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Teaching Softly in Hard Environments: Meanings of Small-Group Reflective Teaching to Clinical Faculty

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*As we become more obsessed with succeeding, or at least surviving, in that [real] world, we lose touch with our souls and disappear into our roles.*--Parker Palmer

Academic medical educators face increasingly difficult choices in balancing their teaching and patient care responsibilities. The time devoted by our community-based clinical faculty to teach on a volunteer basis is being challenged by economic and institutional demands to increase the numbers of patients seen. Most clinical faculty enter the academic arena because of their love of teaching and its intellectual environment, which gets lost or at best, receives less priority, given so many other urgent situations. Still, at every medical school and at every academic health center, both large and small, clinical faculty can be found donating their time to teaching in small groups, an activity that offers little or no remuneration and takes them away from patient care and administrative duties. In many areas of our medical school curricula volunteer clinical faculty are electing to teach less. Yet, for one course, *Reflections on Doctoring*, we noticed that several, busy senior- and leadership- level clinicians have continued to agree to teach small groups of medical students. We took the opportunity to ask them what it was about this course that called them back.

A vast literature exists on *teaching* reflection and reflective practice to trainees in small group settings, yet, with few exceptions the medical literature does not focus on the benefits to faculty themselves. Like multiculturalism or cultural competency, the literature assumes that faculty have a propensity for reflection and that trainees are the only recipients of the benefits of such inquiry. One of the noticeable exceptions is Kumagai and colleagues' important article, "The Impact of Facilitation of Small-Group Discussions of Psychosocial Topics in Medicine on Faculty Growth and Development," which found that small group teaching stimulated not only students' personal and professional growth but also that of the faculty themselves.

Our intent here is to continue and enlarge the questions posed by Kumagai and his colleagues. Specifically, this inquiry focuses on the meanings that clinical faculty derive from teaching medical students in discussion- and reflection-driven small group formats. Why do they leave the comfort zone of clinical teaching and take time away from income-generating patient care activities? What is it about this type of teaching that continues to call them back?

First, we provide a description of the environment in which this teaching takes place for our faculty.

## Background

Northeast Ohio Medical University (NEOMED) includes a community-based medical school that offers a six-year combined B.S./M.D degree. There are approximately 100 students in each of the four traditional medical school years who receive their clinical training at six teaching hospitals that range in distance from 10 to 25 miles from the main university campus. More than 1,900 clinical faculty volunteer to teach our medical students at affiliated hospitals, private offices and clinics, and at the main campus.

This study focuses on one required course for first and second year medical students taught by volunteer faculty at the university campus. *Reflections on Doctoring* (hereafter called *Reflections*) is one component of a longitudinal curriculum (Doctoring course) that spans all four years of the curriculum. It is designed to provide educational experiences that relate to the broad areas of humanism, ethics, and professionalism. Required reading materials for *Reflections* draw from fiction, creative non-fiction, essay, poetry, film, case studies, and other media. Its goals are to promote critical reflective thinking, writing, and discussion aimed at preparing students to:

- recognize and resolve personal and professional issues and dilemmas as they relate to a life in medicine,
- engage in collective discussions aimed at promoting respectful and trusting relationships with colleagues, and a sense of community,
- develop a broadened appreciation for, and understanding of, the human experience,
- be conscious of forces in the classroom and clinical teaching settings that shape their professional identity development and socialization in medicine, and
- develop a broader understanding of the commitments and obligations that attend the privilege of service in medicine.

During the first year, groups of 12 to 14 first year medical students meet eight times, and, during their second year, four times with one or two faculty facilitators. There is a total of 26 *Reflections* faculty, 16 of whom are clinical faculty representing general internal medicine, family medicine, pediatrics, emergency medicine, psychiatry, anesthesia, and hematology/oncology; the nonclinical faculty from the main campus are from the bioethics and humanities program, the behavioral, family and community health sciences department, and from administrative position, including the Dean of Academic Services, Dean of Medical Education, Director of Career Development, and the Director of Faculty Development. Prior to each small group session, students are emailed the goals, objectives and reading assignments and are asked to write a one- to two-page reflective essay on one or more of the themes, issues, or dilemmas presented in the readings. (See table with examples of literary selections) This essay is submitted electronically to faculty one week prior to the group session. Students receive a score of Pass or Fail, based on attendance, engagement during their *Reflections* group discussions, and the level of reflection in their writing, according to the instructions: *This paper is not intended to be a forum for restating the content of the reading; rather, it should be a narrative about your feelings, experiences, and supported opinions as they relate to medicine and being a medical student.*

## Methods

Our study included only those *Reflections* faculty who are clinicians. We were interested in learning from these physician leaders, in particular, who are based, and teach students and residents, at community teaching hospitals and practices, why they continue to volunteer to teach this course each year. The other *Reflections* faculty hold paid university positions, which include responsibilities to teach undergraduate students on the Rootstown campus.

