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Permalink

<https://escholarship.org/uc/item/3vs6z6pn>

Journal

Literature and Medicine, 30(1)

ISSN

0278-9671

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Publication Date

2012-03-01

DOI

10.1353/lm.2012.0015

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Minding the Gap(s): Narrativity and Liminality in Medical Student Writing

Therese Jones, Felicia Cohn, and Johanna Shapiro

“. . . ordeals, myths, maskings, the presentation of icons to novices, secret languages, food and behavioural taboos create a weird domain in the seclusion camp . . . and the novices are induced to think, and think hard, about cultural experiences they had taken for granted.”

Victor Turner, *From Ritual to Theatre:
The Human Seriousness of Play*¹

“I’m Nobody! Who are you?
Are you—Nobody—Too?”

Emily Dickinson, #288²

With the publication of *The Wounded Storyteller*, sociologist Arthur Frank made a major contribution to conceptualizing and classifying patient pathographies or stories of illness. The categories of illness narratives that he identified—restitution, chaos, quest, testimony³— are now widely applied as interpretive frameworks for the patient experience of illness.^{4,5,6,7} Elsewhere Cohn and Shapiro, et al., argue that, at the deepest level, Frank’s categories are relevant to the human condition, to those narratives that emerge from suffering, powerlessness, and loss of control.⁸ Because medical students experience traumatic and transformative events in the course of their training, the stories they construct can also be understood and organized through similar conceptual categories.⁹

With this insight in mind, we drew on and expanded Frank’s narrative framework for a study of values conflicts experienced by third-year medical students during their obstetrics and gynecology clerkships. With approval from our institutional review board, two hundred ninety-nine student reflective assignments were collected between

July 2002 and January 2006 and subsequently de-identified, coded for themes, and analyzed to determine how students responded to the conflicts they described, the values guiding those responses, and what they learned from those conflict experiences that could be applied to future patient encounters. To record our general impressions, we also assigned narrative categories to the stories described in the papers, which are briefly elaborated below.

No Conflict/No Problem Narratives. In these essays, students literally wrote: "I did not experience any ethical conflicts on this clerkship." Their reasons include not having seen enough patients, believing themselves too inexperienced to recognize such conflicts, or feeling that they are simply too "tolerant" of others' viewpoints to experience them. These essays represent a pre-reflective stage of thinking in which students did not isolate perplexing problems because they did not recognize moral conflicts.¹⁰ In our sample, this category represents only two percent of total responses.

Chaos Narratives. In Frank's terminology, chaos narratives are pre-narratives (story attempts that exist prior to the possibility of narrative coherence) or anti-narratives (utterances that are in actual opposition to standard conventions such as chronology or plot).¹¹ They are characterized by a pile-up of calamities which overwhelm the narrator, who describes the experience as isolating and alienating. Because of the lack of control, confusion, and brokenness of chaos narratives, they frighten both narrator and listener. In response to an ethical dilemma, the chaos narrative is one in which the conflict seems unresolvable to the student who is demoralized, disoriented, and ambivalent. These stories also reflect a student's moral distress in that s/he knows the morally correct response to a situation but cannot act because of institutional or hierarchical constraints.¹² Essays of this nature were also a small number, just seven percent, of our sample.

Restitution Narratives. The prevalent characteristic of the restitution narrative is its find-it and fix-it approach to a problem by first acknowledging it and then moving quickly to re-establish pre-disturbance equilibrium. The narrator is restored to his or her pre-conflict state, and life continues on as before. In response to an ethical dilemma, a restitution story is one in which the student identifies a problem but resolves it promptly, usually by invoking a simple, overriding principle such as patient autonomy. This category is rule-based with

an open-shut, problem-solution tone, characterized by the absence of “wrestling” with the dilemma. In a restitution narrative, the narrator attempts to reclaim a stable self, often at the expense of personal values. The highest priority is not personal integrity but reduction of the anxiety caused by emotional disequilibrium, often effected through identification with the desired, powerful other (physician) and concomitant rejection of the powerless, vulnerable other (patient). Restitution stories are usually empowering to the teller but often at the expense of values such as empathy and altruism. The greatest percentage of stories in our sample—thirty-eight percent—are restitution narratives.

