The Role of Reflection in Narrative Medicine

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ABSTRACT: Reflection has become an important tool for physicians and other medical practitioners. However, many forms of reflection exist in the health care literature, with each having particular implications for successful clinical practice. Very little attention has been given to whether reflection is a vital part of narrative medicine and which forms of reflection might be compatible with this approach to patient care. In this article, the most common types of reflection are compared and discussed, specifically regarding their potential role in narrative medicine. Reflection that encourages practitioners to focus on the various perspectives shared within a medical encounter is both in line with the tenets of narrative medicine and has important consequences for patient empowerment.

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Introduction

Scholars have argued that reflection is vital in the delivery of health services, including medicine.[1] In fact, some critics contend that every intervention should be a part of a rigorous "cycle of reflection," which ensures that reflection is on-going, not restricted to any one phase, and critical.[2] In the absence of reflection, the claim is that health services can lose their focus and relevance.

Critics contend that reflection can help restore a balanced practice that may have begun to overlook the needs of patients.[3] For example, reflection helps physicians to remain engaged and patient-centered. Professionalism is also enhanced by this process, along with the competence of practitioners.[4] Through reflection, service providers can discover the truth about themselves and others. Physicians can become aware of their assumptions and biases, so that problems can be clearly and accurately assessed.

On a more personal note, reflection is touted to reduce burnout and restore the voice of physicians.[5,6] The point is that reflection might have a therapeutic function, particularly for promoting serious self-assessment. Specifically, reflection has been identified in the literature as helping physicians deal with traumatic events, in addition to regenerating their enthusiasm and creativity[7,8] and providing an opportunity for catharsis. Reflection allows physicians to examine and clarify their experiences, so that they remain attuned to their patients and practice.

But very little has been said about the role of reflection in narrative medicine. Although narrative medicine is certainly part of the medical field, this approach adds a unique element. That is, a serious question is raised about the character of medical facts. As opposed to traditional medicine, those who are influenced by the so-called narrative turn argue that this knowledge is linked inextricably to the stories persons tell about themselves and their surroundings.[9] Rather than traditionally objective, proponents of narrative medicine describe facts as being mediated by definitions, claims, and other means of interpretation.

Reflection must accomplish something new in narrative medicine. In addition to dealing with issues related to emotions and professionalism, reflection has an epistemological component. Specifically, reflection must assist service providers to gain entrée to the worlds created by the stories patients tell about themselves and their situations. Charon and colleagues[10–12] contend that reflection is important in narrative medicine, although they seem to emphasize merely the cognitive and affective sides of this activity. A much broader discussion of reflection is required in the context of narrative medicine.

The problem is that reflection comes in many forms, with only a few attempts made to classify how reflection has been defined and used.[13] Although somewhat helpful, these classificatory schemes do not consider a factor that is key to narrative medicine. No attempt is made to identify whether a mode of reflection leads to world entry and thus a proper reading of a patient's narrative. Knowing whether a version of reflection is consistent with the aim of narrative medicine should be very important to practitioners.

The thrust of this article is to introduce a scheme that identifies a range of reflections that lead to very different ends. Some promote world entry, whereas others do not. But this scheme is not necessarily linear and does not have to be traversed *ad seriatim*. Instead various modes of reflection are noted, along with their implications. Medical practitioners can judge the type of reflection that is operative and decide whether

a deeper version is required to read correctly a patient's narrative, so that the options for cultivating a more appropriate style can be assessed.

Narrative Medicine and World Entry

Narrative medicine makes a significant shift theoretically away from the medical model.[14] Simply put, traditional medicine is grounded in dualism, whereas narrative medicine is non-dualistic. Dualism, also known as Cartesianism, is essential to the claim that medicine deals with objective evidence. In fact, in the absence of dualism, such a position is difficult, if not impossible to sustain.

Fundamental to dualism is the belief that subjectivity can be separated categorically from objectivity.[15] In more recognizable terms, the mind and body follow parallel tracks, although minimal interaction may be recognized. In the end, primacy is given to the objective side of the equation. Furthermore, subjectivity is thought to cloud an accurate assessment of a case, thereby establishing a hierarchy of knowledge in traditional medical practice.

Compatible with dualism, the body has been viewed typically to be a machine. Although this imagery is somewhat outdated, the current rendition is not much different. The modern focus is physiology and biological markers.[16] The basic idea in both cases is that disease causes a bodily imbalance, which can be detected through a rigorous physical evaluation. Such an investigation is possible only when the influence of subjectivity is adequately constrained.

