence of power imbalances both in healthcare and in narratives, and we try not shy away from these power imbalances as we move through the text. Throughout the semester, I remind myself (and my students) that scholars like Rebecca Garden argue that narrative medicine is "a form of advocacy" (77)—one that should "work towards epistemological expansion" (77) by including the cultural, social, and political threats to human health as inseparable from the individual experience of illness. And yet, we must always ask ourselves "who speaks for whom?" (Garden 78) as well as "how we represent others and who benefits?" (Garden 80). Such questions are essential for avoiding (or at the very least reducing) the potential to misrepresent or colonize the narratives of others. Discussing these issues may be difficult or uncomfortable in an undergraduate course, but we can use the classroom space to reckon with and reflect on how we are made complicit within such structures—and I have found that the best approach to these difficult discussions is

simply to call out their nature as such. Creating safe spaces in the classroom is undeniably hard, but I try to be as transparent with my students as possible in hopes that they will be open to such conversations.

Prompt: Medicine and Racism

For example, I try to address issues of structural racism in healthcare by pairing readings like Richard Selzer's "Brute" with historical information regarding both the Tuskegee Syphilis Experiments and contemporary research studies, such as the effects of racial inequality and cases of Covid-19. "Brute" is a short story that describes a horrifying encounter between an African American male patient and a presumably white physician in the 1960s. The violence of the scene—and the clear power hierarchies represented—leave the reader questioning which of the two men is the actual brute of the story. A story rich in context, metaphor, and imagery, this text is a great entry point for students to practice close reading in a way that engages with structural racism. Our discussion of the text typically centers around how the narrative situates a power dynamic between the healthcare provider and receiver and how race might impact these perceptions. After studying "Brute," one of our first writing prompts asks students to grapple with the relationship between medicine and power—a theme that surfaces numerous times over the course of the semester. I frame these discussions, as well as the texts we study and produce, as the vehicles through which we grapple with learning objectives 4 and 5.

In semesters where I want to pursue a more prolonged and focused discussion of racism and its implications for healthcare, I might turn to Audre Lorde's *The Cancer Journals*—a text that also allows for engaged discussion of the ways not only race but also patriarchy and heteronormativity influence the delivery of care in our health system, particularly for women of color. Olivia Banner has a wonderful discussion of Lorde's text and how it might be used to develop practices of reading that reveal structural racism in healthcare contexts.

Prompt: Epidemics and Pandemics

In addition to race, it is important to include units that address current and historic issues that arise in healthcare because of pandemics and epidemics. One of the clearest examples, at least prior to the year 2020, is the AIDS epidemic that gripped our country and much of the world in the 1980s and 1990s (and continues to ravage other parts of the world even today). In units where we address AIDS, my goal is for students to understand that AIDS was (and is) not just a medical problem—or a failure of science—but a matter of cultural policing and structural discrimination that left thousands with few options for quality care. To get at this issue, we analyze and produce a range of texts from various genres in hopes of cultivating narrative humility and structural competence (learning objectives 2 and 5).

For example, we might view films like *Dallas Buyers Club* or *The Normal Heart* (which can be analyzed textually as a drama or visually through HBO's production of the play). These "texts" are like illness pathographies in that they portray the experience of illness from the perspective of a patient. As for more traditional forms of narrative, there is the popular *My Own Country* by Abraham Verghese, a text students seem to enjoy primarily because it is written from a physician's perspective. Though I have found that many of my students (especially the pre-med students) prefer books written from a physician's perspective, I try to champion the perspective of the patient and the voices of those who suffer. These stories are often uncomfortable, uncertain, unsettling—but necessary. Because of that, I might also assign a few essays from *In the Company of My Solitude: American Writing from the AIDS Pandemic*. Published in 1995, many of the essays in this collection speak to not only the urgency and desperation of the moment, but also the social, political, and even spiritual dimensions of this disease. Typically, these reading assignments are paired with an "illness pathography" writing prompt where students write about their own experiences with illness. In the past, this has included prompts like, Write about illness or a bodily condition from the perspective of a body part, organ, or fluid.

As much as possible, instructors should contextualize such readings with primary texts published in that era, such as the Surgeon General's "Understanding AIDS" pamphlet, which was sent to millions of homes in 1988, or President Reagan's first major speech about AIDS, which did not occur until 1987. We might read news articles or reports from the late 1980s or early 1990s that showcase the (slow) responses by the FDA and pharmaceutical companies in locating effective treatment measures. I often ask students to read advocacy materials developed by the AIDS activist organization ACT UP! or we might view the documentary *How to Survive a Plague*. Due to my own interest in the rhetoric of public memorials, I sometimes even ask my students to read critical analyses of the NAMES AIDS Quilt, and we might watch the unfolding of the quilt on the National Mall during the March on Washington for Gay and Lesbian Rights in 1987. To get at learning objective 5, discussion questions often center around cultural stereotypes or structural systems that prevented certain groups from receiving adequate care.