Journey (Quest) Narratives. Detailed most notably by Joseph Campbell, the typical journey narrative includes the following elements:¹³ (1) The reluctant hero receives a call to step outside of normal life to undertake a difficult and dangerous mission; (2) Along the way, the hero encounters terrible trials and overwhelming challenges; (3) As a result of these tests and tribulations, the hero endures much suffering; and (4) At last, the hero accomplishes the mission, returning to use the acquired knowledge to help others. The journey narrative is uplifting, emphasizing the acquisition of wisdom and redemption through suffering. As Frank writes, it is an inspirational but also overly romanticized trope which can convey the Panglossian message that everything is, eventually, all for the best. In the journey response to an ethical dilemma, the student overcomes “barriers and difficulties” presented either by the conflict itself or by others’ reactions to it and gains insights that can be applied in future patient care situations. At the end of the encounter, the student triumphs by helping the patient and doing right. Although the student struggles, s/he invariably learns valuable lessons. Journey narratives comprised sixteen percent of the total essays.

Compromise Narratives. The general characteristics of this narrative include making some sort of troubling concession and having the sense of participating in something derogatory or shameful. Students in these narratives learn to avoid trouble but at the expense of the virtues of professionalism.¹⁴ Compromise in response to an ethical dilemma occurs when the student, adhering to the perceived values of the medical profession, feels s/he is compromising core personal values either because of expediency, intimidation, self-protection, or lack of confidence. This is a disempowering narrative expressing shame and guilt. It comprises sixteen percent of the total number of essays.

Witnessing (Testimony) Narratives. In general, the witnessing narrative offers testimony to difficult truths neither generally recognized nor explicitly acknowledged. In doing so, it challenges conventional wisdom and expresses a commitment to stand with the suffering other.¹⁵ When writing a witnessing narrative in response to an ethical dilemma, the student not only acknowledges the complexity of the moral issue but also demonstrates empathy for the vulnerable patient. This category is similar to a “chaos” story in that the student recognizes that there is no immediately apparent and expedient solution to the ethical problem but different in that, rather than feeling panic and helplessness, the student stays committed to the patient instead of focusing on his or her own confusion. Thirteen percent of our sample comprises witnessing narratives.

Resistance Narratives. The general characteristic of this narrative is the enactment of opposition to counteract, withstand, or defeat a perceived enemy. In response to an ethical dilemma, a resistance narrative features the student who steadfastly maintains his or her personal values regardless of professional ethics, norms, or pressures. In contrast to a witnessing narrative, the resistance narrative turns on the active protest of the student who consciously chooses to act or not to act because the action would violate personal values. These narratives exemplify what Foucault referred to as “parrhesia” or fearless speaking, the courage to speak under fearful circumstances, to critique powerful institutions or individuals.¹⁶ Resistance narratives are represented in only nine percent of the essays.

As instructive and useful as Frank’s typologies have been in identifying common narrative patterns in this large sample of student writings, another illuminating interpretive strategy has emerged—the narrator’s representation of his or her liminal status. After sharing a subset of essays with a literature scholar (Therese Jones), we realized how the “betwixt and between” position of these student narrators was woven throughout the various typologies we explored in the sample.¹⁷ Thus, while the structure of the story itself might be dramatically different, signifying it as a chaos or journey or witnessing narrative, the ambiguous and fluid position of the student storyteller is remarkably consistent.

In the remainder of this paper, we will first analyze an example of the most commonly represented typology in the sample—the restitution narrative—to foreground the liminal perspective of the student

narrator. Next, we will discuss liminality as it is enacted in human rites of passage, experienced by third-year medical students, and expressed generally in illness narratives. Finally, we will consider the other narrative typologies that students employ to illustrate the displacement, dissociation, and disappearance so commonly associated with liminality.

Case Story: Restitution Narrative and Liminal Narrator

One day, I was walking by a unit where I saw a newborn baby lying peacefully in a little crib. As with many other times in my life, I could not resist . . . saying “hello” to this wonderful little person. I approached the crib and extended my arms At the same time, I heard a loud scream, as an Ob/Gyn resident yelled . . . something about abduction, lawsuits, and incompetence. I grew up in a family of doctors [in central Russia], and my parents always told me that contact and compassion are just as important in patient care as medication and procedures. As future physicians, we have to learn what is appropriate behavior and what is not In this country . . . hospital child abductions occur quite frequently . . . often by a perpetrator dressed in a white coat. From now on, I will be very careful about my . . . conduct . . . and about the consequences of my actions.¹⁸

Telling a restitution narrative in the guise of a fable, this third-year medical student begins with the conventional opening of the genre, a bracketed moment in ordinary time—“One day, I was walking by a unit”—proceeds to the conventional discovery of an extraordinary creature—“a wonderful little person lying peacefully in a crib”—and concludes with the conventional ending of a pointed moral—“From now on, I will be very careful about my conduct.” There’s even a kind of troll lying in wait, a hopping mad resident, in the middle of the tale.

