# Learning Narratively: Resident Physicians' Experiences of a Parallel Chart Process

D Clandinin, M Cave, A Cave, A Thomson, H Bach

**Citation**

D Clandinin, M Cave, A Cave, A Thomson, H Bach. *Learning Narratively: Resident Physicians' Experiences of a Parallel Chart Process*. The Internet Journal of Medical Education. 2009 Volume 1 Number 1.

**Abstract**

ObjectiveThe objective was to explore the efficacy of a narrative reflective practice strategy, the parallel chart process, with residents in family medicine and internal medicine in order to develop professional skills in attending to the patient-physician encounter. MethodsThe research was designed to study the potential of writing, sharing and inquiring into parallel charts as a way to develop residents' skills in attending to the patient-physician encounter. Three groups of participants from two medical disciplines participated: two groups of family medicine residents (FM1 and FM 2) (four per group) and one group of three internal medicine residents (IM1) at the University of [name withheld]. In the FM 1 and IM 1, each resident wrote 10 parallel charts over 10 weeks and in FM 2 each resident wrote five parallel charts over 10 weeks. Each group met bi-weekly with two researchers to narratively inquire into the stories told in their charts. Residents participated in unstructured exit interviews. Transcripts were thematically analyzed. ResultsTen themes emerged: learning to notice/attend closely to their clinical experiences; learning to step into someone else's story; impact on self of hearing other physicians' stories; being affirmed that they were not alone; impact of inquiry dialogue on clinical practice; recognizing themselves as changing over time; recognizing their responsibilities as professionals; experiencing professional community; the recursive nature of their skill development and the importance of taking time to engage in a collaborative narrative reflective practice process over time with colleagues.ConclusionsThe narrative reflective process used in this intervention has potential to foster the development of clinical skills.

## INTRODUCTION

"The patient-physician relationship constitutes the primal exchange within which all medical care transpires". [1] In family medicine, the physician-patient relationship in all uniqueness and particularity is central to therapeutic care. While there is more opportunity for continuity in the practice of family physicians than for internists, it is crucial that all residents, regardless of specialty, remember the encounters and use them as starting points for reflection. These reflections should include both each patient's story as well as the residents' stories of who they are and are becoming as physicians.

Residency programs struggle with finding ways to develop residents' ability to attend closely to encounters with patients. [2, 3, 4] For example, Bethune and Brown [5] use case-based reflective exercises with residents in order to help "…learners extract meaning from their experiences." (p. 472) They share our concern about the need to "…help to bridge the transition between clinical experience and existing knowledge." (p. 472) In this study, we turned to narrative approaches as we searched for ways to create pedagogical situations in which residents might learn this essential part of becoming a physician.

Teaching using approaches from narrative reflective practice is one way of creating situations where residents learn to inquire into their tacit ways of knowing. [6] Narrative reflective practice is grounded theoretically in views of professional knowledge as personal practical knowledge [7] as well as in views of understanding experience and experiential knowledge as narrative compositions as individuals live out, tell, retell and relive their stories. [8]

Within narrative reflective practice, one teaching and learning strategy involves working with physician learners to have them write, share and collaboratively inquire into what Charon [9] calls parallel charts of their experiences. Charon, as do we, works from a narrative view of experience in which people both live and tell stories of their lives. She asks medical students to write stories of their experiences

with patients in parallel charts. In parallel charts students write those things that "…are critical to the care of your patient that don't belong in the hospital chart, but they have to be written somewhere." [9]

In current work [10] we developed a pedagogical strategy for engaging family medicine and internal medicine residents in writing parallel charts and on engaging them in small group shared inquiry into their charts. The process of narrative reflective practice allowed each resident to tell his/her story which then became the starting point for the group's shared narrative inquiry. The group, with the guidance and support of two researchers, narratively inquired into the story through asking questions that point toward temporality (the past, present and future), the personal (what was happening for the person), the social (what events were unfolding) and place. [11] Engaging in this way also directed attention to the multiplicity of vantage points one can adopt within the story.

