Reflection, Dialogue, and the Possibilities of Space

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Abstract

To educate physicians who are capable of delivering ethical, socially responsible, patient-centered care, there have been calls for identifying curricular space for reflection on the human and societal dimensions of medicine. These appeals, however, beg the question: What does it mean to devote space in an otherwise busy curriculum for these types of reflection? This Perspective is an attempt to understand the nature of this educational space in terms of its purpose, uses, dynamics, and limitations, and the underlying components that allow reflection and transformation to occur.

Reflections on psychosocial themes often take the form of dialogues, which differ from the discussions commonly encountered in clinical settings because they require the engagement of the participants' whole selves—life experiences, backgrounds, personal values, beliefs, and perspectives—in the exchanges. Dialogues allow for the inclusion of affective and experiential dimensions in addition to intellectual/cognitive domains in learning, and for an emphasis on discovering new perspectives, insights, and questions instead of limiting participants solely to an instrumental search for solutions.

Although these reflections may vary greatly in their form and settings, the reflective space requires three qualities: safety and confidentiality, an intentional designation of a time apart from the distractions of daily life for reflection and dialogue, and an awareness of the transitional nature—the liminality—of a critically important period of professional identity development. In this open space of reflection and dialogue, one's identity as a humanistic physician takes form.

In medical education, calls for reflection on the patient's experience of illness, the nature of doctoring, the requirements of professionalism, and the psychosocial and societal dimensions of medicine are increasingly being voiced.[1–5] The rationale for these efforts is to enhance the development of physicians who are capable of practicing in a competent, professional, humanistic, and socially responsible manner. These efforts are also driven by an increasing awareness that the teaching of clinical knowledge and skills alone is necessary but not sufficient to facilitate the growth of a professional identity that embraces *phronesis* (practical wisdom), the goal of which is to act in the world for the betterment of both one's self and humankind.[6–9] Reflections on humanistic themes are often prompted by interactions with patients and their families,[10,11] one-on-one dialogues between experienced clinicians and learners,[12] small-group discussions, reflective writing,[13–17] parallel charting,[18] literature,[19–25] theater,[26–30] and the visual arts.[31–35] However, these activities—as well as the types of reflection that they hope to engender—require the creation of space during the learning process,[18] a resource that is in increasingly short supply.

What does it mean to create space in the curriculum for reflection? Does it involve the creation of a specific block of time? A location? An activity? A specific course of study? A required box to check off on a list of competencies? What is this space, and how should it be identified or designed?

The goal of this Perspective is to consider the dimensions and extent of the educational space that are necessary for deeper explorations of the human aspects of illness and doctoring; to develop an understanding of the requirements, characteristics, and components of such a space, as well as its dynamic nature and limits; and to better design an environment for reflective learning and, ultimately, for reflective practice. For this discussion, we defined reflective practice as a formalized "way of doing" that includes reflection (i.e., thinking during or after doing), critical reflection (i.e., reflection to connect individual identity and social context), and reflexivity. Here, reflexivity is meant to be a habit that comprises introspection, intersubjective reflection and collaboration, and a critical analysis of social conditions and injustice.[36,37] By its very nature, reflexivity is connected with human needs and values. On an individual basis, it involves positioning one's own values, identities, and privileges in terms of interpersonal dynamics within a distinctly social context. A conscious effort to foster all of the components of reflective practice and eventually embody them in the habits of professional behavior requires an all-encompassing view of the space in which this occurs.

Space: An Introduction

Among the numerous definitions of space given in the Merriam-Webster Dictionary,[38] several are relevant here:

- a period of time, also, its duration;
- a limited extent in one, two, or three dimensions;
- an extent set apart or available (e.g., parking space, floor space);
- the distance from other people or things that a person needs in order to

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remain comfortable (e.g., invading my personal space);

- a boundless three-dimensional extent in which objects and events occur and have relative position and direction (e.g., infinite space and time);
- a blank area separating words or lines;
- the opportunity to experience one's identity or needs freely; and
- an opportunity for privacy or time to oneself.

