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## Reconsidering Privilege: How to Structure Writing Prompts to Develop Narrative

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## Reconsidering Privilege: How to Structure Writing Prompts to Develop Narrative

### Cover Page Footnote

As Scholar in Residence in the History of Medicine Program, Department of Psychiatry, Faculty of Medicine, University of Toronto, I have had the advice and support of Prof. Edward Shorter, Jason A. Hannah Professor in the History of Medicine and Sue Bélanger, Research Coordinator. The Health Narratives Research Group which is the focus of this essay is offered through the Health, Arts and Humanities Program, University of Toronto, headed by Dr. Allan Peterkin through the Department of Psychiatry, Mount Sinai Hospital.

# Reconsidering Privilege: A Technique for Structuring Writing Prompts to Develop Narrative

## Introduction

Reconsidering privilege is an idea increasingly prominent in healthcare (Gaufberg and Hodges, 2016). The prevalence of this idea has developed concurrently with calls for critical approaches to social issues evident in the larger society. Widespread concern with inequity resulting from privilege was the basis of the 2011 Occupy movement that highlighted “the other 99%” in contrast to the richest 1%. (Gamson and Sifry, 2013). However, it wasn’t until social inequalities with respect to health were clearly identified by the #MeToo movement in 2017 (Roussy, 2018, Soklaridis, et al., 2018) and the COVID-19 pandemic (Templeton et al., 2020) in conjunction with #BlackLivesMatter in 2020 (Egede and Walker, 2020, Landman, 2020) that the thought of reconsidering privilege in healthcare became an idea eliciting determined action by those in positions of power (Nugus, et al. 2020, Cohen Konrad, et al. 2019). The focus of this discussion will be one type of reconsideration that has become prominent in healthcare, that of the privilege of medical professionals (particularly physicians) over non-medical professionals<sup>1</sup> in healthcare decisions.

The importance of Narrative Medicine to this reconsideration is notable and has been addressed by various authors in Volume 4, Issue 1 (2019) of *Survive & Thrive* (Bardsley, 2019, Coret, 2019, Desmarais and Robbins, 2019, and Eberly, 2019). Therefore, with respect to medical professionals, it is of interest that those who participate in multidisciplinary health professions education (HPE) may be willing to reconsider their privilege in relation to non-medical professionals (Halman, Baker and Ng, 2017) as long as they are neither emotionally nor intellectually overburdened. Thus, a technique identified as useful in one multidisciplinary HPE program to encourage a reduction in medical professionals’ feelings of being overburdened with respect to their health research is relevant to this type of reconsideration of privilege. As such, familiarity with the technique—depending on an ordering of writing prompts while encouraging participant drawing and doodling within an equal participation, Narrative Medicine setting—may lead to a greater likelihood of medical professionals reconsidering their privilege in relation to non-medical professionals. As

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<sup>1</sup> For the purpose of this discussion, medical professionals are those who follow the medical model of diagnosis and treatment of illness in healthcare decisions—physicians, surgeons, nurses, dentists and therapists (physio, speech and occupational) are the most prominent examples. Non-medical professionals include any professionals who work with medical professionals employing other, non-medical models, including (but not limited to) social workers, psychologists, community health specialists, acupuncturists, health economists, medical historians, laboratory technicians, athletic trainers, epidemiologists, bioethicists, chaplains, and pharmacists.

the desire for engaging in reconsideration of privilege grows, this result may prove a valuable development.

### Narrative Medicine and the Conversation in *Survive & Thrive*

What is Narrative Medicine and how has the discussion of it been taken up recently in *Survive & Thrive*?

Initially referred to as Narrative Medical Ethics (Charon & Montello, 2002), the evolving discipline became known as Narrative Medicine with publication of its seminal work by Charon in 2006. It was then Narrative was defined as “stories with a teller, a listener, a time course, a plot, and a point” (p. 3) and Narrative Medicine became “medicine practiced with these narrative skills of recognizing, absorbing, interpreting, and being moved by the stories of illness” (p. 4)<sup>2</sup>.

Through its efforts, Narrative Medicine brings to light power distinctions that can lead to miscommunication in healthcare settings. Historically, the focus of Narrative Medicine has been inequalities between patients and medical practitioners (Arber et al. 2006). As a remedy to this disparity, Narrative Medicine has encouraged patients to write their stories (Morris, 2008). The responses of medical professionals reading these stories has become a feature of continuing healthcare education.<sup>3</sup> Following from this work, interest in Narrative Medicine has grown to include other power variances seen in healthcare. An example of these additional power distinctions is the one addressed by this essay—the relationship between medical and non-medical healthcare professionals.

Over its history, *Survive & Thrive* has fostered the development of a conversation with respect to Narrative Medicine.<sup>4</sup> In Volume 4, Issue 1 (2019), four articles address the topic from different perspectives.

