

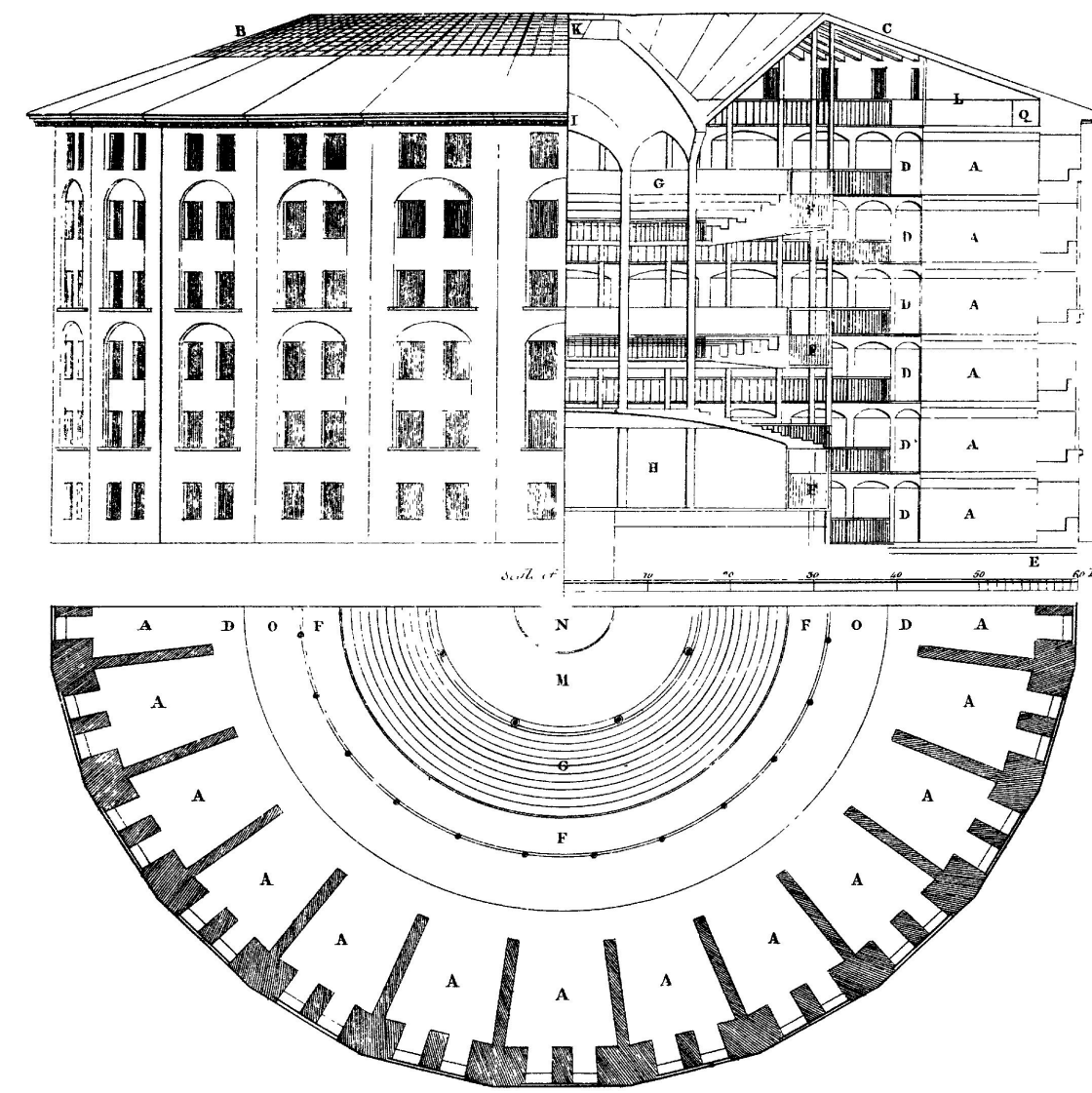
The Panopticon  
by Adam Simpson  
for The New York  
Times (2013)

## Introduction

Jeremy Bentham's panopticon is a theoretical prison that was developed in 1787 as a way to punish and reform people convicted of crime and deter criminal behavior in society. It involved a circular building with a central guard tower, from which an omnipresent and omniscient warden would constantly surveil the inmates who were kept in solitary confinement. Although the prison was never physically constructed, elements of the panopticon are present in many aspects of our social structure and power systems. This paper explores Bentham's original work, the post-modern responses to it, and present day manifestations of the panopticon through a bioethics lens in order to develop a metaphorical tool that can be used to examine and explain how power is systematized and functionalized by those who control it, the effects on those who are subject to it, and how the systems are exploited to the point of dysfunction.