Envisioning space as a central concept in fostering reflective practice offers a multiplicity of options regarding the ways in which reflective practice may be implemented and incorporated into learning. When thinking about creating space to reflect on the human dimensions of illness and care, one may think in terms of time and duration (e.g., an opportunity for a quick conversation between patient appointments in a busy clinic; a formally designated time on a Friday afternoon for a seminar or discussion; or a moment to reflect with a patient, an attending physician, a mentor, or a friend). Space may also be thought of as a specific physical locale, such as a hospital or clinic in which experiences prompt reflection, or as an extent set apart for education, such as a small-group room, a lecture hall, or a dedicated building, in which students are required "to reflect" as a specific educational activity. However, if one looks upon these moments of reflection in terms of the development of professional identity and ethos, other aspects of space, including freedom, opportunity, and possibility, open up and emerge in their fundamental importance to the educational process.

It might be fruitful to also talk about this educational "space" in terms of its uses. Consideration of the human dimensions of illness and medicine and the social responsibilities of the physician concerns patients, not only as physiological entities but also as sentient, social beings-in-the-world. As has been proposed elsewhere,[6,39] topics within this sphere—such as medical ethics, humanism, professionalism, and issues of diversity and social justice—require a way of knowing the world that is fundamentally different from the instrumental, outcomes-directed knowledge that is operative in the biomedical sciences. Similarly, the product of learning in these areas is not just knowledge (i.e., facts) or skills; rather, it is the development of personal values and an orientation towards oneself, others, and the world—it is *understanding*, which may be defined as a deep and abiding engagement with the human aspects of illness and medical care.[6]

The discussion above suggests that the form that these conversations and the associated activities in writing, reading, and the arts take is essentially different from other types of discussions found in medical education, such as case presentations, ward rounds, considerations of pathophysiology, differential diagnoses, or the treatment of specific disorders, debates over evidence for and against approaches in management, or conferences on morbidity and mortality. The conversations about the human or social aspects of illness and clinical practice take the form of *dialogues* between interlocutors who may come from very different backgrounds and may have very different worldviews, social identities, life experiences, and values. Herein, the term *dialogue* is not synonymous with discussion but is used in a very specific pedagogical and interactional context (see Table 1).

Discussions and Dialogues

Unlike a dialogue, a discussion is driven by practical, goal-oriented concerns, with an emphasis on the "objective" consideration and instrumental use of evidence. Participants are expected to use their content expertise to persuade others of their views. In this setting, authority matters, and the discussion has a goal of finding a solution to a specific problem. In contrast, a dialogue taps into each individual's affective, experiential, and identity reserves in an exploration of the thoughts, feelings, and lived experiences of the participants. The intention of this dialogue is the very act of exploration itself, as well as the discovery of new ways of seeing and understanding oneself, others, and the world.

As an example, consider two related situations. First, a medical team evaluates a 62-year-old woman with abdominal pain and jaundice and discusses a differential diagnosis and management plan. Second, the workup culminates in the same team breaking the news to her that she has inoperable, metastatic pancreatic cancer. In the former situation, the generation of a differential diagnosis and therapeutic approach involves a discussion in which clinical reason is operative; professional experience, knowledge, and authority predominate; and members of the team—while carefully deferential to authority—may attempt to persuade others of their views. All of these efforts have the primary goal of arriving at a clinical decision ("what to do") and the secondary goal of teaching learners "how things are done."

In contrast, breaking the life-changing news prompts reflection and dialogue that consists of much more than an abstract discussion. The focus shifts from the strictly clinical to the profoundly human, and there is a point at which individuals "step into" an attitude of reflection and introspection. Here, the questions of life, death,

