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A Framework for Narrative-Driven Transformative Learning in Medicine

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Like bookends, birth and death contain innumerable narratives that we come to experience, recall, and reflect on in a unique fashion throughout life. In hindsight, the bookmarks we leave behind often refer us to poignant ups and downs, many of which pertain to shifts in personal health as well as the health of those we hold dear. In this article, I will demonstrate how in medical contexts such as a terminal illness, our narratives are driven by assumptions we tend to take for granted or rarely challenge as patients. Drawing from transformative learning theory, I will suggest a framework in which medical practitioners invite narratives with the aim of helping patients identify, challenge, and in some cases transform assumptions about their health and worldviews of medicine.

Keywords: *Transformative Learning; Narrative Medicine; Clinical Dialogue; End-of-life Care*

The Little Red Riding Hood Paradox

Do you recall the cause of death for Little Red Riding Hood? For a group of more than 30 adult learning scholars at the 8th International Transformative Learning Conference, the correct response to my question came just as effortlessly as you might expect. Yet, paradoxically, even though these participants ranked their own health as more important than fairytales, few were able to remember basic information given to them during their most recent medical exam. It is my purpose in this article to suggest that narratives may be leveraged not only to enhance the capability of medical professionals to gauge meaning in patients to act more effectively on their behalf, as suggested by emerging disciplines such as narrative medicine (Charon, 2006), but also to raise critical awareness within patients regarding unhelpful or misguided interpretations of illness, a process that may ultimately foster transformative learning. Our natural affinity toward narratives suggests that each story of illness holds an untapped potential for identifying the “big bad wolves” or assumptions that

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disguise, impede, or distract patients from a critical understanding of illness. For lack of a better term, *narrative-driven transformative learning*, a framework that borrows heavily from *transformative learning theory* (Mezirow, 2000), includes a process in which narratives are welcomed or invited by a health care practitioner and collaboratively explored through dialogue that is reflective in nature to identify, challenge, and potentially transform problematic or unhelpful assumptions guiding the narrative. Application in the medical setting demands sensitive crafting and calls for a spirit of mutuality that is unencumbered by medical jargon yet duly informed by objective medical expertise.

To introduce a framework for narrative-driven transformative learning in medicine, I first address the nature of meaning making in the Western medical context, including expectations that medical practitioners and patients carry with them into the examination room. I will suggest a typology in which patients tend to view or fail to view themselves as learners in the clinical encounter. These include the *uncritical patient*, the *critical patient*, and the *critically reflective patient*. This section highlights why it is so important for patients to regain control of their own learning and decision making in the medical context. Next, I call the reader to carefully consider his or her natural connection with *stories* or *narratives*, terms used interchangeably throughout this article, to understand how individuals tend to frame meaning on regular situations and, more specifically, medical situations. In this section and throughout this article, I will incorporate ways in which narratives have been championed as meaning-making devices by preeminent adult learning scholars and introduce studies that support the notion of utilizing narratives as a lever for transformative learning. Then I will introduce how narratives may be used to reframe meaning and how this may have a particularly powerful impact on medical care. Lastly, bringing to light an unfortunate yet common scenario in which physicians bravely deliver grave prognoses to terminally ill adults, I will demonstrate the power of this emerging framework by demonstrating how narratives may be invited to address harmful assumptions and collaboratively rescripted toward a more beneficial outlook, impacting the life of the patient that remains.

The Uncritical, Critical, and Critically Reflective Patient

William James once wrote of certain individuals, "So deadly is their intellectual respectability that we can't converse about certain subjects at all, can't let our minds play over them, can't even mention them in their presence" (James, 1914, p. 37). If we recall our last medical visit, is this passage not emblematic of the modern medical relationship, between patient and physician? A picture of meaningful medical care must not only focus on improving diagnostic and technological capabilities but should also aim to invite a patient's narrative into dialogue, in line with a medical

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practitioner's objective expertise, not beneath it, to empower the patient to embrace a more robust understanding of illness. Currently, however, medical education in the United States seems to inadvertently promote an accelerated, positivist worldview by virtue of rapid advances in technology that require curricula to morph at unprecedented speeds as well as a general reluctance among students to take course electives in the humanities for fear of lowering their grade-point average. Also contributing to this myopia is a strong focus on diagnosing and treating diseases rather than preventing them. This collective context promulgates a classic stereotype for patients who, sine qua non, are wrongly expected to turn like weather vanes with the force of objective expertise. The central question to be considered throughout this article is not "Why shouldn't patients ask why?" when their physician shares their intention but rather, "How can practitioners help patients ask why?" After all, regardless of a practitioner's approach, are patients not already inherently viewing their visit through a lens that incorporates helpful or unhelpful assumptions?

