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Creative Writing as a Medical Instrument

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Abstract Listening and responding to patients' stories for over 20 years as an emergency physician has strengthened my appreciation for the many ways that the skills and principles drawn from writing fiction double as necessary clinical skills. The best medicine doesn't work on the wrong story, and the stories patients tell sometimes feel like first drafts—vital and fragile works-in-progress. Increasingly complex health challenges compounded by social, financial, and psychological burdens make for stories that are difficult to articulate and comprehend. In this essay, I argue that healthcare providers need to think like creative writers and the skills and sensitivities necessary to story construction deserve a vital space in medical education. A thorough understanding of story anatomy and the imaginative flexibility to work stories into open spaces serve as antidotes to the reductive nature of clinical decision making and have implications as patient safety and risk management strategies. The examples that I have selected demonstrate how thinking like a creative writer functions at the bedside, providing tools for clinical excellence and empathy. This approach asks that we re-imagine the importance of story in clinical care: from a vehicle to a diagnosis to its place as a critical destination.

Keywords Writing · Creative writing · Medical education · Medical humanities · Reflective writing · Emergency medicine · Narrative competence

Writing skills at the bedside

Drama rests on "unlikely events surging up into ordinary life and changing it," wrote Robert Koch, eminent writing professor, and part of the writer's job involves making the improbable credible, and then proceeding to make the credible inevitable (2001). This insight is one of many drawn from my life writing fiction that I carry over into my work treating emergency department (ED) patients. For 20 years, it's been a rare ED shift when my expectations about a particular patient haven't been upended, knocked around, humbled or surprised. Life is ruthlessly inventive in the ways it challenges the will and flesh of patients. Should life exhaust itself in this task, patients have a remarkable tendency to contribute to their own despair and tragedy with habits and choices that defy the imagination.

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My work as an emergency physician has always struck me as a fundamentally creative act. This insight is neither groundbreaking nor original. The medical encounter is unscripted, unfolds moment by moment, and involves unique illness narratives; these features require high level communication skills that have been compared to jazz improvisation (Haidet 2007). More than a metaphor, jazz principles imported and applied to the bedside include building communicative space, developing one's voice, and achieving an ensemble (Haidet 2007). Listening and responding to patients for over 20 years, I've appreciated how creative skills and principles drawn from my "other" life writing fiction serve as necessary clinical tools in a busy emergency department.

I consider it a fortuitous accident that my development as a creative writer has been, and continues to be, interwoven with my development as a physician. I'm not referring to writing for the intended purpose of reflection. Reflective writing, along with the close reading of literary texts, has carved out a well-deserved place in medical training for nourishing professional development and practitioner well-being (Shapiro et al. 2006, Reisman et al. 2006). Such writing, incidentally or as a stated goal, may detour into therapy or adopt the function of virtue-building. While admiring these efforts, I question the notion that through writing we can create better people. Some of our most accomplished novelists have dubious reputations as persons. However, I propose that writing stories may produce better doctors.

In this essay, I will introduce basic story principles and illustrate how they've become essential tools in my care of patients. The experiences and insights provided here have accumulated slowly over the years, lending a particular creative slant to my work as a medical educator and motivating me to discover methods that compress, distill and translate critical skills so students can appreciate the coupling of creative writing and the practice of medicine.

The value and success of certain tools depend, in part, upon the talents and vision of the person using them. Any discussion of writing skills as clinical skills must also argue for the importance of artistic habits at the bedside; this includes comfort with uncertainty and ambiguity, an embrace of mystery and conflict, a desire to challenge what is known and to push questions to uncomfortable places. The field of narrative medicine has long demonstrated the importance of narrative skills for all health care providers. Grounded in literary theory, this scholarship prepares students to recognize, absorb, interpret and be moved by the stories of illness (Charon 2008). The role of creative writing in medical education fits within the shadow of this revered tradition. But approaching medical narratives not as a reader would but as a creative writer actively involved in their construction incorporates an alternative set of skills and sensitivities that I've found indispensable for the narrative challenges I encounter. Emergency medicine is mythologized in the media for its blood and mayhem, the need for a swift and dramatic response. This high drama is less common, the demands more explicit and generally easier to respond to than the challenges that are my daily bread—listening and responding to patient stories in a narrative disaster zone (Baruch 2007).