Bardsley, referencing a TEDx talk by DasGupta (2013), stressed the importance of listening deeply to stories in order to develop narrative. This is seen as necessary if those with privilege are to recognize new perspectives with respect to these stories and to make their own experiences accessible. Coret, however, cautions that the

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<sup>2</sup> Narrative Medicine, initially developed by and for physicians, has been adopted and expanded for use by other medical professions. See Artioli et al. with respect to nursing, Vergnes, et al. regarding dentistry and Pearson et al. for surgery, as examples.

<sup>3</sup> See, for example, DasGupta’s 2013 YouTube video on the work she does at both Columbia University and Sarah Lawrence College to teach listening skills to healthcare providers.

<sup>4</sup> The conversation regarding Narrative Medicine has had a measured growth in *Survive & Thrive*. Prior to the 2019 issue, the two previous articles on Narrative Medicine were those by Natasha L. Vos (2017) and Amy E. Robillard (2014).

idea of reinterpreting privilege is not easy because the “asymmetries of healthcare will always exist, and we must continuously be aware of how we approach them” (p. 4). Desmarais and Robbins suggest how these asymmetries are accessed. In their view, this should go beyond the focus of Charon and that of DasGupta at Columbia University who concentrate on Narrative Medicine approaches relying on reading, writing and interpreting literary works. Desmarais and Robbins state, in addition, “live story telling or being in relationship with living stories in the form of a faculty and/or student body may be just as powerful, if not more so” (p. 4). The point being that Narrative Medicine extends to discussions of participants’ personally important stories and moves beyond analysis of noteworthy published texts by professional authors. Eberly, as a non-medical healthcare professional who has attended Charon’s workshops, would concur with this view but believes Charon should be understood to emphasize the importance of creativity to Narrative Medicine. In his view, “Creativity necessarily implies an audience—a teller and a listener—as exemplified in the Narrative Medicine workshops” (p. 5).

Each of the positions taken by these authors should be addressed and considered with a response. There is reason to believe that now is an optimal time to offer such a response.

### Why This an Optimal Time to Reconsider Privilege

If Coret is correct, that asymmetries in healthcare will always exist, why has the discussion of reinterpretation of privilege recently become deserving of the more than thirty-article review by Halman, Baker and Ng on this matter? One reason may be the evident and concurrent change in attitude that has recently been witnessed regarding privilege in general.

Reconsidering privilege has come to the forefront in academic considerations.<sup>5</sup> An important catalyst for the advancement of this reconsideration has been the #MeToo online revolution starting on Twitter August 2017. A mobilization against sexual harassment and assault,<sup>6</sup> this marked the explosion of an idea begun in 2006 by Tarana Burke, to help women and girls who, like herself, had survived sexual violence. The political and legal success of #MeToo regarding the presumption that

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<sup>5</sup> See, for example, Etchells, et.al. (2017) and Lui (2017).

<sup>6</sup> There is no implication in referencing #MeToo that medical professionals are sexually harassing or assaulting either their patients or their non-medical colleagues with their privilege, although this type of behavior is known to occur (Wilhelm and Lapsley, 2000). Instead, medical professionals hold privilege in embracing the “independent physician model” in healthcare decisions rather than a structure based on teamwork and collaboration (Holsinger and Beaton, 2006).

men have a right to make decisions for women<sup>7</sup> has given various socially progressive movements working to reconsider privilege both the will to increase their efforts and the hope that change soon will be forthcoming.

Further to this reconsideration of privilege was the effect of the COVID-19 pandemic in putting people of colour at greater risk for infection. Beginning in early 2020, the unequal effects of COVID-19 in placing African Americans in particular at risk (Yancy, 2020) were further exacerbated by the May 25, 2020 death of George Floyd, an unarmed black man in the custody of Minneapolis police, causing widespread riots calling for defunding the police (Fitz-Gibbon, 2020). This was an apex of the #BlackLivesMatter movement, which had begun in voicing opposition to the violence and systemic racism towards black people as a result of the 2013 acquittal of George Zimmerman in the February 2012 shooting death of African-American teen Trayvon Martin (Hacker et al., 2016).

In another less obvious but more astute context of privilege, physicians particularly of medical professionals have unquestionably enjoyed privilege over their patients and also their non-medical colleagues in maintaining their preferred model of acting independently. To reduce this asymmetry regarding patients, writing prompt methods have been introduced by Charon and DasGupta at Columbia University to numerous healthcare providers over the last twenty years. This in itself has advanced physicians' awareness of Narrative Medicine as well as provided the ethical reasons to reconsider their privilege with respect to patients. #MeToo can be seen as a catalyst to further encourage reconsideration of privilege beyond patients to the healthcare workplace (Flores, 2019). And, as Eberly has clarified, in its focus on creativity, broadening its reach in this and other ways has always been within the bounds of Narrative Medicine.