Quite frequently, the stories patients become or live out in the medical context resemble the uncritical patient, the visitor who does not think to take control of his or her learning by asking critical questions or seeking second opinions but rather assumes that the physician is always right and deserving of full control, regardless of how unwarranted the advice may seem. Physicians and patients may be said to subconsciously collude on this typology. This is unfortunate for the patient because it deemphasizes the irreplaceable role of subjectivity in the clinical encounter. When a patient's story is unpacked, it could lead the diagnosis in any number of directions. A story that bends toward a discussion of comparable symptoms in a sibling, for instance, can contribute indelible knowledge toward a preventative medical strategy by uncovering potentially dormant hereditary illnesses. This is also unfortunate for the physician because this uncritical typology belies the importance of helping patients recognize problematic assumptions, such as assuming that all prescription medication eradicates the illness, rather than merely the symptoms that stem from the illness.

Health care professionals may argue that there are some domains of patient care where the patient should not be critical. Others may suggest that deeper levels of social interaction aimed at helping a patient understand and cope with illness are best located with mental health practitioners. In my judgment, these are regretfully dismissive views of the dialogic processes so essential to shaping the psychosocial space where medical professionals are obliged to help patients make sense of experience. Anxieties associated with dreaded second-opinion seekers may prompt practitioners to prematurely characterize their visitor as a critical patient. These patients may seem to ask too many questions or seem blindly dismissive of anything they do not like to hear. Yet, it seems reasonable that even the most critical of patients could stand to use a better vehicle for meaning making in the clinical encounter, one located closer to home than a sterile examination room and one that privileges active reflection over criticism. This typology also makes it increasingly difficult to guide

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these more stubborn patients toward changing their minds about eating behaviors, prescription changes, or lifestyle modifications that have an extraordinary impact on their health.

In contrast, a critically reflective patient may be thought of as an individual who assumes personal empowerment, seeks to constructively understand his or her situation, and recognizes in some fashion that this must be accomplished at the crossroads of objective intentions and subjective interpretations. In light of the broader aims of transformative learning theory expressed by Mezirow (2000), being critically reflective involves a process of gaining a deeper, more inclusive, and permeable understanding of experience. As these unchecked assumptions, lurking in illness narratives, are increasingly recognized as having a significant impact in an imperfect medical context, a call has been sounded by members of the medical community to locate creative and effective means for guiding patients through illnesses as critical transitions (Finucane, 1999) or medical nodal points (Lamont & Christakis, 2003) in their lives.

Accelerating the pace at which a medical culture in the United States shifts its expectations to critically reflective patients requires change on many levels. Although it may be plausible that I represent the patient's side of the story from an adult learning expertise, admittedly there is a limitation in my ability to speak for physicians and other medical practitioners. I encourage interested readers to refer to leaders in the medical community who have bravely challenged their own assumptions and champion the return of control to patients. Leadership of such a group, the Bravewell Collaborative, includes several pioneers in medicine, such as Kathy Foley, MD, chair of the Society of Memorial Sloan-Kettering Cancer Center in Pain Research; Ralph Snyderman, MD, chancellor emeritus, Duke University Medical Center; and Brian Berman, MD, director, Center for Integrative Medicine, University of Maryland Medical School. In their "Declaration for a New Medicine" on the Bravewell Collaborative (2008) website, these leaders publicly affirmed the following:

> We believe that the empowered patient is the responsible central actor in healing, self-care and prevention and that a person's emotions, trauma and stress levels directly affect the risk and course of disease.

Framing Meaning Through Narrative

As demonstrated in the introduction, it certainly does not take a psychologist or narrative-scholar to demonstrate the power of narratives in framing meaning in a resonant and unforgettable fashion. To understand why our conceptualizations of

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narrative and meaning have remained so similar over time, we might consider a source that is said to have one of the most powerful influences on the modern narrative. It should not come as coincidence that the words *narrative* and *meaning* are both recorded for the first time in English usage in the oral tradition of Beowulf (Barnhart, 1995). To gain an appreciation for the potential of narrative-driven transformations in the medical context, it is helpful to first consider how narrative is perhaps our most preferred method of meaning making.