One story

> Mr. K, a possible trauma patient, is transported to the ED—emergency department—by EMS and police. A decorated military man who suffered from post-traumatic stress disorder (PTSD), he called his girlfriend sounding very anxious. Being at work, she called 911. When the ambulance arrived, he was sitting in his living room, calming himself by listening to music. He might have fallen. Minor damage at home supports the possibility of a fall, as does the slight bruising of his forehead. However, he denies trauma. He forcefully resisted EMS efforts, refused standard precautions to immobilize his neck with a cervical collar and backboard.

> In the ED, Mr. K doesn't answer our questions, undress into a gown, or submit to an exam that may help identify further injury. His escalating defiance draws a horde of muscular hospital security officers who promptly surround his stretcher. Worried that he might pose a potential threat to himself or staff, a nurse requests an order to restrain this powerful man. His girlfriend along with his sister arrive but can't persuade him to cooperate. This rugged man begs them to get him out of the ED.

If he possesses decision-making capacity, I can explain my concerns and permit him to refuse treatment and sign out against medical advice (Annas 1999). My eyes return to the bruise on his forehead, an unimpressive but difficult to ignore reminder that his agitation might be the result of brain injury. When a reasonable risk of serious, imminent injury exists and patients are either intoxicated, chemically altered or deemed to lack decision-making capacity, physical restraint may provide the only efficient way to protect patients and staff and to expedite any necessary testing. The patient's crackling frustration is matched by the nurse's impatience, in particular, with my indecisiveness and reluctance to follow the predefined drill. However, Mr. K seems different. He's neatly dressed. His agitation feels more like profound distress, his physical restlessness a reaction to strain or mental suffering. I can't fit Mr. K into this convenient narrative arc.

Writing, at least for me, isn't a linear process. Not only do I have to write to find out what I'm writing about, but I often find myself taking necessary detours and tangents, sidling and stumbling towards discovery. What's important is not identifying a destination but recognizing that I'm onto something. The prize in that moment might be more questions, but they're sharper, pulling me deeper, and invariably linked to Mr. K's character and his backstory. When stories become disorganized, writers are advised to first focus on character and to identify the central conflict in the situation (Koch 2003). Before I can answer the question, "What's next?," I must first consider who are these people, and what fuels their motivations and desires.

> I step into the hallway with Mr. K's girlfriend and his sister. The girlfriend is understandably upset. Mr. K didn't drink alcohol or take illicit drugs. This behavior is unusual for him. I ask about his military experience, thinking I'd gain insight into his PTSD. The two women share a weighted look, then describe how Mr. K had been raped as a boy. His PTSD had nothing to do with his military experience. My blood turns to ice as I watch the scene unfolding in his room where muscular men surround his stretcher, threatening to tie him down.

I don't restrain Mr. K. I shock everyone in the room by asking that they step away. Good medicine doesn't work on the wrong story. By allowing him space, returning to him a sense of control, I hope to rewrite the narrative error, a form of iatrogenic harm that predicated a miscalculated medical response.

> Mr. K meets my eyes for the first time, and in that expression, a mutual recognition of the profound issues, the subtext, at the core of this drama. Even so, he's too distressed to listen, as I explain my concern for a neck fracture, a brain bleed, or some other injury. His concession to a head and neck exam is quickly aborted when my hands palpate his chest and back. He insists on leaving. No CT scan of the brain or X-rays. It was too late to recover a trusted space. But the genuine attempt matters, possesses a moral valence; dripping with a deep sense of failure, I was startled, and even embarrassed, by the grateful "thank you" from Mr. K and his family on their exit.

As the physician, I can't ignore my place as a protagonist in this drama. I'm faced with a decision that doesn't fit into any neat algorithms or normative codes of conduct. The stakes

are high, the obligations conflicting. Good fiction often intertwines at least two parallel narratives in a scene. Knitted just so, the tiniest gestures, the slightest tug of the thread, can create endless and surprising consequences for multiple characters.

