Creating Space II

Taking narrative and reflection to the next level in medical education, research, and practice

Friday April 13 & April 14, 2012

Beginning at 3 p.m.

Fairmont Banff Springs Hotel

Banff Springs Conference Centre

www.ahssm-eig.ca/creatingspaceii.ca

We are pleased to be affiliated with the 2012 Canadian Conference on Medical Education (CCME) www.mededconference.ca

Creating Space II

April 13 - 14, 2012 (Banff, Alberta)

Taking narrative and reflection to the next level in medical education, research and practice

This symposium has been organized to provide a forum for researchers, educators, and others interested in the role of arts, humanities and social sciences perspectives in health professional education. We are inviting clinical and medical educators, students, practitioners, creative writers and artists, and scholars from different humanities disciplines, to participate in a day-long conversation focused on exploring a diversity of narrative and reflective practices across the continuum of learning, including inter-professional learning. In organizing this symposium, we have hoped to foster an open space for dialogue regarding theoretical framings and methodologies informing current practices, along with opportunities for advancing inquiry in this area by identifying a range of pressing research questions.

... LOOKING BACK, AND FORWARD

This symposium builds on the "Creating Space for Arts and Humanities in the Education of Health Professionals" conference, and has also been inspired by the "Social Science Perspectives on Health Professions Education" symposium - both held in Toronto in May, 2011. The focus of our present meeting, "Taking narrative and reflection to the next level in medical education, research and practice," has also been inspired by, and is intended to expand on, conversations that began at the "Narrative Tradecraft" meeting organized by Associated Medical Services (AMS), held in Toronto, in February, 2011. Our efforts are inspired by the hope that we will continue to meet on an annual basis at rotating sites across Canada. We hope that ongoing conferences and symposia will provide a means of showcasing the innovative work that is being done throughout Canada and elsewhere, support networking and collaboration, and help to develop a community of scholars in this area. We are pleased to be affiliated once again with the annual Canadian Conference on Medical Education meeting, and look forward to "Creating Space 3" which will be held next year in Quebec City, the 2013 CCME host city, hosted by colleagues from the Universite de Laval and McGill University!

It is our hope that an annual symposium meeting will provide a mechanism for expanding an understanding of the contributions of the arts, social sciences, and humanities perspectives in health care and health professional education, as well as providing a forum and a stimulus for us to make contributions to these fields.

A pre-conference symposium associated with the Canadian Conference on Medical Education (CCME)

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- Canadian Conference on Medical Education
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Dear Symposium Participants!

It is our great pleasure to welcome you to this very special meeting which is focused on exploring connections between the arts, humanities and social sciences perspectives in health care and health professional education, writ broadly.

We are delighted that Dr. Lynn Monrouxe has agreed to be our keynote speaker, and are looking forward to her many contributions. The Creating Space II programme includes close to 50 oral presentations and posters. We are delighted to have a wide range of disciplines (including artists and performers) represented in the programme, along with both national and international participants. Creating Space II offers an opportunity for us to extend our understanding of the potentials of narrative, broadly conceived, and significance of reflection, what works and why, along with helping to clarify the range of contributions that narrative and reflection make to education and practice – in part, to address the perennial question, *so what?*

We have attempted to organize the symposium to maximize opportunities for participants to network and discuss evolving issues. We have included two receptions and several breaks which will allow you to view participants' posters. On both days, the posters will be located close to the registration table to facilitate viewing. We have also organized a focused networking lunch on Saturday, where people with interests in specific areas can meet, discuss questions, and exchange information. In addition, we are helping to organize opportunities for participants to meet colleagues over dinner on Friday and Saturday evenings.

Many organizations and people have helped to support and realize our vision for this symposium. We are deeply grateful for the generous sponsorship of the Associated Medical Services, Inc. We would like to express our heartfelt appreciation for the flagship support of CEO, Dr. Bill Shragge as we began to imagine this symposium meeting, and his early encouragement that we undertake this meeting as a collaborative University of Alberta-University of Calgary initiative.

We are also very appreciative of the support of the University of Calgary, the University of Alberta, the Alberta College of Family Physicians, and the Canadian Conference on Medical Education, and all of those individuals who generously contributed funds in support of this meeting. We also wish to thank the Canadian Association for Medical Education (CAME) for its sponsorship of the "Arts, Humanities and Social Science in Medicine (AHSSM) Education Interest Group (EIG)," which helped to promote awareness of this meeting.

We look forward to meeting you! In the end, the symposium will be the sum of all that we bring to it. We expect that it will more than bountiful... We hope that you enjoy the symposium programme, and also enjoy your time in spectacular Banff, Alberta.

Organizing Committee

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Symposium Overview

Abstracts

Additional Information

Symposium Agenda

Day 1 ~ Friday April 13, 2012

3:00 pm	**Registration, & Poster Viewing (Poster Session 1)**
3:45 pm	**Welcome, & Opening Remarks** *... PBM, TR*
4:00 pm	***Maruyama, Grand'Maison, Hovey* (Oral Session 1)** *... CAC*
5:15 pm	**Announcement: Ars Medica/ CMAJ Humanities Poetry & Prose Contest Winners (2012)** *... AP*
5:25 pm	**Reception & Poster Viewing (Poster Session 1)**
6:30 pm	**Dinner - On Own**

Day 2 ~ Saturday April 14, 2012

8:00 am	**Registration, & Poster Viewing (Poster Session 1)**
8:30 am	**Welcome***... PBM, TR; ....* **AMS Greetings, *Brian Hodges***
8:45 am	***Martimianakis, Kuper, Woodman* (Oral Session 2)** *... DB*
9:45 am	***Kancir, Hall, McNaughton* (Oral Session 3)** *.. .PBM*
10:45 am	**Morning Break, & Poster Viewing (Poster Session 1)**
11:15 am	**~ Keynote Address: Lynn Monrouxe, PhD ~** ***...TR***
12:15 pm	***Lunch, & Poster Viewing (Poster Session 2; Networking Lunch)**
1:30 pm	***Crawford, Hickie, Morris* (Oral Session 4)** *... AP*
2:30 pm	***Arntfield, Quilligan, Kelly* (Oral Session 5)** *... MC*
3:30 pm	**Afternoon Break, & Poster Viewing (Poster Session 2)**
4:00 pm	**~ Reflective Response: Lynn Monrouxe, PhD ~***... TR*
5:00 pm	***Transitioning to ...* Creating Space III (2013): DB, with *Fred Hafferty***
5:15 pm	**Reception & Poster Viewing (Poster Session 2)**
6:30 pm	***Networking Dinner, Optional**

see pg. 34, additional information is also available from the registration desk.

Lynn Monrouxe, PhD

Keynote Speaker

Dr. Lynn Monrouxe is a Senior Lecturer, and Director of Medical Education Research at the School of Medicine, Cardiff University, UK. Her research includes inquiry into medical students' professional identity formation, healthcare students' personal incident narratives of professionalism dilemmas, along with a video ethnographic study of bedside teaching encounters focused on student-doctor-patient interactions, and an audio-recorded study of clinical feedback sessions involving students and clinical preceptors. A prolific researcher in this area, she has published in a wide range of journals which include *Medical Education, Academic Medicine, Social Science and Medicine,* and *Qualitative Health Research* among others.

Selected Publications:

Monrouxe LV, Rees CE. (2011) "It's just a clash of cultures" Emotional talk within medical students' narratives of professionalism dilemmas. Advances in Health Sciences Education. ePrint 23/12/2011

Rees CE, Monrouxe LV (2011) "A morning since eight of just pure grill": A multischool qualitative study of student abuse. Academic Medicine. 86 (11) 1374-1382.

Monrouxe LV, Rees CE. Hu, W (2011) Differences in medical students' explicit discourses of professionalism: Acting, representing, becoming. Medical Education. 45 (6) 585-602.

Monrouxe LV, Rees CE, Lewis N, Cleland J (2011) Medical educators' social acts of explaining passing underperformance in students: A qualitative study. Advances in Health Sciences Education. 16 (2):239-52

Monrouxe LV (2010) Identity, identification and medical education: why should we care? Medical Education. 44 (1) 40-49.

Monrouxe LV. (2009) Negotiating professional identities: dominant and contesting narratives in medical students' longitudinal audio diaries. Current Narratives 1, pp 41-59.

Monrouxe LV, Rees CE, Bradley P. (2009) The construction of patients' involvement in hospital bed-side teaching encounters. Qualitative Health Research. 1 (7) 918-930.

Monrouxe LV. (2009) Solicited audio diaries in longitudinal narrative research: a view from inside. Qualitative Research. 9(1) 81-103.

Monrouxe LV, Rees CE. (2009) Picking up the gauntlet: Constructing medical education as a social science. Medical Education. 43:196-198.

Monrouxe LV, Neve H, Rees CE, Sweeney K & Rees-Davies L. (2009) Medical students' explanations of professionalism dilemmas experienced whilst overseas: Who do I think I am? A preliminary report for the Tomorrow's Doctors consultation in the UK.

Saturday, April 14th ... Keynote Address

"Their Story feels linked to You and Part of Your Story": Theoretical and practical aspects of narratives

Lynn Monrouxe, PhD (Cardiff University, Cardiff, United Kingdom)

In medicine, medical education and medical education research narratives are everywhere: from the informal small stories arising within everyday teaching and learning encounters (e.g. bedside teaching) to the formal use of narratives as tools for reflexivity or as data. However, there is no single way of understanding and conceptualising narratives. Thus narratives comprise a sequence of events that may be spoken, written, sung, performed or created (pictures) as informative accounts of events, as personal sense-making activities, as vehicles for the construction and performance of identity and as expressions of embodied values. In this keynote Lynn will explore both theoretical and practical aspects of narratives, leading to the question of how we can *know* if narrative methods are effective in teaching, and whether we really need to know.

Friday, April 13th

Oral Session #1

Art, Medical School and Cancer

M. Michiko Maruyama (University of British Columbia, Vancouver, Canada)

The University of British Columbia undergraduate medical curriculum integrates health perspectives from the humanities and social sciences with the clinical sciences in a course called Doctor, Patient and Society (DPAS). During the first year of medical school, students are taught how to reflect through narrative writing workshops. Throughout the academic year, students are given writing assignments to reflect on their experiences, both past and present. For my first writing assignment, I reflected on the words that a doctor had once told me, "You have cancer." Through narrative writing, I explored, for the first time in words, what it was like to be a patient. At the time of my diagnosis, I was studying Industrial Design at the University of Alberta and I can still remember how terrifying it was when the doctor started to speak Latin – a language that I had thought was long since dead. In subsequent narrative writings, I reflected on how being a patient exposed me to the medical field and how I jumped from the fine arts to medicine. I explored my thoughts and emotions of what it is like to be an artist in medical school and I tried to address the internal struggle between my identity and self… *Am I an artist or am I medical student? Can I be both?...* In a recent narrative writing piece titled "Med Student Robot," I became aware of a type of fatigue that if not careful, can infect a medical student, stripping them of their sympathy. It was then that I realized the importance of art and reflective writing – it helps me hold on to humanity and to maintain my sense of well-being. During this presentation, I will share with the audience parts of my DPAS narrative writings. The style of the presentation will be a monologue, where I will become multiple characters by switching voices and demeanor. The performance will be 8-10 minutes long; however the length can be changed to accommodate a shorter or longer time interval. Through my narratives, I will discuss some of the main challenges faced in medicine, including doctor-patient communication and physician fatigue, from the perspectives of a medical student, a cancer patient and an artist.