In one multidisciplinary HPE program, the creative form that the broadening has taken to promote increased symmetry in the healthcare workplace is very specific. It is to take the writing prompts already common in multidisciplinary Narrative Medicine settings and present them weekly to group participants in a particular order in an atmosphere where participant drawing and doodling is also encouraged. The intent is to give medical professionals and non-medical professionals, acting together in a supportive and non-hierarchical environment, an easily remembered practice of employing writing prompts. They do this while sharing their responses with the other group members who then ask them questions about their response to further develop their research narrative. The goal is to lessen the anxiety and/or depression associated with their research work in healthcare. As such, this method is presented

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<sup>7</sup> The high profile sexual harassment cases of Harvey Weinstein and Jeffrey Epstein—ending in Epstein's cell death in 2019 and Weinstein's conviction in 2020—for example, have had an unprecedented effect on employment law (Pelfrey, 2019).

as a means to improve the probability of reconsidering privilege in a way that is not overly burdensome for medical professionals to sustain.

### Multidisciplinary Health Professions Education

Prior to examining the one particular method of using writing prompts in a Narrative Medicine setting as an example of multidisciplinary HPE, it is helpful to understand exactly what Halman, Baker and Ng consider the criteria for such education in their review.

According to Halman, Baker and Ng, in order for multidisciplinary HPE to be useful to reconsider privilege, it must be critical. In their estimation, critical HPE explores the unexamined assumptions of individuals, institutions and the cultures in which they exist. It does this by raising awareness regarding conditions faced by individuals within the communities involved by questioning complicity with current social conditions by continually perpetuating and reproducing these conditions. Furthermore, for change to be accessible and sustainable, they found that it must be developed within the available support structures.

In their examination of various multidisciplinary critical HPE programs, Halman, Baker and Ng noted that medical professionals participating in such programs may consider non-medical professionals equal during their participation while remaining aware of the actual power inequalities. However, medical professionals can become overwhelmed with learning how to relinquish power and privilege to non-medical professionals during the process of education. When overwhelmed, they describe their feelings during participation as anxiety provoking and requiring a taxing large cognitive investment. These feelings are further reinforced if these medical professionals are given limited access to structural supports for reinterpretation of privilege outside the educational setting. Most concerning with respect to the aim of reconsidering privilege is that, when overburdened, medical professionals emotionally distance themselves in relation to multidisciplinary critical approaches. In other words, things get worse rather than better. And this is evident in the approaches Halman, Baker and Ng studied. There was only limited success in encouraging medical professionals to relinquish power and privilege. More often than not, multidisciplinary critical HPE resulted in the following: increased anxiety, views on inequality being further reinforced, and emotional distancing from idea of equality.

Halman, Baker and Ng point to a number of areas in which caution is advisable if medical professionals who are ready and willing to reconsider their privilege are to successfully engage in multidisciplinary HPE to promote such reconsideration. First, to have an effect, the education must be critical in the ways outlined by these au-

thors. Second, those offering the education must be attentive to signs that participating medical professionals are becoming overburdened. Not only does becoming overburdened lead to medical professionals ending their participation in the education, once overburdened, they are less likely to want to participate in, or even consider, relinquishing power. Third, if such education is to be sustained, structures need to be in place to support medical professionals relinquishing power or the reinterpretation of privilege will be abandoned. Relinquishing of power is a formidable endeavour as inequality remains central to many aspects of medical professionalism: striving for hard to obtain credentials, supporting entrenched institutional hierarchy, continuing the use of technical jargon, valuing the achievement of additional expertise, and assuming the role of master in inter-professional interactions. As a result of these enduring inequities, those medical professionals seeking to reconsider their privilege face additional systematic resistance to change.

#### Requirements for Sustainable Change

As an opportune time to have medical professionals reconsider their privilege in relation to non-medical professionals, it is important that the foresight provided by these researchers serves as a caution in moving forward with this goal. Consequently, any form of multidisciplinary HPE undertaken should incorporate the features identified by these authors for positive results to be forthcoming.

The important attributes for such education, based on these previous publications, include the following points. From Eberly, it is noted that Narrative Medicine has a broad enough mandate for its methods to be employed in multidisciplinary HPE. As such, the methods of Narrative Medicine are able to give foundational backing for the reconsideration of privilege. Yet, if Coret is correct, that asymmetries will always exist, the education provided will require the type of creativity that, as Desmarais and Robbins see it, goes beyond the writing, reading and interpreting text traditionally offered by Narrative Medicine. The need for a teller and listener, mentioned by Eberly, is further emphasized by Bardsley as necessitating a deep form of listening. Added to these requirements, Halman, Baker and Ng found that, to be effective, the education must be critical of the status quo from a number of perspectives. As well, for medical professionals not to become overburdened, an appropriate form of structural support need be available if medical professionals (in particular, physicians) are to continue with the education and sustain their reconsideration of privilege once the educational process is complete.