The easiest option appealed to prevailing standards of medicine and risk management. Head trauma and agitation demand that the physician rule out any head injury or medical causes. Physical and chemical restraints are sometimes necessary to protect the patient from potential life-threatening injury. However, a justifiable mode of action doesn't necessarily make it right or the best option. In such situations, not only are the physician's clinical skills tested but also his character. The Greek word for character, ethos, shares the same root as ethics. Character is linked to conduct. In this way, well-constructed stories have a moral dimension. How can I send a patient home knowing there's a small chance of a missed injury? What if the mechanism of restraint carries a higher likelihood of harm? Moral duties are not always simple.

Restraining this particular patient felt inhumane. Empathy, in this situation, required a calculated diversion from accepted medical standards. This situation serves as one example when the reductive nature of medical training with its strong focus on finding *the* right answer feels insufficient or even obstructive for extracting meaning or even gaining traction in the stories laid out before me. The stories I hear are often imperfect, fragile things. They can feel like stream of consciousness, not logical constructions or expertly rendered texts discussed in the classroom. Sometimes patients can't find the right words to express their concerns or needs or have a poor understanding of their needs or cloak them in denial or pride. Their voices often tremble, as if squeezing illness, socioeconomic burdens and a faulty healthcare system and trying to extract hope. I often find these stories overwhelming, ungraspable and intimidating, a discomfort echoed so eloquently by John Lantos when he wrote, "It is a rare doctor-patient encounter in which the patient's felt needs can be met, because the patient's felt needs are generally enormous, perhaps infinite" (1999, 42). Regardless of the challenges presented by the content or form of their stories, patients expect a response from me. This task, regardless of how difficult the circumstance, is made easier when I work from inside the story, and respect its particular demands.

Anatomy of a story

A story is propelled by character, conflict and desire. Complex characters want something badly and are driven by inner or outer forces to act (Koch 2003, Egri 1960, McKee 1997). But obstacles interfere with their pursuit. Their response to these challenges not only propels the plot but also provides a charged occasion where characters are tested, allowing their true natures to emerge in finer relief.

These larger structural concerns provide a more compassionate prism for understanding those patients who present with distressing symptoms that elude any definable etiology or represent unconscious expressions of life stresses or secondary gain. By fixating on a diagnosis and finding none or dismissing any biomedical basis for symptoms, I risk diminishing the patient's distress and miss an opportunity to address those vital but hidden issues screaming for attention.

> Ms. Smith comes to the ED with abdominal pain. She's had these symptoms for 2 years. She hasn't told her doctor about these pains. Now it's 2 am on a busy Saturday night, and she's serious about getting help. This scenario is common to most, if not all, emergency physicians. Tears wash down her face. I palpate the abdomen, and she's tender everywhere. But her abdominal muscles don't guard against my probing. Blood work is negative. CT scan shows no abnormal pathology. Her pain is real, the origin

> confusing. When I run through possible causes of her pain, I ask how's she doing. Work? Family? After a long pause, she discloses that her husband left her two days before, which made the pain that much harder to tolerate.

These turns of events sometimes greet me with surprise, but often I have a sense of incompleteness at the very start. Something's hidden, yet unearthed, and I must work with what I have before me. Stephen King (2002) described stories as found objects, often buried, requiring digging, and rarely extracted intact. In the clinical setting, recognizing the story as a story is necessary before you can analyze, reflect and respond to it.

In the classroom, by presenting a story or poem for examination, the critical and sometimes quite difficult narrative work in the clinical setting has already been done—identifying the story. Most patients have not been to medical school, and their stories sometimes feel to me like first drafts. I rewrite stories ten to twenty times, and I've been crafting stories for many years. How can I treat patient stories like accomplished works knowing firsthand the difficulty of drafting stories in a quiet room without the pressure of a busy emergency department where patients share intimate details with strangers who are simultaneously juggling many patients and might be called away at any second? Wading through a parade of details requires editing, simultaneously cutting that which seem incidental or distracting while seeking elaboration and more explanation for parts that feel underdeveloped. Good writing requires attending to detail, properly organizing and weighing those details, and taking a fresh angle on even mundane situations (Morris 2001).

I treat patients' stories as energetic first drafts though some patients with chronic problems and tragic histories are well practiced in sharing their experience and can unfurl their complicated tale with a clarity and grace that Dickens would envy. Others are adept at editing themselves, omitting critical parts, almost as a form of magical thinking. Warding off disease is easier if the physician can't diagnose it.