The process of storying is said to be "a given in human nature" (Birren, Kenyon, Ruth, Schroots, & Svenson, 1996, p. 3). In fact, stories are an activity primordially anchored in humans, as they are suggested to be "the human equivalent of the mutual grooming that provides social bonding in ape communities" (Butler & Bentley, 1997, p. 5). Narrative is in this sense a birthright. David Lodge suggested narratives are "one of the fundamental sense making operations of the mind" (as cited in McEwan & Egan, 1995, p. viii). Use of narratives appears both in simple descriptions, such as how an apple falls from a tree, and in more complex conveyances, such as the mystery of faith. At any point on this continuum, the framework of narratives often carries significant emotional resonance for those who share them as well as for those who are witnesses. Narratives are also flexible as they may tend to past, present, or future events and can speak of or to individuals, groups, predictions, or hindsight. One thing most narratives have in common is the profound ability to assemble meaning in an emotionally charged manner. Narrative is defined in this article as a personal account or story that brings meaning to bear on a given situation. Also, this article follows a common framework suggesting that narratives should contain the following: (a) the storyteller point of view, (b) a character or set of characters, and (c) a plot or action (Ruth & Kenyon in Birren et al., 1996, p. 4).

In Learning From Our Lives, Pierre Dominicé (2000) offered a helpful overview of personal biographies, a particularly powerful narrative when it comes to framing meaning. In particular, three of Dominicé's points were helpful in guiding me to a narrative-driven framework in which medical professionals actively invite illness narratives from patients with the expressed purpose of challenging problematic assumptions that arise in the medical context. First, stories give the personal dimensions of learning a fighting chance in the clinical encounter where it has become a measurable reaction for practitioners to emotionally distance themselves (Detmar, Muller, Wever, Schornagel, & Aaronson, 2001) and describe a patient's well-being solely through objective terms. Hippocrates, who authored an oath that all physicians in the United States swear to, originally posited, "It is better to know the patient who has the disease than the disease which the patient has" (Ray, 2004, p. 30). In this sense, it is better for us to author the medical context rather than allow the medical context to author us.

Second, Dominicé (2000) suggested that stories tend to promote a restructuring effect, in which individuals may reflect on and reconsider who they are in

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relationship to their experience. In applying this suggestion to medical settings, patients may reflect and reconsider their sense of self in relation to both ailments and treatment options. Patients can essentially become witnesses of the narratives they are living out. This would prove particularly helpful in the common case of patients who undergo painful chemotherapy interventions, when there is little chance of success. Sometimes, however, especially in the case of terminal illness, it may be better to recognize the inevitability of dying and restructure our thoughts, emotions, and behaviors toward more comfortable, constructive activities, such as leave-taking and quiet contemplation. Narratives are essentially a creative resource in which terminal patients may reauthor their own endings.

Third, Dominicé (2000) suggested that those who facilitate a biographical approach to meaning making consider adopting a social contract of confidentiality and trust on personal narratives. Fittingly, such a contract already exists between physicians and patients and has become the subject of relatively new federal regulations aimed at ensuring privacy. By integrating these three suggestions, narratives may serve medical practitioners as useful vehicles through which personal meaning-making modalities can be identified and revised by the patient, including personal frames of reference, points of view, and habits of mind (Mezirow, 2000), which are explored later. Medical professionals who invite narrative can provide patients with a mechanism for structuring anxious energy and a steady platform for the subjective dimensions of learning.

Framing Meaning Through Medical Narrative

In the context of traumatic medical events, narratives are said to provide a particularly strong sense of coherence during a time when thoughts, feelings, and emotions can become wildly fragmented and seemingly incomprehensible. For example, personal meaning behind traumatic events associated with aging may be expressed largely in the narrative forms, such as metaphors, images, and life stories (Kenyon, Birren, & Schroots, as cited in Birren et al., 1996). Some literature has linked an enhanced sense of coherence with positive adaptation (Antonovsky, 1987). In this regard, a patient who has received traumatic news, such as a grave prognosis, may benefit from narrative simply as an organizer of events in world where everything seems to be falling apart. We are "authors of 'the stories we are' by virtue of our capacity for creating and discovering meaning" (Birren et al., 1996, p. 5). Conversely, once a narrative is written, I believe that patients may recognize how events are actually disorganized. Patients may also find that cause-and-effect relationships are not rationally developed but instead emotionally construed. By developing narratives on paper or out loud to medical practitioners who serve as sounding boards, patients may feel compelled to edit or revise their story in a new, more reliable fashion that

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invites the subjective and objective interpretations of medical professionals. Likewise, these narrations may serve to inform the narratives of practitioners, which in turn serve to shape health policy. In a highly personal treatise on the power of anecdote on health policy, Fitzhugh Mullan wrote, "The personal narrative is indisputably a compelling vehicle for transporting perspective and opinion about health policy issues" (Mullan, Ficklen, and Rubin, 2006, p. 7).