However, in spite of its highly stylized structure, the narrative is fraught with contradiction and filled with conflict: between natural human responses and arbitrary professional codes, between emotional connectedness and cultural transgression, between doctoring as intimate and medicine as distant, between the white coat as symbol of good and disguise for evil. The moral of the story might be plainly didactic, but it is also deeply ironic: in the future, this student will refrain from being nurturing and caring, as those impulses are not only deemed inappropriate but can also be interpreted as criminal.

The restitution story itself is an attempt to resolve the ambiguity and confusion that is characteristic of the liminal state. Through a dissociative splitting, the student rejects her actual status and identifies with the powerful other she hopes to become, thus engaging in a kind of re-storying of the incident.¹⁹ Because of its reassuring nature, this type of story is highly desirable for both narrator and listener. However, comfort and resolution come at significant cost to the moral integrity of the narrator, who must not only minimize the suffering of other liminals (patients) but even abandon them in favor of higher status and greater efficiency. In this example, the student's choice of the fabular form is an attempt to shoe-horn the dilemma into a tidy, compact structure often used to socialize its listeners to proper roles and behaviors. As with other restitution stories in our sample, the problem is clear: the medical student is moved to pick up the "wonderful little person," but the impulse violates hospital norms, as conveyed by the irate resident. The student quickly attempts to reduce the anxiety engendered by the resident's intervention by seeking resolution—the "moral" of the story.

In this case, the overriding principle is conformity to the "rule" of protection against infant abduction. In the interests of restoring emotional equilibrium and being perceived as rule-abiding by authority figures such as the resident, the student is willing to sacrifice inculcated family values such as "contact and compassion." However, in making this choice, the student identifies with institutional power at the expense of personal integrity, abandoning both her own liminal self and the liminal other (the suffering child). In an attempt to repudiate the non-status and assuage the discomfiture of her liminality, she must sacrifice her own sense of what is right.

Welcome to the betwixt and between state of liminals whose condition is one of ambiguity and paradox, whose language is one of gaps and gaffes.

Describing, Subscribing, and Inscribing Liminality

Liminal and liminality (derived from the Latin, *limen*, meaning "threshold") were introduced to anthropology in 1909 by Arnold Van Gennep in his work on the rites of passage which accompany every change of place, state, position, and age, and which are marked by three phases:

- separation: an initiate is first stripped of status and then detached from an earlier fixed point in the social structure.
- limen: a passenger is inducted into an ambiguous period of transition.
- aggregation: a subject is given a new status upon reassimilation into society and expected to behave in accordance with certain customary norms and ethical standards binding on incumbents in a system of such positions.²⁰

In the second half of the 20th century, Victor Turner borrowed and expanded Van Gennep's concept of liminality, thereby ensuring widespread use of it in anthropology and other fields such as performance studies. Turner initially formulates the theory in a chapter, "Betwixt and Between: The Liminal Period in *Rites de Passage*," from *The Forest of Symbols*. There he defines states as "relatively fixed or stable conditions which include such social constancies as legal status, profession, office, rank or degree" and characterizes the transitions between them as "a process, a becoming, [and] a transformation."²¹ Three years later, he elaborates the "being and nothingness" of liminal *personae* (whom he eventually designates as "threshold people") in *The Ritual Process: Structure and Anti-Structure*.²² The subjects of the passage ritual are, in the liminal period, structurally invisible though physically visible, detected in what Turner describes as a somewhat "complex and bizarre" symbolism that is attached to them, giving an outward and visible form to an inward and conceptual process.²³

For example, neophytes are defined by labels or names employed to all those undergoing initiation into a different state of life. In the realm of medical education, the designation of "student-doctor" symbolizes being at once no longer classified as one thing (student) and being not yet classified as another thing (doctor). This rhetorical coupling not only signifies the essential ambiguousness of the position, neither one thing nor the other, but also the desired endpoint of the transformation, from one thing to another. In an analysis of medical student stories, Charles Anderson identifies the maintenance and creation of identity as one of four major narrative patterns and elucidates the tension between students' resistance to the loss of personal identity and their longing for appropriation by the medical profession.²⁴ The results of this slippage back and forth are complex and contradictory narratives in which students inscribe medical hierarchy as "simultaneously hateful and desirable."²⁵