## One Multidisciplinary HPE Program

The Health Narratives Research Group (HeNReG) is a University of Toronto program founded in 2012 by the author in collaboration with the Jason A. Hannah Professor in the History of Medicine. In 2015, the Health Narratives Research Group was given the support of the Department of Psychiatry, as an offering of the Health, Arts and Humanities Program, through the Toronto Mount Sinai Hospital and continued its in-person meetings at Mount Sinai until the COVID-19 lockdown. The HeNReG now continues with online meetings through a private Facebook group. It is a multi-disciplinary group offering critical HPE comparable with the type of group that Halman, Baker and Ng considered necessary for medical professionals' reconsideration of privilege. This education is delivered through developing health narratives research that supports equal, non-hierarchical participation of all members. It is accomplished by encouraging a particular technique for promoting equality to be elaborated on in the next section.

The goal of the HeNReG is to re-energize both medical and non-medical health professionals in various stages of their careers in their health-related research. This is done in two ways. The first is through a practice reducing healthcare research-related depression and/or anxiety. The second is by increasing communication among participants from various disciplines at different academic levels. This is accomplished through supporting each participant's awareness of their own research-related values. It also involves getting to know other researchers' points of view. This occurred, until the COVID-19 lockdown,<sup>8</sup> through discussion and thoughtful posing of questions by each member to the others both in person at a weekly two hour meeting and once the weekly activities are posted to a private Facebook group to which all members belong.

The group's philosophy was developed by the author (the group's facilitator) as representing a Wittgensteinian form of life expressed through a particular language game.<sup>9</sup> The focus of the philosophy is that truth is a landscape with various obstacles. In viewing this landscape, two approaches are possible (each a distinct language

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<sup>8</sup> For the last two months of the 2019/20 academic year, the private Facebook group of the HeNReG was the sole meeting space for the group. As of the 2020/21 academic year, the HeNReG only meets synchronously on the private Facebook group set up for the year. There are no in-person meetings as a result of COVID-19.

<sup>9</sup> Both "form of life" and "language game" are terms employed by Wittgenstein in his posthumously published *Philosophical Investigations* referring to language use within a community of language users in both its totality and as a practice. Their connection is seen by Wittgenstein as best identified as a "family resemblance." The Narrative Research theory developed by the facilitator for the HeNReG fits within the philosophical tradition influenced by this seminal 20th century publication of investigating these particular family resemblances. Example of philosophers engaged in similarly influenced projects are Crittendon (1970), Peterman (1992) and Hagberg (2003), Heaton (2014).

game in a form of life). The first is demonstrated through discipline-based research—obstacles are seen as barriers to truth eliminated through metaphorically climbing higher in the landscape. This approach depends on hierarchical organization, meaning that higher views supersede lower ones. Those engaged in discipline-based research strive to create the most accurate aerial view of landscape, similar to a map. The second approach relates to the methods of Narrative Medicine through a form of Narrative Research.<sup>10</sup> In this regard, obstacles are landmarks in truth. Each point of view, in being both unique and necessary to the landscape, identifies a landmark to developing the composite nature of truth. Organization of the various points of view is thus non-hierarchical. This approach strives to reveal multiple points of view in constructing the landscape as part of a community of language users. In discovering truth related to this form of life as represented in this particular language game, the HeNReG acknowledges the importance of discipline-based research while employing a particular Narrative Research method.

The participants of the HeNReG come from various departments across the university and are engaged in some form of health research. An example is the 2017/18 academic year, chosen because it coincides with the beginning of institutional interest in reconsidering privilege that resulted from #MeToo. Members were from the following disciplines: Diaspora Studies, Neuroscience, Economics, Gerontology, Graphic Medicine, Health Promotion, Social Work, Family Practice, Education, Chemical Engineering, Health and Safety Engineering, English, Paediatric Medicine, Medical Information, Adolescent Medicine, Palliative Care, Narrative Medicine and Critical Theory. Upon invitation from the facilitator (author of this article), these members (and those of any other academic year) join the HeNReG based on their interest in being involved with a group that supports equality of participation, is free, voluntary and also non-credit. Before joining, pre COVID-19, they agreed to the particular process for participation. This included a circle format for speaking<sup>11</sup> and being willing to engage in the following: writing to prompts, drawing and/or doodling, sharing results, and joining an online, private Facebook group. The facilitator

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<sup>10</sup> Narrative Research as a methodology has a longer history than Narrative Medicine. For works exploring Narrative Research in different disciplines, see Greenhalgh (2016), Elbaz-Luwisch (1997) and Sandelowski (1991). Narrative Medicine seeks to use narrative techniques to diagnose and treat illness while Narrative Research in a healthcare setting has the aim of investigating health-related interests through the use narrative.