The watch-word nowadays is evidence-based medicine.[17] In effect, this phrase is a euphemism for scientific medicine. At every opportunity, scientific practices are adopted, along with the introduction of increasingly sophisticated technology.[18] The aim of these strategies is to limit the influence of values and interpretation, so that value-free judgments are possible. Better medicine is thought to be the result of this trend.

Those who are informed by the narrative turn are not so enamored of objectivity. They contend that this search for objectivity has been overblown and in practice is unattainable. But why is this the case? The answer to this query is straightforward but involves an important maneuver in philosophy. At issue is a relatively new understanding of language.

The traditional view is called the indexical thesis. In this portrayal, language is compared with a pointer that is thought to indicate or highlight factors in the world. What is assumed is that the elements highlighted are objective. The real benefit of language is that situations can be clarified, so that everyone has a similar focus. The use of medical checklists, for example, treats language in this manner, since standardized terms are introduced to direct the attention of both patients and physicians.

In the framework of narrative medicine, the thrust of language is different. Specifically important is that language is envisioned to be a creative force that mediates everything that is known.[19] Instead of highlighting objects, language is understood to create meaning. Therefore, persons do not simply respond to objects, as Cassell[20] states, but to their meaning. As a result, the use of a checklist is no guarantee that patients are responding to identical prompts, even though standardized language is adopted.

What this change in language announces is the demise of dualism since facts cannot escape the influence of language. There is no escape from narratives, despite the hopes of those who champion evidence-based medicine. Given this anti-dualist position, the emphasis in medicine shifts to the worlds created by narratives. Kleinman[21] refers to these domains as "moral worlds."

The point at this juncture is that narratives create the situations where individuals and communities reside. Like every story, these storylines have characters, plots, and endgames. A logic is present that specifies the rationale for all interaction, with illness enmeshed in the various discourses. To understand this condition, including acceptable remedies, entrée must be gained to the worlds created by the narratives that are operative. The search for objectivity is tempered in favor of a proper reading or interpretation of a patient's world. Especially noteworthy is that this domain represents a reservoir of knowledge that is crucial to medical care, since effective interventions are guided by the themes that are revealed.[22]

Reflection has a difficult job in narrative medicine, beyond encouraging a more acute memory, review, or detailed analysis of events or behavior. Now, the goal is to achieve a closer interpretation of what is happening, rather than becoming flexible and receptive to new input. Vital to reflection in narrative medicine is to illustrate and overcome boundaries that circumscribe and separate worlds, so that entry to a patient's world is possible. After all, how persons define themselves, others, and their relationships has a lot to do with how they envision and respond to illness.

Modes of Reflection

In this section, various modes of reflection are discussed. Particularly important is that they are very different in terms of their respective aims. Most of these styles, as should be noted, do not lead to world entry and promote the program of narrative medicine (Figure 1).

Taking a break

The simplest form of reflection relates to a respite from a project, a time out period from the daily grind and turmoil of a busy schedule. This mode provides a breathing space, a step back to determine "where are we?" and the ability to obtain a calm picture of a situation.[23] The basic principle is that occasionally everyone needs a break from the action to regenerate and make sound judgments.

In medical practice, this style is revealed when practitioners claim that reflection has a therapeutic effect.[24] Specifically, reflection can foster self-healing on the part of physicians and others by allowing them to be honest with themselves. They can address, for example, uncomfortable emotions or ideas and gain