Table 1
A Comparison of the Characteristics of Discussions and Dialogues

Characteristic	Discussions	Dialogues
Approach	Chiefly cognitive	Cognitive, affective, experiential
Intent	To introduce and defend one's opinions	To explore thoughts, perspectives, feelings
Emphasis on	Objectivity	Subjectivity and intersubjective interactions and relationships
Authority	Preserved	Shared or suspended
Method	Persuasive and instrumental—to convince others of one's views	Exploratory—to illuminate different perspectives, experiences
Requirements for interlocutors	Technical, scientific background and knowledge	One's whole self—values, worldviews, life experiences
Goal	To arrive at a solution, a consensus	To generate new questions, possibilities

suffering, and care are explored. Furthermore, if the conversation is approached with authenticity and awareness of the human meanings of the situation at hand, the members of the team as well as the patient and her family engaging in dialogue may bring previous life experiences, personal values and worldviews, thoughts, and feelings into their considerations of what it means to give and receive such news. Although never completely absent, authority in this situation may be suspended or shared: It is the authority of ownership of past experience, of feeling—the authority of the subjective I ("this happened [or is happening] to *me*," "*I* feel this way about what has happened").[17] The resultant conversation—at least under ideal circumstances—may generate new insights, perspectives, and questions and may facilitate an opportunity for transformation: a chance to bear witness to moments of tragedy, mystery, richness, and wonder in which people, including the patient and her family, the learners, and the attending physician, may all change.[39] The lessons from these experiences and dialogues have the potential to "go deep" within the self—to become internalized and, as described by Polanyi,[40] "to dwell within" us—in our tacit knowledge of ourselves, each other, and the world.[6]

So how does one describe the interactions that take place during this type of dialogue? In exploring matters involving the human condition, each interlocutor may engage his or herself in its totality in this interaction. In other words, each brings forth a unique perspective with which he or she organizes the world into something that is comprehensible. The French sociologist Pierre Bourdieu[41] called this disposition *habitus*. According to Bourdieu, habitus connotes cognitive and behavioral schemata shaped by past experiences and social and economic identities, which in turn structure an individual's perceptions and actions in the world.[41] Habitus is flexible and mutable; it is an enduring and unconscious expression of objective differences, such as class, privilege, and power, in subjective ways of seeing and acting in the world. A dialogue may call forth deeply held beliefs, memories, and values of participants in ways that may clash with each other; this resistance may afford an opportunity for each to critically reexamine his or her own perspectives and actions and lead to new ways of seeing and knowing.

Essential Characteristics of Reflective Space

As we have implied above, reflective space is characterized by its *fluidity*: Opportunities and circumstances to create moments of reflection vary tremendously, and therefore reflective space cannot be defined by a specific locale, activity (course, program, workshop), or setting (ward rounds, clinic appointment, operating room). Instead, it must be defined by the nature of the interactions that take place when individuals are engaging in reflection and dialogue about the human dimensions of medicine. Therefore, to look at space in another way, one must consider what characteristics are necessary to optimize these interactions. In this context, three requirements can be identified: a need for safety, a sense of separateness, and an awareness of transition. First, a sense of safety and confidentiality is paramount. Differences in power and privilege—brought into these dialogues from social circumstances steeped in disparities of both power and privilege—must be acknowledged and balanced as much as possible to allow all participants to engage in open discourse.

Second, there must be intent to create such space, even if the opportunity is transient. That is, the interlocutors by agreement must remove themselves from the distractions and exigencies of daily life—if only for a considered moment of reflection. Although the settings may vary greatly from small-group discussion rooms, staff rooms in clinics, and private moments in a corner of a hospital ward, intentionality defines the framework of this space. It sets it apart and designates the space—as well as the time involved—as devoted to reflection and dialogue. "Why," one asks, "must there be a deliberate separation for this type of reflection from other aspects of clinical thought and care?" Unless reflective dialogues on the human aspects of illness and medical care are intentionally given space to happen, discussions involving the biomedical aspects of clinical care and the "technical rationality"[42] that drives them will predominate the exchanges and silence other forms of thought and exploration. In this sense, this separation is related to the conscious decision to act mindfully[43] rather than a physical separation per se. It is a deliberate act to psychologically separate oneself from the chaotic flow of life to "step into" an attitude of reflection. We do not mean to say that these activities are "extra" or should be seen as "add-ons" to one's usual activities; on the contrary, they represent an essential element in the development of the professional self.