In my estimation, nowhere has the power of narrative been expressed more powerfully in medical education than by the field of narrative medicine (Charon, 2001), a relatively new discipline in which physicians elicit meaning from patients' unique accounts of suffering. Narrative medicine is an emerging practice that aims to improve the narratalogical competencies (Charon, 2001) that enable clinicians to elicit the patient's story, enter into meaningful dialogue, and make critical medical decisions on their behalf. Charon (2001, p. 1898) described how narrative is an inherent aspect of medicine.

> Medical practice unfolds in a series of complex narrative situations, including the situations between the physician and patient, the physician and himself or herself, the physician and colleagues, and physicians and society.

Charon (2001) developed a powerful framework in which illness narratives are elicited, absorbed, interpreted, and responded to by physicians. Although the emerging discipline of narrative medicine greatly informs our appreciation for narrative in the medical context, at this point in time important differences between narrative medicine and narrative-driven transformative learning require delineation. Differences can be understood in terms of where learning is intended to take place, the intensity of reflection, and the subject matter considered through narrative.

First, narrative medicine predominantly locates learning and subsequent behaviors, such as more meaningful diagnoses with the medical practitioner. Conversely, a narrative-driven transformative learning framework describes a process in which medical practitioners lead patients in developing their own critical view of meaning on medical events through narrative. In fact, it might be appropriate for medical professionals to develop a deeper appreciation and understanding of how narratives serve to transform their own worldviews and behaviors as patients themselves prior to leading patients through a similar process.

Second, although reflection is implied in the narrative medicine movement, it is not yet fully developed in terms of a more critically reflective framework that directly challenges assumptions. Instead, narrative medicine suggests a process of absorption in which clinicians witness and empathize with patients' medical realities. Introducing transformative learning to this equation presents a far deeper construct for critical reflection and change in the patient. In this sense, reflection is composed of more than a moment of thinking or believing we feel what another is experiencing.

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Instead, it requires what Dewey described as a more "active, persistent and careful consideration of any belief or supposed form on knowledge in light of the grounds that supports it" (Dewey, 1933, p. 6). In transformative learning theory, Mezirow provided a framework for a more critical form of reflection, through which an individual may conduct such examinations on the content, process, or premise of an event—in this case, a storied event. A narrative-driven transformative learning framework leverages personal narratives to identify how we tend to examine these areas, and search for new ways, with the assistance of physicians, for instance, to construe a more critical medical narrative.

Third, the subject matter of critical reflection in my framework extends beyond a mere description of what occurs between physician and patient toward an active attempt to challenge the environmental and sociocultural structures surrounding these actors, especially those that impede progress or growth in the name of meaning making. It is relatively difficult to understand the way a medical culture constrains our viewpoints, once we have entered it, without developing a narrative to capture and reflect on the experience. For example, it is not uncommon for terminal patients to describe how physicians fail to engage in dialogue after delivering a grave prognosis. Although narrative medicine may seek to elicit stories that describe the experience, a narrative-driven transformative learning framework actively seeks and challenges underlying assumptions. In this example, patients may pull from their narratives to begin challenging why physicians sometimes assume that death itself is an end that must be avoided at all costs. In doing so, patients may come to the conclusion that physicians' assumptions are rooted in a medical culture that is "focused almost exclusively on curing illness and prolonging life, rather than on improving the quality of life and relieving suffering" (Morrison & Meier, 2004, p. 2582). Practitioners guided by allopathic assumptions often find additional ways to avoid end-of-life discussions, such as formally handing off all emotional aspects accompanying poor prognoses to psychotherapists or informally to nurse practitioners. An enhanced understanding of this subject matter can lead us to more helpful decisions, such as avoiding chemotherapy or even seeking a second or third opinion.

Reframing Meaning Through Narrative

Studies investigating the impact of narrative devices on transformative learning yield a variety of results. A recent body of research suggests that a diverse range of complex topics, when elevated to narrative forms, including ideologies comprising culture (Pauline, 1997), factors surrounding self-efficacy (Kelly, 2007), and perspectives balancing group and individual work (Flor, 2007), may be effectively moderated through individual or group reflection.