> Ms. Jones doesn't feel right, that's what she tells me. She denies chest pain. She denies being short of breath. She isn't nauseated, but the meatball grinder, she suspects, upset her stomach. She doesn't smoke cigarettes. No family history of heart disease. She's kind, patient, very pleasant though she's waited four hours to see a doctor. Where's the story here?
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> The smell of cigarette smoke wafts from her clothes piled upon the chair. Didn't she just say she didn't smoke? I ask for clarification. She normally smokes a pack a day but "quit" 2 days ago because she felt weak and tired. This fact registers less like missed information and more like foreshadowing, an opening to a larger story. I return to the beginning. Mrs. Jones had chest pressure, not pain. She wasn't short of breath but did have this sensation of being unable to take a full breath in. I inform her that these symptoms may indicate a possible heart attack or coronary artery disease. She says this thought had passed through her mind but doesn't want to stay in the hospital for further evaluation. "Isn't that why you came to the hospital?" I ask. She shakes her head. She wanted reassurance that it wasn't her heart. I move deeper into her story. She is the dutiful caregiver for her mother who suffers from severe dementia, and if she stays in the hospital, her mother would be left alone with her son who has his own problems.

The writing process has been described as alternating between "passive, open, daydreaming intuitiveness, followed by worked-out, thought-through, fully developed acts of judgment and control" (Koch 2003, 8). I never begin with the question, "What's this story about?" Intellectual analysis too early can interfere with the shape and evolution of a story. The story must have an emotional core.

Rewriting the clinical encounter

Narrative skills are central to the work of caring for patients. Analyzing the meanings of illness, imagining illness from multiple perspectives, identifying narrative threads and sensitizing the ear to the uses of language are often achieved by reading and analyzing written works (Charon and Montello 2002).

Writing a story is fundamentally different than reading a story, just as the breadth of knowledge, decisions and concerns facing someone who does home repair differ from those of someone who designs them. Being present at the beginning, holding each piece in your hand, figuring out what belongs, where and why, demands a level of examination, a set of decisions, an attention to detail that may get taken for granted by those looking from the outside in.

Close reading skills are valuable, but this approach harbors the allure of the quest, the search for a particular buried treasure. Even if educators pose questions of the text, even criticize it, or use it to leap off into larger vistas, the text itself possesses a weighty presence, the work rife with meaning and secrets. I don't want to discount close reading because good writers must be good readers. However, close reading poses risks, carries with it the eerie whiff of puzzle-solving, reductive medical problem-solving applied to narrative.

Subjecting a story to critical analysis was described by Eudora Welty as "examining the writing process in reverse…as though a story—or any system of feeling, could be more accessible to understanding for being hung upside down" (Welty 1993, 109). She described analysis as an 'ever-narrowing' travel backward, while the writer of a story is bound in the opposite direction, working into 'open spaces.' "The choices multiply, become more complicated and with more hanging on them, as with everything else that has a life and moves" (109).

Finding answers isn't as important as asking the proper questions along the way, exploring each narrative trail completely for the promise it might hold. It's not uncommon in my own writing that minor story-lines or characters in early drafts become the central actors in the end. I might have imposed my will upon the story, not realizing the pulsing heat ran elsewhere. When listening to patients, it's important to recognize when you're listening only for the dominating narrative line suggested by their presenting symptoms, previous physicians or the nursing note out in triage. By starting at the end, you risk favoring those elements that support or justify suspicions or conclusions to the exclusion of critical details and choices that might have captured your attention if encountered during the way.

> A Guatemalan woman in her forties returns to the ED a few days after being treated for mild pneumonia. She's nauseated, dizzy, tired, and hasn't any appetite. She believes her pneumonia is getting worse, the antibiotic is making her sicker, and she is unable to sleep. She denies cough, fever, difficulty breathing.

A patient diagnosed with pneumonia lacks symptoms and physical exam findings for pneumonia. The problems that concern her aren't typical side effects of the antibiotic that, in my opinion, she doesn't need. She doesn't appear sick but overburdened and sad, which is where I direct my questions.