The epitome of "stepping into" a space of reflection and mindfulness can be found in *cha-no-yu*, the traditional Japanese tea ceremony. Although the tea ceremony has its antecedents in China, it began to flourish in the 15th century under the great Zen abbot Ikkyu (1394–1481) and later achieved a unique Japanese character through the teaching of the tea master Sen no Rikyu (1522–1591).[44] The tea room in which the art of tea is practiced is classically a tiny, hatched roof hut measuring 10 feet by 10 feet. The guest entrance, while elevated off the ground, is only three feet tall, which requires anyone attending the ceremony—from the Shogun himself to the lowliest vassal—to leave ostentation, literally, at the door and humbly crawl into the space. During the highly ritualized ceremony, the tea master whisks the tea in especially dedicated tea bowls that are works of art in themselves. The tea—frothy, warm, and bright green in color—is slightly bitter in taste and has an earthiness in the aroma that emanates from the bowl. After drinking the tea in three or four stylized sips and rotating the bowl in a prescribed manner (depending on the school of tea one follows), one sits in quiet contemplation of the artistry of the bowl, the pattern of tea that remains in the bottom of the bowl, the play of light across the *tatami* mats that cover the floor, the scent of the incense, and the chirp of the cicadas that comes through the open window. The atmosphere is redolent of *wabi*, a sense of rustic simplicity, and *sabi*, a deep, rich beauty that comes with asymmetry, imperfection, and age.[44] The design of the tea room, the rituals of the ceremony, and the aesthetics of the surroundings all serve to isolate this moment, this experience—the world of tea—from the outside world and to cultivate the Zen *mushin no shin* ("no mind" or "empty mind"), a state of being fully present and not preoccupied by extraneous thoughts or distractions. The tea ceremony is the

embodiment of the type of pause for reflection that is so critical in all types of mindful practice; however, this does not mean that something so elaborate should be done in daily practice. In fact, undertaking such reflection in isolation runs the risk of marginalizing it rather than making it an essential part of daily life. The point here is that dedicated, intentional pauses in daily activities must be created to fully develop a reflective, mindful aspect of clinical practice. The challenge remains, then, to weave an appreciation of the sense of tragedy and wonder so often witnessed in medicine into daily thoughts and conversations.

The third quality that characterizes this space for reflection is an awareness of its transitory nature—that is, its liminality. The concept of liminality was originally introduced by the French anthropologist Arnold van Gennep,[45] who proposed that all societies have "rites of passage" that characterize major life events (i.e., childbirth, adolescence, adulthood, marriage, and death). These rites are ritual embodiments of transition—of what van Gennep called "*périodes liminaires*" or "*stages de marge*"[45]—in which an individual goes from what she was to what she is to be. The life of an individual in any society is a series of passages from one age to another and from one occupation to another. Wherever there are fine distinctions among age or occupational groups, progression from one group to the next is accompanied by special acts, like those which make up apprenticeship in our trades.[45]

Van Gennep[45] describes each rite as having three stages: a preliminal stage involving separation of the individual from his or her former life and self-identity; a liminal stage ("*stage de marge*") in which the transition itself occurs; and the postliminal stage in which the individual is incorporated into the new group. At each stage, there is a conscious awareness of the transitory (or liminal) nature of the process, which separates one's previous self (the "profane") from one's new sense of self (the "sacred").