One section of a recent collection of personal testimonies, *What I Learned in Medical School*, is organized around the theme of “shifting identities” with an emphasis on the need for the student to “somehow reconcile his or her previous identity with a new professional medical identity that has been imposed over all others.”²⁶ It is worth noting that this new identity has not only been *imposed*, signifying medical students’ common representation of themselves in this process as “disempowered victims”²⁷ but also that it is *superimposed*, covering over or obliterating what students represent as a past and essential self. In the aptly titled, “Medical School Metamorphosis,” one contributor to the book describes the suddenness and completeness of separation from a familiar social reality and her various roles within it to another space where she now resides: “One day I was an average twenty-three-year-old married woman from a small Texas town, the next I was a ‘Medical Student.’”²⁸ The dissolution and dislocation are so profound that she can “no longer carry on a normal conversation with people outside”²⁹ of what Turner terms the “seclusion site” where liminals are removed and concealed.³⁰

Neophytes such as the student above are not only set apart from others, “commonly secluded, partially or completely, from the realm of culturally defined and ordered states and statuses,” but they are also indistinguishable from one another, having “no status, insignia, secular clothing, rank, kinship position, nothing to demarcate themselves from their fellows.”³¹ And, while neophytes find themselves in a social structure of a highly specific type—a hierarchy—they themselves form a community. Within this social structure, there exists a set of relations of a very simple kind: between instructor and neophyte, there is complete authority and complete obedience to that authority; between neophyte and neophyte, there is complete equality.³² The passivity and malleability of neophytes, constantly reinforced through ordeals and consistently reified by invisibility, are themselves the externalization of the process whereby “the neophytes are being ground down to be fashioned anew and endowed with additional powers to cope with their new station in life.”³³ The most significant characteristics of this grinding down are submissiveness and silence. Yet, among neophytes themselves, there develops an intense comradeship and egalitarianism: “Secular distinctions of rank and status disappear or are homogenized.”³⁴

Finally, Turner is emphatic that liminality be understood as transformation—a change in being rather than a mere acquisition of knowledge: “During the liminal period, neophytes are alternately forced and encouraged to think about their society, their cosmos, and the

powers that generate and sustain them. [They] must be a *tabula rasa*, a blank slate on which is inscribed the knowledge and wisdom of the group."³⁵ Knowledge and wisdom in this context are not simply an aggregation of words and sentences but have ontological value: they refashion the very being of the neophyte.

Following from both the theories and practices of Levi-Strauss, Turner expresses the difference between the properties of liminality and the properties of the status system with binary oppositions.³⁶ The following is a selection from Turner's exhaustive list of the pairings most typical of the third-year:

- transition/state
- homogeneity/heterogeneity
- *communitas*/structure
- equality/inequality
- anonymity/systems of nomenclature
- absence of status/status
- uniform clothing/distinctions of clothing
- absence of rank/distinctions of rank
- humility/pride of position
- silence/speech
- acceptance of pain and suffering/avoidance of pain and suffering
- dependency/autonomy

In the section of her memoir, *Final Exam*, devoted to the clerkship year, Pauline Chen writes of the requirement and necessity for medical students to "reconcile incompatible ideals or 'counterattitudes'—values as diametrically opposed as detachment and concern, certainty and uncertainty, humanism and technology."³⁷ She aptly compares the process of students wildly vacillating between each of those extremes or, in relation to Turner, determinedly moving from one side of a dichotomy to another, as "adolescents searching for a sense of identity." Of course, the most common subjects of passage rituals are adolescents who, as liminals, not only display the physical qualities of both childhood and adulthood but also reside somewhere between dependence and autonomy, and in her own early experiences on the wards, the slightly built Chen describes feeling more like an awkward and susceptible "pediatric patient than a competent and immune doctor," more like a child than an adult.³⁸

While the authors of the 1961 sociological and interactionist account, *Boys in White: Student Culture in Medical Education*, could not

reference Turner's conceptualization and elaboration of liminality, which would appear a few years later, their book can be read as a vivid and remarkable illustration of it. From its outset, the authors approach the process of medical education and clinical training as a rite of passage, also framing it as sexual and social maturation—a "sort of adolescence": "In this book, we shall talk mainly of boys becoming medical men."³⁹ Moreover, they employ the most recognizable elements of a traditional threshold stage, exploiting that imagery to describe the process of medical education: "In our society, among the most desired and admired statuses is to be a member of a profession . . . attained not by going into the woods for intense, but brief, ordeals of initiation into adult mysteries, but by a long course of professional instruction and supervised practice. But science and skill do not make a physician; one must be initiated; to be accepted, one must learn to play the part. . . ."⁴⁰ And they telegraph the distinction between the external acquisition of knowledge and internal transformation of self: "The student is someone who is learning to be but is not yet a doctor. He cannot become a doctor without completing his training . . ." or his transition.⁴¹

