A Way Forward in the COVID-19 Pandemic

Making the Case for Narrative Competence in Pulmonary and Critical Care Medicine

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ABSTRACT

Each surge of the coronavirus disease (COVID-19) pandemic presented new challenges to pulmonary and critical care practitioners. Although some of the initial challenges were somewhat less acute, clinicians now are left to face the physical, emotional, and mental toll of the past 2 years. The pandemic revealed a need for a more varied skillset, including space for reflection, tolerance of uncertainty, and humanism. These skills can assist clinicians who are left to heal from the difficulty of caring for patients in the absence of families who were excluded from the intensive care unit, public distrust of vaccines, and morgues overtaken by our patients. As pulmonary and critical care medicine practitioners and educators, we believe that cultivating practices, pedagogies, and institutional structures that foster narrative competence, "the ability to acknowledge, absorb, interpret, and act on the stories and plights of others," in our ourselves, our trainees, and our colleagues, may provide a productive way forward. In addition to fostering needed skills, this practice can promote necessary healing as well. This perspective introduces the practice of narrative competence, provides evidence of support for its implementation, and suggests opportunities for curricular integration.

Keywords:
narrative competence; education; moral injury; healing; pandemic

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As the field of pulmonary and critical care medicine continues to accelerate discovery through research, technological advancements, big data, and fast-paced, high-acuity care, it is essential that equal attention be paid to the intensely human aspects of this specialty. The coronavirus disease (COVID-19) pandemic has brought into sharp focus the shared suffering of patients, their families, and healthcare practitioners, as well as a lack of adequate opportunities and resources across medicine to attend to our shared humanity. We, as pulmonary and critical care medicine practitioners and educators, believe that cultivating practices, pedagogies, and institutional structures that foster narrative competence in our trainees and colleagues will provide one beneficial path forward in this vital project of healing from the COVID-19 pandemic.

NARRATIVE COMPETENCE

As defined by Rita Charon, M.D., Ph.D., narrative competence is "the ability to acknowledge, absorb, interpret, and act on the stories and plights of others" (1). This concept developed within the field of narrative medicine, which is both an interdisciplinary, academic area of study and "a methodology of clinical intervention based on a specific communicative competence" (2, 3). The central principle of narrative medicine is the recognition that "the giving and receiving of accounts of self are the central events in health care—whether the account is given by a patient, family member, student, clinician, or members of the lay public and whether it is received by a doctor in the office, a circle of peers in a teaching session, a multidisciplinary team meeting in a clinic, or a Congressional hearing about health reform" (4). Narrative medicine models of clinical care recognize that the practitioner is always "in" or a part of the care story, not a detached observer who must remain outside it (5). Instead, narrative medicine examines the discourses of health care; teaches healthcare practitioners how to receive and acknowledge the patient experience; engages attendance to our emotions and thoughts; and allows us to develop competence in the recognition, absorption, and interpretation of stories of self and others.

Narrative competence is an essential component of pulmonary and critical care medicine trainee communication training, although historically it has not necessarily been recognized as such. Educational interventions focused on developing narrative competence can prepare trainees to pair evidence-based practices with an understanding of patients' lived experiences and, from there, engage in shared decision making (6, 7) and effective and collaborative counseling. Methods of narrative competency training such as the collaborative analysis of creative works, close reading, reflective writing, and facilitated group discussion (5) can occur in the

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classroom and on the ward, helping trainees enhance their facility for close listening and intentional observation, stimulate their creativity, and increase their capacity for reflection and perspective taking (8). In addition, developing narrative competence holds the opportunity for concerted training in self-reflective practices combined with an exposure to the arts—be it film, music, paintings, or literature—to promote a better sense of self as well as meaningful relationships with colleagues and even the public (9–11).