Considered in this context, the process of medical education and postgraduate training has commonly been seen as one of the most transformative periods in the lives of those choosing this path. Each stage—the preclinical years, clinical clerkships, graduation, internship, and residency—is in essence a period of transition, of becoming someone new. As Wald and colleagues[15] point out, reflective activities, including writing and feedback, assist medical students during their rites of passage in the development of reflective capacity and professional identity. To extend this argument, one might say that these moments of reflection—these dialogues in the broadest sense—represent the rites of passage whose cumulative effect mark these periods of transition: Ideally, they represent activities of deliberate educational intent that employ the qualities of dialogue (i.e., exploration, engagement of one's whole self, openness to new perspectives and insights) and a conscious awareness of liminality to assist learners and teachers to incorporate new experiences into a continuously developing sense of self. Two points are worth emphasizing here. First, although the process of medical education involves major formal transitions (preclinical student to clinical clerk, medical student to resident, resident to attending physician), each stage contains innumerable transformative events or periods in which individuals and their perspectives may change in fundamental ways. Second, this transformation does not end with the end of formal training. Illumination in this context does not imply permanent enlightenment. Indeed, this type of teaching and learning embodies the notion that individuals—learners and teachers alike—are capable of change. Each moment and each stage represents an open space in which learners and teachers may explore a wide array of possibilities of being-in-the-world: ways in which reflective practice with humanistic intent may cultivate clinical excellence and patient-centered care.[39] In this sense, this vision of medical education finds resonance in Pinar's[46] phenomenological view of the curriculum as a lived text: Education is not only a matter of what is learned and what skills are acquired but is also a process of lived experience that fosters the development of a professional self and orientation to the world.

Conclusion: Space and Place

The geographer Yi-Fu Tuan[47] makes a distinction between space, which in Western cultures represents freedom, and place, which represents familiarity and safety:

> Space is a common symbol of freedom in the Western world. Space lies open; it suggests the future and invites action. On the negative side, space and freedom are a threat.… To be open and free is to be exposed and vulnerable. Open space has no trodden paths and signposts. It has no fixed pattern of established human meaning; it is like a blank sheet on which meaning may be imposed. Enclosed and humanized space is place. Compared to space, place is a calm center of established values.

These comments echo those of the philosopher Gaston Bachelard,[48] who noted in the *Poetics of Space* that the sense of home, invested with personal experience and significance, transforms space into something more than a simple location: "In this dynamic rivalry between house and universe, we are far removed from any reference to simple geometrical forms. A house that is experienced is not an inert box. Inhabited space transcends geometrical space."

By designating space for reflection and dialogue on life, suffering, death, and dying, as well as the human meanings of providing care and comfort to those afflicted, one transforms curricular space into a learning place that is invested with feeling and experience. As with knowledge that "goes deep," this learning place is "a special kind of object. It is the concretion of value, though not a valued thing that can be handled or carried about easily; it is an object in which one can dwell."[47]

However, there is not a complete transformation from space to place: Ideally, this locale retains both the safety and security, as well as the emotional "indwelling," of place and the freedom and possibilities of being and becoming of space. As Tuan[47] remarks in a broader context: "Human beings require both space and place. Human lives are a dialectical movement between shelter and venture, attachment and freedom."

To return to the question we posed earlier: What is this space for reflection, and how should it be designed? From this discussion, one can surmise that there is no single answer. Moments of learning about the human side of medicine may occur in a variety of settings ("places"), in a multitude of situations, dealing with a plethora of conditions—all of them human. In fact, there are so many

potential opportunities that additional or separate "space" for reflective dialogue may not necessarily need to be created at all; instead, it may be identified and intentionally designated as such as part of the usual clinical activities. Under all of these circumstances, however, the space is defined not by physical locale, time spent, or even physical isolation from other activities. Instead, it is defined by the intention to designate this time, this place, this conversation as one that involves reflection and dialogue about the human elements of medicine and medical care. And yet, there is another challenge: How does one learn the human—perhaps even lyrical—language and vocabulary through which an understanding of these "*périodes liminaires*"[45]—these "moments of being"[49]—may be expressed? Through explorations of the self and the other via literature, writing,[14,50] theater,[27] and art[31]—those activities that allow for an understanding of the mysteries of being and becoming.

Safety, intentionality, and awareness of transition, these are the essential qualities—the dimensions—of the educational space in which the human aspects of illness and medical care may be fully explored. Through the creation of a place of safety and support, through deliberate moments of reflection and dialogue illuminated against the chaotic flow of daily life, insights and feelings, as well as individual and human life, are validated and affirmed, and interlocutors step into an open space[39,51] in which a humanistic professional identity may be forged.

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