After approval from the university's Institutional Review Board, an electronic invitation was sent to each of the 16 clinician faculty members seeking voluntary participation in a focus group, based on the following six questions that were included in the message:

1. What are your reasons for teaching ROD sessions?
2. What have you found enjoyable about teaching ROD sessions?
3. What has been challenging for you as a ROD teacher?
4. In what way/s is teaching in ROD different for you from other types of teaching you do at NEOUCOM and/or in the clinical setting? In what way/s is it similar?
5. How would you describe the meaningfulness of teaching ROD sessions for you?
6. Has your experience teaching ROD sessions influenced your perspective about or approach to patient care?

We held two focus groups for 11 faculty members; one responded via telephone interview, one through written response, and four through one-on-one interviews. One of the authors (EW) acted as moderator for all focus groups and interviews. She restated and clarified questions and facilitated discussion by eliciting responses from each participant. Two authors (LZ and EW) transcribed the audio recordings of the focus groups and interviews; all participated in data analysis and written preparation of this manuscript. Each author independently conducted close readings of the transcripts, conducting thematic analysis by searching for categories and themes. All authors met as a group to share findings and reach consensus. These categories and themes are discussed below.

## Results and Discussion

Two themes of meaning related to the faculty's personal interpretations of the *Reflections* teaching experience emerged. They loosely follow the questions posed to them during focus groups and one-on-one interviews. These themes are 1) the rewards of being around young, passionate, non-jaded students; and 2) the meaning and impact of the readings and small group discussions which inspire faculty to examine the ongoing development of their own professional and personal identities.

### Rewards and Realizations of Teaching Medical Students

Faculty reported that *Reflections* did something *for* them, including the pleasure of interacting with medical students. For some faculty, *Reflections* resulted in nostalgia that was inspired by a learning environment where it is "interesting to be around medical students, to try and remember myself when not so many years ago, I was in the same position." Another faculty member felt that as a NEOMED graduate, "I think I can more easily than some, place myself in the student's position, with some knowledge of what 'the system' is like here."

In spite of the relative inexperience of their students, several *Reflections* faculty observed differences in the benefits of teaching students and residents. One physician noted how interesting it was to see

> how [students] reacted to certain stories, which I knew would be a completely different reaction from the residents from my personal standpoint. Some of the stories really affected them deeply just from their own personal experiences. Especially when there was a pancreatic cancer death … it affected them with force. [In contrast] some of them [students] were really taken aback by interactions with some of the residents… [who were] more guarded.

This observation related to what other faculty noted as students' refreshing lack of jadedness and cynicism. One physician noted,

> I noticed that when we have students with us on rounds, and we're trying to do some of this [reflection] with residents, that the students were sometimes more readily involved in the discussions. They were very, very anxious to have opportunities to talk about some of the softer issues or attitudinal issues that are affecting their care of patients.

Another physician said:

> It's actually nice to see someone who's not so jaded as the residents were earlier and can have a lengthier discussion, because when you get a resident… you don't really delve into some of the residents, because, OK you see them and you can tell they are so not interested in this case and the discussion, and you want to get done yourself and move on and just provide the basic facts. But then one of the previous M4 students from last year –

> who is a resident – has been fantastic. We've been actually having detailed discussions about how they would perceive and what they would do in their practice if they were in a similar setting. But I do not do it for 99% of the residents who come through. It's just not really worth my time when they're not interested.

In addition to being more willing to talk than residents about their observations and questions, students brought a significant amount of diversity to the discussion, particularly through their interpretations of the readings. One clinician explained that the experience of teaching *Reflections* has taught her tolerance for the very personal perspectives students bring to the *Reflections* classroom: "He's a Muslim, he's Christian; she's Catholic; he's an atheist; he could be a Satanist for all I know. . . I have to learn how to be more inviting." This statement may translate to this clinician's desire to develop skills and confidence in initiating and facilitating safe and open discussions with students around race, religion, and sexuality.