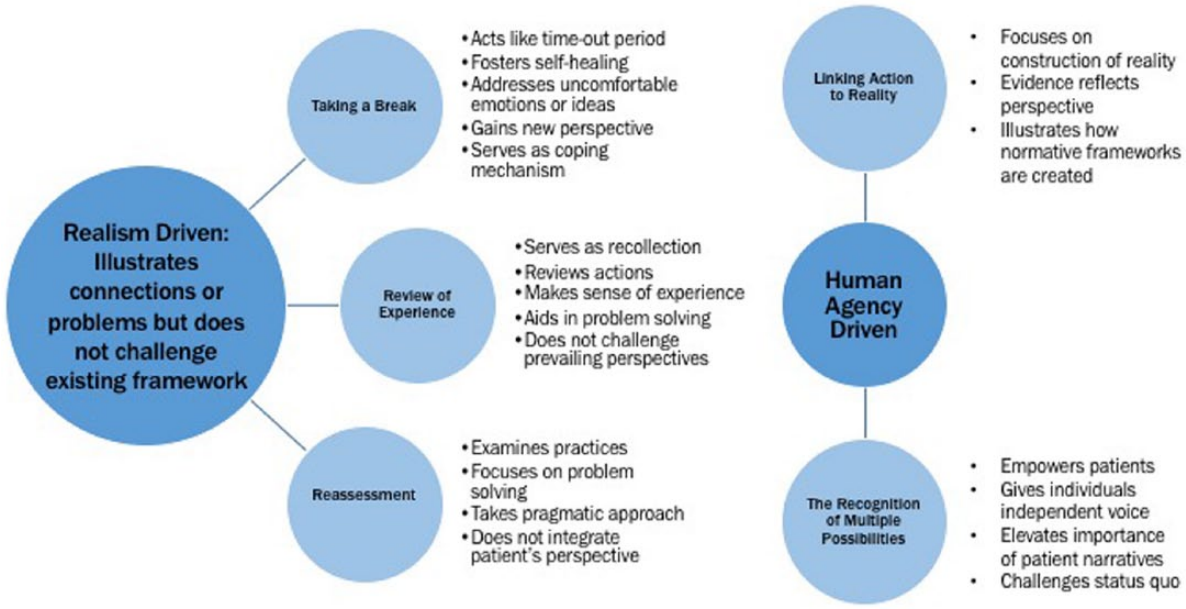

Figure 1. Modes of reflection.

a new, more productive perspective on these elements.[25] This sort of reflection is not necessarily transformative but serves primarily as a coping mechanism, so that practitioners are better equipped to deal with the harsh aspects of their daily routines.

Review of experience

The next style of reflection can be characterized as recollection. This activity consists primarily of an overview, that is, a review of the intervention experience. At this point, the work of Dewey[26] is often mentioned. He defines reflection as making connections that were not originally seen to make sense of experiences. Implications and consequences are some of the insights that are derived from this mode of reflection.

Reflection is designed to assist practitioners to review their actions.[27] Sometimes an experience may spawn issues that need to be unraveled and clarified before an intervention can continue. Unexpected consequences may have occurred, for example, that can be resolved through sufficient reflection.[28] Simply put, reflection can aid in problem solving.

Central to this reflection is recapitulation. Experiences are reviewed and expanded if certain issues were overlooked or arose unexpectedly. This style constitutes what Schon[29] calls reflection "on-action" and does not necessarily lead to critique. His point is that grasping new connections should not be equated with a challenge to prevailing perspectives or the realization that a patient's expressions or behaviors have been interpreted incorrectly. Alternative visions are not typically a product of such reflection.

Reassessment

At this juncture, the cardinal issue relates to the clarification of values and goals. Bringle and Hatcher[30] characterize this reflection as bringing together experience and the goals of an intervention. The thrust of reflection is the examination of any obstacles that have been encountered. If experiences occur that are inconsistent with the aims of an intervention, changes should be made. Any misalignment should be corrected early to improve the likelihood of a successful treatment regimen.

The operative principle is that reflection provides the opportunity for a careful examination of practices.[31] In this case, there is deliberate (re)thinking and a plan of action to root out any problems and encourage constant improvement.[32] But this mode of reflection is very pragmatic and focused mostly on the achievement of goals.

The general framework of a practice or intervention is not emphasized by this reflection. Nuance may be introduced, along with slight modifications, but a new direction is not necessarily illustrated. Why a patient responded negatively to a new protocol may be explored and corrections made. But the general framework for understanding the issue at hand is not thrown into relief. The perspective, or world, of the patient is not brought to attention through this reflection.

The three examples of reflection discussed thus far are based in realism.[33] That is, reflection sticks close to reality, past or present and does not venture beyond illustrating connections or impediments. Reflection advances little beyond mimicry and at best provides expanded descriptions of practices or behaviors. But acquiring clarity does not necessarily involve the insight that the framework of treatment is limited or wrong. The key omission is that these modes of reflection do not have the epistemological component required by narrative medicine.

The next two modalities come close to meeting this requirement. These forms extend beyond the present conditions and consider the role of human agency. They incorporate Schon's[29] notion of "knowing-in-action" and try to address the vision behind current practices. As required by narrative medicine, the

current intervention framework can be overcome, so that patients are understood in their own terms.

Linking action to reality

This approach to reflection exposes the link between human action and the intellectual framework that sustains an intervention. As Schon[29] notes, the focus of attention are the assumptions that are operative and guide a particular medical practice. This method is more in line with Kant[34] than Dewey because the mind is treated as inventive, as opposed to merely engaging in recollection or reassessment.

Particularly noteworthy is the epistemological shift that is underway. Because the mind is creative and shapes whatever is known, every aspect of medical practice, including facts, is thought to have contingent significance. All medical practices are revealed to be predicated on a perspective about health and illness or a narrative. What reflection grasps is the nature and implications of this mental action.[35] Particularly important is that the limits of the operative perspectives are exposed, along with the decisions and interpretations that construct these outlooks.