However, it is in their account of the clerkship experience itself that many of the specific characteristics of liminals elucidated by Turner emerge, such as change in fixed status and loss of prior identity: "The student has no legitimate grounds for expressing discontent with his situation, since that situation is defined by men more experienced and more capable of exercising responsibility than he. This stands in marked contrast to his position as an academic student, where he is defined as an independent thinking being to whom propositions must be demonstrated logically and empirically before he need accept them."⁴² Turner's concepts also enrich the authors' description of the paradoxical existence in which third-year students simultaneously negotiate a hierarchical system that demands subordination and an egalitarian community that facilitates cooperation. For instance, the authors report that: "Fully three-fifths of traumatic experiences reported have to do with situations in which the fear of making a bad impression on the faculty predominates. The students picture themselves as at the mercy of a capricious and unpredictable faculty which can, at its discretion, impede or halt their progress toward a medical degree and act in accordance with these premises, endeavoring to make good impressions and avoid making bad impressions."⁴³ Yet, bound by their common role, students collectively distribute responsibilities, share tips on cutting work load, identify learning opportunities, and keep track of one another.

In his 1997 follow-up study, *Making Doctors*, Simon Sinclair identifies additional qualities and characteristics of liminality as described by Turner such as the wearing of a uniform—the short white coat—that makes students “immediately recognizable” and “ambiguously official” at one and the same time.⁴⁴ They stand apart and blend in. Sinclair also describes the very real sense of dislocation and disorientation of third-year students who must now enter a “different world . . . where finding the way is difficult in a three-dimensional maze.”⁴⁵

The motif of traveling to another world or another country is familiar, surfacing in published narrative accounts such as Perri Klass’s *A Not Entirely Benign Procedure* (in which she describes the hospital as “an alien and somewhat hostile environment”⁴⁶) and in “Parasympathizing,” another account from *What I Learned in Medical School*. There, the writer conveys the social, intellectual, spiritual, and, in his case, literal homelessness of the third year: “I often found myself wandering along the outskirts of the medical center . . . my mind confused about where I was headed, where I might get some rest. I became familiar with the other denizens of the call rooms. One student stayed there every third night for months on end . . . another student stayed for three months and even moved her television into a room to try to simulate comfort.”⁴⁷ In keeping with the motif of traveling to a foreign country, Sinclair also writes on the acquisition of another language, the highly formalized clinical discourse that illustrates another element of transition for the liminal.⁴⁸ Klass is especially attuned to the transformative process of speaking words, performing acts, and becoming other: “I am afraid that as with any new language, to use it properly you must absorb not only the vocabulary but also the structure, the logic, the attitudes. At first you may notice these new and alien assumptions every time you put together a sentence, but with time and increased fluency you stop being aware of them at all. And as you lose that awareness, for better or for worse, you move closer and closer to being a doctor instead of just talking like one.”⁴⁹ This transition from describing an illness experience as a patient would to developing a clinical narrative as a physician does is one of the most prominent indicators of the liminal stage in medical education.

Not surprisingly, the category of liminality has also served as a way to understand how illness experience as illness experience is rendered in narrative accounts. In that context, two formulations of liminality have been offered: as a term to describe periods of disruption by illness, in which structure and routine are abandoned, and as a social view of the state of being of those with chronic disability whose position is judged as indeterminate and cloudy.⁵⁰ For instance,

Arthur Kleinman documents the apartness of the seriously ill with particular clarity in which certain labels “encase the patient in a visible exoskeleton of powerfully peculiar meanings that the patient must deal with, as must those of us who are around the patient,”⁵¹ and in *The Absent Body*, Drew Leder recognizes that coming to awareness of the body is alienating, confronting, and incommunicable to someone who has not shared the experience.⁵² For many third-year students in the narrative examples we have selected below, there is recognition and expression of their shared liminality with patients.

Displacement, Dissociation, and Disappearance

In this section, we explore how the third-year students in the study employ different narrative typologies in an attempt to address their liminal status, especially when recognizing and wrestling with perceived ethical conflicts on the obstetrics-gynecology clerkship. We argue that liminality itself can and does prevent students from becoming engaged or taking a stand when confronted with an ethical dilemma.