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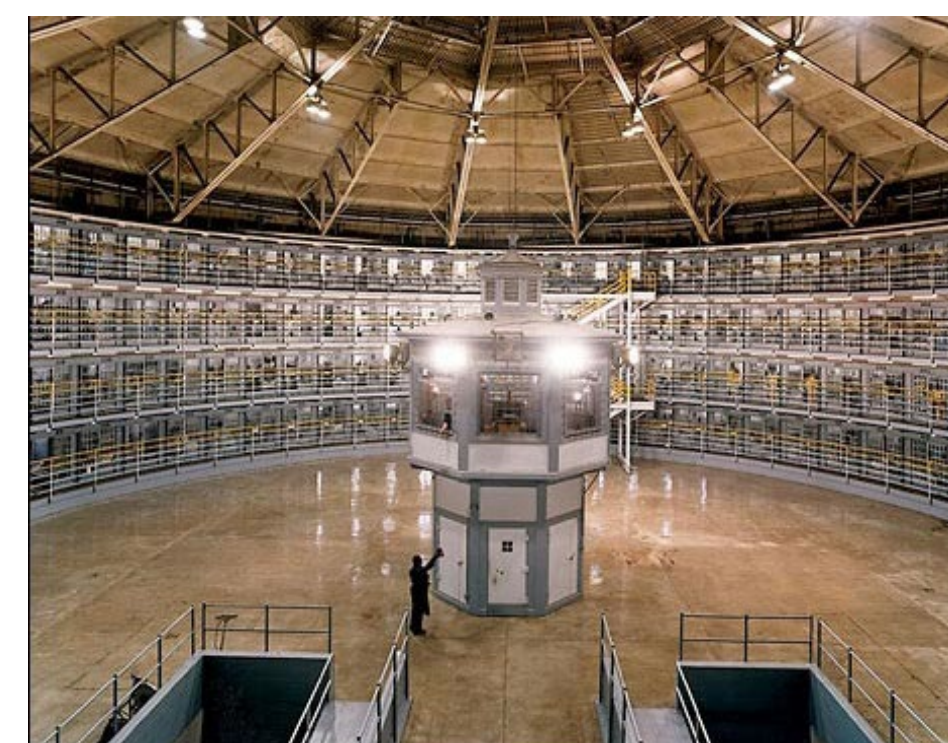
[nubaira.khan@temple.edu](mailto:nubaira.khan@temple.edu)



Plan of the  
panopticon  
drawn by William  
Reveley (1791)

As the country with the highest rate of incarceration in the world, the U.S. has an idiosyncratic relationship between social structure, power distribution, and population control. This stems from the systemic enslavement, displacement, and genocide of Black, Brown, and Indigenous people, and has carried into the modern world as the prison industrial complex.

Michel Foucault argues that the way a polity establishes systems of crime and punishment is a reflection of the power structures that construct said systems. Therefore a rigid, centralized power structure is illustrated through the U.S. prison-industrial complex, which houses a captive workforce and has relatively high return-rates both in recidivism and investment.



Stateville Prison,  
F House in  
Illinois, USA  
by Doug DuBois &  
Jim Goldberg  
(2002)

## The Panopticon Thought Experiment

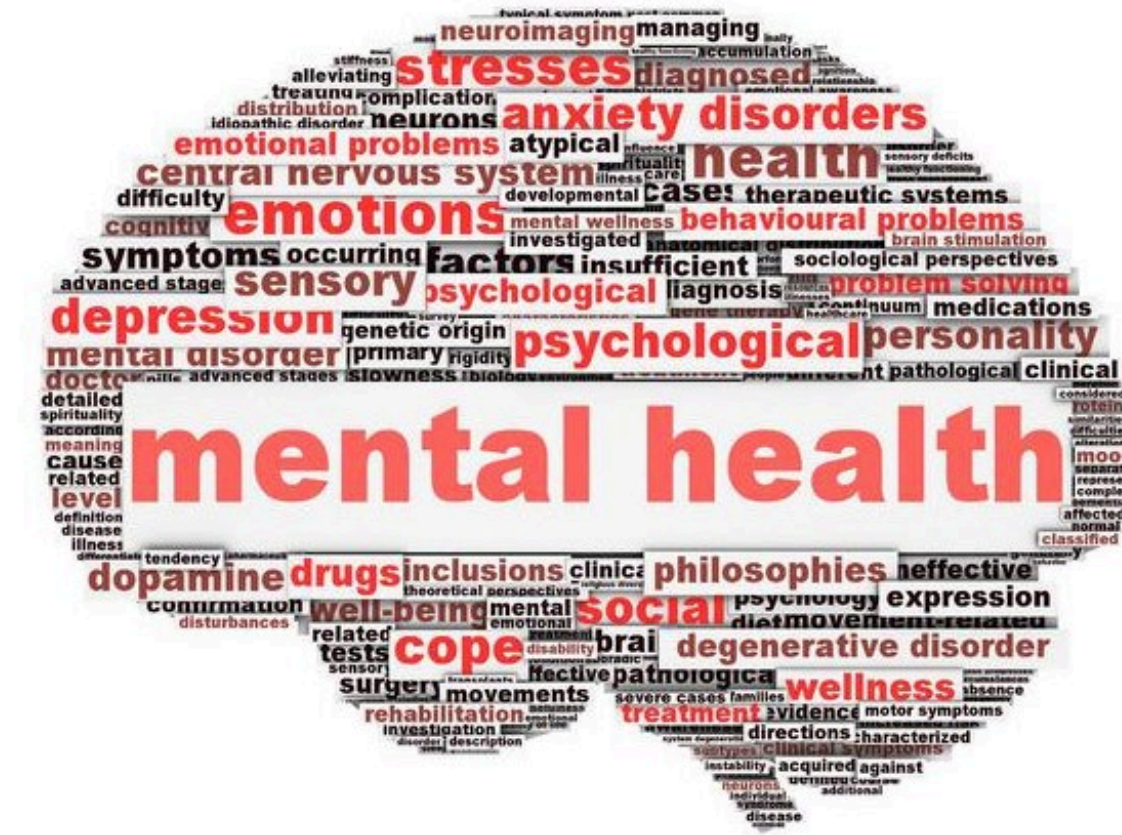
So while the panopticon was never actually built, iterations of it can be found in corporate structures, education systems, public service institutions, you name it; all have some elements of discipline and surveillance in a centralized power structure that relies on isolation and imprisonment as tools to control a population.