Because for some students, AIDS may seem like a historical problem that no longer troubles the medical community as much as it once did, this unit can be a nice segue into discussions on the global impact of AIDS, which is still ongoing. Or we might use this as a transition to discussions of COVID-19 and comparisons between the two health crises. Writing prompts then center around cultural interpretations and reactions to illness, where I encourage students to write from perspectives outside of their own.

Prompt: Medicine and Sexual Orientation

The discussions of sexual orientation that often result from a unit on AIDS can then move into readings related to discrimination experienced by queer and trans communities, particularly at the hands of the medical establishment and policy makers. In this case, I usually assign readings from a wonderful anthology edited by Zena Sharman called *The Remedy: Queer and Trans Voices on Health and Health Care*. This anthology contains a series of real-life stories related to the cultural and structural challenges faced by

patients who are non-heteronormative or non-binary and seeking care within our current health system. Published in 2016, the topics addressed are both timely and significant for our students to absorb, interpret, and respond to.

Again, it is important to contextualize these readings with current events that impact the health and safety of these communities. Current policy revisions in states like Texas and Arkansas concerning queer and trans youth could be a place to start, especially since such discussions also bring up bioethical issues concerning parental consent in youth healthcare decisions.

The potential prompts in this unit can be varied. It could be worthwhile to ask students to write about the assumptions of our society's medical establishment, who they serve and who they forget or disenfranchise (learning objective 4). Other prompts might ask students to write about a time when they were stereotyped or stereotyped someone else. Alternatively, instructors might ask students to write about a time they were silent and the effects of their silence.

Prompt: Medicine and Media

Perhaps it is already becoming clear, but for me, another important consideration to make when developing course materials is related to genre. Because not all students engage with the same kinds of materials the same way, pushing the bounds of what is considered an acceptable "text" to study can be a way to engage students who do not learn best through reading traditional monolithic texts. In this sense, I try not to cater too heavily to one kind of learning style or one type of text, especially since the dominant narrative structures we privilege in the United States too-often come from a canonized white, able-bodied, heteronormative, male perspective.

In past semesters, I have assigned graphic medicine texts from Whit Taylor, Allison Bechdel, or MK Czerweic. A growing interest in the humanities more broadly, graphic medicine uses comics to tell stories of illness through the combined use of written word and image. While some may cast graphic

medicine aside as a distinctly low-brow form of storytelling, many graphic medicine texts incorporate clinical data and scholarly research within the stories they depict. For example, graphic medicine artist Whit Taylor is passionate about graphic medicine as an artistic *and* scholarly form of storytelling within the realm of public health. Taylor's many publications in *The Nib*, such as "The Myth of the Strong Black Woman," "African-Americans Are More Likely to Distrust the Medical System: Blame the Tuskegee Experiment" or "What Is Race?," reveal the ways in which well-researched comics can be used to reveal the blind spots in our ideas and assumptions by making visible what often remains culturally or structurally invisible in our healthcare system. While Taylor's comics often deal with issues such a race, mental health, loss, and self-discovery, graphic medicine artists address a host of health-related issues. Moreover, this growing subfield is slowly gaining academic recognition as well.

For example, *Disability Studies Quarterly* published a journal article by Sarah Birge that critically examines two comics about individuals with autism: *The Ride Together* by Paul Karasik and Judy Karasik and *Circling Normal* by Karen Montague-Reyes. Whenever I assign graphic medicine texts, I try to pair them with academic texts such as these—doing so not only helps orient students who are potentially unfamiliar with the genre, but also instills in students the belief that, though these texts are comics, they are significant and worthy of close attention. It is important for writing teachers to open up not only the kinds of texts students consume in our classrooms, but also the kinds of texts they are invited to produce (learning objectives 2 and 3). Studying graphic medicine is a way to model different kinds of storytelling students might engage with through their writing.

In this unit, we might experiment with comics or photovoice as a form of creative expression and a visual research tool where people use images to capture and reflect on reality. One such exercise asks students to create an image or compile a collection of images (broadly construed, this could be a photograph, a drawing, a comic, etc.) that depicts one of the following questions: What is it like to be sick? What is it like when someone you love is sick? Students must give each image a title and caption.

Following the adage that instructors should meet students where they are, I try to pull other kinds of media into the classroom as well. For example, we might have a section dedicated to Medicine and Song, where I ask students to listen to the album *Hospice* by The Antlers, a moving meditation on mortality, guilt, and hope, even in the face of hopelessness. Students then submit other songs, written by themselves or others, that we might engage with that center on the experience of illness and/or caregiving.