The use of reflective journals in these qualitative studies seems to provide a safe space through which individuals may enhance or modify their view of self and their environment. Karpiak's (2003) study of 20 graduate student biographies suggests a

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particular significance in the telling of stories, in which growth and development become observable. Karpiak (2003) demonstrated how this space begins to take form through critical thinking: "The feature of critical thinking, so central to perspective transformation, begins as the individual, the subject, becomes the object of the narrative and looks at self as if at another" (p. 113). Similarly, in the *Journal of Transformative Education*, Johnson's analysis of personal biography suggests that narratives carry the power to introduce the "I" to "Myself" (Johnson, 2003, p. 243). What are found to be central to this particular process are elements of personal control, agency, and direct action. Not surprisingly, these same attributes are central to modern theories on coping (Lazurus & Folkman, 1984; Pearlin & Schooler as cited in Folkman & Moskowitz, 2004). In this sense, narrative activities also present a particularly powerful avenue for coping, which can lead to more beneficial behaviors.

Adult education research generally supports the notion that beyond an introspective activity, personal narratives also provide individuals with an effective platform for working with, enhancing, or modifying who they are (Wilson & Hayes, 2000). Through narratives, individuals are essentially free to change by creating any number of possible selves, thus restorying and transforming their lives (Randall as cited in Birren et al., 1996). However, it is critical to note that the pool of available possible selves for any given individual is said to be delimited by his or her immediate sociocultural and historical context. In terms of a medical context, these derivations can be attributed to any number of predominant models, images, and symbols assimilated from popular media and through the individual's immediate social experiences. In this case, we might consider narratives of medical experiences, particularly in Western cultures, to exist a priori, prepackaged, or prescripted by sociocultural norms, awaiting passive assimilation or critical reflection by both medical practitioners and those they care for.

Literature that speaks to the psychology of narratives largely suggests that stories not only direct self-knowledge but also specific behaviors. Narratives may point out what we have come to admire in ourselves as well as things we wish to change in a substantive fashion. In this sense, narratives present a powerful means for creating possible selves. The concept of possible selves is well anchored in the field of psychology and is generally agreed to mean how one regards alternate ways of being oneself. Narratives, in this sense, can serve individuals like flashlights revealing the hopes and fears that lie in wait behind the views they hold of themselves.

Reframing Meaning Through Medical Narrative

Integrating narratives for the purpose of encouraging critical reflection in medical dialogue is crucial for two reasons. First, voice and agency are said to be critical characteristics that foster perspective transformations (Cranton, 2006). The more learners believe they are being heard, understood, and accepted, the more likely it is they will experience some form of transformation (Anderson & Goolishian,

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1992). Second, to be critical of our own stories, we must first be able to acknowledge them as valid representations of meaning in a medical context such as terminal illness. The power of a narrative-driven pedagogy in the context of unexpected traumatic events has been studied somewhat indirectly through a transformative learning lens, as traumas seem to resemble the same types of disorienting dilemmas (Mezirow, 2000) that perspective transformations are said to stem from. This paper subscribes to Mezirow's (1991, p. 167) description of perspective transformations, where individuals realize how

> assumptions have come to constrain the way we perceive, understand, and feel about our world; changing these structures of habitual expectation to make possible a more inclusive, discriminating, and integrative perspective; and, finally, making choices or otherwise acting upon these new understandings.

It is customary for patients and medical professionals in the United States to rely hastily on advances in medical technology (Charon, 2006) rather than engage in rigorous critical reflection and dialogue about our assumptions, two activities that if enacted first may provide improved insight about our value judgments, decisions, and coping behaviors on illness and effective care. This common allopathic, jump-to-treat-patient frame of reference is especially problematic for terminal patients who are forced to confront their very own annihilation, rendering a feeling of hopelessness (Greer, 1991) and a greater likelihood of maladaptive coping behaviors.

Terminal patients present a strong contextual argument for this application by medical professionals because grave prognoses carry an impressive litany of unchecked assumptions that too often lead to destructive coping behaviors. In focus groups and interviews with hospice professionals, I have begun to address such a framework by developing a research strategy to explore how narratives are invited and reflected on between patients and nurses, with the expressed purpose of forming and potentially transforming meaning about death. In preparing this strategy, my literature review suggests that in the context of terminal illness it is not uncommon for patients to adopt problematic perspectives, such as believing that "death is for anyone but me" (Kubler-Ross, 1969) or that death is "God's way of punishing me." For many, an enhanced sense of meaning in this scenario has been demonstrated to mean the difference between adaptive behaviors, such as creating a will, and maladaptive behaviors, such as drug abuse or suicidal ideation (Merriam & Reeves, 1998; Larson & Tobin, 2000; Von Gunten, Ferris, & Emanuel, 2000; Ray, 2004).