## METHODS

Ethics approval was obtained from the Faculty of Medicine and Dentistry Health Research Ethics Board. Informed consent from all participants was received. Pseudonyms have been used for all participating residents. In order to recruit participants, researchers presented sessions to residents in one Family Medicine clinic as part of an academic half-day and to a group of chief residents in one Internal Medicine department. In Internal Medicine, the chief residents then explained the study to the whole resident group and asked those interested to contact the researchers. All residents were advised that they would be asked to write a parallel chart on one clinical encounter each week for 10 weeks and to attend bi-weekly sessions to share and discuss their parallel charts with other participating residents and two researchers. In the first family medicine group four residents (two men, two women) participated. In the second family medicine group, four residents, all women, participated. In the internal medicine group, three residents (one man, two women) participated. Data are from 11 residents, in two disciplines, and in three groups.

After five sessions, short exit interviews on what they had learned about their experiences were held. Each participant was asked the following three questions:

1. "What were your overall experiences of writing parallel charts, sharing them and hearing others share their charts?"
2. "What was your overall sense of whether, and in what ways, this was a learning experience for you?"
3. "What did you learn about yourself from the experience?"

This paper reports the results of a thematic analysis of the exit interviews. Two experienced researchers read the interview transcripts to identify segments that suggested repeated or emphasized points. Points were summarized and grouped into themes. Ely, Anzul, Friendman, Garner, and McCormack-Steinmetz [12] described a theme as "…a statement of meaning that runs through all or most of the pertinent data, or…one in the minority of data that carries a heavy emotional or factual impact." (p. 150) In order to provide a measure of validity, a draft manuscript was sent to the residents to ensure the paper represented their experiences. The draft was sent after all the exit interviews had been transcribed and analyzed. No quantitative measurement of agreement with the findings of the researchers was recorded. No residents requested alterations to the text.

## FINDINGS

### Figure 1

Ten themes were identified through the thematic analysis

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|---|---|
| Theme 1 | Learning to notice/attend closely to their clinical experiences |
| Theme 2 | Learning to step into someone else's story |
| Theme 3 | Impact on self of hearing other physicians' stories |
| Theme 4 | Being affirmed that they were not alone |
| Theme 5 | Impact of the inquiry dialogue on their clinical practice |
| Theme 6 | Recognizing themselves changing over time |
| Theme 7 | Recognizing their responsibilities as professionals |
| Theme 8 | Experiencing professional community |
| Theme 9 | Recursive nature of the development of their skills |
| Theme 10 | Taking time to engage in a collaborative narrative reflective process over time with colleagues |

## THEME ONE: LEARNING TO NOTICE/ATTEND CLOSELY TO THEIR CLINICAL EXPERIENCES

Participants spoke frequently of how engaging in the parallel chart process helped them to attend more closely to their clinical practice. Alicia (FM 2) noted, "when you start writing narratives you realize what details are important that you need to write down so that you can come back to it later." She also noted, "sometimes *really don't have something but then it makes you sit and wrack your brain and there is something actually." Hannah (FM2) said the experience helped her "take the time to see all the things*

*you're learning from your day to day encounters. Commenting on going "from one patient to the next" without "time to really think about things," the parallel chart process made her sit and think about it….I saw things, like I drew things out from patient encounters of days ago that I thought [were] just regular encounters but then when I thought about it, it was actually different and deeper and so…it is a way to not become numb to it because after a while it becomes routine and you don't stop and think about it.*

Lane (IM 1) found herself noticing more about her encounters as she looked

for something to write… "I don't know if I think about those people more because I wrote about them or because I picked them because there was something that I was already feeling about them…because I had to pick…those are the ones I'm going to remember."

Ellen (IM 1) noted, "it was harder to come up with the story, sometimes you had to reach…but I think it surprised me how sometimes it was easy to find something, like even some of the everyday mundane things". Miriam (FM 1) also described how she became attentive as she kept "…an eye out for something to write about". The rigour and structure of the narrative reflective process created more wide-awake, 'attentive to the encounter' physicians.

## THEME TWO: LEARNING TO STEP INTO SOMEONE ELSE'S STORY

Participants found listening to others read their charts to be a powerful experience. While Josh (FM 1) spoke of the importance of noting "[e]ach individual's reaction to that situation", listening to others read their charts "also forces you to ask yourself, 'well what would you do in that same situation as well?'". Relating his comments to one person's reading of a chart, he said, "[y]ou can kind of either agree with him or disagree with him…but it's a situation that you can put yourself into and see how you would react". Part of stepping into someone else's story was the recognition of themselves in another's story.