Because it is so familiar to us, the panopticon could be developed into a thought experiment, like the Trolley Problem or Mary the Color Scientist to examine different positions within the system, identify crucial points of power, and theorize potential dysfunction. It would be valuable to better understand what is to be gained from systems like the panopticon, who stands to benefit, and at what cost. As a metaphorical tool, the panopticon acts as a framework for the State, simplifying the relationships and structures of the action of power, and can act as a gateway to deeper ethical and philosophical concepts. These ideas are worth teaching, learning, and exploring because we live in a society with inequity and injustice and if we are able to better understand the mechanics of power at both the systemic and interpersonal level, it would create a introductory understanding that informs how we construct and reform our social, economic, and political systems.

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## Introduction

Nearly 50% of Americans will meet the diagnostic criteria of some form of mental illness in their lifetime (Mehta & Edwards, 2018). Patients with mental illness have a lifespan that is, on average, 25 years shorter than individuals without mental illness and are at 2-3 times the risk of diabetes, heart, and lung disease than the average population but do not receive adequate treatment at a proportionate rate.

As a country, there are very negative stereotypes held towards individuals struggling with mental illness and substance use disorders even though they are among the most common conditions in the population.

This stigma against mental illness often prevents individuals from seeking care for their symptoms and causes medical providers to treat patients with mental illness differently than those without them.

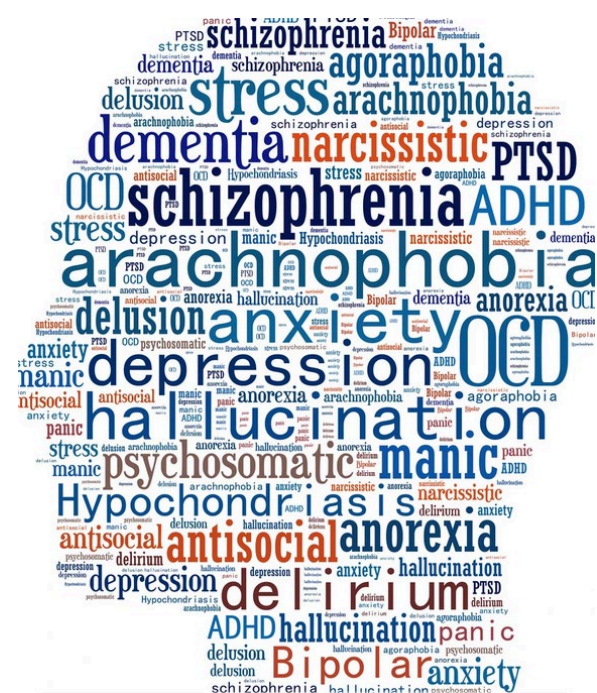
Healthcare providers' stigma against patients with mental illness has been identified as a significant barrier to healthcare access and recovery and has been associated with decreased quality of care for patients with mental illness (Knaak S, Mantler E, and Szeto A, 2017).

Stigma can be seen in the way providers speak about patients with mental illness, the way the medical record labels patients with mental illness, and even how health care providers themselves fail to seek treatment when suffering from mental illness themselves.

### Real examples of bias:

A woman informed me, "Before I started choosing not to disclose [this information], I just encountered a lot of suspicions that I was drug seeking which actively led to worse care. It was ironic because I was usually disclosing [my history of opioid use] to ensure that I was not given opiates" (personal correspondence, 2021).

A medical student recalled a patient with a history of schizophrenia who had come in for a neurology appointment complaining of headaches and vision loss (personal correspondence, 2021). After the initial neurological exam and imaging were complete, the team concluded the patient was **delusional** and wrote off the symptoms as a **psychosomatic manifestation** of the patient's schizophrenia diagnosis. After the ophthalmologist finished their exam, they determined that the patient had 50% vision loss, and upon reexamining the images, they found a **large pituitary tumor** that was compressing the optic chiasm causing loss of vision and headaches.



## Startling statistics:

- Out of 102 patients admitted with OUDAE, **55.9%** of patients had addiction mentioned in their **discharge summary** plan. However, only **23.7%** received addiction medicine consultations, and only **24%** received psychiatry consultations (Rosenthal, Karchmer, Theisen-Toupal, Castillo, and Rowley, 2016).
- **49%** of patients were **readmitted** for a total of 131 total readmissions, and **27.5%** were still injecting substances at the time of admission.
- Out of the 102 patients enrolled in the study, **25.5% were deceased** at the study's publishing, with a median time of death **305.5 days** after their original admission date (Rosenthal et al 2016).
- **90%** of **state licensing applications** inquire about **past diagnoses**, including depression and anxiety, even if the treatment occurred before medical school (Behbahani and Thompson, 2020)
- Studies have found that by the **end of the first year of medical school, 57%** of **medical students** had **moderate to severe** symptoms of **anxiety**, with an additional **27% having moderate to severe symptoms of depression** (Jones, T.R., North, C.S., Vogel- Scibilia, S., Myers, M.F., Richard, R.O., 2018) and **1 in 10 students** reporting **suicidal ideation** at some point during the 4 years of medical school (Temple University Doctoring Lecture).
- **300-400** physicians and medical students **complete suicide** every year (Jones et al., 2018)



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## Contact

[tuc69890@temple.edu](mailto:tuc69890@temple.edu)



## OUR WORDS MATTER



### Abstract

Stigma in the healthcare system is widely documented. A significant medium through which stigmatizing thoughts, opinions, and attitudes are propagated is language. Stigmatizing language can create barriers to care, while inclusive non-stigmatizing language has the ability to highlight a patient's strengths, humanity, and potential for recovery. While several institutions have implemented campaigns and interventions aimed at reducing stigma in healthcare, research examining the impact of these interventions is limited. Specifically, no studies have examined the effects of language-focused campaigns on patient outcomes. My thesis reviews the current literature on stigma and stigmatizing language in healthcare and proposes a hypothetical study designed to assess the effects of a clinician-facing training that emphasizes the use of non-stigmatizing language on opioid abstinence in patients newly diagnosed with opioid use disorder. Potential limitations in study design and data analysis, along with possible implications of study results, are discussed.