Holding Hand, A Significant Physician's Role: Testimony of a physician/spouse

Paul Grand'Maison (Université de Sherbrooke, Sherbrooke, Canada)

"I do not know where my road is taking me, but I walk better when your hand holds mine" Alfred de Musset. "Lie beside me. Hold my hand. It reassures me". Nicole's words during her last days of life. She was 60 and had been my wife for 38 years. The disease plagued her for almost 10 years. Mutilating surgery, radiotherapy and chemotherapy brought remission for 6 years. Nicole's last two years of life were governed by aggressive treatments, debilitating secondary effects and progressive loss of energy. Moments of fear and hope, rage and acceptance, sorrow and joy, tears and laughter, winces and smiles, confidences, prayers, closeness, friendship and love. November 20th 2011, the disaster is confirmed: countless bone metastases, almost no functioning liver and no more possible treatment. Hospitalization from December 6th to 8th for drainage of ascites. Nicole's decision to come back home. At her physician's suggestion, celebration of Christmas on December 10th with our 2 children, their significant others and our 2 grandchildren: laughs, tears, pictures and memories. The next 4 days, Nicole stayed in her (our) bed surrounded by us affectionately caressing her, trying to say goodbye and to give her permission to leave. On

December 14th, Nicole died calmly, her mother, her children and myself lying in our large bed beside her. Her breast cancer was over. Nicole was suffering both in body and soul. *"It is over. We stop. Hold my hand"* was what she was repeatedly saying in her last days. We did so, hoping that her walk on that frightening road that is the end of life would be soothed. Nicole also held our hand helping us on our road of letting her go. Throughout the years, Nicole's physicians held her hand physically. They also held her hand through their medical expertise. They did so by their clear explanations and ability to have her confront reality with always a dose of hope and by their listening and respect of Nicole's questions, concerns, fears and wishes. They did so through their frankness, by sharing with her their possibilities and limits including the difficult decision to stop treatment and by telling us to have Christmas two weeks before December 25th. They did so through their unquestionable commitment to serve, to be there and to care for her, constantly assuring psychological and emotional support. Each patient consciously or unconsciously says to his physician: "I do not know where my road is taking me, but I walk better when your hand holds mine". As physicians, we have the opportunity to physically hold a patient's hand. However, our professional duty does not stop here. We must use all aspects of our competence to accompany our patients through their experience of health or disease, whatever their physical or moral suffering, insecurity or sorrow. Doing so does not mean constraints to be feared, but rather, real engagements that are significant occasions for growth, both as a professional and as a person. Commitment to do so is for me one of the most important characteristics of what I call "A Great Physician".

The Relational Aspects of Learning with, from, and about The Other

Richard Hovey & Robert Craig (University of McGill, Montreal, Canada; University of Calgary, Calgary, Canada)

This paper focuses on relational considerations for enhanced interprofessional collaboration, patient centered care and leadership in healthcare. This interactive presentation will engage participants to explore previously held or encultured understandings of this phrase and through discussion to re-consider its meaning within their current learning and interprofessional context. This presentation will provide reflective perspectives on the meaning of these three simple words and how they work to enhance of diminish the relational aspects of interprofessional collaboration / education and patient centered care. *The partnership between doctor and patient remains separated by an unbridgeable divide . . . and yet even in these most difficult cases the doctor– and, who knows, perhaps the patient as well– must give due recognition to the fact that what is involved is always a relationship between two human beings*. (Gadamer, 1996, p. 171). In the healthcare setting, the value of effective interprofessional collaboration (IPC) and interprofessional education (IPE) for enhanced patient safety has been well established. Yet, the fundamental tenets of IPC/E and patient-centred care rely on the oft- overlooked quality-of-relationships between and among healthcare practitioners (HCPs), patients, and their families. Several manuscripts have highlighted the role of relational aspects in fostering improved patient-centred care and IPC/E(s). Further still, the inclusion of the patient and their family members as co-collaborators within the interprofessional team has provided an additional layer of safety. It is evident that relationships are paramount in the construction of the motto 'learning with, from, and about others,' as the phrase most often describes how collaborators come together to learn, engage, and form interprofessional relationships with each other. In the context of healthcare, those others represent a diversified group of people from which we may learn and who may be IPC/E core team members, peer colleagues, patients, and their family members, as well as participants in research studies. As a greater diversity and larger number of stakeholder voices are included in the IPC/E conversation, a more sophisticated outcome can occur: ultimately, to ensure safety and quality of care for the patient. Despite the frequent use of the phrase learning with, from, and about and the learning opportunities it implies, communication, IPC, IPE, and patient-centred practices remain conspicuously absent from many everyday healthcare interactions. Despite

Saturday, April 14th

Oral Session #2 ~ AM

The Narrative of Discourse and the Stories of Discoursing "Subjects": Lessons for health professions education from a study of interdisciplinarity and knowledge-making

Maria Athina (Tina) Martimianakis (University of Toronto, Toronto, Canada)

Discursive narratives are windows to social relations that are historically specific. They exist outside of social actors, yet they are productive in the way they constitute "subjects" through rationalized aesthetics – ways of being and seeing the world. In contrast, the experiential narratives of social actors offer insight into the material effects of social relations, including ways in which people draw on or resist discursive narratives to improve their lives. These stories have roots, in that they are grounded in everyday activity and encapsulate people's experiences, hopes, feelings and ethics. How can one methodologically combine the exploration of these two types of narratives, and what can be gained from doing so? A method evolved through the exploration of discourses of interdisciplinarity is described. In addition to a traditional archive of texts, mini-archives were also compiled for the study subjects that included artifacts associated with their knowledge-making activities. These individuals were then interviewed for personal stories illustrating their "uptake" of interdisciplinarity discourses as well as their experiences in "being" interdisciplinary. The focus of the first half of this research was on describing the narrative and limits of the popular discourse of interdisciplinarity. The second half focused on the materiality of this discourse, particularly how its story line was reproduced and resisted as "subjects" unfolded their personal stories of interdisciplinarity in descriptions of their every day activity. This research was framed theoretically in Foucault's later work which explored how people constitute themselves as moral subjects of their actions, while at the same time being disciplined by institutions into being certain types of people. Foucauldian ethics is witnessed in the strategic deployment of discourse when rationalized as a moral imperative. What this concept does not account for is the meaning making activities of discoursing subjects. To speak to this, an additional analytical layer focusing directly on the lived experience of interdisciplinary subjects was incorporated to elucidate how people experience the dominance of the popularized discourse of interdisciplinarity. The mini-archives assembled allowed analysis of a much broader network of activity for each participant than is typical for phenomenological studies. It also led to formulation of a substantiated articulation of how the researcher perceived participants were projecting their professional identities. This perspective was shared with participants during their interviews, offering them opportunity to 'correct' the reading of their archive, thus increasing the integrity of the experiential results. Through this method the broader systems of thinking that operate on knowledge production were identified and insights were gained into the microworld of individuals trying to make sense of contemporary knowledge making imperatives. Further, the hidden curriculum of interdisciplinary work was made visible, for it was discovered that in the context of promoting collaboration, organizations created the conditions for increased competition for resources, rewards and legitimacy. Many other aspects of health professions education could also be productively explored using this narrative method, unearthing the effects of the discourses that structure both our educational work and the clinical care around which it is centred.

Using Narrative Tools to Theorize the Clinical Encounter: Lessons from literary theory

Ayelet Kuper (University of Toronto, Toronto, Canada)

The fundamental relationship in medicine is the patient-physician dyad, and the creation of meaning in the patient-physician encounter is central to medical care. There are many disciplinary and theoretical paradigms that are relevant to this meaning-making. While approaches from literary theory have not been prominent in this area within medical education, the conceptualization of the patient-physician

encounter as a narrative event points to their potential utility. Mikhail Bakhtin's notion of the utterance highlights the necessity of "the other" in the development of meaning while remaining grounded in the corporeal reality of the body and in linguistic structure. For Bakhtin, all meaning-making is fundamentally intersubjective; the existence of the basic unit of communication, the utterance, requires the existence of another subject, whether present or implied. In addition, utterances are created within context-dependent, normative speech genres. While we assimilate many different lay speech genres as we master language(s), there are also specialized genres within certain groups or fields. Since meaning can only be created intersubjectively, we are reminded that in order to allow for such meaning-making each utterance must be constructed within a speech genre that is appropriate to its addressee. The dialogical meaning-making and attention to language foregrounded in this theoretical framing also call attention to the importance of naming, including both denotation and connotation, as an act of establishing shared meaning. Bakhtin's ideas and his focus on the dialogical have been taken up by social theorists such as Dorothy Smith, who acknowledges his influence on her argument for the intersubjective creation of knowledge while extending his textual ideas to the social interactions of individuals. She moves away from the more traditional notion of knowledge as the product of an individual, positing instead that knowledge is brought into being by the encounter between two subjectivities. Smith does not deny individuality or individual subjectivity, but rather emphasizes the need for two separate subjectivities in order to create meaning. These lenses, which are grounded in and draw on literary theory, have multiple suggestive implications for analysing the patient-physician encounter as a narrative event. It involves the creation of meaning through the intersubjective encounter of the subjectivities inherent in both patient and physician; these subjectivities have access to situated speech genres that guide their utterances as they interact with each other. The meaning created in their encounters honours subjectivity and agency while remaining based in the physical, material reality of the biological bodies they share as humans. Practically, attention to such conceptualizations of the patient-physician encounter, enriched with concrete examples from the clinical world, could give trainees narrative-based approaches to making sense of important aspects of clinical care in ways that honour patients' stories of illness. Most medical training experiences do not, however, provide their students with the language and knowledge to make use of these theoretical framings. An expansion of the medical humanities within medical education could provide these future physicians with the intellectual tools to analyse their subsequent realities and to carry an understanding of intersubjectivity forward into a coherent clinical praxis.