BROKEN NARRATIVES, NARRATIVE EMERGENCIES

Decontextualized, the idea of devoting training to developing narrative competence during a pandemic may seem unnecessary and even extraneous. The pandemic has revealed much of what is broken in U.S. society and health care. There is an awareness that individual action that is not paired with larger societal change is unlikely to impact the serious structural issues and unequal suffering of historically minoritized populations. However, it is increasingly clear that many of the resulting hardships of the COVID-19 pandemic experienced by pulmonary and critical care medicine practitioners are also associated with "broken" (12) societal, professional, and personal narratives. Trainees are coming of age professionally in this larger sociocultural milieu.

The politicization of the pandemic and mitigating measures such as vaccinations and masks have created competing stories of COVID-19 in which science- and research-based analyses of pandemic conditions come head to head with accounts that deny the seriousness or even the existence of the disease and that frame prevention and treatment measures as violations of individual rights and forms of government control. In this context, healthcare workers have simultaneously been depicted as "heroes" and profit-seeking agents of the state. In systems that lack the resources for healthcare workers to do their jobs and rely on altruism to fill gaps created by low staffing levels, we are left physically, emotionally, and spiritually exhausted, with little capacity to absorb or attend to the suffering of patients, colleagues, families, or ourselves. These conditions have created widespread disillusionment and moral injury, which have severely challenged clinicians' historical understandings of themselves as scientists, healers, and patient and community advocates. During times when our collective identity is threatened, it becomes critical for us to affirm our stories with and for each other. Thus, in addition to working toward structural and equity-based changes, our profession's response to the pandemic must include creating individual and communal means to engage with damaged narratives of identity. An ability "to acknowledge, absorb, interpret, and act on the stories and plights of others" (1) will be a necessary part of doing so. Pulmonary and critical care medicine trainees, many of whom only know the practice of critical care within the context of a pandemic, are particularly vulnerable to such disillusionment.

Narrative competence allows clinicians to value their own humanistic development and to practice with empathy, reflection, professionalism, and trustworthiness (13, 14). The practice of narrative medicine enhances our sense of connection with patients and allows us to form more meaningful therapeutic alliances, contributing to resilience and potentially ameliorating feelings of hopelessness and futility (15). If practiced

within teams, narrative medicine improves group cohesion and workplace satisfaction, mitigating burnout, moral injury, and compassion fatigue (16–18). These benefits are particularly relevant for pulmonary and critical care medicine trainees during the COVID-19 pandemic.

NARRATIVE COMPETENCE IN PULMONARY AND CRITICAL CARE MEDICINE TRAINING

Like all medical competencies, developing trainees' narrative competence requires iterative, integrated, and evidence-based curricula. Fortunately, there is a wealth of research and resources available for graduate medical educators interested in such programming. Narrative medicine textbooks (5), workshops (19, 20), and online certificate programs (21) can provide faculty and other educators with introductions to the principles and practices of narrative medicine. Healthcare institutions and systems affiliated with universities can look for "in-house" expertise among their academic colleagues. Health and medical humanities programs and departments of English offer potential expertise. The explosive growth of online modes of curriculum delivery gives departments access to preexisting online narrative medicine programming as well as nonlocal highly trained narrative medicine experts, supporting the development, implementation, and facilitation of curricula that foster narrative competency.

Training programs can begin developing their trainees' narrative competence by increasing individual and institutional recognition of the narrative nature of clinical work and its importance in medical education. Narrative competence is rooted in fundamental educational theories. It has parallels with cognitive learning theory, which posits that learners do not passively absorb information but rather must interact with subject matter to effectively learn (22). Cognitive learning theory's core concepts, including generation, elaboration, and deliberate self-practice and self-reflection, are highly relevant for teaching narrative competence (23). Similarly, the principles of adult learning theory, or andragogy, are concordant with the teaching of narrative competence. These include layering new knowledge and conceptual understanding on prior knowledge and experiences, ensuring content is immediately relevant, and a focus on active learning (24). In a complementary fashion, Kolb's experiential learning theory describes a four-phase cycle in which a learner has an experience, reflects on the experience, makes meaning of the experience, and then applies new knowledge for the next relevant experience they may encounter (25). Kolb's experiential learning theory is frequently cited as the educational foundation of simulation-based medical education (26), but it also finds parallels with methods of narrative competency training. The experience in question does not have to be placing a chest tube but rather engaging with a work of art, a patient's story, or one's own written reflection. It is crucial to be able to make meaning of experiences in medicine (27), and narrative competence represents a powerful framework for educators to ensure that their trainees cultivate this vital skill.