<sup>11</sup> The circle format eliminates competition to speak that comes from putting up one's hand. Knowing they will get a chance to speak when it is their turn in the circle, there is no need for any member to feel neglected during the discussion. After the March 12, 2020 COVID-19 lockdown at academic institutions, in-person meetings were no longer possible. As a result, this feature of the HeNReG was unable to be continued. However, as the private Facebook group permits online responses to be viewed one at a time when members participate, competition to participate does not exist. As eliminating competition is the goal, the private Facebook group synchronous meetings are a reasonable substitute for the circle format of in-person meetings.

is both the originator of group and of the technique and each year participates equally as a member of the HeNReG.

Members can join the HeNReG throughout the academic year. There is a natural break at the end of the calendar year. Otherwise, the group meets yearly from the first week in October to the last week in April for at least two hours each session at the end of the workday. With the agreement of those in attendance, the group can extend the meeting time for further discussion. The longest the group has ever opted to meet is four continuous hours.<sup>12</sup>

### The Narrative Research Technique

At the initial meeting of each academic year, participants in the Health Narratives Research Group (HeNReG) are asked to describe themselves with respect to their research related to health in a five-minute written response. For the purpose of this group, research is equated with a personally valued health interest the focus of the participant's time and energy. It does not necessitate the aim of publication, although research publication is encouraged. Pre-COVID-19, once their description was complete, each participant was given the opportunity to read what they had written out loud to the others one-by-one, going around the circle. After each person read,<sup>13</sup> members took turns asking clarifying questions of the current reader to further elaborate on their research related to health. This process continued until each member had the opportunity to read their piece and to receive and answer questions from the others.

Following this initial meeting where their research related to health is defined, for the remainder of the academic year, participants write for five minutes, stream of consciousness, to these prompts of the week created and provided by the facilitator.<sup>14</sup> Pre-COVID-19, after a participant's reading at the in-person meetings, each of the other members posed a question corresponding to the prompt of the week to the current reader to further refine what the reader valued with respect to their research

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<sup>12</sup> This ability to opt to meet for longer than the two hour period allotted was a result of the group meeting at the end of the workday with no bookings to follow.

<sup>13</sup> For online participation, the prompts were sent to members the day before the meeting by Messenger. Following the COVID-19 lockdown, the facilitator would begin the online meeting by typing in the responses to the prompts that had been received by Messenger up until the time of the meeting. At that point, participants would begin entering their questions to the other members and responding to questions they received.

<sup>14</sup> The facilitator participates as an equal member to further eliminate hierarchy in the group. Stream of consciousness writing is encouraged to reduce the anxiety of participants potentially thinking that their work is not good enough to share.

related to health. The participant whose work was the focus of questioning answered every question received in turn before the process was repeated with the next person.

What is unique about the writing prompts offered by the facilitator, not found in other Narrative Medicine groups, is the order of the questions asked. The purpose of the ordering is to support the philosophy of the group related to how the landscape of truth is approached in Narrative Research. This is done by having each participant, through responding to the writing prompts, come to know what is most objective about their position in the landscape and then increasingly discover what is more subjective, expanding their understanding of the landscape.<sup>15</sup> This is done by asking questions in a particular order over the weeks. “When” questions (the most objective) are posed first, then “where,” followed by “who,” “what,” “how” and then “why” (the most subjective). Each type of question is the focus of a different prompt for at least four weeks. As an example, “when” questions asked in sequence over four weeks might include: When did you first become interested in your research related to health? When did you last ask for advice from a non-medical colleague regarding your research related to health? When did you feel that you were overburdened with your research related to health? When did you consider that you were working as part of a team on your research related to health?

Before the March 12, 2020 lockdown, the facilitator took notes on what was said by each participant, posting these notes to the private Facebook group each member agreed to be a part of when they joined the group.<sup>16</sup> In doing so, members who were unable to attend a particular meeting could read online the prompt, the responses, the questions asked of each responder, and the replies to the questions. For those who were never able to attend the weekly meeting in person, the option was also available of having the facilitator provide the weekly prompt the day before the meeting via Messenger. In this case, the participant responded to the message by texting for five minutes and sending the response to the facilitator. The facilitator

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<sup>15</sup> This technique was developed through the facilitator conducting a Wittgensteinian thought experiment into what type of ordering of questions might help participants feel most relaxed in a potentially stressful situation. As subjective questions are, by their very nature, the least precise, it was reasoned that they were more intimidating and should be asked only once the more objective questions had been posed.