> The tears pour down. She has been treated with antidepressants in the past but stopped when she became pregnant and remains off them because she is breast feeding her six-month old. Her husband blames her for the unexpected birth of their fourth child. She wants to return home to Guatemala though she's lived in Rhode Island for years. There are many stresses here, and the past few days, not sleeping has made the situation worse. Thoughts rush through her head at night since she started the medication. All the medications prescribed for her pneumonia cost over a hundred dollars, and she and her husband already face stark financial difficulties.

Under the cloak of a medical problem was a patient in need of significant mental health services, as well as social work assistance, which would have been lost if the narrative remained confined to her pneumonia and medication side effects.

Probing for the heart of the story is a different task than collecting a thorough patient history. History taking is an essential and a vital part of the practice of medicine and thus a critical piece of medical education. But the questions asked are scripted. The answers are often interpreted in context of that script. Chief complaint. History of present illness. Review of systems. Past medical history. Past surgery history. Social history. Ask the questions, fill in the boxes. It's an excellent instrument for diagnosing a medical problem, but it's a blunt tool for extracting a story. One model of history taking professes a more imaginative approach that consists of "building" a history rather than "taking" one (Haidet 2003). Possessing a working understanding of story along with a solid grounding in medical history taking permits a fluid and flexible approach to narratives that don't obey traditional expectations. The old adage that up to 90 % of medical diagnosis can be made through medical history alone is predicated on one fundamental assumption—that a patient's symptoms relate to an identifiable disease.

But every ED patient possesses an urgent need to tell a particular story at that moment. That the medical problem isn't considered critical shouldn't discount the patient's critical need to share it. Desire drives story. Whether you're lying in the bed or standing at the foot of it, each person in a medical encounter wants something. Their actions are less important than the factors motivating them (Egri 1960, McKee 1997).

Every character is constructed differently. Two people rarely experience the same disease in the exact way, just as two individuals' perceptions of any similar experience often differ. A storied approach asks how this person will respond to this disease under these conditions. People suffering from chronic pain are one category of patients who are often stereotyped and erroneously viewed through the same suspicious lens of bias and easy judgment. But their experiences and expectations vary. An epidemic number of patients in chronic pain are inadequately treated; at the same time, prescription opioid misuse, including criminal diversion and death from overdose, have also achieved epidemic proportions.

Thinking of patients as characters isn't meant to objectify them but to amplify the focus on the individual who happens to have a disease instead of concentrating on the disease that happens to reside in a person.

There are so many stories with pain at their center. Some patients seek treatment so they can engage in life, but others view pain as an opportunity to withdraw from obligations, to feed a drug habit, or exercise criminal mischief. Varying pain thresholds, tolerance to treatment modalities, interpretations of meaning and expectations from health providers further complicate the elementally human endeavor of relieving pain.

Embracing conflict

The practice of emergency medicine is punctuated with difficult patients, but more often we're confronted with difficult stories. The clinical situation is confusing and pressured and often doesn't make sense. You feel like you've hit a dead end. In the clinical setting, such moments can be the source of frustration, anguish. When writing stories, these moments aren't any less frustrating, only they are perceived and embraced differently. When writers find their characters stifled, stuck against unexpected corners or dead ends, the serious work of knowing your characters has finally begun. Philip Roth once said, "You're looking, as you begin, for what's going to resist you. You're looking for trouble" (Lee 1984).

Writers seek out narrative pressure. True character is revealed by the choices individuals make under pressure. The greater the pressure, the deeper the revelation, the truer the choice reflecting the character's essential nature. These tough moments, when the stakes are highest, are when we learn most about ourselves and others. In medicine we do everything to avoid conflict, or ignore conflict, or dance around it when it occurs. This doesn't mean we should pursue conflict in medicine. Rather, we should recognize its potential value, probe and explore those challenging moments, and identify those uncomfortable emotions at play. Those feelings require very close narrative attention. Often that's where you find the heart of the story.

If I were writing Mr. K's story, a former soldier making threatening gestures requires a motive. His initial emotional state was treated as pathology that demanded a response, rather than as evidence of his character which could, perhaps, reveal an important backstory. Medical stories begin elsewhere.

Tension is created by building a gap between expectation and result (McKee 1997). Mrs. Jones came to the ED seeking reassurance about her chest pain and discovered the realization of her fears. What will she do now? Will her expectations change? The risk of a heart attack wasn't enough to persuade her to stay in the hospital. It required an appeal to her role as a loving caregiver for a family that needs her, and how a heart attack would impact *their* lives.