Faculty can teach components of narrative competence by modeling reflection and attention to the narrative aspects of health care in their clinical work and didactics. This may be as simple as demonstrating that faculty value story and explicitly modeling close listening and attentiveness at the bedside. Faculty can also reinforce

the importance of language in discussions with each other and in patient presentations, such as deliberately choosing to use the phrase "patient reports" rather than "patient denies."

Many of our most rewarding moments as clinicians are contingent upon being able to understand and connect with the story of our patients and their families. Yet, if we consider how patient cases are presented in morning reports or morbidity and mortality conferences, all personal aspects of the patient's story are often stripped away; social details are not included if they are deemed not pertinent. Presenters can instead choose to include some element, whether social, historical, a poem that the patient finds meaningful, or a picture that motivates the patient's recovery, and use it as a point of reflection for the group. This object can be the inspiration for a writing prompt that can help bridge the gap between the vantage points of the patient and the clinician. Alternatively, a contextually related piece of art can be used in a similar way. The poem "Talking to the Family" by John Stone is used by authors of this perspective to reflect upon the challenges of delivering serious news.

Grand rounds and journal clubs provide additional opportunities to expose trainees to narrative competence and the field of narrative medicine. Educators can also seamlessly incorporate narrative elements into social justice curricula and leadership tracks (28). When fully developed, narrative competence curricula allow pulmonary and critical care medicine trainees to gain skills in the Accreditation Council for Graduate Medical Education core competencies of interpersonal and communication skills and professionalism (29, 30, 31).

We acknowledge that it can be challenging to effectively integrate narrative competence training into a pulmonary and critical care medicine trainee's workday, especially in high-acuity environments such as the intensive care unit (ICU) or busy outpatient pulmonary medicine clinics, but we urge educators to lean into this challenge. Narrative competence not only is integral to the daily practice of pulmonary and critical care medicine but also can play a powerful role in addressing the individual and communal burnout that has arisen during the pandemic. When we consider the competencies we train for, we recognize that, though unstated, many are contingent upon developing narrative competence. Facility with story is embedded within many of the domains, from reflective practice to professionalism and communication.

REFLECTING ON AND SHARING OUR STORIES

We offer examples below of how educators can incorporate narrative-focused teaching activities into everyday educational practice in pulmonary and critical care medicine, and then we conclude with two poignant illustrations of the power of story.

When working with learners in an outpatient pulmonary clinic, start or end each clinic session with a read, reflect, and respond exercise (e.g., using one of the essays discussed below or included in this issue of *ATS Scholar*). Alternatively, one could choose a patient story (not a clinical case) once per month to discuss as a clinical group: tell the patient story and allow time for group reflection and response. Another option is to start or end clinic staff meetings with a guided read, reflect, and respond exercise using pieces

of visual art or writing. In the ICU, one could dedicate a teaching session to completing a read, reflect, and respond exercise with learners. Such activities can also lay the foundation for more in-depth narrative competence training.

Even seemingly mundane elements of critical care training, such as social media policy sessions, can offer opportunities to discuss narrative topics such as the patient's ownership of their own story and the effective, ethical use of social media platforms for professional and community advocacy (32). Indeed, the past 2 years have demonstrated the critical importance of uniting medical knowledge with the capacity to engage with story. Pulmonary and critical medicine practitioners have served dual roles as clinicians and public health educators, combating misinformation. They have been moved by story to advocate for policy change at national and international levels around adequate staffing and appropriate personal protective equipment. They have written opinion pieces and editorials that seek to shift public sentiment and recalibrate awareness of risk. They have written eloquently of the suffering within the walls of the ICU for their own healing, bringing their own stories to the fore.