<sup>16</sup> The notes included the questions each member received from the others after reading their response to the prompt as well as the replies each participant gave to these questions. The responses to the prompts themselves did not require recording as the responses, when written on paper, were handed to the facilitator at the end of each meeting, pre-COVID-19. Those recorded by participants electronically were sent to the facilitator through Messenger for posting to the private Facebook group for the HeNReG. This represented the only method once COVID-19 necessitated a lockdown. A new HeNReG private Facebook group is set up for each academic year.

then read the response of the online participant to the group and the members provided questions that were later posted on the private Facebook group, following the meeting. It was at this point that the off-site participants could see and respond to the questions that were posed to them at the meeting.

### Drawing and Doodling

Drawing was added to the HeNReG in 2016 based on a request by an artist member of the group. As a continuing member, this participant periodically provided drawing prompts during each year. When such prompts weren't given, the group had been encouraged by the artist and facilitator to doodle with various art materials provided. The intention of the artist was to encourage drawing as a way of thinking in the group. As well, the artist<sup>17</sup> wanted participants to recognize that drawing is an additional way to communicate beyond writing that should be supported in academic settings.<sup>18</sup>

Those in attendance at the HeNReG have been encouraged to draw or doodle while waiting to ask and answer questions related to their responses to the writing prompts. Simultaneously, participants have worked on whatever they chose to draw (with or without a prompt) during the entire course of the meeting, in contrast to the five minutes provided for responding to the writing prompts. At the end of the meeting, members have shared their drawings or doodles with the group, described their content, and then provided them to the facilitator who photographs and posts them to the private Facebook group for later viewing by all participants. There is no judgement of work produced and all drawings and doodles are welcomed equally.

### Results for Medical Professionals

In the HeNReG, medical professionals have represented approximately one quarter of the group's participants in any year. Those medical professionals who join believe in the idea of considering all participants equal. To this extent, these medical professionals are already addressing the idea of reconsidering their privilege in their willingness to join the group. All medical professionals who have participated have praised the group in its goals<sup>19</sup> and felt that the technique employed was personally helpful to

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<sup>17</sup> The artist is no longer a member of the group in 2020/21; however, the practice of doodling remains a feature of the online group.

<sup>18</sup> Communicating healthcare issues with drawing is being accomplished in medicine through graphic medicine, i.e., comics focused on medically-related issues. For information on graphic medicine, see Czerwec, et.al. (2015).

<sup>19</sup> This praise has been provided directly to the facilitator at various sessions of the group as well as formally, twice a year, through a standardized feedback form that estimates the creative and supportive experience of the HeNReG.

them in reducing their depression and/or anxiety related to their own healthcare research. However, medical professionals were the participants who were most likely to feel the need to leave the group before the end of the academic year.

The majority of the information provided on the feedback forms members have been asked to complete at the end of each term is in the form of answers to multiple choice questions. In addition, participants are encouraged to provide written comments to complete the feedback form. The written comments from medical professionals for the 2017/18 academic year included the following:

Physician 1

Having to think on my feet and respond to questions I wasn't prepared for meant I had to know my topic well. Interrogating things I thought I was comfortable with showed me that I wasn't as comfortable as I thought. Now I know to never get too comfortable. The biggest strength of this group is its unconventional nature.

Physician 2

I enjoyed learning from the other group members and interacting with health researchers from various disciplines. I thoroughly enjoyed the writing prompt and art prompt. I think this group will help me engage in more self-reflection, which will strengthen the quality of my research.

Physician 3

Allowed me to brain storm topics and values in a free-style, thought and mind-provoking manner. Even better, I can often mull over the discussed thoughts over my favourite cup of steeped tea, which enhances my neuronal exchanges.

This Group has members from a broad walk of life who take the trouble of meeting up and sharing their views on research and its philosophy. That is the most important essence.

Thanks to... the moderator who made this happen. It deserves a place to stay, period.

Physician 4

It helped me focus on the details that I wanted to express—to organize and focus the various concepts I would like to express. It was a very welcoming group and very detailed organization by the leader.

I needed to be clearer with my research question. I was expecting the seminar to be more about learning narrative.

I loved the enthusiasm of our leader and her commitment to the process.

Medical professionals who left the HeNReG before the end of the academic year did so for a variety of reasons. These included, feeling: *anxiety*—either the content they revealed to the group was too emotional for them or they felt pressured by time conflicts, *overburdened* by having to think about equality—considering it something perhaps more suitable for younger people, or *frustration*—there were no structural supports in their departments to continue the HeNReG practice to consider other healthcare professionals as equal.

Physicians with the most seniority had the greatest difficulty responding to the drawing prompts given in addition to the writing prompts. Initially, these senior physicians did not feel comfortable drawing and declined to do so. Once they did draw, one created a picture of himself presenting his work to an audience (fig. 1) and the other drew a tree (fig. 2). Neither felt they were able to return to the group in sessions following the completion of their drawings (although they did keep in touch with the facilitator after leaving the group). The drawings were shared with other members of the group at the end of each session. In comparing their drawings done the same day with those of the other group members, it is possible that the drawing skills displayed by the other group members at that same meeting (figs. 3, 4, 5, 6) made the two senior physicians feel overburdened regarding what they thought they should be able to accomplish and frustrated that their skills were unable to match their intentions and this may have contributed to their leaving the group.