I'm sometimes frustrated not by patients with difficult medical issues or challenging personalities, but by patients or families with great needs and unpractical or unrealistic expectations. Patients with unmet desires may become dissatisfied, angry, perhaps even feel compelled to take legal action. This discomfort manifests itself in different situations. One example: the media portrays a proportionally high likelihood of survival after cardiac arrest—not only survival, but patients surviving neurologically intact—that contradicts the grim statistics (Diem et al. 1996). Families are often surprised, shocked, even angered when informed that we couldn't resuscitate their loved one.

Maybe one can follow a certain "bad news" script in the context of preexisting illness when death is expected and the physician has an established relationship with the family. The scene takes on a different tone with sudden deaths when I'm introducing myself to family and friends for the first time while expressing my remorse at their loss. To do this compassionately and efficiently, I try to understand quickly the characters. I review old medical records, contact their physician if possible, ask questions of the bereaved. I'm amazed how often they'll freely share their own back stories. Members of the same family often express a range of responses to the news, and the behavior is usually deeply woven to their relationship to the patient when he or she was alive. Life ends when the heart goes stone still, but stories of that life and of those close to that life beat on.

Teaching the imaginative dimension

The only way to become a skilled writer is to roll up your sleeves and slog away with pen and paper or to tap numbingly on those computer keys. Nothing replaces experience, getting dirty. Medical training is no different where for all the hours spent toiling in the lecture hall and anatomy lab, true expertise can only be achieved through the care of patients.

One of the biggest challenges I faced in teaching this material involved applying experiential exercises in creative writing in such a way that medical students would find them worthy and relevant. Establishing an atmosphere where experimentation, creativity and risk-taking are the norm is of absolute importance. Teaching the elements of any competently written story—voice, point of view, language, dialogue, setting and other architectural materials—without addressing the wonder and need that compels someone to express himself in a bold and daring fashion felt like serving bones without the meat.

The solution to the task came into clearer focus through a partnership with Kelli Auerbach, MFA, a novelist/screenwriter who at the time was faculty at the Rhode Island School of Design. We co-created and co-taught an experimental elective course that placed medical students and RISD art students in the same learning environment.

The elective, titled "No Innocent Eye: Knowledge and Interpretation in Art and Medicine," asked medical students to engage in topics and work with skills and processes not typical of medical training. We asked students to write, to create, to work in teams, to discuss their projects and offer feedback. Details of this course are described elsewhere (Auerbach and Baruch 2012). Our primary goal for the medical students involved taking them out of their comfort zones, encouraging them to think more creatively and critically about medical practice and medical care. This task, we felt, would benefit from working alongside art students engaging with similar work.

We began with writing exercises, the essentials of the writing craft, and whenever possible, connected these elements to the experience of being a healthcare provider or a patient. We emphasized attention to details, and how the tiniest details, carefully chosen or noticed, can reveal character. We explored the many ways a piece of writing changed by the many choices a writer makes in what is included or cut out of a piece. We analyzed story structure and story arc, placing them in the framework of medical stories where characters are patients, families and healthcare providers.

For example, an exercise exploring text and subtext lead to a discussion of the slippery properties of language. Using point of view exercises, students inhabited the roles of different narrators. Describing a scene from the perspective of two people of vastly different ages and experiences forced students to enter the mind and emotional landscape of these individuals. The writing varied depending upon the voice, distance, and motivation of the narrator.

I built upon this work in a seminar titled "Pragmatic Medical Humanities," which, as the title suggests, concentrated on how humanities and story operate as bedside skills. This Brown seminar also emphasized the craft of writing. Borrowing from the ethos of the RISD course, students were encouraged to take chances. An assignment centered on patient stories asked students to read chronic disease blogs. I wanted them to experience narratives that might be more spontaneous, emotional, and unpolished compared with edited narratives found on bookstore shelves. They were asked to absorb, contemplate, and write a creative piece based upon on what they read. One male student wrote a poignant first person account from the point of view of a mother with myasthenia gravis, a potentially devastating neuromuscular disease where muscles weaken with use, and how she allocates her efforts to meet her daily responsibilities. Making breakfast for her children, driving them to school, work and chores, dinner plans. Each decision, big and small, diminishes the strength available for the next task. Another student explored form with his final project, focusing on illness narratives in the music of singer/songwriters Warren Zevon and Vic Chestnut. Each artist battled serious disease that eventually claimed his life. The student examined how their experiences with pain, frailty and declining health, and their stance towards mortality, were reflected in their lyrics and music. In another final project, a student probed point of view by writing a scene of three voices in three columns on the page. The scene portrayed a noncompliant sibling with chronic illness, a parent's reaction, and the voice of a third person commenting on each.