If narrative language does in fact allow individuals, including patients, to "delve beneath the outward show of human behavior to explore the thoughts, feelings, and intentions of agents" (McEwan & Egan, 1995, p. xi), it then becomes a moral imperative for medical education to integrate narratives as a central means for helping patients make sense of diagnoses. Likewise, I believe that this narrative-driven

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transformation framework holds the key for patients who wish to become better informed consumers of health care by engaging in active reflection. To develop a framework for this process, it is helpful to observe areas where this occurs naturally. Through the familiar devices of story, nurses may be in a position to help patients such as these to critically examine unhelpful ideologies, rigid points of view, and stubborn behavioral patterns.

Several components of this particular example suggest that Mezirow's transformative learning theory is a highly suitable framework as it may be tailored by practitioners to better understand and facilitate dialogue and critical reflection toward increasingly meaningful and beneficial medical perspectives and outcomes. Stories have the potential to unearth "purposes, values, feelings, and meanings . . . we have uncritically assimilated from others" (Mezirow, 2000, p. 8), such as those represented in the culture of health care described earlier. Transformative learning theory suggests that adults can learn to think logically about such influences, free themselves from the problematic frames of reference through critical reflection and dialogue, and change their outlook and subsequent behaviors (Mezirow, 2000). In this manner, rather than jumping to prescriptions for sedation, or unnecessary and painful chemotherapy, transformative learning theory suggests that patients might first reflect and talk with others about how the common assumptions underlying health care, the power influence of medical professionals, and death-denying worldview in the United States shortcut the role of the patient and physician in incorporating their own life's experiences to construe a more meaningful plan of action—one which ultimately welcomes their fate. Instead of continuing to focus on beating the illness, the patient may edit their final chapter to include leave-taking, creating a will, or spending time at home with family and friends via hospice care.

Mezirow (2000) advised that adults deliberately learn not to take things for granted. This requires that we attend to our past experience to construe a new or revised experience that may serve as a more meaningful steward to future action. In the absence of such a process, adults passively and tacitly draw on acquired frames of reference or mindsets of assumptions that prescribe affective, behavioral, and cognitive expectations; values; moral preferences; paradigms; learning preferences; and sense of self about the experience. Frames of reference manifest and are observable in and through expressed points of view, described as "sets of immediate specific expectations, beliefs, feelings, attitudes and judgments" (Mezirow, 2000, p. 18) and stem from an individual's habit of mind. These frames of reference may become apparent as patients critically revisit personal narratives they have written or shared. Habits of mind on the other hand are said to serve individuals as "broader, more abstract, orienting, habitual ways of thinking" (Mezirow, 2000, p. 17). Meaning perspectives, such as those explored in narratives about death and dying, contain key attributes, such as (a) epistemic or what knowledge an individual has and how they

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obtained it, (b) sociolinguistic or how social norms are influential, and (c) psychological or how individuals come to view themselves (Mezirow, 2000, p. 17).

The following are examples of potentially harmful perspectives that arise frequently in the context of a grave prognosis, which may become more apparent through the personal narrative of the patient as well as the medical professional.

Example 1. Regardless of available sedation, as a terminal patient I must refuse such interference and endure the physical agonies associated with my disease—no matter how debilitating—in an attempt to resemble Christ in his suffering. This is out of my hands now, and as a result, I do not have the power or capability to learn.

Example 2. As a medical professional, death on the part of a patient constitutes failure on my part, and therefore I must treat this patient immediately and rigorously to avoid such failure even if they are predicted to have less than 0.05% chance of survival after chemotherapy.

The perspectives noted above may be observed to collude with and reinforce each other. This collusion is captured by Mezirow's (2000) incorporation of intrasubjectivity in transformative learning theory, which suggests that we often accept the interpretations of others to some degree as true or justified depending on the other's experience, intentions, and character. Harkening to the modern medical relationship, patients often assimilate what their physician says automatically because the physician is educated, experienced, and authoritative. However, Mezirow stressed that interpretations may only become more justifiable if we critically reflect on the assumptions that support these collective frames of reference surrounding the experience.