Another physician felt *Reflections* was especially meaningful, because he gets to be "around people who exhibit hope for a life in medicine…What is it about why am I attracted to the young people? … It's about the adults who are so cynical, negative and these people [students] have just such hope for their lives—they are playful, creative, idealistic." A similar sentiment was echoed by another who felt honored to be privy to students' most personal feelings and thoughts and "Knowing I'm a friend, knowing that I'm trusted knowing . . . that they want to tell me and that they appreciate what I tell them."

From the relationships formed during the two years of *Reflections,* several faculty expressed pleasure in witnessing their students growing emotionally and being able to connect with them not merely as students or future healthcare professionals, but as *persons*. One identified his two most enjoyable experiences in the course, the first "when I read their writing, especially after I've seen them progress. . .The second thing is seeing them open up as people. . . who they are [as they] become a little more open and honest." Others elaborated on this dimension of the course as enabling students to take risks and disclosed their personal experiences and feelings. One faculty member began to see his students taking chances after their second or third writing assignment where "the self-disclosure was almost breathtaking." He was less impressed with the quality of writing than with the honesty of his students and their willingness to take real chances when they wrote, "I just don't feel this way, because…" The student's openness to being vulnerable enabled this physician to be equally self-disclosing in his comments: "So I kind of felt that what was happening is they were taking chances and that prompted me to take chances with them, and that definitely deepened this collegiality."

## Meaning and Impact of Teaching *Reflections*

Faculty reported that Reflections did something *to* them by making them more aware, sensitive, and reflective of their lives, within and external to, medicine as clinicians, teachers, and lifelong learners. An experienced faculty member shared how he was challenged to remember and reevaluate his own attitudes and beliefs, "So I have to reflect myself in preparation and to look back on the experiences and things I've seen and done that relate to the reading and think about what did I do back then and why did I behave or act that way."

### As a Clinician.

One clinician revealed how his exposure to the literature and poetry in *Reflections* has renewed his sensitivity to patients' stories and their suffering:

> So a woman comes to me and tells me a story about how her daughter died, her husband died; she's devastated and she all of a sudden found herself going with a lady friend and buying a bunch of yarn and knitting scarves and giving these scarves away as gifts, and she wanted me to have one. I've never been sensitive to that whole metaphor about trying to create order out of chaos through the knitting of the scarf.

This caregiver's reflection is illustrative of Donald Schon's reflection-on-action, which he describes in a much broader context. Reflection is integral to the *art* of medicine, allowing a physician to reflect on patient interactions which are not solved by bringing specialized knowledge to a clearly defined problem. According to Schon, "It is this entire process. . .which is central to the art by which practitioners sometimes deal well with situations of uncertainty, instability, uniqueness and value conflict" (Schon, p. 50).

Similarly, in response to the question about if and how the *Reflections* experience influenced perspective and/or approach to patient care, one respondent said, "I probably have allowed myself to think more from the patient's perspective, [which is] a step in providing patient-centered care. . . The course certainly deepens that experience for me."

Several clinicians revealed how the readings assigned for *Reflections* reminded them about what it is like to be a patient by imagining what their own patients were experiencing. One physician, in particular, expressed how participation in the course made him reflect on his own assumptions about patient care and medicine:

> It made me think more about problems from the patient's point of view. . . You know the bane of our existence in medicine is the non-compliant patient. Instead of just kind of getting angry or frustrated because patients don't do what I've asked them to do, which I know would make them better and they should have the good sense to do, I think about why aren't they doing it. Instead of trying to convince people that they should do what I tell them to do to begin with, I actually ask them now.

The rewards of relating to students as persons also may increase the desire of these clinicians to connect similarly with their patients -- a connection essential for relationship-centered care. The 1994 Pew-Fetzer Report calls for physicians and other health professions to "acknowledge and value their capacity to be self-reflective, that is, make explicit their ability to reflect on their own interpretations of the phenomena of illness and the importance of doing so. In this way they can become more open to different ways of responding to the experience of their patients" (Tresolini, p.22).

Another clinician similarly pointed out that his teaching experiences in the course have made him "more sensitive to what's motivating me as well." Another echoed that, "I really feel like I'm a better doctor because I do this. I'm much more attuned to what I am bringing to the patient encounter. I'm much more conscious of how I might be perceived or what my attitudes might be."