## THEME THREE: IMPACT ON SELF OF HEARING OTHER PHYSICIANS' STORIES

As they stepped into others' stories through listening to their charts, they noted the impact this had on who they were and were becoming as physicians. Josh (FM 1) noted it gave him "… insight into other people's interpretations of situations. And then you also find out a lot about the other people themselves". Corrine (FM 2) noted,

you could get the different perspective of your story through somebody else's experience of something similar, but then you could also contribute to someone who's maybe feeling really anxious or negative about what they were doing and you can try and help manage that a little.

Sarah (FM 1) was influenced by "hearing feedback from other people." Chris (FM 1) noted "[w]hat I found really useful was hearing other people's stories because it showed me how people thought." He described a particularly powerful instance when one resident spoke of a pregnant teenage mother, noting "[t]hat was a good one. I remember that and I really liked how everybody approached the situation differently."

As they wrote, shared, listened and inquired into each others' experiences, they saw the dialogue was influencing how they thought about situations. Chris (FM 1) realized that even "[t]hough we all have similar training…everybody thinks in a different way and it kind of opened me up to that."

Jerry (IM 1) spoke of a similar experience:

We all had been taught to think the same way about Internal Medicine problems. Not that everybody has the same mind in Internal Medicine and that's what…was so great 'cause you're…looking through a lens….that these doctors who you see every day doing their clinical duties and that's all you know….Ellen writes a history and a physical and I read her notes and her conclusions and it's similar to the way I do it. But when I see…her reading her charts, the things she finds funny or unusual or whatever, I thought that was really great, sort of identifies people in your mind…it's like the missing half…it's like when you look at the moon and you see it's a half moon, you know the other half is there, it's just shadowed and you can't see it right now…You know it's there and then all of a sudden they read their story and you see the other half.

## THEME FOUR: BEING AFFIRMED THAT THEY WERE NOT ALONE

Participants spoke of this often. Ellen (IM 1) noted she found medical school "very isolationist" and when she had to go "through my clinical rotation you felt you're all by yourself with your preceptor and you're scared". The narrative reflective practice process helped her understand that "I'm more resilient than I think I am and I'm not alone, even though a lot of times I feel like I am." Later in the

interview she added a further reflection:

sometimes in our professions we are quite separated and we don't know if what we are doing is right or normal or what our feelings are...we kind of hide behind our doctor persona or whatever. As soon as we hear that other people have similar experiences or similar feelings in different experiences, that sort of thing is normalizing and interesting to hear how other people experience [things].

Ellen's reflections on this theme were echoed by Lane (IM 1) in her exit interview with the researcher. She noted "for example, Ellen talked a lot [in the group] about lacking confidence and people making her feel not good and stuff so it was kind of nice to know that other people feel that way because I feel that way too."

The theme was recurrent in both discipline groups. Mary (FM 2) noted, "what I learned was…we're all in the same condition together…we all have similar fears or similar questions." Sarah (FM 1) noted, "[s]ometimes it's very encouraging to know some of the residents were on the same page as me." While a sense of connection with others in the group was prompted sometimes by an awareness of "being on the same page", sometimes the sharing led to an appreciation of other participants' different perspectives, which, in turn, led to a re-examination of the physician narrator's perspective and clinical decision making.

## THEME FIVE: IMPACT OF THE INQUIRY DIALOGUE ON THEIR CLINICAL PRACTICE

Josh (FM 1) realized, after sharing a chart in which he was concerned that a patient was not taking his advice, he had begun to re-story the situation:

Instead of being me against the patient, instead of me feeling intimidated or upset with the patient's actions and reactions, I was more fitting in with I know why they're feeling this way and I now know why they reacted that way. It may not be right or it may not be wrong but I had better insight.

Chris (FM 1), less sure of a change in his practice, said, "I don't know if it would have changed what I did but at least I have that in the back of my mind." Sarah (FM 1) noted "[s]ome of their cases I sometimes remember and I think if I come across the same case as [that], I'd have other ideas…Not only mine. You have other options to rely [on in] the situation". Ellen (IM 1) spoke of how "it sort of opened my eyes to experience things differently or just look at things differently…you get a different perspective and sometimes it just makes you more observant in a different way". Jerry (IM 1) said,

I just feel that difference is helpful…I just thought it was neat to see how everybody sees things differently because we all wear coats and we all wear stethoscopes and we all walk down the hall in teams and it's sometimes hard to differentiate what the actual differences are between people.