In transformative learning theory (Mezirow, 2000), it is said that adults may validate beliefs through *instrumental learning*, in which they make meaning by empirically testing and controlling their environment. For instance, a patient may determine whether chemotherapy enhances well-being through direct experience. Adults may also learn through *communicative learning*, a type of dialogue, for example, between patients and nurses to assess reasons that support problematic beliefs (i.e., death must be avoided at all costs). Consider the following call for research by Park & Blumberg (2002) as it applies to the potential of narrative in forming and transforming meaning:

> While the role of meaning-making has been examined to some degree, little is known about how, through writing or otherwise disclosing, people actually change their perceptions of events (situation meaning) or their larger systems of understanding and responding to their environment (global meaning). Assessing whether changes occur in people's appraisals and meaning structures is critical because these changes are most

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commonly invoked in theories about the mechanisms that underlie the often-noted improvements in health and physical functioning. (Park & Blumberg, 2002, p. 599)

Integrating Diverse Perspectives on Transformative Learning

Taylor (2005) argued that transformative learning is largely researched and understood through seven paradigms, of which three are particularly applicable to the theoretical development at hand. Using Taylor's analysis is a helpful way of understanding how multifaceted and considerably far reaching the concept of transformative learning is. The paradigm characterizing my argument may be thought of as a psycho-developmental approach to transformative learning in that the "view of transformation is epistemological change . . . both change in our meanings and meaning form" (Taylor, 2005, p. 460). In other words, the framework I am presenting addresses not only the changes in meaning but also how the very frames through which meaning is formed change. Second, a narrative-driven framework connects with a cultural-spiritual paradigm because it is concerned with the "connections between individuals and social structures" (Taylor, 2005, p. 461). For example, narratives may allow us to understand how nurses and patients assimilate pernicious Western worldviews on death and dying. Taylor also added that a cultural-spiritual approach contains the goal of fostering "narrative transformation—storytelling on the personal and social level . . . engaging the learner holistically . . . contextually situated, both in place and history" (Taylor, 2005, p. 461). Finally, this approach connects with what Taylor called a planetary view, which "takes in the totality of life's context" (Taylor, 2005, p. 462). Taylor stressed that what is fundamental to this paradigm, in particular, is "an emphasis on quality of life issues," which serves as a central justification for the framework described in this article.

Introducing a Narrative-Driven Transformation Framework for Terminal Patients

An emerging, narrative-driven transformative learning framework for medical contexts, which is based strongly on the theoretical propositions of transformative learning (Mezirow, 2000), comprises seven processes, including a feedback loop in the form of learning journals and communities of practice to inform future use. Described below through the context of delivering a grave prognosis, these seven steps include the following:

1. Elicit the patient's capacity and willingness for critical reflection.
2. Determine cultural parameters and make accommodations.

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3. Frame the discussion as a collaborative event.
4. Invite the illness narrative and facilitate critical reflection.
5. Guide reflection toward tentative best judgments.
6. Maintain a learning journal.
7. Incorporate and assess newfound awareness in future discussions.

Elicit the Patient's Capacity and Willingness for Critical Reflection

A patient must first demonstrate a reliable degree of physical, cognitive, and emotional capacity for reflective discourse. For instance, physicians might begin to interpret this capacity by studying the physical functioning trajectory of representative populations. With this information, practitioners can begin to determine whether patients are likely to be interrupted by physical dysfunction or dementia as to render themselves ineffective participants of reflective discourse. For instance, cancer patients tend to have more extended well-being trajectories in contrast to organ system failure or dementia (Lynn, 2001). Effective participation also requires emotional maturity, characterized by "awareness, empathy, and control" (Mezirow, 2000, p. 11), which relies on a health care professional's ability to recognize subtle cues indicating emotional preparedness. Open-mindedness is also essential for transformative learning. "Bruner defines open-mindedness as 'a willingness to construe knowledge and values from multiple perspectives without loss of commitment to one's own values'" (Mezirow, 2000, p. 13).

Determine Cultural Parameters and Make Accommodations

If a patient demonstrates both the capacity and willingness for critical reflection, a practitioner should determine appropriate cultural parameters. Cultural parameters reflect boundaries for discussion as informed by specific values shaped by a patient's culture. According to Mezirow (2000), "Cultures enable or inhibit the realization of common human interests, ways of communicating and realizing learning capabilities" (p. 7). The epistemology of pain and dignity, two central notions of meaning surrounding death, varies considerably between individuals. Every dying experience is unique and must be qualified by patients themselves (Chochinov, 2002).

Frame the Discussion as a Collaborative Event

The profound suffering that accompanies end-of-life discussions calls for a more intimate exchange, in which the medical practitioner gazes into their patient and the patient gazes into himself or herself (Magid, 2000). Practitioners should avoid complex medical jargon and introduce transformative learning as a collaborative event, honoring the subject matter expertise of both physician and patient because "solidarity, empathy, and trust are requisite to the learners' commitment to a transformative

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learning group" (Mezirow, 2000, p. 12). Although medical practitioners are trained in sophisticated knowledge regarding the science surrounding a patient's prognosis, the patient experiences with utmost accuracy a subjective understanding of death and suffering. In this context, end-of-life discussions should be initiated in the spirit of coinquiry and mutual transformation.