Another "text" I might pull from in our Medicine and Media unit is a videogame called *That Dragon, Cancer*, a narrative videogame that retells the story of a child's battle with cancer. In addition to playing the videogame, we might also read academic texts that engage with the game (O'Hern). Allowing for these breaks in the genre expectations of the course often engender lively and invested discussion among the students. And the writing prompts can engage with genre and perspective in meaningful ways since not all prompts are strictly textual, either. In the past, students have combined a passion for art with their narratives—creating visual representations to demonstrate the tensions they see operating, sometimes under the surface, of the clinical encounters represented in the texts we "read." One student once included music as a necessary component of their final portfolio, providing a link to a Spotify playlist of songs to set the tone for each written entry. Indeed, each time I give this writing assignment, I am surprised by what I receive from students and excited to give them feedback.

Outcomes and Effects

By casting a wide net in terms of the "readings" and "writings" assigned, I hope to support my students in developing narrative competencies across a range of genres and health-related topics. Given that cultural and structural inequalities manifest in more than just the narrative space between the physician and the patient, students need heightened sensibilities to more than just the traditional narrative. Thus, I feel we must expand the genres we include in our course materials so that students can navigate the diverse

terrains they may face in their futures—and I follow the same tenets in developing the assignments I ask students to produce.

As Desmarais and Robbins point out, "[n]either the academy nor our health system are solely responsible for the reasons why health inequalities exist, but both can play a part in reversing historic inequalities and promoting social justice." As instructors of writing, equipped with the training to provide the kind of narrative competence that the health humanities advocates, it is our responsibility to promote this kind of reversal. In asking students to engage with these course materials, I try to instill the belief that becoming literate in the cultural and structural disparities in healthcare in the U.S. is required of everyone, not just those who are interested in going to medical school. From our work in the classroom, we discuss and write about why it is important to study the health humanities and how attention to illness stories can have a profound effect on how we conceptualize healthcare both in the way it is practiced *and* in the way it is received. Though perhaps overly idealistic, my hope is that students will take these writing exercises with them into their careers and use writing as a critical tool for exploring the narrative, cultural, and structural dimensions of their own practice (whether it is medical practice or some other career path). Moreover, the feedback I received from students on course evaluations bears witness to the benefits of this approach.

For example, one student commented, "I never realized how good it feels to write about a hard experience or about strong feelings. The act of putting it all out onto the paper not only serves to heal but also to begin to strengthen. I am now getting in the habit of writing about profound or difficult experiences because, one, it helps me feel better about the experience, and two, I can come back to these writings later to analyze and learn from what I was feeling in those moments. The skill to both write and respond critically to those writings in one gained from this course."

Another student mentioned, "through this class I've learned that writing really can help you to heal, while encouraging others to seek the care that they need. Although I am not going into the medical

field (maybe later in life, I'm not sure) like the majority of the other students, I think that this is a lesson that can be applied towards social struggles, mental illness struggles, and so much more."

Finally, when asked to connect the course to their future career aspirations, one student (who dreams of being a physician) said, "Entering this course, I expected to work on mastering the tricks to reading and appreciating illness memoirs. However, I realize now this practice can be stretched to photography, film, video games, and poetry; on all of which I have had the opportunity to exercise narrative analysis… I hope to dig deep into the details of each patient story, and consider more than just the surface-level speech. I am going to stress an analysis of the untold story, and study body language and narrative structure. In the end, I hope my patients know I am fully attentive in listening to and valuing their story as the foundation of their healthcare plan. Without this narrative, treatment is impersonal and the most valued aspects of life are overlooked. I hope to practice narrative medicine to avoid these shortcomings, and provide holistic, compassionate care."

Hopefully these narratives provide at least some testament to the benefits of incorporating narrative medicine into writing courses. But beyond student testimony, one of my core beliefs is that we (as writing instructors) have an obligation to address the lingering effects of COVID-19 on our students and our communities. Moreover, this specific approach encourages important conversations about injustice in our society and the cultural and structural systems that enable and sustain the existence of such injustices. I offer this toolkit as an invitation to writing instructors of all kinds since there is room for this kind of approach in creative writing, composition, professional and technical writing, science writing, intercultural communication, and many other kinds of writing classrooms. In addition to the benefit of broad application, narrative medicine as a pedagogical approach to writing instruction can be responsive to the problems we face in the moment, problems that, for some, are a matter of life and death. By channeling writing instruction through a narrative medicine lens, instructors might help students make sense of these problems and locate a path towards healing.

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