### Contact

Alison G. Richard – [tuj16371@temple.edu](mailto:tuj16371@temple.edu)

### Proposed Study

#### Methods

- Prospective pre-post interventional study
- Pre-intervention group: patients receiving standard medication for opioid use disorder treatment as usual
- Post-intervention group: patients receiving care from clinicians who have undergone training in the use of non-stigmatizing, person-first language
- Intervention:
  - Training slide deck for clinicians created based on principles derived from literature review of stigmatizing language in healthcare
  - These principles include use of person-first language, elimination of pejorative terms, use of inclusive terminology, avoidance of labeling patients, avoidance of using social identifiers, and avoidance of patient blame

#### Participants

- 125 patients in each group (250 patients total)
- New diagnosis of opioid use disorder as defined by DSM-IV criteria
- Expressing a goal of complete abstinence from opioids

#### Primary Objective

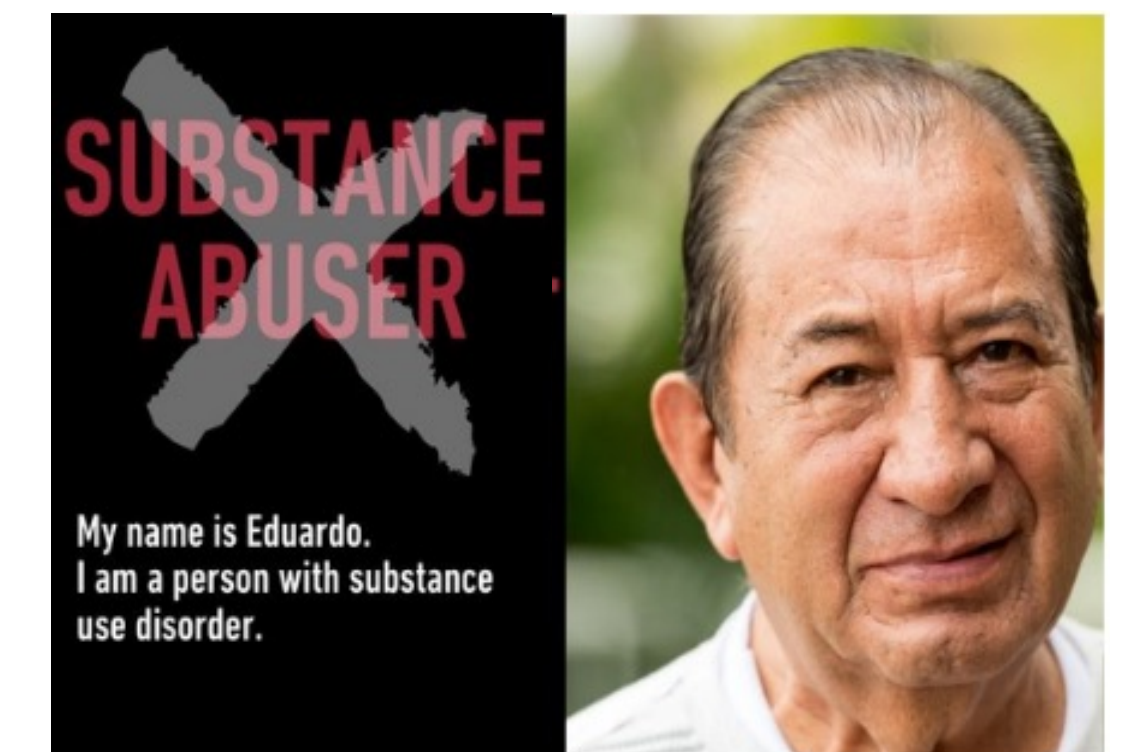
- Determine the impact of one year of OUD treatment from clinicians who have been trained in the use of non-stigmatizing language on patient abstinence from opioids as measured by urine drug testing and self-report measures

#### Secondary Objectives

- Explore the impact of this intervention on:
  - Patient satisfaction with quality of care
  - Measures of patient quality of life
  - Clinician attitudes towards individuals with substance use disorders