Biological Citizenship, Medical Institutional Space, and Literary Analysis: A doctor's narrative reasoning

Dorothy Woodman (University of Alberta, Edmonton, Canada)

In *Inside/Outside: A Physician's Journey with Breast Cancer*, Dr. Janet Gilsdorf is diagnosed with breast cancer and her professional relationships are altered when she becomes a patient of her colleagues. In Gilsdorf's account, medical institutional space, like a nation-state, delineates territories and categorizes citizens. Gilsdorf, however, in depicting medical institutional space as a geopolitical territory with borders, language, hierarchy of bio-citizenship, also finds a means by which to open up its borders and to reconceptualize bio-citizenship into an over-determined site of engagements. Her vehicle for such spatial mobility and multiple identity-associations is the literary delimitation and de-limitation of medical language itself. In addition to their scientific functions, medical words, she writes, are rich in metaphoric associations and etymology. Both scientific and literary associations are necessary to describe the complex experience with breast cancer as a doctor and as a patient. In recognizing the spaciousness of medical language, its multi-lingual power, Gilsdorf also claims the same for delimited medical spaces and the citizens that enter them. Her struggles with competing voices and narratives result in a compassionate, humane vision of medical care. I will explore two moments from Gilsdorf's memoir as an literary inter-

vention into medical discourse and practice. First, I will provide a literary reading of the moments when the pathologist gives her the designation of "cancer," and then later, when her husband, a doctor, examines her breast in their bedroom. Secondly, I will likewise read the private, reflective moment when Gilsdorf is in her bed, ill from her chemotherapy. Here, she ponders the polysemy of medical language and, in parsing its rich associations, creates a form of citizenship that situates the biological within a matrix of destabilized identities. Medical language can express the science and affect, the empirical and aesthetic aspects that make up human illness: Gilsdorf becomes, in effect, the bilingual cosmopolite traversing borders and spaces. By recognizing the literary expansiveness of medical terms, Gilsdorf also demonstrates how medical and private spaces overlap, how identities are multiple, and how the literary use of medical language enables the latter to traverse the former. Her work eloquently describes, through a lived experience, the complexity of human engagements in medical spaces. In her struggle to be a doctor/patient she articulates how doctors and patients share much in common; more than this, she uses medical terms and analogies as the means by which to do so. Gilsdorf, as a doctor/patient, bears witness that medicine can be enriched, without compromising medical care, by diverse representations and expressions of disease as well as by fluid, overlapping identities. Her memoir serves as an example of how doctors' honest reflections upon the tension between medical practice and identities with the complexity and ambiguity of medical relationships offer opportunities for comprehensive critique of medical practice.

Oral Session # 3~ AM

Reading Curriculum in Undergraduate Medical Education at the University of Toronto

Jesse Kancir, & Allan Peterkin (University of Toronto, Toronto, Canada) [with Ayelet Kuper, Pier Bryden, Debra Hammer]

Use of literature in medical schools has been shown to enhance reflective capacity and help students challenge biases and assumptions. This project is a collaboration between the Working Group on Health Humanities and physicians with the Faculty of Medicine at the University of Toronto, the Health, Arts, & Humanities Project at Mount Sinai Hospital, and the Wilson Centre. Building on the idea that an exposure to selections from the humanities not only makes the experience of medical education more enjoyable but also fundamentally broadens the understanding of the experience of illness and healing, this project aims to provide students with material to appreciate the profession which they have just entered. Currently, one to two readings per week based on students' medical sciences courses (including community health and clinical skills courses) are used to enrich the learning experience of first-year medical students. For example, a week focusing on cardiovascular physiology includes Margaret Atwood's "The Woman Who Could Not Live With Her Faulty Heart" inserted at the beginning of the students' lecture notes for that week, with the aim of amplifying their understanding of the experience of sickness. With strong support from the Undergraduate Medical Education Curriculum Committee in the Faculty of Medicine at the University of Toronto, this new segment of the curriculum has allowed students to be introduced to the medical humanities from their first experience with academic medicine, establishing the importance of this viewpoint of the medical profession and creating a platform for the further development of student's various interests in this topic. Throughout the curriculum, selections from the viewpoint of both the health provider and patient are provided to strengthen the student's understanding of the clinical subject matter being addressed. Poetry by John Keats, a story by John Updike, a diary entry by Beethoven: all of these make for an interesting, poignant, and refreshing addition to learning medicine. The first-year curriculum has been implemented this year with warm reception by students having just entered medical school. Permissions for the clerkship readings are currently in the process of being obtained and the second-year curriculum is being completed with aim for distribution to students in September 2012. The presentation proposed to the Creating Space II committee will explore the concept in

more detail, showing how clinical examination skills, principles of physiology, and social determinants of health have been offered with freshness to new training physicians and will highlight how medical students have played a prominent role in guiding this project, effectively creating an environs for thinking, analyzing, reflecting, and – perhaps more importantly – enjoying medical studies.

Faking Affect: Quaking in the patient's boots

Nancy McNaughton, & Kerry Knickle (University of Toronto, Toronto, Canada)

Background: Standardized Patients (SPs) are lay persons employed extensively within health professional education to help teach a range of clinical skills. SPs are not "real" patients nor do they represent real patients but rather health care professionals' ideas about patients. The actual "patient" always remains a phantom. As an embodied affective presence literally in front of and in physical contact with health professionals, simulated patients (SPs) are a fertile site of knowledge production as well as transformative learning. They teach about emotion and affect, engage affectively in the presentation of clinical material and have developed an educational methodology for facilitating understanding and experience of emotion and affect. This is a nomadic space that is productive of more than new understanding: a space of continually negotiated tensions between imagination, reality, fantasy, authenticity, complicity and duplicity. Small moments provide paths to be followed in relationship with the "other's" movements. It is a dance, not a march. What is the relationship between acting and inhabiting another person's story? What are we doing when we interpret another's story and what are the implications? SP exchanges with trainees and practicing health professionals offer opportunities for ethical and aesthetic commitment to learning as a form of mutual metamorphosis and mutation. Such pedagogy recognizes the effects of knowledge production as materially implicated – on real bodies and lives and which require conversations and multiple perspectives. Intended Outcomes:. Through a reflective simulated patient training exercise and facilitated discussion the participants will examine their unique responses as both story teller and listener. We will begin to explore the various tensions between different affective registers. Participants will begin to discover the ways in which emotion and affect inform their interactions.

Addressing Suffering: Using a patient's narrative for interactive, interprofessional education

Pippa Hall, Susan Brajtman, & Lynda Weaver (University of Ottawa, Ottawa, Canada; Bruyere Continuing Care, Ottawa, Canada)

Background: Interprofessional collaborative care is an essential part of palliative care. Interprofessional education (IPE) is a response to the need for more effective, collaborative, person-centred teamwork. Suffering is a complex combination of physical, psychological, socio-cultural and existential factors often experienced by patients facing a life-threatening illness as well as by their families. Health care providers must collaborate together to address this suffering. Methodology: We used a patient's narrative as the media for an interprofessional group of students to learn to address suffering. Development began with a team of four students as narrative developers: 1st year medicine, 4th year medicine, 1st year nursing, and Masters in English literature. In collaboration with academic faculty, they developed common interprofessional and profession-specific learning objectives for pre-licensure students in six specific health care professions: medicine, nursing, physiotherapy, occupational therapy, social work and spiritual care. This team completed a literature review on suffering then conducted interviews with academic and community content experts in palliative care. From this information, they created an extensive profile and life history of a fictional patient with multidimensional suffering. From this profile, 49 monologues (one to four paragraphs of text written in the first person) were authored and categorized into physical, psychological, social and spiritual domains (9). The story was then created into an on-line interactive module, supplemented with video, audio and/or photographs. Faculty from the Theatre Depart-

ment at the University of Ottawa provided further character development and acting performances. The monologues can be used alone as an interactive synchronous, small group activity, or in the asynchronous on-line format, where learners choose a unique navigation strategy. In both versions, no one learner can see/navigate the whole story, so participants must share their understandings to address the suffering and develop a collaborative care plan. With ethics approval, volunteers were recruited to pilot the on-line module. Evaluation data included pre-post responses on a validated 'Attitudes Towards Health Care Teams' questionnaire; pre-post case study reports; a learner satisfaction questionnaire; a three-month post-module survey. This on-line module has subsequently been used as part of an interprofessional class on palliative care for pre-licensure students. Results of Pilot Study: 21 students, representing nursing, medicine, spiritual care and physiotherapy completed the module. Nineteen were women; 56% had experience with on-line learning; 53% had previous interprofessional experiences. High pre-module attitudes towards health care teams increased slightly. All were highly satisfied with the learning experience. Pre-post case studies showed learners doubled their identification of spiritual and physical issues and identified the need for teamwork five-fold. The overall learner satisfaction from the class was also positive. Conclusion: Students increased both their appreciation of the need for health care teams and the components of suffering.

Oral Session #4 ~ PM

Training Fourth-Year Medical Students toward Residency Competencies: Methods from narrative medicine

Shannon L. Arntfield, Kristen Slesar, Jennifer Dickson, & Rita Charon (University of Western Ontario, London, Canada; Columbia University, New York, United States)

Purpose: This study sought to explore the perceived influence of rigorous narrative medicine training on clinical skill development of fourth-year medical students, focusing on competencies mandated by the Accreditation Council for Graduate Medical Education (ACGME) and the Royal College of Physicians and Surgeons of Canada (RCPSC-CanMEDs) in areas of communication, collaboration, and professionalism. Method: Open-ended survey questions and a focus group were used to query twelve medical students enrolled in an intensive one-month narrative medicine elective regarding the process of narrative training and its influence on clinical skill development. An iterative thematic analysis of both datasets was carried out by each author. Data triangulation was achieved. Results : Response rate for the weekly survey was 91% and focus group participation was 50%. Five major findings about the contributions of narrative medicine in medical education emerged. Students perceive that they: develop and improve specific communication skills; enhance their capacity to collaborate, empathize, and be patient-centered; develop personally and professionally through reflection. They report that the pedagogical approach used in narrative medicine training is critical to its dividends and that narrative training is misunderstood by others and perceived as counter-culture. Conclusions: Participating medical students reported that they perceived narrative medicine to be an important and effective means of enhancing communication, collaboration, and professional development. The authors contend that these skills are integral to medical practice, consistent with core competencies mandated by the ACGME/ RCPSC-CanMEDs, and difficult to teach. Future research must explore sequelae of narrative medicine training on actual clinical performance.