Alicia (FM 2) changed her practice when she began keeping a notebook. "In my little black book I'm just writing a thought on, not necessarily the diagnosis or prognosis or the management of the patient but what this encounter with the patient or attending to the resident might mean."

## THEME SIX: RECOGNIZING THEMSELVES CHANGING OVER TIME

Participants spoke of how they came to see the changes in themselves differently over time. As Josh (FM 1) thought about the experience over the ten weeks, he realized that, as he returned again and again to the initial experience, he saw his ideas change. Because he kept his parallel charts in a computer file with other study materials, he said the charts were on the:

Same page as everything else and you're looking back on things and just seeing…what did I think about this at the time? So I think my views kind of shifted a bit…I mean it was clearly different from the way I felt at the meeting itself when we spoke about it.

Josh (FM 1) also addressed the temporality of the parallel chart process, noting:

And then I found myself waffling about it afterwards and I went back and said, well maybe, it could be this and, you know, she was only twenty-two or twenty-three years old and she's alone and her friend is not very supportive and so all those other things came into play…initially I felt a certain way and then when I went back to write things down afterwards, I might feel slightly differently towards it.

Ellen (IM 1) began to think about all she knew: "You look back and it's like wow, you actually do a lot and go through a lot in our training." Hannah (FM 2) noted:

I went from sort of thinking of it [narrative reflective practice] as one other thing I had to do, to something that was actually good for me and good for my soul…it's made my…experience in medicine much more rich [to] actually take the time to see all the things you're learning in your day to day encounters.

Corrine (FM 2) spoke of "self discovery" through the process and of awakening to "a much stronger belief in social justice…it helped me recognize it's a really important part of medicine for me".

Each participant, noticing change in themselves, seemed, in the telling of their stories, to be seeking "narrative coherence". [13] They hint at dissonance as they try to integrate their experiences but they also seem to be forging links between who they were, who they are and who they are becoming, as physicians. Recognition of change in self over time includes a developing sense of professionalism. At the individual level, Corrine tells us that her conviction about the importance of incorporating a strong belief in social justice has been reinforced and will be a significant part of her practice of medicine, but she does not say that this "important part of medicine" is important enough to be a required element of professional practice for all physicians.

## THEME SEVEN: RECOGNIZING THEIR RESPONSIBILITIES AS PROFESSIONALS

While several, like Corrine, spoke about recognizing and interpreting their individual responsibilities as professionals, there was little defining of professional behaviour per se. Participants acknowledged that others might see things differently and there was a respectful acknowledgement for individual interpretation and practice of professional behaviours. For example Josh (FM 1) noted there were others "[w]ho do feel certain obligations that go beyond…what is expected of them".

Miriam (FM 1) was more reflexive in examining her own professional behaviour and addressed the importance of professional autonomy when making a clinical decision. She referred back to one of her charts:

I remember one time when I was reading the one about how there was that lady that asked me what I believed, if I believed this was MS and that was bothersome to me because I did and yet I didn't tell her that. And I had some misgivings about that and sort of Chris's [comment] 'it's just not your role!'…And I thought that that was a fair statement. But you know at the end of the day…you have to come to that balance on your own.

While Hannah (FM 2) did not identify any specific reflexive moments of becoming aware around professional responsibility she did comment that the narrative reflective process:

was a way to maintain your humanity…in all this…you can turn into something that is rather cold and routine and…you treat every patient the same way and you…don't think about personal stories…and become very efficient. But I think you lose part of your humanity.

In this, Hannah is speaking of maintaining her humanity when with patients. She may also be inferring that the parallel chart process and the reflective discussion with colleagues allowed her to acknowledge her humanity. Several participants spoke of the value of the relational aspect of the narrative reflective process. This contrasts with the reported reflective learning experience of 4$^{th}$ year medical students in the UK. [14]

## THEME EIGHT: EXPERIENCING PROFESSIONAL COMMUNITY.

The residents' comments indicate that the process of narrative reflective practice was fostering a strong sense of community. Josh (FM 1) spoke of how:

I do feel a certain connection to everyone in that group itself. So that was nice….Being able to talk about these things amongst yourselves…you get a better understanding for the people who you're working with as well. And…it would make personal or professional relationships stronger.

Miriam (FM 1) also spoke of the professional community, noting, "[t]hat always surprised me…it just helped me take into consideration when you're seeing people and you're also working with colleagues how it's going to affect everyone sort of differently."