### Implications

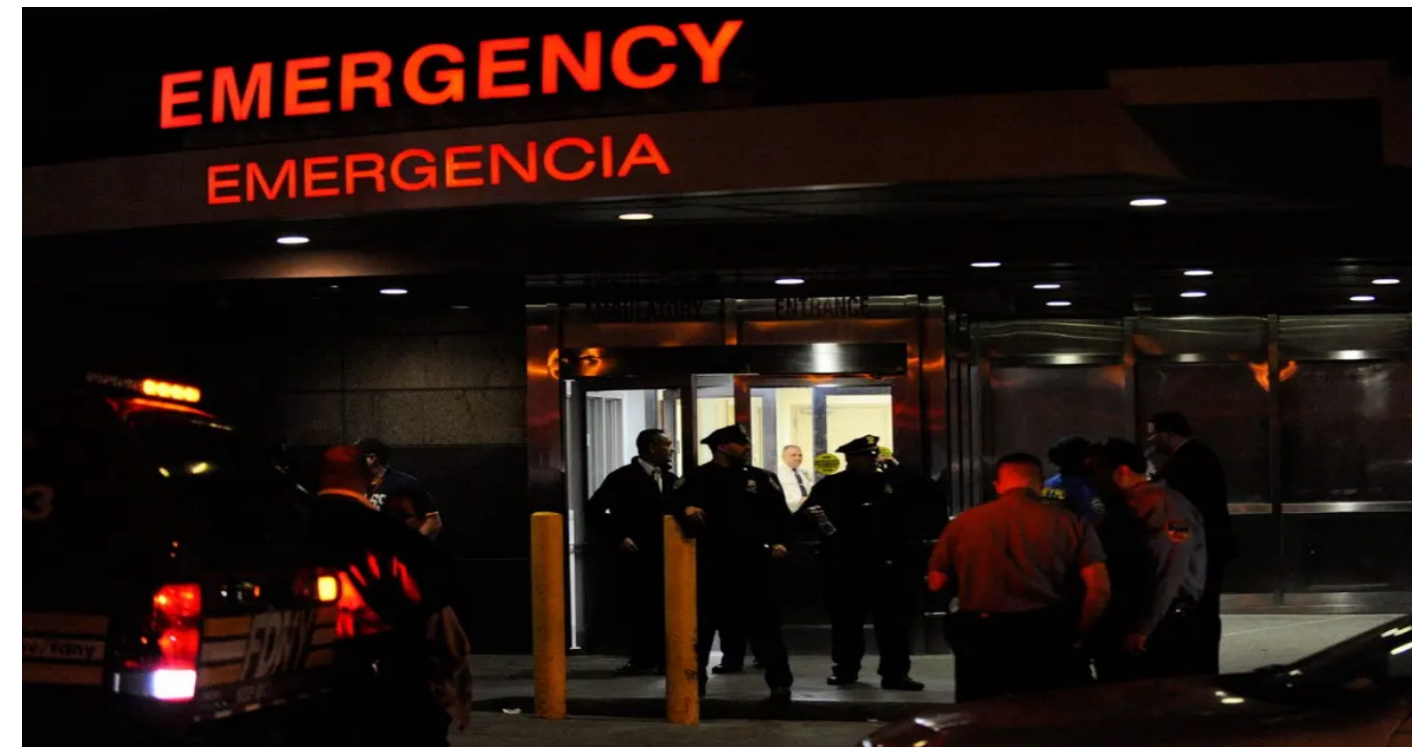
- Treating opioid use disorder is incredibly challenging and multifaceted, and patients often face numerous setbacks throughout the course of treatment
- Recent data from the CDC demonstrate that the opioid epidemic in America is far from resolved
- In the 12-month period from May 2020 to April 2021, drug overdoses reached 100,306, a 28.5% increase from the 78,056 deaths during the same period the year before
- If the results of the proposed study were to suggest that the use of non-stigmatizing language in a clinical setting had a positive effect on reduction in substance use in patients with opioid use disorder, providers would have another evidence-based, easily implemented tool for helping patients work towards recovery



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- <https://www.templehealth.org/for-physicians/reduce-stigmatizing-language>





## Abstract

Structural racism has been identified as a major source of medical vulnerability for urban populations. Police brutality is a consequence of structural racism and a critical social determinant of urban health that is associated with both physical and psychological injury. However, the presence of law enforcement agents is common in the healthcare setting, especially in the emergency department. The emergency department occupies a critical social role as a major source of healthcare for vulnerable urban populations, yet very little is known about patients' opinions regarding police activity in the ED. This study contributes to the growing body of literature on the pathogenic effects of structural racism by designing trauma informed methodology to identify and contextualize patient perceptions of police presence in the emergency room.

## Objectives

- Provide a qualitative analysis of patients' experiences with the police in the ED and how it shaped their opinions of healthcare providers/systems
- Determine if patients' opinions are associated with exposure to childhood trauma and/or community exposure to police

## Contact

sharmaine.g.ross@gmail.com

## Trauma-Informed Research

Trauma informed practices reconceptualize patient engagement through a health equity and social justice lens by prioritizing inclusivity and collaboration.

- Recognize both the ubiquity of trauma and potential paths for healing and recovery
- Integrate knowledge about trauma into research policies, procedures and practices
- Identify the signs and symptoms of trauma in participants and researchers
- Promote transparency, participant choice, and empowerment

## Methods

- **Interview and qualitative analysis**
  - Hourlong interview conducted by PI and social worker with trauma-informed certification
  - Setting: 3 community organization sites or teleconference
  - Coding framework: developed using constant comparative method
- **ACEs Study**
  - 10-question screen that assesses child maltreatment and household challenges
  - Determine the association between ACE scores and answers to questions regarding police/healthcare workers' perception of patients
- **Mapping Study**
  - Generate a graduated color map representing the association between of police activity per city block group for the calendar year and the rate of negative responses to questions regarding participants' general opinion of law enforcement

## Anticipated Results

- Patients will endorse interactions with police throughout multiple stages of their care
- Participants with high ACE-Q scores will have higher rates of perceived discrimination by police and healthcare providers.
- Participants living in block groups/neighborhoods with higher police activity will have more negative opinions regarding police presence and have less trust in medical institutions.
  - These findings may be blunted in participants with established relationships with healthcare providers.
- Most participants will still support the presence of law enforcement in some form, likely with the implementation of standardized guidelines for patient interactions.

## Discussion

- Historically, public aid to the poor has been accompanied by surveillance and stigmatization. Police presence may discourage vulnerable communities from seeking care and may decrease the quality of care they receive.
- The medical community has a moral obligation to address the social, economic, and cultural factors that shape the daily life of the patient.
- Future research/next steps: joint meetings between stakeholders and participants to determine actionable items; pilot program for standardized police-patient interactions.