Can Reflection be Used to Empower 4th year Student-Doctors to Communicate their Learning Needs on Ward Rounds: An action research study

Sally Quilligan, & J. Silverman (Cambridge University, Cambridge, United Kingdom)

Introduction: The ability to reflect is advocated by the General Medical Council (2009) as an important quality that future doctors need to develop, to work effectively within today's complex healthcare envi-

ronment. This action research study (Reason and Bradbury 2008) sought to explore the value of critical reflection when used to empower student- doctors to engage in ward round learning. Traditionally student-doctors have been taught clinical education through participation in apprenticeship-style hospital attachments, a key feature of which is the ward round. More recently Dewhurst (2010) and Quilligan (2010) have identified that clinicians and students are questioning the value of the ward round as a learning experience and that students adopt a passive approach to learning. Drawing upon socio-cultural models of learning (Wenger 1998) and using critical reflection (Brookfield 1998), this study helped students to reflect on the factors that enabled or disabled them to learn in the clinical environment and to explore approaches to overcome identified barriers. One key challenge was finding ways to communicate their learning needs on ward rounds. Methods: Over a 5 week attachment, eleven 4th year student-doctors engaged in an educational intervention involving audio-diaries (n=40) in which they reflected on observed ward round interactions, and reflective learning discussions (n = 3) incorporating goal setting activities. These discussions were used to help students critically reflect on the potential learning opportunities on ward rounds, the challenges to accessing these opportunities and how students could communicate their learning needs to seniors. Focus groups were used pre and post the intervention to evaluate outcome. Results: 1) The intervention enabled students to engage in critical reflection and challenge the assumptions that underpinned their prior understanding of knowledge and learning. As a result, students identified a richer range of learning opportunities beyond core medical science; these included communication skills, patient management and ethical issues; 2) Students set 23 goals relating to becoming more active participants in the ward round; 18 were positively evaluated; 3) 9 months after completing the study eight students reported feeling confident to communicate their learning needs on ward rounds. Furthermore, they had transferred this learning to other clinical environments. Discussion: This study engaged student-doctors in exploring learning in the complex world of clinical practice by drawing upon recent authentic clinical experiences. Using audio diaries and guided discussions students engaged in critical reflection by challenging their assumptions, sharing their experiences, considering alternative perspectives and exploring alternative approaches. Critical reflection on their understanding of learning and how they were perceived by other team members enabled them to understand the central importance of communicating to seniors their role and learning needs. For references, email saq23@medschl.cam.ac.uk.

Dr. Who? Narrative Analysis as a Means of Understanding Professional Development at the Undergraduate Level

Martina Kelly, Deirdre Bennett, Margaret O'Rourke, & Anthony Ryan (University College Cork, Cork, Ireland)

Background: Professionalism is increasingly emphasised as a key outcome of medical training(1, 2). Yet despite from much soul-searching as to the nature of professionalism(3), few models exist to guide aspiring doctors nor their teachers. Some suggest that perhaps medical education itself erodes key aspects of professionalism (4). Reflective practice is frequently promoted as a means to promote professional development (5). Yet the format of reflective practice can vary. Clandinin & Cave (2008)(6) suggest the use of narrative analysis as a means to ensure 'pedagogical space' within postgraduate training as means to explore professional development. We wondered if a narrative framework could be applied to reflective writing across our undergraduate curriculum, with a view to gaining a better understanding of how medical students develop professionally. Research question: What can narrative analysis tell us about the professional development of doctors at undergraduate level? *Methods*: In our medical school we offer an integrated curriculum. We have a diverse student population comprising 60% Irish students & 40% intake from other nationalities of which Canadian and Malaysian students form the majority. A purposive sample of students (male/female; direct entry/postgraduate entry; Western/Asian ethnicity) were iden-

tified (n=10). Reflective written materials from year 2, 3 & 4 were compiled into a longitudinal record. Each was read and analysed using a narrative approach (7). Each record was 'restoryed', paying attention to time, place and person. Particular emphasis was placed on the issue of temporality. The authors acknowledge dynamic interactive relationships with the students concerned. Ethical approval was granted from Cork Regional Ethics Committee. Results: Data analysis is ongoing. Excerpts of narrative analysis will be presented. Results will draw on work by Monrouxe (8) and in relation to situated learning theory (9). Discussion points: Narrative within a curriculum; creating longitudinal records. The ethics of narrative analysis. 'Doing' narrative analysis. Conclusions: Narrative analysis can provide a unique insight into student professional development. For references, email m.kelly@ucc.ie.

Oral Session #5 ~ PM

What is Going on in This Picture? Reflection on Visual Narrativity and the Hidden Visual Curriculum in Medical Education

Allison Crawford, Sabrina Nurmohamed, & David Matthews (University of Toronto, Toronto, Canada)

This proposed presentation will engage viewers in a simulation of a new medical elective, started with students at the University of Toronto. Students participated in a six-week course at the Art Gallery of Ontario in which we viewed works of various materials and genres, followed by lessons in life drawing and image-making with an artist. We understand visuality as core to medical communication, diagnostic and therapeutic practice. Medical practitioners are continually guided by their visual observations. And yet, this process is not typically a formal part of the medical curriculum; and because it is not often make explicit, it is even less frequently reflected upon. There have been several recent inquiries into creating pedagogical opportunities for medical education through art galleries (Elder et al. 2006; Klugman et. al 2011). Most of these studies, however, focus on aims of improving the technical competence of medical students, such as improved precision in description of patients (Bardes, Giller and Herman 2001), or improved description of disease markers and diagnosis (Dolev, Friedlaender and Braverman 2001; Kirklin et al. 2007; Naghshineh et. al. 2008). We are more interested in providing an opportunity to develop students' visual narrative competence – to make explicit the process by which observation becomes intelligible through narrative. Our approach to image exploration is based on Abigail Housen's Visual Thinking Strategies (VTS) methods, and theoretical frameworks drawn from visual anthropology and cultural studies. VTS uses a mode of open-ended, collaborative narrative inquiry to explore the meaning of images. This approach has been shown to be adaptable to different stages of aesthetic development, and to advance students' stage of aesthetic development. These advances occur through scaffolding students from emotional judgments based on personal associations, to improving classificatory and descriptive precision, through to a more mature and reflective level, where the viewer can engage with an image's "time, its history, its questions, its travels, [and] its intricacies". In other words, students become more self-reflexive viewers, capable of greater critical curiosity. We hypothesize that these skills are directly transferable and applicable to the clinical encounter and are an important part of identity formation in the learning physician. The VTS framework also offers the opportunity to sensitize pre-clinical students to their visual experiences, as an alternative to viewing within disease, structure and function frameworks and contexts. We will demonstrate this method of group looking and inquiry through the exploration of five works of art. In addition, we will present findings from our focus groups with the medical students involved in the course, and engage the audience in a discussion of the intersections and divergences of *visual* narrative competence and narrative competence. Future directions from this work include upcoming interprofessional opportunities. For references, email allison.crawford@utoronto.ca.

Fractured Narratives

Catherine Hickie (Newcastle University, Newcastle, Australia)

In a hospital in regional NSW, Australia, medical students from three universities come for clinical psychiatry attachments. Although they share the same wards and clinical teachers, there are competing university affiliations, non aligned schedules and differing assessment and structured learning requirements that set the students apart from each other. To heal this schism, two psychiatrists (each affiliated to a different university) held a session each week for any medical students on clinical psychiatry placement at the hospital. The numbers were small, a minimum of 2, and maximum of 8 students. Each week the makeup of the group changed as students came and went. At any one meeting one student might be completing their clinical attachment, others were in the middle of it and yet others were there for the first time. Only the two psychiatrists were constant. Students were invited to give a case presentation at their second or subsequent meeting, having participated in the discussion in the first week. The instruction was simple: tell the group about a patient you have seen as if you were a junior doctor calling a consultant after hours. Be short, punchy, and relevant but give a feeling for the person and their predicament. And give a feeling for any problems you encountered as you took the history. The group was asked to listen to the brief presentation without interruption. One of the psychiatrists then led the group to ask for more of the story, add their own views, experiences and advice. In the psychiatric unit of regional hospital there are recurring themes: disadvantage, self harm, depression, drug and alcohol abuse, distance, as well as resilience, independence, and courage. The students histories captured elements of all this. But the group questions and discussion added something else. Often a student who was listening to the presentation recognized the story from an earlier encounter with the same patient and gave an alternative perspective. "He told *me* something different", a student said at one session. And on a different occasion- "I was afraid to sit with him, I am surprised you got all that history" and yet another session - "she was so funny when I saw her, I really enjoyed it." Formal case presentations focus on presentation of history and clinical findings, diagnosis and management. Our medical student group with their pooled perspectives inadvertently created an opportunity to consider questions about the narrative. How important is the idea of "the truth"? Does our reading of someone change when a colleague gives a different account? Do we as doctors (and doctors- to- be) hear differently when we are afraid, tired, or entertained? Should we trust our gut? Does our gender alter what we listen for or what we are told?

The Paradox of Prescribed Reflection

Rachel Morris, S.B. Barclay, & E. Borgstom (Cambridge University, Cambridge, United Kingdom)

Reflection is considered to be essential for good professional practice (Lachman and Pawlina, 2006) and in 2009 the General Medical Council of the UK (GMC) made it a new requirement for UK medical graduates to be able to '…continuously and systematically reflect on their experiences.'(GMC, 2009). Medical graduates need to be equipped with the tools to use self-reflection in their practice; this implies the need to teach and assess self- reflection on medical undergraduate courses. Since 2007, in the final year of the University of Cambridge Clinical course, during their senior medicine, surgery and general practice attachments, students are required to write reflective essays about their experiences of meeting patients approaching the end of life. Students are asked to write an account of the patient's background and history of the illness, their psychological and social problems and to reflect on legal, ethical, spiritual and existential issues. They are also asked to reflect personally on their own learning and any professional issues which they may encounter in their future care of patients nearing the end of life. This presentation discusses the results of two qualitative research projects about students' views of this narrative reflective writing exercise. For one research project, students completed an evaluation questionnaire about the reflective exercise. The other project was a discourse analysis of the students' essays from a previous

year. Themes and issues from both projects were compared by the researchers of the two studies; there was considerable overlap and the discussions served to highlight a new area of interest – the paradox of prescribed reflection and the tensions teaching reflection can create. Overall, the exercise was successful in meeting its aims and objectives and students valued the opportunity to meet these patients. Most students passed and were considered by tutors to be demonstrating reflection. Yet students' remarks demonstrate several paradoxes. Many students agreed that the intervention improved the learning experience, although they did not necessarily think that it increased their capacity for self-reflection. Several students considered that they already reflect. The students' writing suggested a struggle between reflection and being seen to demonstrate reflection. Many students indicated that they would prefer to reflect in a different, or more informal, way whilst others thought the essay was useful because it made them reflect. Together the studies reveal some tensions about teaching reflection. Firstly, a balance must be struck between a prescriptive structure and letting students be free to write what they want. Secondly, there is a tension between expecting students to openly reflect on their personal feelings and formally assessing this reflection. Lastly, the required nature of reflective writing, and its perceived educational value, was seen to interfere with rather than complement the other work students were doing as part of their course. Understanding students' perceptions of self-reflection and being aware of these tensions which may exist within the hidden curriculum is essential in order to enhance the opportunities which exist in the teaching and learning of self-reflection.