Ellen (IM 1) noted her group members "definitely talk to each other more and I think I connect with them on a different level…I think we have a different connection than we did before." Mary (FM 2) said, in the group,

you build a relationship in a very special way…you're building a relationship in a community of medicine because hopefully lots of us will stay in this community to practice and then we will know each other on a level that we do not [usually] get from partying or working side by side in the clinic 'cause you never had enough time to do this stuff.

While being present for, and building relationships with, one another were identified as strengths of the process, the residents also spoke of the internal conversation which they continued to have even after they had presented their narrative and the group had engaged in the shared narrative inquiry. These continued personal reflections were largely reflections on the 'rightness" of their ways of being,

including their clinical diagnosis and decision making skills. We concluded that the experience of building relationships in a community of medicine was not at the expense of their individual professional development.

When the researchers embarked upon this approach to learning, they were aware of the residents' full schedules and that the first priority of medical learners are usually learning technical skills and acquiring biomedical knowledge. We were interested to hear from the participants that the reflective and reflexive learning continued as they listened to others' stories in the group.

## THEME NINE: RECURSIVE NATURE OF THE DEVELOPMENT OF THEIR SKILLS

In the exit interviews participants described how the reflective process was a recursive one. Josh (FM 1) noted:

Because even if I went first and I was done, when the next person was talking you're still thinking about your situation, still applying everything back to it so the process did continue on. It didn't just end when you said, O.K. let's move on now…it didn't just end right there. And whether it's at the end or not, I mean you kept on thinking about it.

They described how the process caused them to wonder about their thinking and practice as physicians, not only in the context they described in their parallel chart, but in other clinical contexts as well.

Jerry (IM 1) spoke metaphorically, describing that in the narrative reflective practice group:

I get to glimpse myself from the outside. And that was a neat experience just to do that…I feel like I can't really verbalize what it is though…it was just sort of this ability to see outside the thought patterns that I usually have. Because you don't usually realize there is an outside when you're thinking or sitting there writing in your charts and seeing your patients. You don't think about what it looks like from the outside…it makes me…more apt to be self aware…maybe that's what this project helped me do a little.

## THEME TEN: TAKING TIME TO ENGAGE IN A COLLABORATIVE NARRATIVE REFLECTIVE PRACTICE PROCESS OVER TIME WITH COLLEAGUES

All participants noted the importance of having the structure of narrative reflective practice that required them to engage in the writing of parallel charts, sharing their parallel charts, hearing others' charts and engaging in the shared inquiry with a sustained group. Jerry (IM 1) said, "[t]here's so much potential and capacity in these experiences that we all have, that we share collectively and it's just this weird culture that doesn't get opened up right? Don't you feel that?" Miriam (FM 1) noted:

Residents, for their own sanity, should be able to look at some of this stuff and examine what it is that's going on, if it bothers them, if it doesn't, why or why not. I think that's important because I just don't know how else you can compartmentalize so much of what you see….You just tuck it away in little boxes and you don't talk about it.

Josh (FM 1) spoke of appreciating the focus "…on different topics." He added:

This was different because first of all, we were allowed to say what we had to say about a specific topic. There was questioning on your end but more in the sense of trying to push us to explore our interpretation, experience, feelings, for ourselves.

Josh noted the importance of each resident focusing on his/her own experience and "… not what you want to hear. But what we really felt at the time…But the questions were posed to us to think further about the situation."

Chris (FM 1) described the challenge of the writing process. "I can write things on a more technical sense quite easily like, if I have to write a paper or whatever it's fine but something like a parallel chart, it's expressing my personal feelings." He commented on needing to learn a new way of writing that drew on tacit knowing rather than on the technical content knowledge he learned in medical school. He also spoke of the importance of listening to the other residents' parallel charts. "What I found really useful was hearing how other people thought because I'd never done that before in medical school or really thought about it that way." He contrasted his experience of writing, sharing and inquiring into his and his colleagues' parallel charts with other small group experiences as he said, "[d]uring medical school we'd have small group sessions where we'd talk about things but none of us had the experience to say, this is what I'd do…all we knew is the medical stuff, right?"

As they described their overall experiences, Josh (FM 1) spoke of how when he was "…able to talk about it, I think that adds a different element to it." Chris (FM 1) noted "[t]he writing was less important than hearing how other people thought about a situation, getting feedback that way." Sarah's (FM 1) experience was different than Chris' as she

said "I guess writing was easier than reading it aloud…Sometimes…I…put myself back to the situation and it was hard for me to continue."