The key outcome of this reflection is that medical evidence is a matter of perspective. In narrative medicine, this revelation is significant. Implied is that narratives matter when trying to determine the facts of a case and that each story may deploy a different perspective on illness. When and where a particular narrative may apply becomes an important issue, particularly the conflict that may arise between a patient's and physician's perspective on sickness and treatment. Those who recognize this prospect are in a better position to develop appropriate interventions.

Reflection thus challenges persons to recognize how their narratives shape their views on issues. This Kantian inspired mode of reflection exposes the interpretive activity whereby medical knowledge and practices are organized and used. Reflection does not simply confirm or recollect behavior related to medical affairs, but illustrates how normative frameworks are created, gradually internalized, and become an acceptable part of interventions. The impact of the narratives that are central to this outcome is recognized.

The recognition of multiple possibilities

Recognizing the influence of patient's stories is the cornerstone of narrative medicine. But also important is that persons take a more active role in their cases. They should not be intimidated or demure about offering their input. As some critics argue, patients should be empowered to give direction to medical practice so that their needs are met.[36]

The final mode of reflection includes the epistemological position just discussed, but makes a maneuver required for empowerment. At this stage, reflection reveals that the current perspective on medicine is only one possibility among many, and thus various other options can be considered.[37] In this way, patients can envision why their input is so crucial and act in a bold manner to be heard. Kant believed that this sort of reflection enables persons to make authentic statements that do not merely mimic those advanced by authorities.

Research has illustrated that the clinical setting tends to marginalize patients.[38,39] Not only are they constantly interrupted, they are overwhelmed regularly by medical language and practices that seem foreign. What this mode of reflection accomplishes is to illustrate that this situation is not natural but framed or staged and thus open for negotiation. The interpretation that a physician has of a patient's condition can be challenged so that a more relevant depiction can be offered. In other words, a patient's narrative can emerge from behind the dominant diagnostic nomenclature and plethora of medical technology.

Empowerment is encouraged because the worlds of patients are illustrated to be a vital element in medical care. Along with this insight is the realization that they can offer correctives to their medical records or any facet of an intervention. Patients can begin to comprehend that their narratives are as important and even more significant than any other input into their treatment.

Reflection and Worlds

Clearly, the term reflection has a lot of meanings and should not be used loosely. Whereas some types seek clarity, others provide a respite from the everyday routine. In none of these styles, however, is the structure of the clinical setting questioned. Reflection is merely a pragmatic response that attempts to improve the current situation.

Some other modalities—the final two in this discussion—are more profound. They are non-dualistic, like narrative medicine, and illustrate how clinical practice is replete with narratives.[20] Although many physicians may deny this premise, both doctors and patients bring narratives to the medical setting.[40] This more radical reflection illustrates how these stories influence every aspect of an intervention, such as how both parties think about illness and treatment.

The idea is set in motion that significant attention should be paid to patient narratives if treatment is going to be relevant and effective. But additionally, patients are provided with the opportunity to become bold and demand active input into their medical evaluation and plan of action. And gradually, they may begin to ask why their narratives should be given a back seat to those of physicians or anyone else on the treatment team.

The world of patients is elevated in importance, while gaining entrée to this domain becomes a priority. Once this demarche begins, a thorough portrayal of a patient's condition is possible that extends beyond the usual, and often irrelevant, evidence provided by the standard instruments.[41] The result is that an improved medical practice can ensue.

Conclusions

Reflection is an important component of social interventions, including medicine.[42] The point of this process is to facilitate learning and consolidate information, so that medical practice

is enhanced. In narrative medicine, the aim is similar, but with a slightly novel twist. What is meant by learning and information is different from traditional medicine.

What is unique is the elevation of patients' narratives and their worlds in importance. Learning and information are derived from world entry and the knowledge that is found in this domain. But as noted in this discussion, some modes of reflection lead to the narratives involved, while others do not. Practitioners who are interested in narrative medicine should recognize this issue and be selective about their adoption of reflection.

Specifically important is that reflection without an epistemological dimension has little utility in narrative medicine, because this strategy requires that the impact of narratives be illustrated. But additionally, a style that does not question the underlying framework of current practices, and reveal this perspective to be merely a possibility, will not likely empower patients to demand to have their narratives heard. In narrative medicine, a change is required that patients become actively involved in their care.

The message is that practitioners should adopt a mode of reflection that is consistent with their goals. They must take the time to examine the aims of the medicine they practice; they must probe deeper than the science and techniques and ask foundational questions. And if narrative medicine is chosen, only particular styles of reflection will keep this orientation on track. This insight should not be lost.

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JWM, BAF, and CS contributed to the article concept and design. JWM wrote the first draft of the manuscript and BAF and CS edited and made revisions. All authors reviewed and approved the final manuscript.

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