Back to the Drawing Board: Rethinking approaches to care through the arts

Melissa Tafler, & Jeff Nachtigall (Baycrest Centre, Toronto, Canada; Sherbrooke Community Centre, Saskatoon, Canada)

This presentation will describe The Open Studio, a model developed through a unique collaboration between a clinical social worker and a professional artist that integrates the professional arts on multiple levels within a health care organization. The Open Studio model is a visual arts studio designed to facilitate opportunities for true self exploration and creative expression for various stakeholders of a health care system. This is not a craft room, or art therapy. The open studio is a peer group environment where all participants are artists, and as such are treated as equals. Therefore there are no hierarchical relationships such as "teacher" and "student" or "patient" and "therapist". Through its applications to patients, students, clinicians, staff and the community at large, the studio model has the ability to impact on the culture of care within a health care setting in a way that re-humanizes health care, and refocuses on the personal narrative as the basis for understanding our practice and informing our approaches to care. For health care clinicians, the studio provides opportunities for engaging with the arts as an effective clinical tool, as clinicians can meet a client in an authentic place of discovery and exploration where neither are the expert and both are learners. This has far reaching effects on enabling a deeper and lasting connection, facilitating empathy, and awareness of the personal narrative that should inform our work. The studio facilitates the creation of a safe environment that is free of clinical hierarchies and discipline specific roles. The studio embraces the "mistake" and celebrates the "mess" as an integral part of the creative process. As a society we have handed art over to a select few. We are intimidated by what has become an academic pursuit, and forgotten the importance of the intuitive approach to creativity. The Open Studio nurtures this process and challenges the individuals perceptions of art; tearing down the walls that separate us from our creativity and enabling a freedom to explore ones unique form of expression. The studio environment facilitates the necessary ingredients for the development of foundational elements of interprofessional collaboration (IPC). Tapping into the universal nature of the creative process is an innovative way for practitioners to begin to relate to one another through commonalities that cut across professional, cultural and educational divides and for teams to see aspects of one another that are previously unacknowledged. The student practicum and education experience as it relates to the studio will be discussed. The Open Studio model has been implemented within a long term care facility in Saskatoon and the artists experience will be described, as well as how a studio can be an innovative environment for health care practicum as it allows students to see illness and disability redefined as strengths and possibilities through the use of art, and then consider how approaches to practice may change if the arts informed theoretical frameworks.

Reflections of a medical student: The benefits and challenges of writing poetry to enhance clinical knowledge and promote self-reflection and growth

Sarah Fraser, & B. Das (Dalhousie University, Halifax, Canada)

At Dalhousie University, it is possible for medical students to propose humanities project ideas for their required elective assignments. For my final project in an emergency medicine elective, I am writing a book of poetry inspired by reflection on my clinical experiences. Three goals guided me in my writing:. 1) *enhancing medical learning through poetry* ...the process of writing the book has given me the opportunity to transform my new knowledge into a form that is personally meaningful. In this way, my learning has been reinforced. For me, the expression of concepts through poetry promotes clarity and recall of both information and experiences. For example, I more readily recall the patient encounters that I have

written about than those I did not. Often, writing poetry was a different yet effective form of studying; 2) *self-reflection on clinical experiences ...*writing poetry provides an outlet to express my emotional reactions toward patient encounters. This has caused me to rethink and examine my behaviour and actions, essentially reliving the clinical experience. Some of the poems are written from the patient perspective: studies have shown that medical students and residents tend to decrease their levels of empathy as their training advances, and poetry written from the patient perspective is one way to counteract this worrisome trend; 3) *developing techniques that create space for writing ....*finally, though writing poetry is a passion of mine, I noticed that my opportunities became less frequent as the medical school workload intensified due to academic and clinical demands. It was essential to find a way to start writing again. By incorporating creative writing into an academic requirement for myself, I was making time for it in my life. My current goal is one poem per day. On those days when 'the Muse' fails to beckon - and when the quality of the product is less than desirable - the writing and its contingent benefits are still taking place.

Knowledge Translation: Lessons learned from theatre developed from narrative research

Paul D'Alessandro, & Gerri Frager (Dalhousie University, Halifax, Canada)

Ed's Story: the Dragon Chronicles is a verbatim play developed from narrative journal entries by Ed, a 16 year old with advanced cancer, and the 25 qualitative interviews conducted after Ed's death with family, friends, and members of his healthcare team. The play has been performed in Ontario, Quebec, and Nova Scotia since September 2010. Our retrospective, non-randomized cross-sectional study collected responses of medical students and residents who had seen a performance between September 2010 and November 2011. Trainees were asked a mixture of open- and close-ended questions. 46 medical trainees responded (60.9% female, 39.1% male, mean age 26.2 ± 3.2) from 5 Canadian medical schools, who had viewed the play 58 times. The responses, collected via a confidential web-based survey, were overwhelmingly positive and profound. A strong majority of trainees agreed that the play was a good learning experience (84.8%) and should be experienced by all medical students (75.5%). A majority of trainees agreed that the play taught them lessons they will use in their medical career (71.1%), and none disagreed with this statement. Trainees' comments highlighted the play's authenticity and realism, strengthened by the use of verbatim dialogue. Trainees' comments highlighted the play's effectiveness at demonstrating interdisciplinary care. Trainees reported that the play generated new insight into patients' experiences; inspired reflection on their own experiences as medical students and residents; and complemented clinical experience. *"If Ed, at 16, can be this insightful, it reminds me how much I have to learn about each new patient."* Several trainees reported that they identified specifically with one of the physicians represented in the narrative play, who expressed guilt about aggressive treatment that led to untoward outcomes. *"It was intriguing and comforting… to know that staff physicians experience the same hesitations, fears, and frustrations that we do as students."*Trainees reported that they preferred the play to other teaching modalities, including simulated patients and problem-based learning cases. *"I felt like the play brought back the idea of humanity in medicine. I think our medical school instruction tries to teach us things right down to how we should express empathy… like they are slowly turning me into a robot… This play helped bring back the idea of what medicine is supposed to be about."* Video clips from the play will be shown to highlight these results. Interestingly, in spite of any perceived selection bias, the response to whether a viewing should be incorporated into core curriculum was mixed (45.3% agreed or strongly agreed, 35.7% neutral, 19.0% disagreed or strongly disagreed.) Future research, including a focus group, is planned to qualify these responses, and determine the most effective means to share this innovative, well-received project. The opportunity to evaluate the impact of the play when it is integrated as part of Dalhousie University's core curriculum for 2nd year medical students starting in the spring of 2012. Paul D'Alessandro, a 3rd year medical student, and PI for this study, is one of the actors in this play.

Telling the Patient's Story through Narrative-based PBL Case Studies.

Robyn Schell (Douglas College, New Westminster, Canada)

Studies show that patients experience better outcomes when their care is oriented to their needs and desires and when they are involved in their own care. Despite years of attempts to create curriculum that builds patient-centered skills and values, there is evidence that as medical students progress through medical school, their patient-centeredness declines, especially as they move through the clinical years of training. Designing Problem-Based Learning (PBL) case studies around the patient's story may have the potential to support the development of patient centered skills and provide a richer context for learning. PBL is a well known pedagogy in medical education that centers on the case study as a catalyst for learning and teaching. My paper discusses what is meant by patient-centered skills and values, critiques current medical education and practice which can tend to be physician-centered, discusses the literature on the impact of patient-centered skills on improved patient outcomes, and how integrating narrative-based case studies may help develop patient-centered skills and attitudes. My presentation will include video taken from my earlier work on narrative-based PBL case studies that introduces the story of Sean, a young man worried about his rash and a feeling of lethargy that has led him to jump to a number of frightening conclusions about his health. In my presentation, I'll also describe how my current research intends to further explore the integration of narrative-based case studies into PBL and how this may enhance the development of patient-centered care.

The Patient Experience in Altered States of Consciousness: Combining the patient narrative with visual art

Wendy A. Stewart, Amber Young, & Anne Chiasson (Dalhousie Medicine New Brunswick, Saint John, Canada)

The brain generates rhythms on an electroencephalogram that is dependent on their level of wakefulness, exposure to medication, whether a patient has experienced a seizure, or if there has been some type of brain injury. In states of altered level of awareness, including sleep, particular patterns can be documented in the brain waves. The patient's experience in these altered states of consciousness can be varied, and the patient histories combined with visual art are a powerful way to express these normal and abnormal states. This project involved a literature search pertaining to the patient experience in altered states of consciousness, a review of imaging techniques to explore brain function and structure, and the collection of patient narratives relating to their experiences. All of this information is being collected in collaboration with a visual artist who is creating a series of abstract works depicting the patient experience. These works will be combined with the narratives and used to teach undergraduate medical students and the public about the different disorders and experiences. This presentation will summarize the narrative histories, show examples of the artworks and explore how this can be used in teaching.

A Narrative Spiritual Self-Reflection Process: Building competency for spiritual care

Doreen Oneschuk, & Zinia Pritchard (University of Alberta, Edmonton, Canada; Covenant Health, Edmonton, Canada)

Spirituality can be defined "as a connection between the essence of one's self, another, and Other, thereby affecting one's sense of wholeness within oneself and with an ultimate reality" (1). Spiritual care understood as the ability to assess patients' spiritual health and manage spiritual issues is emerging as an interprofessional competency (2). At the heart of spiritual care is the clinician's capacity to engage patient story, a skill that is facilitated by the clinician's own self-reflective practices and growth in self-awareness. Patient narrative, which may involve a mixture of hope, meaning, purpose, but also aspects of disillusionment and despair can provide fodder for the health care provider to self-reflect on personal beliefs, values, and experiences that affect their own spiritual journey, healing, and personhood. This

poster will permit symposium participants to experience a narrative reflection process that would aid trainees in documenting personal spiritual narrative reflections following patient encounters. Email doreen.oneschuk@albertahealthservices.ca for references.