For instance, the displacement and separation of the liminal state provoke both uncertainty and mistrust; lacking the security of a familiar role and context (the psychological and emotional experience of “homelessness”), students are less capable of “speaking up” in this new culture.⁵³ Moreover, infliction of ordeals such as academic pressures, long hours, and “pimping” further disorient and distress students. As they begin to doubt their previously unassailable competence, they become more skeptical of their instincts toward discerning the moral.⁵⁴ And while invisibility reinforces the sense that students do not exist in any important way and their opinions of, or responses to, situations are irrelevant, interchangeability encourages the idea that “someone else” will step forward. Thus, the masking and silencing of the unique individual begets concealment and repression in all situations, including situations presenting an ethical problem. Finally, the psychological splitting that can occur in the liminal state allows students to participate simultaneously in two lives: their personal lives based on deeply held beliefs and values and their professional lives characterized by moral confusion and uncertainty. In essence, the general discomfort and suffering of liminality urge students toward aggregation or the longed-for assimilation into the culture of medicine.

Under these circumstances, many students are reluctant to “make a mistake” or, as they may experience it, to speak truth to power. However, it is also true that because the very condition of liminality

destabilizes the subject, there is no guarantee that consolidation will occur precisely as the panopticonic authorities expect and desire.⁵⁵ As Turner notes, the resolution of liminality comes through “transformation,” and the system “hailing”⁵⁶ the individual expects that transformation to support its values, assumptions, and priorities. However, as at least some of the narrative typologies below indicate, transformation can take many forms. When the liminal is “broken down” with the expectation of being reformed, not only the system but also the individual himself or herself can influence and shape that reconstitutive process.

Liminality and No Problem/No Conflict Narratives. In this not uncommon excerpt, the student begins by explaining his immunity to or obliviousness of ethical conflicts in the ob/gyn rotation because “I was fortunate enough to be placed [passive voice] in *strong functional units with superb chemistry and communication* [effective teams] which is important to the overall impression *one* [from personal pronoun to impersonal] takes from each of *our* [and back again] learning experiences” (our emphases). This example of a no conflict/no problem narrative is typical in that it represents a kind of “pre-consciousness” with regard to the liminal state. For instance, these narratives appear most frequently in the early months of the third year, suggesting a “state of innocence,” a phase in which students are, as yet, unwilling to acknowledge their “betwixt and between” state. The student writers appear to be applying moral brakes to the inevitable process of transition in order to resist any ethical responsibility they must assume as student-doctors. The characteristic blankness suggests that students prefer to abdicate moral agency and to accept, even embrace, the structural invisibility of the liminal state. The detached narrative position mirrors the stance of a mere observer of clinical events.

Liminality and Chaos Narratives. The invisibility and silence associated with liminality, which Leder describes as disappearance, are the most obvious and most common elements in many of the chaos narratives we analyzed. For example, while passing as a member of a health care team poses no practical problems, it does pose moral ones: “It doesn’t take long to learn to blend into the background without asking permission or introducing oneself as a medical student. Is this lying? Am I a Peeping Tom?” Many students, as represented in the four excerpts from various sources below, make connections between the powerlessness and helplessness of patients and their own passivity and submissiveness:

The anesthetized patient lacks the ability to defend herself [against violation]. I as a student cannot do anything to protect the patient's dignity without endangering my own position.

If the patient had challenged the attending, I would have sided with [her] and spoke up. Instead, both the patient and I complied and remained silent.

I felt that the patient was pushed and influenced, but I handled the situation by doing nothing.

I ended up doing the pelvic exams on all the patients . . . and I didn't argue. Apparently, it is the norm"

Exactly to what the pronoun "it" refers, either the examination of unconscious patients or the paralysis of medical students, demonstrates the ambiguity of liminality as well as the fluidity of its norm and signals either an intentional or an unwitting identification between the patient and the student.

Telling chaos stories is neither empowering nor reassuring for liminals. Their very structure and tone mirror the incoherence and confusion of the liminal state; they depict its inherent condition of submissiveness and silence; and their open-endedness signifies both the lack of significant resolution and the hope for positive change. All of these elements are exemplified in the circular narrative below of a student who not only wants to care compassionately and respectfully for his patient but also to restore his own moral equilibrium. When neither outcome is achieved, the student feels helpless and hopeless: "The conflict presented itself as we tried to communicate the steps of the procedure to a completely blank stare. According to my personal values, I wanted to stop us from proceeding with the procedure until the girl was more receptive and comfortable with the procedure. However, this may never be the case At the end of the procedure, I still did not feel that my conflicting beliefs were reconciled, as she still had a blank stare and added tears from the pain of the procedure."