Aspects of writing share habits of mind with other artistic endeavors as well as the imaginative act of doctoring. The smallest details reveal and betray character. Not only what is said and unsaid, but the nuanced space that surrounds words, the vitality and tone of the voice. A common exercise I use with students when first gathering as a group is to ask them to introduce themselves and to give one, and only one, telling detail that offers a glimpse of who they are. I typically begin by admitting that I frequently trip walking upstairs, which is unfortunate but true and usually elicits a few chuckles. What impressions come into focus with that detail? I'm a klutz or lost in thought or maybe always in a rush? I'm an inveterate and poor multi-tasker? Maybe I have a

balance problem or poor depth perception? This one detail works on many levels. It also demonstrates a voice, a tone towards life. I'm not afraid to laugh at myself. This one detail expands outward, opens up to many narrative possibilities. The picture of me becomes both clearer and more mysterious. I've usurped their expectations with this small gesture. But they also become aware of their reactions. The carefully chosen detail can tap preexisting memories in the reader or the listener. Left with little else, they unconsciously start filling in the gaps.

By playing with words, students begin to figure out how cutting sentences can give words room to breathe. Sometimes less is more, and readers fill the space with their own interior landscape, rife with memories, emotions, biases and preconceptions. What we say to patients, and what they tell us, is more than information. The words we choose, and the voice in which they're delivered, contain hints to our history, values, desires and character.

In conclusion: the medical encounter as a blank page

I write to discover what I'm writing about. The payoff comes when a character startles me with a line of dialogue, or the narrative leaps into unexpected directions. The narrative will dilate in specific areas and constrict in others. The search for meaning isn't a linear process. I don't start with a "big" idea and fill it with muscle and connective tissue. The goal isn't to make a construction that works but to be messy and to risk making mistakes. Control the narrative too tightly and it feels forced, static and inauthentic.

In my experience, imaginative flexibility and a sophistication in story structure is becoming absolutely necessary as growing socioeconomic burdens in the community coupled with a shifting healthcare landscape have resulted in ED narratives of increasing complexity, nuance and urgency. Medical educators and academic medical centers have been challenged to supplement scientific reasoning with narrative based reading and creative reason in the fine arts (Doukas et al. 2010). Creativity and innovative problems solving skills must be nourished, the medical mind recalibrated to the importance of process (Ness 2011).

Creative writing encourages this search for new connections and the discovery of fresh relationships between disparate ideas. Hopefully, it promotes a heightened understanding of story and gives healthcare providers another set of tools for appreciating the "characters" they care for, their desires, as well as the obstacles, real or perceived, frustrating their way. The physician/writer William Carlos Williams said: "the whole point of stories is not 'solutions' or 'resolutions' but a broadening and even a heightening of our struggles—" (Coles 1999, 129).

This paper offers only a small opening into the many ways that writing and medicine feed each other in my professional, academic and literary lives. They don't speak loudly or boast boorishly, and for the past 20 years, I've enjoyed the slow reveal of their invisible hands. Writing is a humbling process for me, and medicine demands similar humility. Writers must be sensitive to what their characters want, not what we think they want. Similarly, physicians must recognize, and accept, the many possible endings a patient's story might take, and why the narrative could take that direction. Any conflict shouldn't be ignored, deemphasized or mechanically handled but probed and pulled apart. As part of these efforts, physicians must question their habits and feelings.

Making this effort matters. I believe it carries moral currency because the experience and process of creative writing develops qualities and skills that make for better doctors. What the writer Amy Hempel said about the writing craft applies equally to the practice of medicine. "What affects you is hearing the attempt at the note. More effectively than someone hitting the note perfectly" (Winner 2003).

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