Community Based Projects: Enquiry and narrative combined in undergraduate medical education

Jennifer Carpenter, Sheila Pinchin, & **Jessica Sleeth**, (Queen's University, Kingston, Canada)

*I heard the chaplain speaking to some of the other guys, but I'm not really the God type. Besides, what would He want to do with me – I must have 'LOST CAUSE' or 'TOO EVIL TO BOTHER WITH' written across my forehead – this place is colder than Hell. I quickly shrugged off the faint desire to have someone to talk to, someone who would listen…(*Curtis Van Doorma)

Experience alone is not sufficient for learning to occur. The experience must be interpreted and integrated into existing knowledge structures to become new or expanded knowledge. Reflection is crucial for this active process of learning. (Sandars, 2009)

Students in first year undergraduate medicine at Queen's University are required to conduct enquiries into resources in the local community that support patients in specific at–risk populations. The purpose for this *Community Based Project* is to afford students the opportunity to determine how health care support occurs outside the walls of a doctor's office, experience how patients negotiate this health care journey, and analyze what gaps exist in health care and support in the community. Ultimately, students are asked to engage in adopting the patient's point of view to develop empathy, demonstrate insight, and critically question patient care. Two products occur from this small group enquiry: students develop a poster from an outline common to many conferences and present orally their findings as a *poster slam* in a poster fair approach to their peers and to faculty and representatives from community health care and support agencies. However, students are also required individually to write a narrative from the point of view of a simulated or composite patient that details his or her health care journey based on the findings of the community enquiry. While some students struggle with the narratives, and question whether "literature" belongs in medicine, creative and powerful writing forms including mock physician and police reports, simulated case studies, video interviews, first person dialogues and poetry have been included since this project was initiated three years ago. This exercise of student imagination linked to enquiry yields a combination of empathy and objectivity that forms the basis for patient centered medical care, (Charon, 1986) and provides a novel model for "service" in education about patient care (Moulton, 2000). Results of both the poster and narrative learning activities and rubric, and student evaluations, demonstrate that learning objectives for advocacy, professionalism, population health (global health) and the medical expert have been met. Unanticipated results have been enhanced student volunteerism and student service initiatives including the "Did You Know" pamphlet for family doctors, and updating the KFL&A Community Resources Database, such that student service opportunities are now built into the projects. Email carpentj@queensu.ca for references .

Medicine at the Movies: Exploring first year student response to "Doctor's Diaries" in a narrative reflective practice module

Melanie Bodnar, Pamela Brett-MacLean, & Marie-Therese Cave (University of Alberta, Edmonton, Alberta)

A literature regarding the introduction of pedagogies to encourage reflection in medical education is beginning to develop. A number of contributors in this area have suggested that watching films and sharing stories can expand a student's awareness which can foster reflection, insight, and empathy. Given their l limited experience of medicine in the pre-clinical years, we have used full-length film screenings to foster reflection in our first-year Patient-centred Care course in the Faculty of Medicine & Dentistry at the Uni-

versity of Alberta. In 2010, we screened the film "Doctor's Diaries" for the first time. This film documents the lives of seven young medical students over the course of their medical education, from the first day at Harvard Medical School until they are brought together again 17 years following graduation. This film documents the complexity and challenges of medical education along with those beginning and establishing a career in medicine. In this poster we describe how our use of this documentary was received, and the kinds of reflection and insights medical students described. Four main data sources were used: 1) a close reading of the film (undertaken by the study team); 2) student and 3) faculty preceptors' written responses to feedback forms they completed following the film screening and small group sessions, and 4) students' written reflective responses to the film. We used qualitative analysis to identify a variety of themes characterizing the students' reflective narratives. We highlight first year students' insights, and early experience of gaining a sense of who they are becoming as a physician. We also discuss the value of the "Doctor's Diaries" documentary as a film resource in facilitating narrative reflection among first year students. We anticipate that our findings will be of interest to a wider community of medical education researchers and medical humanities scholars who are concerned about adequately preparing medical students for the challenges of medical school and entering the medical profession. This study contributes to an emerging evidence base regarding various pedagogical strategies and approaches that can effectively support students within a context in which the value of personal-professional knowledge and professional identity formation are considered integral to medical education.

Using Popular Literature to Enhance Interprofessional Education in End-of-Life Care

Pippa Hall, Pamela Grassau, David Wright, Patrick Marshall, & Susan Brajtman (University of Ottawa, and Élisabeth Bruyère Research Institute, Ottawa, Canada)

Since 2002, we have used popular literature, complemented with film, story-telling, drama and art, to explore death and dying with students in medicine, nursing, spiritual care and health sciences. The elective 36-hour course, "Death Made Visible" is led by 4 interprofessional faculty members. Students meet for three hours weekly in the evening. During the first hour, students meet within an interprofessional group of 10-15 students, where two to three students present their personal written reflections on the assigned weekly readings. One of the faculty members facilitates the discussion. Guests from other disciplines who have expertise in the area/topic covered in the readings often co-facilitate. The whole class then assembles for further discussion and learning activities under the guidance of the teaching faculty. Results: Student satisfaction is indicated by increasing numbers of students requesting to take the course, and there are waiting lists each year. Enrolment has increased from eight students in the first year to the current 40. Course evaluations are enthusiastic and have demonstrated transformative learning, and an appreciation of different perspectives. Students' comments will be shared, a sample of which includes: *"I loved the byplay and interaction between the professors and the different specialties. I absolutely loved the course and the ideas on how to deal with palliative care;" "The course covered a variety of topics that we typically never discuss: we discussed ethics, dealing with other people, interactions with other professional groups, we discussed a lot of things, it wasn't just only death. We're so much more ready for that world";"It was fantastic, listening to everybody, not only the facilitators but spiritual care [students] and all of the nurses [students]. Everyone who came who had a piece to bring and experience to bring;""This is the only course that has given me the opportunity to look into myself to see what I can give to others, as well as challenge the thoughts and beliefs I have around death…"*

Narrative as Reflective Practice: Stories in family medicine in Canada

Robert Wedel, **Ruth Elwood Martin,** Inese Grava-Gubins, Lynn Dunikowski, Ian Cameron, Francine Lemire, Richard Boulé, Patrick Sullivan, Cal Gutkin, & Stephanie Fredo (College of Family Physicians of Canada, Toronto, Canada)

I write entirely to find out what I'm thinking, what I'm looking at, what I see and what it means. What I want and what I fear.—Joan Didion

Stories and narrative have been used since time began to inform, instruct, and entertain. They offer a window onto the world of the teller's experiences, stimulate the imagination, and offer opportunities for reflection. It is increasingly believed that narrative can also add a powerful dimension to the education and practice of physicians and other healthcare providers. As a component in the educational curriculum, narrative can help students understand the patient's experience of illness, and can provide insight into ways of providing patient-centred care. Narrative can also support learners in developing their professional identity and in countering the effects of the hidden curriculum. Experienced practitioners can use narrative to develop reflective practice skills, help resolve ethical challenges, serve as a reminder of the human element in care delivery, and understand the power of relationships—the basis for all that transpires in care delivery. As a research tool, narrative can be used to develop and test hypotheses, to answer those questions that cannot be answered by quantitative research, and to disseminate results. *Stories in Family Medicine*, an open access website developed by the College of Family Physicians of Canada's (CFPC) History and Narrative Committee, is part of a qualitative narrative inquiry research project that gathers and categorizes stories by physicians and others about the delivery of primary care in Canada. Searchable by theme, subject, and author, the database offers users a wealth of stories that demonstrate the power of narrative in education, practice, and research settings. This poster will highlight the website, drawing on stories contained in the database and the peer-reviewed literature to explore the role of narrative in education, practice, and research.

Second Poster Session Abstracts

Poster Session 2 Abstracts

Fostering Reflective Practice through Narrative: The potential of the ePortfolio program

Anna Byszewski, **Pippa Hall**, Emma Stodel, & Stephanie Sutherland (University of Ottawa, and Learning 4 Excellence, Ottawa, Canada)

Background: In 2008, the University of Ottawa (uOttawa) launched a revised undergraduate medical education (UGME) curriculum based on the seven Can MEDS roles (Medical Expert, Communicator, Collaborator, Health Advocate, Manager, Scholar, and Professional), with the addition of Person as an eighth role to bring in the dimension of mindfulness and personal well-being. To evaluate students' attainment of competency in each of these eight roles, the electronic Portfolio (ePortfolio) program was developed. The program is a mandatory component of the curriculum for students in the undergraduate medical education (UGME) program, spanning the four years of the curriculum, currently in the fourth year of its inauguration. *Encouraging Reflection:* The program provides both a face-to-face and online forum for students and their ePortfolio coaches to reflect together on the evolving roles of the physician and to celebrate their successes in gaining competence in each of these areas. Within each of the French and English programs, students are randomly divided into groups of six to eight by administration at the start of the UGME program and assigned a faculty member as their coach. This results in 24 groups each year; 6 French and 18 English. Students remain in the same groups with the same coach for the entire four year program. The electronic portfolio format provides students and faculty a space to engage in ongoing reflective discussions and interactions that are not bound by time or space. It encourages development of narrative competency and a safe environment to debrief challenging situations encountered in the learning process. The program is supported by a strong Faculty Development program, with coaches expected to attend two of the three faculty development sessions held yearly. *Results:* Students have posted narratives, poems, art and videos. Students' reflections are evaluated using a rubric that focuses on the integration of, and reflection on, the objectives of the CanMEDS roles. A formal program evaluation has not yet been done, but we have seen in our work as coaches, and through discussions with other coaches at

the Faculty Development sessions, that issues relevant to the hidden curriculum are being made explicit by the students through the ePortfolio program. This paper will highlight our reflections on the students' postings, as well as the challenges and successes we have experienced along the way. Examples of narrative postings from the Sample ePortfolio will be shared during the presentation. We have learned to be patient and to foster and protect the program when it comes under threat. It takes time to grow and evolve into a sustainable and powerful tool which we anticipate will promote development of both the art and science in future health professionals.

The Caduceus Project: Expressing the heart of the healing professions

Dr. Gerri Frager, & Miro Davis (Dalhousie University, Halifax, Canada)

The Caduceus Project was one of several projects developed by the 3 Artists-in-Residence based at Dalhousie University Humanities Program with funding by the Robert Pope Foundation. Selection criteria specified that the artist share their time both at the medical school (engaging with interdisciplinary students in the health professions, with staff, and faculty and integrate their work in the clinical settings). Applications from 24 artists from diverse disciplines were submitted: visual arts (sculpture, fabric, illustration) the performing arts (dance, film), and the narrative form (story-telling, poetry). A selection committee representing community, undergraduate medicine, clinical care, and the artistic community selected 2 visual artists and 1 performance artist. One of the visual artists and co-author of this abstract, Miro Davis, conceived and implemented the Caduceus Project. The Caduceus Project is a visual narrative compilation. It is a large scale (9 foot winged) sculpture of metal work and ceramics contributed to by members of the medical and healthcare community inclusive of trainees and faculty from nursing, pharmacy, and medicine; and staff working within Dalhousie's medical school. The symbol of Caduceus, much as for Asclepius, carries a long history of representing the healing profession of medicine. The art pieces symbolize what each individual values in the healing professions and what brought them to their work. Several contributors shared the meaning behind their art piece in a taped recording. Contributors to the Caduceus Project were engaged though a variety of venues: staff, students, and faculty dropped by tables set up in the medical school lobby to create their piece; and psychiatry residents participated in a workshop on creativity and physician wellness. With facilitation by Miro Davis and Don Rieder (one of the other Artists-in-Residence), and a staff psychiatrist and co-ordinator of Humanities for the Department of Psychiatry, the residents explored movement, through individual, paired and group experiences and created the wings of the Caduceus sculpture. *The Caduceus Project: History & Healing* was co-presented at Pediatric Grand Rounds by a medical historian, and the 2 co-authors of this abstract. Those attending the Grand Rounds, largely practicing clinicians, were encouraged to "make their mark" through etching and molding copper discs in response to the question "What brought your heart to this work?". All contributions are being complied along with audio recordings of patients and families to accompany the student and faculty voices. The Caduceus Project will be toured throughout the Maritimes starting in mid-February. Representative sections of the metal work and one medical student's reflections follows in written format. Should this project be accepted for the Creating Space II Conference, the presentation will include the completed Caduceus sculpture including the accompanying audio clips. *"My design is a wing, and in particular, a Phoenix wing. The story of the Phoenix is that Phoenix rose from it's own ashes to start anew. As a cancer survivor, that's a story that is very dear to my heart. So, I think that survival through illness and being born anew kind of drove me to be a doctor."* a medical student.