Mary (FM 2) highlighted that "I needed that formalization more than I thought I would…[the] sharing part is actually more important than anything…it's not a one shot activity. It's the writing, the speaking it, the hearing it reflected back at you and the comments of your colleagues." Alicia (FM 2) described the process of:

putting [it] down in words and actually reading it to others is, in itself, the learning experience…if you don't put it down in words…it doesn't solidify what you've learned from this experience…hearing other stories, you learn a lot about what they're expressing, their experiences…and then it…makes you think and [when] you raise a question or...help them to see their situation in a different light…by listening to other stories…it raises questions in your own mind.

Within the medical culture there is a belief that all conscientious physicians reflect on practice but that lack of time is an obstacle to reflection. [15] The participants realized they needed more than just time in order to reflect; they also needed a formalized process for reflection and a willingness to participate in the reflective process. They describe the value of this way of learning, and the paucity of opportunities for it in medical education.

## DISCUSSION

Although our study only involved 11 learners, the themes identified were common among the groups. The 4 stages of the reflective process (choosing a clinical encounter, reflecting when writing about the encounter, further reflection when reading aloud in the group and reflection through a narrative inquiry approach) overcomes the limitations of previous studies that used one or two of these stages. [5, 14] Henderson et al's study reported the reflective learning experience of 4$^{th}$ year medical students in the UK in which a sample of 4$^{th}$ year students were asked about their experiences of a narrative reflective process. In this process they wrote two narratives as part of a significant event analysis exercise. These written reflections were then discussed in one-on-one interviews with their general practice teacher and again in a small group of peers at the end of their three week general practice rotation. The study authors reference other studies, which support their finding that students find the process of reflection difficult. There were several differences between the participants in Henderson's study [14] and our study. Aside from the obvious disparity of age and stage of medical learners, another was the hierarchal difference between student and preceptor and the mandatory nature of the exercise for the students. However the process of reflection was also different. The students did not meet with a group of their peers until later in the process, and then only once, and there was no reading aloud of their reflections, either in the one-on-one meetings with their preceptors or in their small groups.

In our study, opportunities for each participant to read aloud and the centrality of sharing amongst peers as part of the process along with the regular meetings of groups, contributed to a sense of safety, which in turn prompted further reflection. The depth of the reflective inquiry sustained with the same group over time allowed, we believe, participants to risk expressing differences. It is remarkable, given the different viewpoints expressed both in the narratives and the ensuing group reflection, that the participating residents found the group process so cohesive.

The participants in our study were volunteers so the findings may not be generalizable to all physician learners. We report here preliminary findings of an ongoing research process. Future areas for research include the impact of this narrative inquiry process as part of a formal medical postgraduate curriculum.

Our study adds to the understanding developed by Bethune and Brown [5]. In our study we involved residents in a shared group inquiry process and made narrative reflective practice a more explicit focus. Bethune and Brown reported the reflective exercises offered the residents a future learning strategy, allowed them ways to look for deeper meaning in the patient-doctor interaction and helped them understand themselves better. Our findings were congruent with theirs, but the shared narrative reflection fostered an inquiry stance in their writing, their reading aloud in the group and in the subsequent dialogue, an attentiveness to their own stories over time and a deeper sense of professionalism.

As the residents spoke in the exit interviews they reminded us of what Kelsall [15] wrote: "[w]e all have stories. The stories of our lives….Our stories intertwine with those of others, we change and affect each other's stories." (p. 1263) While Kelsall was noting how physicians' and patients' stories were mutually shaping, we heard these residents speak of how the experience of the group was an experience of a storied professional community.