The various reasons offered by medical professionals for needing to leave the group are reminiscent of the difficulties Halman, Baker and Ng identified in their review for why the results of multidisciplinary HPE have been found lacking. In this regard, Coret's view that asymmetries may always exist is supported. However, what is important to note is that even though the medical professionals left the group before completion, each informed the facilitator that the technique offered by the HeNReG was valuable and was able to reduce their depression and/or anxiety related to their personal healthcare research. And to the extent that the technique involved processing and responding to the questions offered by other healthcare professionals, each medical professional was provided with an opportunity to reconsider their privilege during their participation as part of the HeNReG.

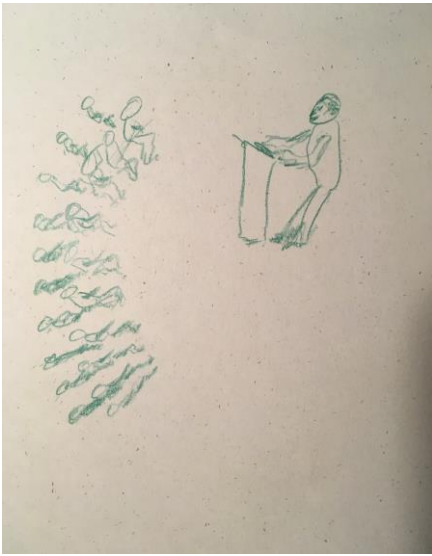


fig. 2



fig. 1



fig. 4



fig. 3





fig. 5

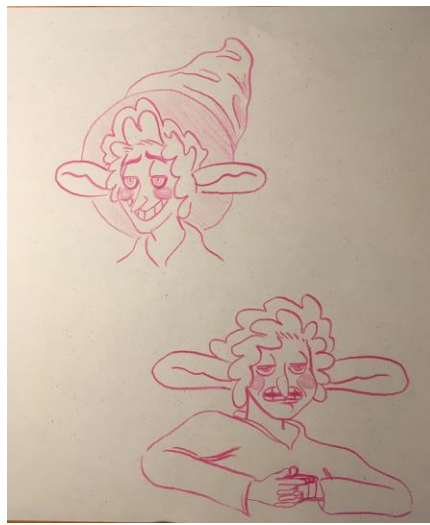


fig. 6

The primary problem in sustaining their reconsideration was one related to working conditions outside the HeNReG setting within hierarchical structures. In all, the HeNReG had limited success with medical professionals being able to reconsider their power and privilege beyond the HeNReG meeting space.

#### Results for Non-Medical Professionals

Non-medical professionals participating in the HeNReG consistently outnumbered medical professionals each year. The possible contributing role of non-medical professionals in their own continued acceptance of hierarchical organization in the healthcare workplace is an aspect of multidisciplinary HPE that has not been highlighted by previous researchers. Yet, this result was found in the HeNReG.

Similar to the medical professionals, non-medical professionals joined the group with a belief in the participants' equality. Nevertheless, some non-medical professional members each year felt they had to leave the group part way for reasons comparable to those of medical professionals. These reasons included feeling: *anxiety*—as a result of the unusual cognitive investment, *overburdened*—with the emotions that came to the surface in responding to the prompts, and *frustrated*—there were no structural supports available to introduce the technique used at the HeNReG in their work-

place. It can be noted that although the relationship between medical and non-medical healthcare providers may be asymmetrical, the issues regarding what keeps equality from being broadly accepted in the relationship are similar for both type of participants.

One non-medical professional who enjoyed the group and considered it helpful—but still communicated feeling anxious, overburdened and frustrated—offered this lengthy account of her experience with the HeNReG. This well-articulated view serves as an example of the benefits and limitations non-medical professionals may have with respect to participation in the HeNReG.

1) Process—I learned about an effective narrative methodology for facilitating non-judgemental dialogue about personal health narratives. I found there was enough structure to guide participation without requiring specific skills, knowledge or meeting preset expectations. Participants met each other where they were with acceptance.

2) Content—this group was effective in its composition of diversity and skills and experience. Yet we were able to find common ground to relate to each other at times, supporting a sense of connection.

While I have experience writing and communicating, doing so on a personal level so openly with others I don't know well or at all is a challenge. This group helped to create a safe space to do so and feel that other participants were interested and respectful. [The author] facilitated and maintained boundaries very well. She has a demeanour of openness and non-judgement essential to the success of this initiative.

I appreciate the format of inquiry presented in this group via a series of unexpected questions/prompts posed over the course of several months. I look forward to reviewing my answers to these questions to consider what, together, they reveal about my intentions, thought processes, passions, blocks and unaddressed exploration.