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## Introduction

Disgust is a part of medical education. Whether in the anatomy lab, the operating room, or the hospital wards, medical school is often the first time that future doctors see human suffering manifested in bodies that elicit embarrassment, disgust and fear. Over the course of training, seeing such bodies goes from exceptional to commonplace as doctors learn to witness and empathize with suffering without becoming overwhelmed by it. In this thesis, I examine students' first encounters with abject bodies in the anatomy lab, their later encounters with such bodies in their clinical years, and the educational programming shapes students' gaze towards these bodies as they develop from laypeople into professionals. I argue that while medical humanities curricula implemented into gross anatomy help students manage challenging personal feelings elicited by the corpse, taboos and silences during the clinical years prevent students from thinking deeply about how patients experience having bodies that elicit disgust. The dearth of reflection on feelings of disgust during clinical training leaves doctors in training ill-equipped to promote and maintain patient dignity during medical care, particularly at the end of life.



"A Student's Dream"  
1906 photograph marking gross  
anatomy as a rite of passage

Photo Credit: A. A. Robinson/DMHC

## Contact

Hannah Sagin, tui05029@temple.edu

## History of Anatomy Education

- Cadaver labs have never been a neutral or purely scientific learning space, and are often the first site at which medical trainees confront death and dying in a visceral way.
- Since dissection became common in the mid-19th century, anatomy instructors have long grappled with the extent to which they emphasize the affective component of anatomy lab and its role in professional identity formation.
- In the 1960s and 1970s, following a post-WW2 boom in medical sociology, cultural interests in death and dying, and public pressure to counteract the culture of "detached concern" in medicine, medical schools began implementing medical humanities curricula into anatomy coursework, and began to implement the first donor ceremonies into medical schools.
- Many anatomy instructors today argue that the hands-on interaction with the corpse offer students something a computer model could never teach. Medical schools now use anatomy courses to encourage reflection on death and dying. These programs tend to be learner-focused, without room for the voices of patients who may be culturally different from students.

## Transition to Clinical Education

- Students continue to encounter situations that elicit disgust in their clinical education; these encounters happen with less structure, oversight and reflection than in the anatomy lab
- Unlike in the anatomy lab, mishandling feelings of disgust in the wards and clinic comes with the potential for patient harm
- While disgust is a common emotion in clinical settings, there is a culture of shame and silence for both patients and providers that prevents open acknowledgement and discussion around these feelings

Students at Temple University's 2019 Donor Celebration, a recent tradition common at US medical schools

Photo Credit: <https://medicine.temple.edu/news/honoring-those-who-give-their-bodies-science>



## Disgust in Clinical Practice

- There is a limited literature about how practitioners experience disgust and process this emotion in clinical environments.
- Most of the existing literature is written by and for nurses, and focuses on the hands-on caregiving done primarily by nursing staff. Very little has been written about how physicians specifically encounter disgust and how this impacts the care they provide
- Physicians have a unique role in helping patients make big-picture decisions about their treatment plans and goals. Disgust related to current symptoms or fears about future distressing symptoms often plays a role in patients' treatment decisions.
- It can be challenging for physicians to explore disgust with their patients, particularly when they are unable to fully prevent or palliate symptoms like complicated wounds or incontinence.
- Physicians need more guidance and practice handling these conversations with their patients.

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## Introduction

The conflation of the terms 'sex' and 'gender' within the medical community has significant consequences on some of the most vulnerable identities, particularly transgender people and especially trans people of color. The eventual delivery of poor health outcomes for trans people first begins with the fundamental philosophical and socially constructed definitions for 'sex' and 'gender' as they inevitably present themselves in the medical literature, as well as the medical literature's basic understanding of non-normative sexuality. As a result, medical school education does not provide physicians in training with the adequate tools to provide care for trans people, or anyone outside the spectrum of accepted normative sexuality (heteronormative sexuality), and in addition primes them to further perpetuate and reinforce stigma.

The issue is thus two-fold, with our baseline assumptions about 'sex' and 'gender' coming to inform our implementation of medical literature and education.