Liminality and Compromise Narratives. In many compromise narratives, students either symbolically split their roles and identities, "I separated my 'physician hat' from my 'personal moral hat,'" or literally remove their minds and bodies as ways to function: "I handled the situation by trying, in my mind, to separate myself"; "I put aside my personal

values for the moment"; "I tried to talk myself out of what I had seen take place"; and "Sitting here away from the hospital and thinking more about the situation as a person than a medical student. . . ." Such splitting is evident in the following excerpt when the narrator separates a present "not-handling" self from a future "handling" self, illustrating the characteristic dissociation of liminality:

At that time it was determined that the fetus was no longer viable (no movement, no visible heart beat). The patient was instructed to go home to await the onset of labor over the next three days. If the patient did not go into labor within that time frame she was to return to L&D so that an induction could take place for delivery of her dead fetus. I view this as an ethical dilemma because I find it morally wrong to ask a woman to carry a dead fetus around for up to three days. . . . I was not in a position where I could "handle" the situation . . . if I'm ever in a position where I can "handle" the situation, I would do it differently.

These narratives both exemplify and reinforce the powerlessness of liminality. They do little, however, to resolve it because, unlike the restitution narrative, the student derives neither a sense of alliance nor identification with powerful others but instead endures a sense of guilt and shame for having betrayed her personal beliefs and standards.

Liminality and Journey Narratives. The motif of a journey organizes many of the student narratives, as illustrated in the following example:

I have learned that finding the best way to deal with a complex situation is usually not immediately apparent, that it is a process that can involve some conflict within the team of healthcare providers, that it is considerate and right for a doctor to take the time to thoroughly explain his opinion instead of bluntly throwing it out there and refuting another's ideas. The road to doing the right thing, or the best thing, has twists and turns, and patient care can benefit from a team of people wrestling with their own consciences and with each other.

In terms of the construct of liminality, the journey story seeks identity consolidation, but at a higher level than the student occupied initially, which will incorporate significant moral lessons. The "road to doing the right thing" is long and hard but worth it for the end result, the

“benefit.” The journey narrative emphasizes the transformational potential of liminality. Unlike the restitution narrative discussed earlier, this potential does not necessarily imply “joining” with the established medical hierarchy but rather, gaining heightened wisdom and compassion (“a team of people wrestling with their own consciences and with each other”). Nevertheless, it does share with the restitution narrative a focus on the resolution of the liminality of the student in favor of a powerful status. However, rather than minimizing a patient’s liminality by acting the role of competent, efficient technician, the patient’s liminality transforms student into a healer who reaches back to help both this patient and others. In this narrative, by fully participating in the journey, the student becomes part of the team.

Liminality and Witnessing and Resistance Narratives. In their discussion of liminality and cancer experience, Miles Little and colleagues describe the existential crisis of a person who faces a choice that might achieve what Heidegger calls “authenticity” or that will undoubtedly reify the boundedness and entropy of the transitional space,⁵⁷ or as Turner describes it, the “cultural realm with few or none of the attributes of the past or the coming state.”⁵⁸ From the perspective of authenticity, some medical students are able to recognize that their own immediate and embodied displacement makes them especially attuned to that same state in patients, who are also fellow travelers. The witnessing narratives engendered by this recognition, along with some resistance stories, assume a radically different position toward liminality from that of most other typologies. The following narrative is an example of witnessing:

Suicide and euthanasia are also quite controversial. If this patient had been at home, with access to morphine, she might have been able to end her life as she chose. While in the hospital, it was up to us. It would be illegal for us to give her a narcotic overdose, even if she asked for it. The ethical obligations here are murky. Some would say physician-assisted suicide is terrible. Others say helping those who are suffering die is a moral obligation. I am not sure which the correct answer is This situation was not mine to control. I could not force the hospice team to make arrangements for our patient, nor her daughter to take time off work to care for her. Perhaps neither of these options was even possible. Instead, I did what was possible. I comforted the patient the best way I could. I left her alone when she was sleeping. I rubbed her

back and held the bucket while she threw up. I listened to her stories. . . . I will never forget her. I will always try to comfort those who are suffering.

In both witnessing and resistance narratives, students embrace rather than reject their liminal status as a way of expressing compassionate solidarity with patients. Witnessing and resistance empower the students through identification with, rather than rejection of, the oppressed as is clearly visible in the following resistance narrative:⁵⁹

During the course of the interview with this patient, I learned about several other health and psychosocial issues going on . . . that were related to her complaints and important to her medical care overall When I presented this patient to my resident, she was very annoyed that I was telling her all of this information about the patient the message I got from this resident was that I should not even have let this patient tell me about significant episodes in her medical history I feel that it would have be wrong for me not to present these aspects of my patient's history to the resident once I knew about them even if I thought that was what she wanted. . . . As medical students, we are often under pressure to conform to the particular system of whomever we are working with for a particular day In this situation, I told the resident that I believed that everything the patient had told me was important given the fact that this was our first contact with the patient.