Learning about Mental Health through the Voices and Experiences of Mental Health Consumers: A community-based medical education experience

Siobhan Farrell (Northern Ontario School of Medicine, Thunder Bay, Canada)

Community and Interprofessional Learning (CIL) is a component of the undergraduate program for medical students in Years 1 and 2 at the Northern Ontario School of Medicine. These weekly sessions in the community expose students to the role, scope and value of other health professionals and community resources. Benefits for medical learners include developing skills in interprofessional collaboration, recognizing the role and value of other health professionals, and developing a range of professional attitudes and skills. NISA/Northern Initiative for Social Action is an organization run by and for consumers of mental health services in Sudbury, Ontario, and is used as a CIL site. NISA develops occupational skills, nurtures self-confidence and provides resources for recovery by creating opportunities for participants to contribute to their own well-being. Members have the opportunity to learn and develop skills in a number of programs, including the Writers' Circle and Artists' Loft. Since NISA operates with an open-door policy, learners interact with staff and directly with consumer/survivors of mental health services in a peer-supported environment. They also participate in activities that expose them to an integrated arts/health understanding of the lived experience of mental illness, providing them with tools to improve their powers of observation, communication and compassionate understanding. From these experiences, learners begin to identify obstacles related to the specific realities and needs of the mental health community. Their experience at NISA is divided into the following areas: 1) Meeting with Writer-in-Residence: This is an opportunity for learners to discuss concerns or questions with the facilitator and gain an understanding of the skills, opportunities and challenges inherent to instructing and motivating consumer/survivors in the literary arts; 2) Participating in a magazine-based learning activity. This helps to familiarize learners with the history and purpose of Open Minds Quarterly, a literary magazine. Through guided exposure and discussion, learners have the opportunity to understand the opportunities and challenges of writing-based communication in the consumer-survivor setting. Emphasis is also placed on the role of effective written communication in humanizing the experience of mental illness.; 3. Members sharing experiences related to reading exercise. This meeting with members gives learners the opportunity to gain an understanding of the lived experience of mental illness in comparison and contrast to the written experience; 4) Participating in a visual art-based learning opportunity. As mental health consumers develop observational skills in analyzing and interpreting experiences and emotions in visual art forms, learners are also able to communicate with artists and gain an understanding of the applications of art therapy in recovery; 5) Comparison between experiences of the sessions between themselves. In the last activity, learners have an opportunity to review their experiences with each other regarding their interaction with mental health consumers. As this is the first year that learners have been placed with this program, NOSM will be reviewing evaluation and anecdotal data to determine the effectiveness of this experience in enhancing understanding and empathy for mental health consumers. The poster will share available evaluative data.

Co-creating Novel Conversational Spaces: Implications of talk and narrative in couples and family therapy

Jared French, & Marnie Rogers (University of Calgary, Calgary, Canada)

This paper presentation begins by discussing the metaphor of 'space' and its use in describing different contexts co-created by health professionals and patients' use of talk and narrative. We then present on the impact of language use in facilitating spaces of reflection and in the co-creation of new narratives in couples and family therapy. In particular, we present on both researchers' respective research projects: 1) a doctoral research project which focuses on conversational spaces of reflection, generativity, and commitment in family therapy, and 2) a masters research project on how cohabiting couples (or couples

who live together but are not married) tell stories of relationship mutuality, togetherness, and "we-ness," and how interactions between couples and the research interviewer created opportunities for such narratives to be told and witnessed. This macro/micro perspective provides a broad theoretical approach that is relevant to a wide range of health professionals, while demonstrating its application in specfic instances with families and couples. The presentation ends by inviting a discussion on how health professionals' choice of language and lines of questioning help co-create patients' novel and preferred narratives across different healthcare settings.

Adapting Theatre Practice to Enhance Role-Playing and Communication Skills of Health Professions Trainee

Laura J. Nelles, Catharine M. Walsh, Jill Stier, & **Heather Carnahan** (York University, Toronto, Canada; University of Toronto, Toronto, Canada)

"All stories are read and created through the lens of social and cultural experience, and this means that narratives are inevitably interpreted in many different ways. Recognizing that stories have multiple interpretations involves identifying the limits of one's own horizons, and an interest in seeing alternative perspectives." The effective use of standardized patients (SPs) to train health care professionals through experiential learning in a variety of clinical scenarios is well established.[2,3] However, the costs of using such methods may preclude their use in some programs. Peer role-playing has been used in the University of Toronto Occupational Therapy program as an alternative to standardized patient-based education. Peer role-playing is thought to allow students to gain insight into and reflect upon the roles they portray, thus providing benefit for both the peer actor as well as the learner.[4] The use of peer role-playing has been shown to enhance motivational interviewing skills as effectively as standardized patient based education.[5,6] However, the students are not always effective role players and the quality of the experience relies very much on the ability of the individual, creating an uneven learning environment. Objectives: This presentation will describe an acting workshop that was designed to build the students' awareness of their physical habits, the ways in which we construct meaning based on our own narrative experience and how we can bring this awareness to understanding the narrative experience of our patients/clients in health practices. Discussion of data collected from the program evaluation will illuminate ways in which these methods can be applied to health professions education. Approach: The presenters will discuss the process of the various acting and self-reflection exercises that were used with the participants and how this foundation was then used to teach them to perform specific client roles for the purposes of training each other. Additionally, the OT students' perceptions and the educational benefits of the acting workshop will be discussed, including data collected from their interviewing skills OSCE that showed that those students who received the workshop prior to their interview practice class, scored significantly higher on communication skills, as measured by a validated global scale[7], than those students who received the workshop after the OSCE ($p < 0.05$). Practice Implications: Communication and interviewing skills are essential competencies of OT practice. Enhancing self-reflection and an understanding of how narrative works can impact these skills. Novel methods of training using applied theatre practice can help to optimize learning and improve resource utilization. Conclusion: Incorporation of the peer-learning strategies proven to be effective in this study can help to enhance the educational benefits of simulation-based training and ultimately communication skills. Email lj.nelles@sympatico.ca for references.

Teaching Health Professions Students About the Consequences of War and Militarism Using Literature and Photography

Martin Donohoe (Portland State University, Portland, United States)

In light of the two hundred and fifty wars that occurred over the course of the Twentieth Century, the increasing percentage of casualties among non-combatants, the wars with Iraq and Afghanistan, and the

potentially unending "war on terrorism," health professions schools have paid increasing attention to educating students and practitioners about the health consequences of war and militarism. Lectures and courses are being devoted to the consequences of large-scale conflict, which include deaths, injuries, psychological morbidity, famine, environmental degradation, poverty, and the collapse of health care delivery systems. Non-medical literature, long recognized for its contributions to health care education, offers health care professionals and students the opportunity to vicariously experience the sequelae of conflict and to reflect upon the horrors of war and the benefits of peace. This presentation will discuss works of fiction and non-fiction that address eloquently and evocatively the consequences of war and the ethical dilemmas consequent to the delivery of health care under conflict situations. An annotated bibliography of readings will be provided to those interested in developing curricula or merely sharing moving poems and short prose with students and colleagues. Brief excerpts from the works of Mark Twain, Primo Levi, Wilfred Owen, Siegfried Sassoon, Elie Weisel, and others will be read aloud. Famous war photographs will supplement the literary material. For further information, see the War and Peace page of the Public Health and Social Justice website at http://phsj.org/war-and-peace/.

Using Literature About Death and Dying in Health Professions Education

Martin Donohoe (Portland State University, Portland, United States)

Health professionals are frequently exposed to death. Literature provides an ideal medium for discussion with students and patients regarding their reactions to death. Clinician-writers speak from the privileged vantage point of having witnessed, during training and in practice, myriad responses of patients and their surviving loved ones to death and dying, This session draws on the presenter's 21 years of teaching literature and medicine and introduces short works of literature, suitable for educational and therapeutic venues, which eloquently describe the responses of clinician-authors and their fictional characters to death, in hopes of stimulating clinicians to read passages with their patients, and educators to use these selections in the classroom and on teaching rounds in order to promote introspection and facilitate discussion. Authors to be discussed include John Keats, Anton Chekhov and William Carlos Williams. Meditative analysis of these authors' perspectives can provide readers with valuable insights and may alter their outlook on life and death. Reading and discussion can increase clinicians' empathy and compassion for their dying patients and help them to acknowledge their own mortality and better prepare for their own deaths. A list of works and websites will be provided to assist those interested in furthering their own education and/or developing curricula.

Braid Sharing Circle: Aboriginal ideology in a medical school setting

Norry Kaler (Dalhousie University, Halifax, Canada)

Many Aboriginal cultures use sharing circles as a means to communicate, problem-solve, and build stronger communities. Although each Aboriginal community conducts these circles with practices unique to their own culture, there are some common themes that characterize sharing circles. It is the commonalities and ideology of Aboriginal sharing circles that have inspired Norry Kaler, a Dalhousie Univeristy medical student, to begin a *Braid Sharing Circle* open to all his medical student and resident peers. The basic principles that guide these bi-weekly sessions are as follows: everyone has the opportunity to speak, only one person speaks at a time, the person can share anything they wish, and all things spoken in the circle are kept within the circle. This form of peer support in an open, compassionate atmosphere has been received with much enthusiasm. Students have a safe place to discuss the stresses of medical school, personal relationship problems, as well as share positive aspects of their life. It also allows participants to develop a key skill that is often overlooked in the medical curriculum: the art of listening without judgment, and to simply be the ears that lighten the burden of others.