**As a Teacher.**

One respondent tried to describe how meaningful it is "when I think my group is connecting in some way with the material." Others identified specific rewarding moments when students have epiphanies and when they observe students begin to "open up as people . . . being more open and honest." One clinician spoke of teaching as transformative for both students and faculty:

> You can just tell that in certain essays that [something] really hit home for that student. Really seeing them reflect and saying that this really meant something to me. . . I appreciate [that] they can share that with me. . . I've thought this many times, and I've seen the students say, "I haven't thought of it that way. That's a really good point. You kind of have an 'aha' moment. And you can see them have those moments too. That's the most enjoyable—to see both myself and them think of something in a completely new way that we've never thought about before.

Many faculty described how the *Reflections* curriculum and experience enhanced their understanding of their path to becoming experienced clinicians and teachers, including their role in the overall enterprise of medical education. One clinician spoke to how *Reflections* reinforced his views that medicine is a service profession. "That's one of the most important things I want to convey to students in this course, that it is a service profession . . . to do what's in the best interest of the patients even if we don't like the patient and even if we don't think the patient is worthy of our efforts."

#### As a Lifelong Learner.

One experienced faculty member said that the literary selections remind him that, "Even back in the days when I was in med school, I always made sure that I was reading something that was non-medical at any point in time. Sometimes it went slowly because I didn't have that much free time, but I always had some book in progress."

Another clinician became particularly interested in the author of a few literary selections required for a *Reflections* session. He said that, **"**Some of his essays really were life changing for me," which led to his going to a bookstore with the intention of buying everything he could find written by this author. Another clinician expressed, "I like the readings. I enjoy reading non-medical things. It gives me an opportunity to read things I might not ordinarily choose to read or even know about." Another respondent agreed and expressed the joy he felt in getting to read literature "not for survival data . . . [but] just to read." One found a "surprising appreciation" for poetry, which he "would not have admitted to three or four years ago." Lastly, a physician said that *Reflections* is personally meaningful, because it is an activity associated with reading, sharing stories, and connecting with colleagues "who think in a like-minded way."

Two specific categories that emerged from the data we collected are: 1) how teaching *Reflections* differs from other teaching; and 2) the challenges of teaching *Reflections.*

### How Teaching *Reflections* Differs from Other Teaching

Faculty noted the following differences between teaching in *Reflections* and teaching in the clinical setting in terms of teaching content, process and persona.

#### Differences in Content.

Unlike the objective, factual content taught in the clinical setting, *Reflections* content was described as "subjective," "full of emotion," with "a spectrum of answers – not just one." One clinician noted that in *Reflections* there are "no right or wrong answers," in contrast to the content in the clinical setting where "there's an established way of doing things. . . A lab value is normal or abnormal . . . A given drug is the treatment of choice or it isn't." Another clinician similarly explained that the content is not so "cut and dry," because the content of stories, poetry, and film depicts wide-ranging human experiences and responses which are not as neatly interpreted and reduced as a clinical presentation.

**Differences in the Teaching Process .**

Clinical faculty differentiated between how they teach for *Reflections* and their usual mode of teaching in the hospital and office settings. The primary difference is that the *Reflections* sessions demand reflection by both the teacher and the student on one's personal beliefs and experiences which are raised by reading and discussing literary works.

One clinician explained this difference this way: "It's not so much imparting factual knowledge as it is experiential knowledge. You're not asking them to give you a differential diagnosis. . . You're asking them to reflect on a very personal level. I don't do this on rounds." Another faculty member described feeling somewhat uncomfortable in facilitating *Reflections* sessions where, unlike leading clinical rounds, there was no "clinical fallback," when he could "just cut the touchy feely and go to the clinical stuff."

Many of our clinical faculty reported how "messy," "less structured," "less hierarchical," and even "difficult," *Reflections* is compared to other types of teaching. Some expressed how challenging it was to teach medical students, not only because of their lack of clinical experience but in life experiences as well. One faculty member compared the challenge and the importance of teaching *Reflections*:

> How to treat patients and how to think about families and how to put yourself in their shoes. They don't have those experiences because they're young. They're not married; they don't have children; they haven't had the experience of getting yelled at; they haven't made the mistakes and said something about a patient and turned around and they are right there…It's hard to say that this is probably the most important class you'll take in medical school, but you just don't understand it yet.