As we attended to these residents' developing sense of professional responsibility we were mindful of a quotation from Remen in Gold:

We are in danger of losing the story of medicine, and that it is a way of life. Our story is about compassion, service and integrity. About kindness to all and a reverence for all life. About love. It is a very important story for our time. We are trading that story for the story of science…We need to stay connected to who we are and what matters. (p. 1275) [16]

Remen's quote and Gold's [16] use of it reminds us of Miriam and Josh's acknowledgement of their growing sense of their professional responsibilities. The need for developing a stronger sense of physician identity, including a sense of professional responsibilities, is a much-needed aspect of undergraduate and post-graduate medical education. Without a well-developed sense of physician identity, it is difficult for beginning physicians to attend closely to who their patients are and who they are in relation to their patients. Narrative reflective practice groups, including writing parallel charts and collaborative inquiry into written parallel charges, offer promise. The narrative reflective process is not the same as a Balint [17] group or an informal social group telling stories. Key differences from the Balint approach are the focus on engaging in the narrative inquiry process [10] to inquire into multiple ways to interpret the story. The Balint approach, rather than an inquiry process, uses a psychotherapeutic process to engage in reflection. Often there is a problem focus in the Balint group approach. Similarities between the processes include working towards honing the physician as an instrument of healing, attending to the story and a transformative process for the physician. In Salinsky's [18] editorial on Balint group dynamics, we note significant differences in group purposes and leaders' intentions for the group. The writing of the chart in the narrative inquiry process described in this study is another layer of reflection shared by the facilitator and participants.

## CONCLUSION

For some time professional education programs have been urged to provide ways for learners to reflect on experiences, as reflective practice is recognised as an important part of becoming professional. [19] At all levels of medical education it is a challenge to create these opportunities. Medical education programs struggle to find ways to create spaces for reflection on the patient-physician encounter. Teaching physician learners how to be with their patients is central to the College of Family Physicians of Canada's [20] standards of accreditation of residency training programs which stress the importance of "…guided reflection on clinical experience." (p. 20) They also require that residents"…be encouraged to expand their self-awareness in the context of providing patient care." (p. 20) We recognize that young physicians with little life experience may be overwhelmed by their feelings and retreat into the conventional scientific model for self-protection. Often this can be done in a small group so that all students learn from each other's insights (College of Family Physicians of Canada).

The Royal College of Physicians and Surgeons of Canada [19] identified seven core CanMED roles. Three of the roles (collaborator, scholar, professional) enunciate competencies around reflective practice that participating residents spoke of as significant learnings from their experiences in narrative reflective practice. Under the role of collaborator, one key competency is that physicians need to be able to "[e]ffectively work with other health professionals to prevent, negotiate and resolve interprofessional conflict." (p. 15) This is addressed by narrative reflective practice as demonstrated in Themes 2, 4, and 8. One enabling competency under this key competency is the ability to "[r]eflect on interprofessional team function." (p. 16) (Theme 2)

In the role of scholar, physicians are to "…demonstrate a lifelong commitment to reflective learning, as well as the creation, dissemination, application and translation of medical knowledge." (p. 21) (Themes 2, 5, 10) One key competency within this role is the ability to "[m]aintain and enhance professional activities through ongoing learning" (p. 21) (Themes 5, 6, 9). An enabling competency within this key competency is the ability to "[r]ecognize and reflect learning issues in practice." (p. 22) (Themes 1, 3, 10) In the role of professional, one key competency is to "[d]emonstrate a commitment to physician health and sustainable practice." (p. 23) An enabling competency within this key competency is to "[s]trive to heighten personal and professional awareness and insight." (p. 24) (Themes 7, 9) The themes that emerged from the participants in this study all spoke to developing these competencies.

Narrative reflective practice groups, involving both writing parallel charts and shared narrative inquiry into those charts, show that we can create pedagogical situations in which residents:

- become more conscious of who they are in the physician-patient encounter;
- learn to step into other physicians' stories;
- can have their practices changed;
- can recognize how they have changed over time;
- and can learn to see their professional responsibilities within a professional community.

## ACKNOWLEDGEMENTS

The authors gratefully acknowledge and thank participating residents and the support of the McLeod Fund in the Department of Family Medicine, University of Alberta. This study, undertaken from 2006 to 2009, was funded by the Scott MacLeod Fund at the University of Alberta.

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## Author Information

**D. Jean Clandinin, Ph. D.**
Departments of Family Medicine and Internal Medicine, University of Alberta

**Marie T. Cave, M. Sc., P.G. Dip Counseling**
Departments of Family Medicine and Internal Medicine, University of Alberta

**Andrew Cave, M.B. Ch.B., M.CI Sci FRCGP, FCFP**
Departments of Family Medicine and Internal Medicine, University of Alberta

**Alan Thomson, M.D., Ph.D.**
Departments of Family Medicine and Internal Medicine, University of Alberta

**Hedy Bach, Ph.D.**
Departments of Family Medicine and Internal Medicine, University of Alberta