The Interpretative Arts

Richard Hovey. (McGill University, Montreal, Canada)

The role and application of philosophical hermeneutics, narrative (-story) and conversation, personal and professional reflection and as an emerging research approach will be explored. The interpretations of narratives (-stories) are core to uncovering the meaning of living with chronic illness, cancer education, and preventable medical harm. Multiple experiences of unique or common events can provide new information as evidence to inform a wide range of educational practices and applications. Such reflections and interpretations co-create new knowledge to inform healthcare on numerous levels including medical / professional education and clinical practice. This session will provide an overview of how philosophical hermeneutics as a research approach can be used to inform healthcare and to create new understandings from reflection and interpretation within an interdisciplinary hermeneutic process. Participants in this session will have the opportunity to engage, converse and collaborate with each other within an interpretive reflective experience. To align with the idea of expanding appreciation and understanding of the possibilities of narrative and arts-based learning, and generating or enhancing a reflective openness in health professional education, this session offers a conversation about the art of understanding. Reflections on narrative, refection, interpretation and understanding include: 1). To understand each narrative as text (where texts can be art, actions, pictures, is not to understand the person who one has had the conversation with, but to interpret the text that was provided to the researcher or practitioner. Understanding text is accomplished through the act and art of interpretation. Gadamer (1989) states, "since men [woman] cannot be aware of everything their words, speech and writing can mean or something that they themselves did not intend to say or to write, and consequently when trying to understanding their writings, one can rightly think of things that had not occurred to the writers" (1989, pp.183 – 184). Otherwise, the text remains in its structured form and is read by reconstructing how the text came into being or how the person came to their opinions. Because the interpreter is interested in understanding the text itself, the interpreter re-awakens the text's meaning (Hovey, 2006; Gadamer, 1989); 2). According to Kearney hermeneutics refers to the practice of discerning indirect, tacit or allusive meanings, of sensing another sense beyond or beneath apparent sense. This special human activity may in turn call for a method of second- order, reflective interpretation involving a process of disclosing concealed messages, either by a) unmasking covered-up meaning (hermeneutics of suspicion) or b) by disclosing surplus meaning (hermeneutics of affirmation). In short, I understand hermeneutics as the task of interpreting (*hermeneuein*) plural meaning in response to the polysemy of language and life. (2011, p. 1); 3). Gadamer explains that, the (hermeneutic) circle of understanding is not a "methodological" circle, but describes an element of the ontological structure of understanding. This happens even in conversation, and it is a fortiori true of understanding what is intelligible in itself and as such offers no reason for going back to the subjectivity of the author (Gadamer, 1989, p.293). For references, email rhovey@ucalgary.ca.

Interdisciplinarity in Healthcare

Richard Hovey (McGill University, Montreal, Canada)

The purpose of this paper is to provide an example of how deconstruction and metaphor can be helpful and engaging ways to analysis complex organizational structures. This paper is grounded within the philosophy and application of Derrida's conceptualization of deconstruction for health/medical education and practice as well as an understanding of how we, as interdisciplinary collaborators, consider the assessment of multiple dimensions of health supported through utility of metaphor. By proceeding with specific deconstructions of complex organizations we are continually opening-up other possibilities and considerations of understanding health by learning from alternate interpretations. Interdisciplinarity means to approach a topic, person, or thing in its totality, and its fragments because all influence a per-

son's overall health. Deconstruction and metaphor provide a means for understanding this educational process through conversations about interdisciplinarity. *Learning from deconstruction and metaphor:* Learning should be transformational. As such, new or different understandings, even seemingly insignificant ones, may lead to other more substantial and profound understandings of a topic, person or thing as we become open to other possibilities, conceptualizations and interconnections of knowledge. As reflective practitioners and students we need to question ourselves as we conduct health assessments to whether "something else is going on here". The opportunity to learn from other students, professionals, disciplines, and communities offer alternative ways to understand the complexity of interdisciplarity in healthcare. An invitation for the participants to (re) consider health, in other ways than their own discipline- specific and sometimes encultured understandings of health theories, knowledge and practice are open to discussion. It is also important to be reminded that when our discipline-specific knowledge and understandings of practice, research and learning are challenged, this experience may be initially one of negation, i.e., to dismiss new information as unfamiliar to one's foundational paradigm specific understanding, "because something is not what it was supposed to be" (Gadamer, 1998, p.354). If we view medical education and practice as a field of interdisciplinary conversations, patient outcomes become more holistic and inclusive. Whenever people are conversing, they are co-constructing meaning while learning from knowledgeable others. Accordingly, it is through the participant's own interpretation and subsequent conversations with others not from their health perspective and subsequent knowledge that new learning may lead to other unique understandings; transformational understanding, i.e. when one's way of understanding something changes due to learning from another with a re-conceptualization of knowledge into new understandings of the same topic. In this way, medical education and practice embraces the idea that the greater number of voices who enter into the conversation about medical education the greater the sophistication of the outcome and the greater possibility of medical education of promoting person-centered, collaborative and innovative practices. To initiate this conversation, the concept of deconstruction needs to be addressed through Jacques Derrida's conceptualization of deconstruction. Through this activity using an inquiring approach to connect seeming unrelated concepts, the deconstruction of Justice and Laws was applied to Health and its Dimensions, in order to borrow from one paradigm/philosophy to gain a unique understanding of interdisciplinarity for health education. Deconstruction offers a significant reflective process of our personal and professional narratives about interdisciplinary with the use of metaphor to bring it back into the real world of medical education and practice. For references, email rhovey@ucalgary.ca**.**

Off the Coffee Table: Photos and narratives of the experience of teaching and learning nursing in rural settings

Olive Yonge, Florence Myrick, Linda Ferguson, & Quinn Grundy, (University of Alberta, Edmonton, Canada; University of Saskatchewan, Saskatoon, Canada; University of California, San Francisco, United States)

Researchers at two University Faculties of Nursing, across two prairie provinces, conducted a participatory research project with rural nurse preceptors and their students. Digital cameras were provided to participants in an endeavour to capture images and participant narratives of what it is like to be a preceptor or learning to practice nursing as a student in rural settings. Throughout the duration of the preceptorship, participants documented their experiences through photographs, including sharing their cameras among their colleagues, friends, and family. Participants selected photographs for inclusion in the data and narrated these photographs during several audiotaped interactions with members of the research team. Participants analyzed their own images and provided narrative explanations of the importance of these images to their understanding of, and experience of rural nursing. Using data from all four rural sites, both images and narratives were further analyzed for themes depicting the experience of

being a rural nurse, as either preceptor (Registered Nurse) or preceptee (student). Key themes included: the impact of landscape, team work, teaching and learning and the community. Both preceptors and their assigned student preceptees expressed a great deal of enthusiasm for the project, indicating their commitment to rural practice and an appreciation for both the complexity and contextual implications of practicing in rural Canada. Many indicated a much broader understanding of the social determinants of health, interprofessional practice, and teamwork, and all indicated that the project expanded their own understandings of rural nursing. An electronic version and hard copy of this photography collection was created with the view of using it as a recruitment tool for nursing student preceptorships and potential employment opportunities. It is our hope that this narrative depiction of rural nursing, teaching and learning will capture the attention of educators, clinicians and policymakers so as to give credibility to this unique area of practice.

Applying Arts-based Education to Medical Student Learning about Child Maltreatment

Christine Wekerle, Jessica Malach, Anne Niec, **Joyce Zazulak**, & Nicole Knibb, (McMaster University, Hamilton, Canada)

Visual literacy approaches have been utilized to enhance patient-client communication, physician empathy, and better locating patient presentation within socio-cultural-ecological context. As a more novel way of learning, arts-based approaches may be especially well suited to areas that are more challenging in terms of the levels of physician-community agency interaction and local expertise. Child maltreatment is a key candidate, as mandatory reporting for the physician requires training in detection, communication, management, and coordination. However, most hospitals do not house child abuse and neglect specialty teams, and most medical curriculum does not provide dedicated instructional time within the undergraduate learning program. Presently, there is robust and mounting literature on the broad range of mental health and physical health issues for maltreated persons across the lifespan, indicating that victims do present a wide array of issues and specialty services, although maltreatment may not be necessarily queried (e.g., adolescent suicidality, substance abuse, asthma, etc.). The objective of this presentation is to overview McMaster's visual literacy program for child maltreatment education (4, 3-hour small group-based learning held at the McMaster Museum of Art), designed for McMaster medical undergraduates. The focus of this presentation is course structure and sample content, how the visual arts are integrated with both maltreatment case presentations and pertinent evidence-based literature. The pre-post evaluation strategy surveys undergraduate medical student knowledge of maltreatment features, as well as self-reported and observed skills.

Additional Information

Receptions and breaks are included in your registration. One pre-paid beverage is provided at each reception.

Networking Lunch ~ Saturday, April 14, 12:15 to 1:30 pm

A networking lunch has been arranged and will be held in the Conservatory in the Fairmont Banff Springs Hotel, providing a spectacular view of the Bow Valley. Pre-paid boxed lunches, ordered during online registration will be available for pick up at the Conservatory. A few extra boxed lunches are available—please check at the Registration Desk if you are interested in purchasing one. Other symposium delegates are welcome to enjoy their lunch in the Conservatory if they wish to bring an alternate meal, and partake in networking discussions facilitated by members of the Organizing Committee (maximum capacity of 56 in the Conservatory).

Networking Dinner Opportunities~ Friday, and Saturday

Many wonderful conversations are experienced at the end of the day, after the formal symposium programme is over. Dinners, which are "on your own" on both Friday and Saturday, offer a wonderful opportunity for welcoming our international colleagues, and connecting with symposium delegates who share your interests in narrative and reflection in health care and health professional education!

Restaurant reservations have not been arranged for ***Friday evening.*** At the Registration Desk, a listing of restaurants in Banff will be available for symposium delegates to review to consider their dinner options following the reception at the end of the first day. The organizers have made ***reservations at several restaurants on Saturday evening,*** following the closing reception, to help continue conversations that will have begun at the symposium.* Sign up sheets for different restaurant options will be available at the Registration Desk (see clipboards).

Thanks to Suzanne Welsh for organizing this, along with all other detailed aspects of the symposium!!

**NB: The cost of dinner, and enjoyment of the evening, is the responsibility of the delegate(s).*

Notes and Thoughts

The Canadian Association for Medical Education (CAME) sponsored Arts, Humanities and Social Science in Medicine (AHSSM) Education Interest Group (EIG) was introduced to support networking and information sharing among those engaged in arts-based, humanities and social sciences-based teaching in medical and health professional education.

We welcome you to join us! Subscribe to our e-listserve, visit our website, or become a CAME member and be recognized as a member of the AHSSM EIG, and listed in our online membership directory. We hope that you find this website to be a useful resource. We plan on expanding and refining it over time. We look forward to your feedback!

ww.ahssm-eig.ca