**Differences in Teaching Personas.**

In addition to content and teaching practices, faculty explained how their teaching personas in *Reflections* differed from that of preceptor at the bedside or at the lectern in front of a hundred or more students. Because of the subjective nature of *Reflections*, many faculty acknowledged their own personal and professional struggles to sort out the complexities of the assigned readings and then to determine if they should, and, then, how to, reveal this to the students. One clinician imagined that students must find it refreshing "to see a clinical faculty person who's struggling with issues. . . I think it's so important for them to recognize that we don't always get this right, and we don't always get the answer." The clinician respondents found this ability to step aside from being "right or wrong" equally refreshing. According to one physician, "In the clinical aspect as attending physicians, we're usually looked upon as having answers to everything. In these types of situations [in readings for *Reflections*] there aren't answers, or the answers are going to be much more diverse." Another physician disclosed that:

> It's an opportunity to share some of the tenderness, the vulnerability, and the risk and the concerns that often churn about without ever being processed. This is an opportunity to unfold that kind of stuff… and it just appeals to me, because it's an opportunity for these young, soon-to-be physicians to focus on how they're going to be as doctors. They get plenty of time later in the clinical arenas about how they're going to DO things in medicine. I want them to focus on how they're going to BE.

**The Challenges of Teaching *Reflections***

Faculty identified several teaching challenges related to 1) the student's ability to reflect on the readings in their essays and during group discussions; and 2) the unique nature of teaching the value and practice of reflection.

One clinician pointed out that, "There is a general perception that this material is less important than the rest of the curriculum, and I don't think that will ever change, quite frankly. And sort of a corollary to that is . . . that it is not cool to open up in a group setting." This is another example of a teaching challenge for faculty in initiating and maintaining an optimal environment for sharing personal reflections with peers and with faculty. Some faculty felt as though they were "pulling teeth," and questioned whether students knew how to contribute to a group discussion, or whether they were fearful of opening up and sharing their thoughts and feelings. Others pointed out the difficulty of discerning if a student is uninterested or just quiet. One physician shared this:

> To me the most frustrating thing is the reticent student or the student who is just not interested in participating - the person who has head in hand, rolling eyes, shifting in the chair. I'd almost just like to . . . ask them to leave. I have to work harder as a teacher in the *Reflections* sessions than I do on the floors . . .You can bring the quieter ones out a little bit more when on a medical floor, because it's basically cut and dried. In *Reflections* I still struggle trying to bring out the quiet ones.

When students seem reluctant, uninterested, or disengaged, some clinical faculty leaders worried about shutting discussion down by being too directive, offering too much about their personal experiences, or disclosing what they thought and felt as they read the assignments. "Sometimes I struggled to not 'over-direct' the sessions. I could tell it happened when the group seemed to fall silent and mine was the predominant voice," explained one faculty member. Another struggled with how to engage inexperienced students who brought little or no clinical experience to the discussions, questioning how not to "overtake the discussion and share my experiences, when I'm the only one who has had the experience with a patient like that."

Most *Reflections* sessions focus on a particular theme—emotions, for example, or clinically-focused topics, such as addictions or cancer—based on short stories, essays, and poems often written by physician-writers. Although all assigned readings explore complex issues, some faculty found the genre of poetry the most challenging to understand and teach and guessed that students did as well. One physician admitted, that in his group, "We barely get any direct comments from the poetry selections. . . . It seems difficult to write about or even discuss."

Many respondents were challenged by the task of judging the quality of the students' reflective essays and their class participation. Due to their busy clinical schedules and patient obligations, some found it difficult to find the time to read and then provide written comments on the students' essays, particularly for average or less-than-average work (e.g., summarization of the readings with little, if any, personal reflection). One physician described the challenges of evaluating the students' writing: "There are some that are clearly excellent, and they're easy. But I would say that 75-90% of them are very mediocre, and I don't know how to react to that except to put check marks on them and say, OK you did the assignment . . . and I don't have much more to say about that." Another explained it this way: "I consistently wrote that in my comments to them… 'This is really a nice summary of the assigned readings, but I'm left wanting to know where you are in all this and what does this imply for your professional development, and next time why don't you think about that and reflect more on that when you

write.'" Several faculty agreed that some students needed encouragement and "permission" to write in the first person about their feelings, beliefs and opinions, rather than to compose a summary of content written in the third person, as many of them were conditioned to do in high school and college. Faculty are able to model reflection in their written comments on student essays and during group sessions when they share their personal responses to the readings supported by their experiences.