I can see how I may initiate a group like HeNReG in the future—either as a sole initiative or in combination with a larger initiative.

Contributing at a distance via online post to Facebook has, in my opinion, advantages and disadvantages for me. Advantages include: Ease of participation without the 1 hour + commute (and associated time and expenses) to Toronto. It also enables me to write more freely when I am not in front of others which, at this time, I find myself still a bit self-conscious on a personal

level (not professionally). This is a group opportunity for me. Disadvantages include not being able to develop interpersonal relations skills and affiliations because I'm not face to face with others in the group. I'm still a bit uneasy about sharing detailed personal info on Facebook generally.

Those participants (medical and non-medical) who were most likely to continue on with the HeNReG process for the full academic year were ones who had previously participated in other Narrative Medicine opportunities in addition to the HeNReG. Furthermore, the more a participant had attended previous Narrative Medicine groups in the past, the less likely they were to indicate feelings of having to leave the group because of anxiety, frustration, or being overburdened because they felt there were no structural supports in place to make change in their workplace. In fact, if they did leave, it was for reasons having to do with time conflicts with their work. These more practiced participants, if they did have to leave, usually returned either later in the term or in the years that followed (the group retains a number of members going into each new academic year).

## Discussion

The focus of the Health Narratives Research Group is developing health narratives research in a multidisciplinary setting depending on equal, non-hierarchical participation. As such, its primary concern is improving the ability of healthcare researchers to know what they value in relation to their research, discovered in collaboration with other healthcare professionals, in order to sustain them in their future research. This primary aim is not specifically finding a way for medical professionals to relinquish their power and privilege. Nonetheless, the success of #MeToo, in moving society to rethink the power and privilege of men over women, and the questions regarding inequalities brought to the forefront by COVID-19 and #BlackLivesMatter, have given reason to suppose this is a relevant time to assess the ability of the HeNReG to assist in the reconsideration of power and privilege by medical professionals. This is especially so given the review by Halman, Baker and Ng and the recent interest of *Survive & Thrive* authors in the capacity of Narrative Medicine to encourage medical professionals to reconsider their power and privilege.

The philosophy of the HeNReG agrees, as is also argued by Desmarais and Robbin, that Narrative Medicine is a field that goes beyond writing, reading and interpreting text. And, as Eberly claims, what it can mean to go beyond these is to include the oral telling of stories and asking questions related to these stories. In orally focusing on what it is that each participant personally values of their healthcare research through question and answer, the HeNReG applies an approach supported by Bardsley—one requiring deep listening.

It may be unlikely that Eberly, when identifying Narrative Medicine as always creative, had in mind including drawing as a necessary component. However, if, as Halman, Baker and Ng suggest, we are to support reconsideration of privilege that is critical of the unexamined assumptions of individuals, institutions and the cultures in which they exist, then there may be no greater preconceived notion in education than the belief that aimless drawing (doodling) is antithetical to academic writing. Recent research in the area has shown that, contrary to this pervasive view, doodling is not detrimental to academic writing.<sup>20</sup> If anything, those who doodle when listening to the stories of others have been found more likely to have reduced anxiety levels and develop their memories with respect to understanding and interpreting narrative.

Nevertheless, it cannot be assumed that the HeNReG, although employing a new technique to order prompts in Narrative Medicine and adding drawing and doodling as part of the process, has allowed medical professionals to reconsider their privilege outside the HeNReG setting. The reason—this has not been directly tested. To do so, the goal of the HeNReG would need modification to investigate whether medical professionals who participate in the HeNReG are more willing to reconsider their privilege in the workplace setting with respect to non-medical professionals as a result of participation. How frequently participants have engaged with the HeNReG and with other forms of Narrative Medicine in the past would be important variables to take note of in such a study. In response to #MeToo and #BlackLivesMatter, further research in the workplace should also take note of power and privilege differences of white male medical professionals over female and minority non-medical healthcare professionals.

Encouraged by the continuing influence of #MeToo and #BlackLivesMatter during these COVID-19 times and supported by the review of Halman, Baker and Ng, there is reason to suppose that medical professionals increasingly are becoming interested in reconsidering their privilege in relation to non-medical healthcare professionals. As more medical professionals engage in various forms of Narrative Medicine, and particularly in the Narrative Research technique of the Health Narratives Research Group, they develop an increased familiarity with such reconsideration. When this occurs, the HeNReG may have provided one way to help medical (and non-medical) professionals reduce feeling overburdened in reaching this goal. This is because participants will have gained a technique they can easily employ as appropriate structural supports for the reinterpretation of privilege are encouraged to become available.

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<sup>20</sup> See the work of Aaron (2011), Adoniou (2012), Drake (2018), Fernandes, et. al. (2018), and Wammes, et. al. (2016).

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