Resistance narratives refuse to resolve liminality at the expense of personal values and, in contrast to a witnessing narrative, adopt a position of active protest. They are, in a sense, a celebration of liminality in that it is the very "betwixt and between" status of liminality that allows and encourages the student to stay true to her principles, even in the face of powerful forces urging a different choice. In this example, the student resists socialization into the dominant medical system, pairs with her patient, and actively defends her interaction.

Concluding Thoughts

In our sample, students were more likely to tell restitution stories than any other type of story, reflecting the modern and technologic

find-it-and-fix-it mentality that still predominates in medicine.⁶⁰ The homeostatic, rebalancing nature of restitution stories is reassuring to everyone involved, students and faculty alike, and serves as a convenient mechanism for reducing the anxieties associated with liminality by allowing identification with powerful insiders. However, students also share other types of narratives that relate to their status, narratives that leave them mired in liminality (chaos, compromise); allow them to escape it through transformation (journey); or enable them to choose, even to celebrate, it (witnessing, resistance). They should be encouraged to tell stories that are appropriate to their situations and to those of their patients. Further, they deserve support from educators who recognize students' vulnerability and dependency and who enable them to tell more painful, more complex, and fewer tidily resolved stories.

NOTES

1. Turner, *From Ritual to Theatre*, 42.
2. Dickinson, *The Complete Poems of Emily Dickinson*, 133.
3. Frank, *The Wounded Storyteller*, 75–168.
4. Auxiliadora et al., "Once Upon a Time . . .," 7.
5. Whitehead, "Quest, Chaos and Restitution," 2237–38.
6. Ezzy, "Illness Narratives," 606–07.
7. Thomas-Maclean, "Understanding Breast Cancer Stories via Frank's Narrative Types," 1647–49.
8. Cohn et al., "Interpreting Values Conflicts," 589.
9. Shapiro, *The Inner World of Medical Students*, 14–15.
10. King and Kitchener, *Developing Reflective Judgment*, 48–50.
11. Frank, "Asking the Right Question about Pain," 213.
12. Jameton, *Nursing Practice*, 5–6.
13. Campbell, *The Hero With a Thousand Faces*, 41–210.
14. Brainard and Brislen, "Learning Professionalism," 1012.
15. Clark, "Holocaust Video Testimony, Oral History, and Narrative Medicine," 270.
16. Papadimos, "Foucault's 'fearless speech' and the Transformation and Mentoring of Medical Students."
17. Henderson, "Medical Student Elegies," 119–32.
18. All direct quotations are from student narratives.
19. Ginsberg and Lingard, "Using Reflection and Rhetoric to Understand Professional Behaviors," 204.
20. Van Gennep, *The Rites of Passage*, 21.
21. Turner, *The Forest of Symbols*, 93–94.
22. Turner, *The Ritual Process*, 95.
23. Turner, *Forest*, 96.
24. Anderson, 284.
25. *Ibid.*, 286.
26. Tanaka et al., "Shifting Identities," 61.

27. Anderson, 286.
28. McNeal, "Medical School Metamorphosis," 70.
29. Ibid.
30. Turner, *The Forest*, 98.
31. Ibid.
32. Ibid., 99.
33. Ibid., 101.
34. Turner, *The Ritual Process*, 95.
35. Ibid., 103.
36. Turner, *Ritual*, 106.
37. Chen, *Final Exam*, 45.
38. Ibid.
39. Becker et al., *Boys in White*, 3.
40. Ibid., 4.
41. Ibid., 9.
42. Ibid., 260.
43. Ibid., 283.
44. Sinclair, *Making Doctors*, 197.
45. Ibid., 196.
46. Klass, *A Not Entirely Benign Procedure*, 58.
47. Takakuwa, "Parasympathizing," 108.
48. Sinclair, 201.
49. Klass, 76–77.
50. Little et al., "Liminality," 1490.
51. Kleinman, *The Illness Narratives*, 22.
52. Leder, *The Absent Body*.
53. Caldicott and Faber-Langendoen, "Deception, Discrimination, and Fear of Reprisal," 870.
54. White et al., "A Qualitative Exploration," 599.
55. Foucault, *Discipline & Punish*, 195–228.
56. Frank, "Enacting Illness Stories," 33–34.
57. Little et al., 1491, x.
58. Turner, *Ritual*, 103.
59. Coulehan, "Compassionate Solidarity," 597–98.
60. Martin and Peterson, "The Social Construction of Chronicity," 581–82.

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