A concrete example of how reading, reflecting upon, and responding to stories helps navigate the emotional challenges of the pandemic can be found in an essay by Rana Awdish, M.D., in which she explores her interaction with a long-term patient who was resistant to following hospital-mandated policy for masking:

> *I watched the last, loosely held feathers of my compassion fall to the floor. I considered gathering them, wanting only to start an all-consuming fire.*
>
> *I couldn't save anyone.*
>
> *My eyes stung and swelled, and my heart sank in an undertow of hurt and shame. Her words had released a tide of grief that filled the charged space between us, trapping us in the small cinder-block room.*
>
> *We were spun of different thread. (33)*

Awdish articulates both the unrelenting weight of the pandemic's emotional and physical strain on her clinical practice and her own act of "recognizing, absorbing, interpreting, and being moved to action" by the patient's recount of not seeing her grandchildren owing to hesitancy regarding vaccination (32).

In another poignant example, Randall Curtis, M.D., M.P.H., a pulmonary and critical care medicine physician and renowned investigator in the field of palliative care, reflects on his experiences both inside and outside of the ICU as he faces a terminal diagnosis of amyotrophic lateral sclerosis (ALS):

> *My final lesson, learned more recently, is to live every day as if I have a terminal disease. I don't mean to glorify having a terminal disease by any stretch of the imagination! I would give almost anything to not have ALS. However, having this disease has allowed me to focus on what is most important to me and to let go of things that are not as important. Focusing on the important has been something I have worked towards for 25 years and with which I have struggled at times. In the past, I would often classify too many things as "important" and find myself unable to really focus on the most important because of too many distractions. Nothing about the physiological effects of ALS has increased my ability to focus. Instead, realizing how limited my time is, I have found the inner strength to focus. I believe I always had that strength, but oftentimes chose not to use it. My advice, for what it is worth, is to find that strength even when you aren't put in that position by a terminal illness. (34)*

By sharing his writing, Curtis broadens our lens to include what his illness experience makes available, illustrating the centrality of "the giving and receiving of accounts of self" (4) in health care.

CONCLUSIONS

The COVID-19 pandemic has highlighted both the altruism and the suffering of our colleagues as they operated under relentless uncertainty and risk to their own physical and psychological safety. Spaces must be created for us to reflect on the cost of working in a vocation that can push practitioners to their limits as well as the burnout, moral injury, and compassion fatigue that we collectively feel (16). There is an unmet need for honest reappraisal of our field, our role in the lives of our organizations and those we serve, and our self-definition and identity in a changing medical landscape in which clinicians have alternately been worshipped and vilified. Doing this with others, in communion with them and their narratives, fulfills our human need for community during this difficult time.

Narrative competence is a vital skill that, as educators, we must instill in trainees. Although much work remains to be done, cultivating practices, pedagogies, and institutional structures that foster narrative competence can provide a path for pulmonary and critical care medicine trainees to hold space for reflective practice and appreciate the intensely human aspects of their work. In doing so, they can find means to better "reach and join their patients in illness, recognize their own personal journeys through medicine, acknowledge kinship with and duties toward other health care professionals, and inaugurate consequential discourse with the public about health care" (1).

Committed to our collective healing, the keynote address for critical care medicine features Drs. Rana L.A. Awdish and Megan M. Hosey in "Restoration in the Aftermath" at the American Thoracic Society Annual Meeting 2022. Two examples of narrative reflection are available to readers in text and audio format (*see* the data supplement).

Author disclosures are available with the text of this article at www.atsjournals.org.

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