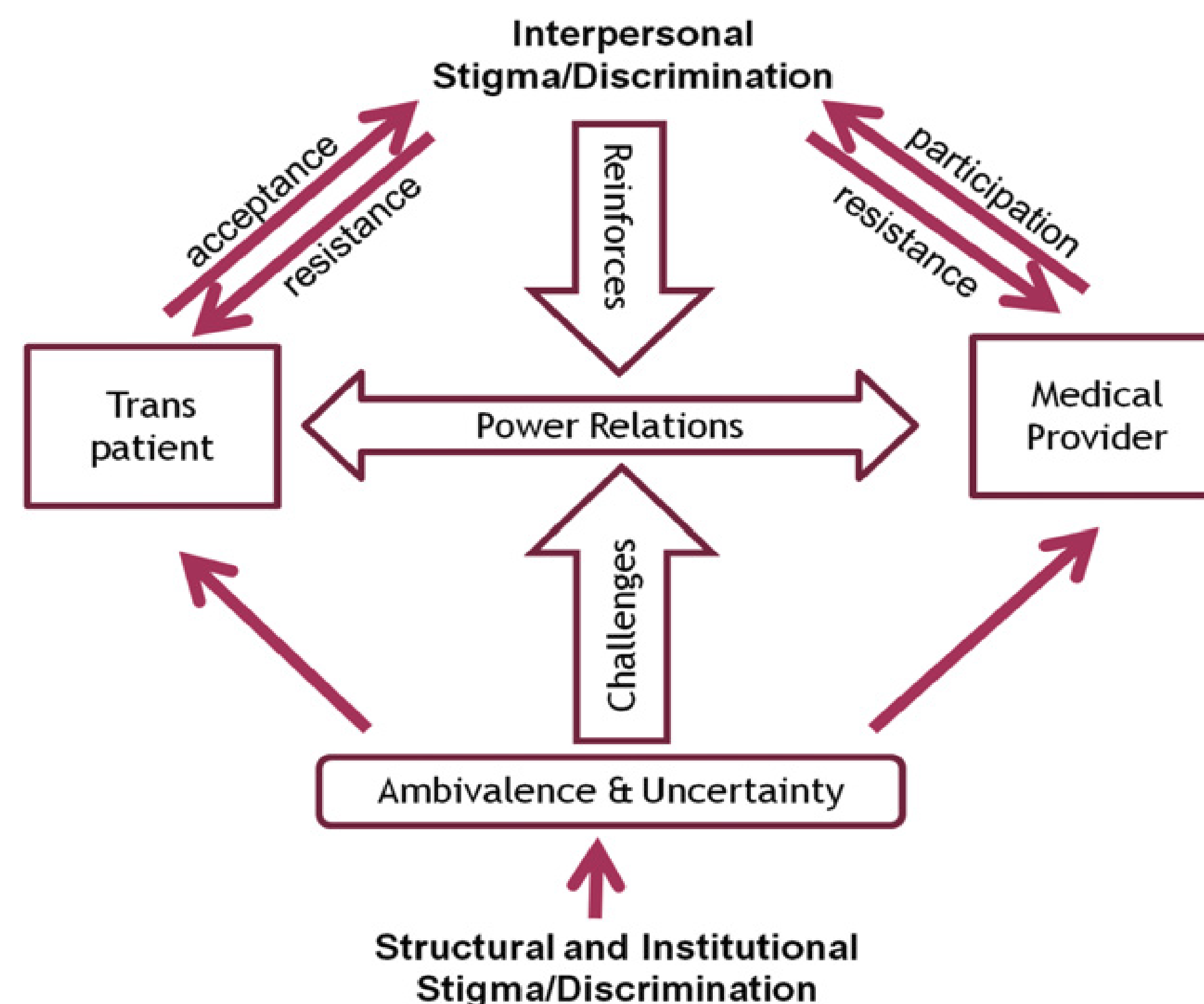
## Contact

[tul09320@temple.edu](mailto:tul09320@temple.edu)

See my bibliography for a full list of references!

## Issues with 'Sex' and 'Gender'

- Often, the terms are used interchangeably in scientific literature to confusing results (Hammarstrom & Annandale).
- We take 'gender' to be understood as socially constructed (yet still binary) yet 'sex' is appealed to as having a 'realness' that gender does not contain.
- Sex is socially constructed *as well as* gender and should itself be equally vulnerable to criticisms.
- As scholars have pointed out (See Fausto-Sterling's work, among others), sex as a biological concept is *not* truly binary, with sex characteristics being much more variable and pluralistic.
- Subsequently, the misconstrued biological understanding of sex acts to reinforce biases and discrimination even outside the medical community (see Bettcher on Transsexuality).



Poteat et al, "Managing uncertainty: A grounded theory of stigma in transgender health care encounters."

## Consequences and Solutions

- The breakdown of understanding, internalization of a wrongful binary and sexism in medicine has serious downstream consequences, particularly on how the medical literature and physician interaction with patients occurs
- Trans individuals often rely on the medical literature, which is limited in its scope and does not accurately capture trans experiences of sexuality and identity (Bettcher, Latham). It limits trans experience to the "wrong-body" model. Trans individuals attempt to use language that will be accepted by their physicians, despite its accuracy.
- Additionally, physicians enter interactions with their trans patients with ambivalence and uncertainty. Physicians 'remedy' this discomfort by asserting their authority over the patient, via stigmatization. This furthers the structural barriers to healthcare that trans people face and is worsened when trans people of color seek healthcare.
- Solutions to provide better care to trans people and subsequently to all marginalized communities involves firstly,
  1. Revising the medical literature to expand queer and trans experiences, and *not* positioning them as 'abnormal.'
  2. Adjusting and structurally changing medical school curriculum to take an informed and active role in educating physicians on queer sexuality and identity, in addition to *not* positioning non-normative sexuality/identities as less important.