Invite Narrative and Facilitate Critical Reflection

As reviewed earlier, common assumptions often shape the stories that patients live out when presented with grave prognoses. To help patients break free from these uncritical narratives, practitioners must create a space for the patient to reconstruct deeper meaning of the experience. By guiding patients in externalizing their story, critical reflection may become more manageable. A method known as *self-narrative* is said to create enough psychological space for people to essentially reauthor themselves (Wilson & Hayes, 2000). By asking patients to explore how they might redraft the conclusion of their life story, including behavioral decisions, practitioners may help patients enrich the personal meaning of transition and avoid destructive coping strategies. Informing this improved storyline are perspective transformations, which may result from critical reflection. To help challenge personal assumptions about dying, physicians, nurses, and chaplains may encourage patients to pull from broader life experiences to reauthor their remaining hours, instead of the immediate, preoccupying narrative on dying. Next, the practitioner may actively infuse medical knowledge, as well as wisdom gained from experiences with other dying patients, into the patient's overarching narrative. The ideal end result of this reflective method is a conarrative that, markedly different from the patient's original account, should indicate more informed judgments about treatment options and coping strategies.

Guide Reflection Toward Tentative Best Judgments

During reflective discourse, practitioners may help patients extract a series of decisions regarding medical and spiritual care supporting their story. Here, the practitioner guides newly formed conclusions into active decision making on physical, psychological, and spiritual interventions. According to Mezirow (2000), a "mindful transformative learning experience requires that the learner make an informed and reflective decision to act on his or her reflective insight" (pp. 23-24). Once patients have adequately reflected on their situation, they may be more inclined to form judgments about treatment options and lifestyle changes.

Maintain a Learning Journal

With each grave prognosis, health care practitioners themselves should strive for a deeper understanding of how specific interactions influence the reconstruction of

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meaning and beneficial coping strategies among patients. Maintaining a learning journal will not only inform subsequent encounters with dying patients but may also be shared effectively in communities of practice within hospitals and similar institutions.

Incorporate and Assess Newfound Awareness in Future Discussions

As end-of-life discussions are a continuously emerging practice, it is essential that key takeaways from this narrative-driven approach be transferred from learning journal entries and communities of practice into a reflexive practice of facilitating meaning with patients. The critically reflective practitioner will make it a habit to carry and assess their new understanding of narrative meaning-making processes through unique dialogic encounters with patients. Here are some questions to consider:

1. Now that I have engaged in a process of understanding my patient better through personal narratives, how do I understand myself better?
2. How do these new insights serve as a set of expectations that I will bring into my next patient encounter?
3. Does it work better to guide these conversations when I have made a connection with the patient or allow it to unfold naturally?
4. In my last exchange, how was I more
    a. empathic as a result of shared narratives?
    b. aware of my own narrative in relation to the patient?
    c. expressive of my own emotions?
    d. curious about the patient's narrative?

Conclusion

Contemporary research focusing on the interplay between narrative and transformative learning indicates that personal stories can be explored to develop deeper meaning across a variety of contexts and professions. This article has established that narratives are a particularly helpful resource in medical settings, where medical practitioners tend to work on rather than with patients to address illness. In this sphere, critical reflection is often abandoned by patients who subscribe to the myth of the omniscient practitioner as well as by practitioners who subscribe to the myth of the unknowing patient. By exploring the specifically grievous medical context in which professionals discuss end-of-life issues with terminal illness, this article provides a detailed example of how narratives can be used to address particularly harmful assumptions about death and dying and can be collaboratively rewritten to provide a more lucid and comfortable outlook on the life that remains. In sum, narrative-driven transformative learning is both a dialogic progression toward deeper meaning

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and a reflexive practice in which health care professionals welcome or invite illness narratives, guide patients through a process of collaborative critical reflection on assumptions including the premise of the narrative, and arrive at a transformed way of understanding of the illness experience. This process holds the potential to produce profound shifts in meaning regarding the patient's sense of self, personal responsibility, and adaptive coping behaviors, which are otherwise driven by tacit beliefs and value judgments. By inviting a storied representation of meaning, health care professionals can begin to draw patients into a more proactive and critical mindset regarding their health and well-being.

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