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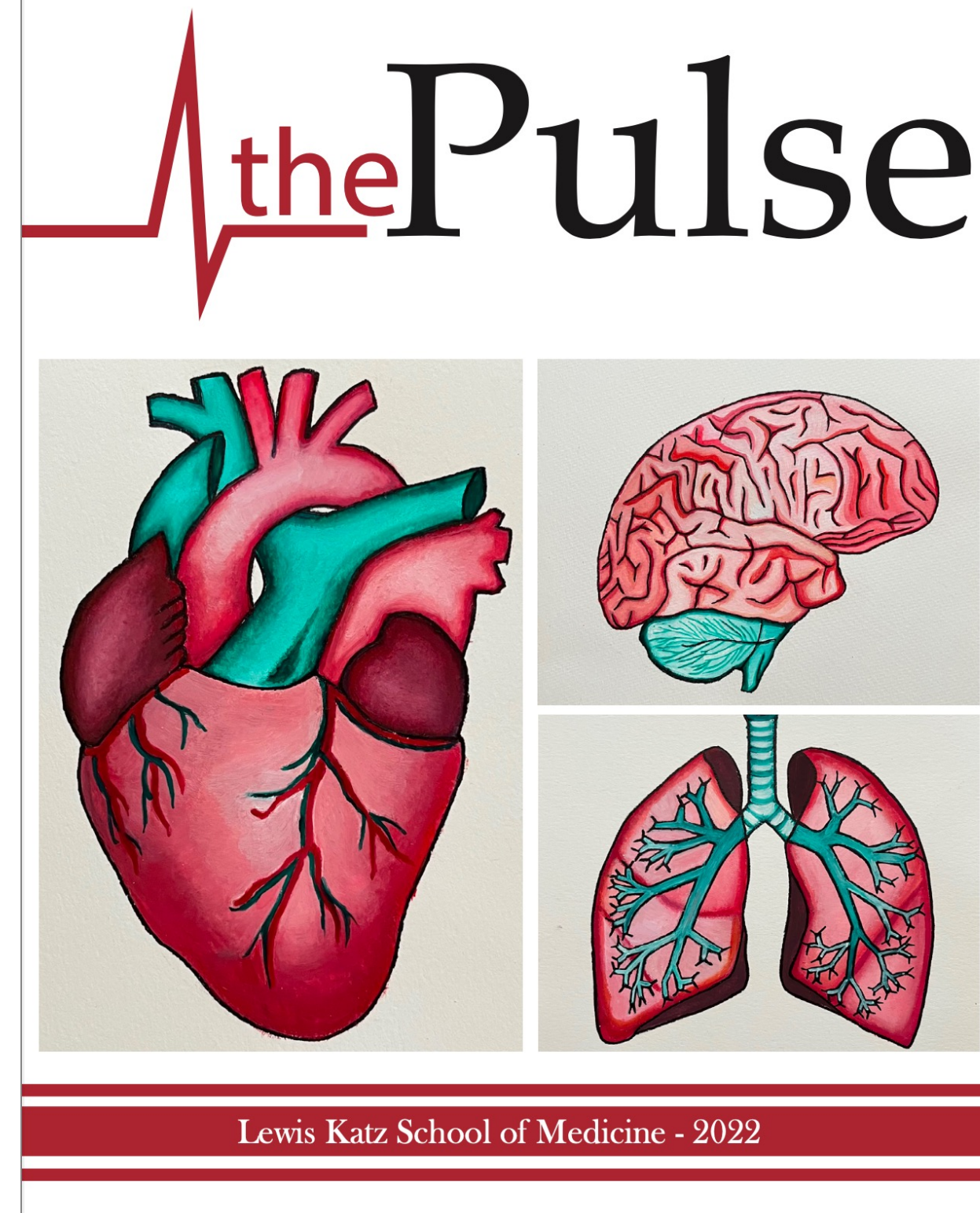


## Introduction

Medicine is rooted in science, ethics is rooted in reason- but in reality, human life is neither lawful nor orderly; rather human lives are composed of a myriad of contradictory stories that are constantly changing, interweaving and clashing with one another. The plots of life stories are not determined by logic or fact alone, but influenced by emotions, circumstances, and factors beyond human control. Physicians cannot truly treat their patients well if they are applying only general scientific knowledge to their situations, in the same way bioethicists cannot truly determine the moral choice if they are relying only on nonspecific, non-contextualized logic. Medicine and ethics must both be practiced with an understanding of the particularity and uniqueness of the person and situation at hand. And how do humans communicate and understand the particularities of their lives with each other? Through stories. The self is constructed through experience, and experience is structured narratively; therefore the identity of a person lies within the continuity of their ever-developing inner narrative. In the context of medicine and bioethics, patients' inner narrative takes the form of an illness narrative, or an account of the personal experience of illness and medical experience. Bioethics must acknowledge the role that both illness narrative and overall inner narrative play in the ethical decision making of patients and healthcare providers alike. This can be done through application of narrative medicine. Medical care and bioethics must both be practiced through a narrative lens in order to truly meet the humanity of both patients and practitioners. There are practical methods to integrate narrative skills into clinical practice, as well as tangible benefits to doing so.

## Contact

tuj22777@temple.edu



The Pulse Literary Magazine, a yearly publication of narrative works by medical students at LKSOM

each rooted in the understanding of the centrality of stories to patient's lives and illnesses. Narrative bioethics is a division of narrative ethics related to medicine. Narrative ethics is the idea that narrative is a way of ethical understanding which provides moral education, engenders empathy and moral sensitivity, extends the range of ethical experience, and allows for exploration of different approaches to dealing with a particular ethical situation. There are many practical aspects of narrative that can be applied to bioethics, such as:

- Acquiring narrative skills
- Determining how narratives are built
- Recognizing how narratives convey knowledge about the world
- Awareness of what happens when stories are shared
- Assigning meaning and organizing life through narrative

Narrative medicine a way of thinking of narratives as a critical component of healthcare. It is the art of practicing medicine with the narrative skills of recognizing, absorbing, interpreting, and being moved by patients' stories of illness. Practically for physicians and ethicists, it means informing clinical practice through the reading, writing, telling, and receiving stories. There are many aspects of narrative medicine,

## Impact of Narrative Care

There is a well-documented phenomenon of a decline in the empathy level of medical students after their first year of clinical rotations. However, with a narrative-based education, this can be combated. Narrative awareness has many benefits for practitioners, aside from helping them maintain empathy. Engendering narrative skills and engaging with stories helps practitioners become more aware of their emotions, allows them to engage more deeply in the suffering of their patients, and gives them an outlet to cope with the hardships they face through sharing stories with other practitioners.

Narrative skills also bring awareness to the power dynamics inherent to the patient-practitioner relationship and the story they are co-creating. Practitioners must recognize who is truly voicing the story- whether they are assigning credibility to the patient or another practitioner. The way in which a story is told is colored by the context it is told within, and thus settings and co-authors both determine the meaning that is taken from a singular story. In this way, a patient may not have complete control over their illness story, and it is important to recognize how a patient is characterized as their story unfolds because it has the power to impact how they are treated. Ultimately, practitioners must be cognizant of the overall impact that the story they co-create has, both on the patient and others. Hopefully, through engendering narrative care, medicine and bioethics can bridge the ever-widening gap between patients and practitioners, and ground care and moral decisions in narrative reality.

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