The challenge of assessing students' written reflections is well documented. In one published study about teaching reflection as part of the formal medical education curriculum, Wald and Reis examined the challenges for faculty in assessing students' writing. They support the use of structured assessment guides for composing feedback on reflective essays, based on faculty needs for "qualitative and quantitative methods for analyzing RW [reflective writing] such as close reading, thematic analyses and the use of a rubric to evaluate level of reflection" (Wald and Reis, p.748). Although we agree that our faculty would benefit from reviewing validated frameworks for thinking about a student's reflective essay, we share Wald and Reis' concern that the singular reliance on a rubric can lead to its "compromised authenticity with students adopting a more formulaic approach to reflective writing" (Wald and Reis, p. 748). For the *Reflections* course, we value and encourage the unique teaching (and assessment) approaches of our faculty leaders who report that their personal relationships with students develop as an ongoing "conversation," which begins during *Reflections* sessions and continues with personalized written feedback on the essays. This faculty-student relationship must counteract any fixation by students or faculty on a list of criteria toward a "grade."

One physician expressed frustration as a co-facilitator, because he had to relinquish control of the group. He explained, "When your co-facilitator is taking your group in a way that you didn't want to take it, you have to learn what to do in that situation. We're used to, I think in most cases, being the one who's in charge… At work we're used to being the one, and that doesn't necessarily happen with a co-facilitator."

**Recommendations**

In addition to providing insights about how our clinical faculty experience teaching and participating in *Reflections* sessions, this study has served as a needs assessment for continued research and faculty development.

Based on the response of participants in this study, we believe that *Reflections* faculty, course directors and students would benefit from additional qualitative studies on the teaching methods and outcomes, the meaning of the *Reflections* experience to all faculty and students, and if and how it meets the goal of promoting critical reflective thinking for professional development .

Several faculty development needs also emerged from the data. Prior to each *Reflections* session, faculty meet to share teaching intentions, approaches and questions. An annual retreat for *Reflections* faculty includes an assessment of the year's literary assignments, agreement on a syllabus for the next year, and a faculty development session on a topic related to reflection in medicine. As a result of this study, we will plan additional faculty development workshops and resources for faculty to develop knowledge, skills and confidence in establishing and maintaining a safe setting for sharing personal reflections, engaging students in small groups, including how to optimize co-facilitation, assessing and providing feedback on student essays and teaching with poetry.

**Conclusion**

We were surprised and pleased with the revelations of the clinical faculty for *Reflections*, which answer Parker Palmer's provocative question in *The Courage to Teach*, "Students are dependent on teachers for grades; but what do teachers depend on students for?" (Palmer, p. 142). It has deepened our understanding of how reading and sharing reflections with students about literary perspectives of medicine provided the opportunity for clinical faculty to examine their teaching roles, relationships with patients and their own continuing professional development.

It has also renewed our commitment to continue to offer a required course for all of our medical students to gain insight into who they are, and who they aspire to be, as physicians, through shared reflections with faculty as colleagues who walk the same professional path. We have a new appreciation of the importance for teachers and learners to stop… and step outside the usual classroom, lab and clinic teaching venues to reflect on the joys and challenges of patient care, teaching and lifelong learning.

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Table 1: Themes and Topics

**Themes and Topics**

1. Rewards and realizations of teaching medical students
2. Meaning and impact of teaching *Reflections*
   - As clinician
   - As teacher
   - As lifelong learner
3. How teaching *Reflections* differs from other teaching
   - Differences in content
   - Differences in the teaching process
   - Differences in teaching personas
4. Challenges of teaching *Reflections*

Table 2: Examples of reading selections and authors

**Examples of Reading Assignments for *Reflections***

| Title | Author |
| --- | --- |
| *Like a Prayer* | Rafael Campo |
| *Girl with the Pimply Face* | William Carlos Williams |
| *Imelda* | Richard Selzer |
| *Playing God* | Michael LaComb |
| *Invasions* | Perri Klass |
| *Anatomy Lesson* | Jack Coulehan |
| *Talking to the Family* | John Stone |
| *A Small Good Thing* | Raymond Carver |
| *Talking to Grief* | Denise Levertov |
| *My Own Country* | Abraham Verghese |
| *What the Doctor Said* | Raymond Carver |
| *The Last Deal* | Jerome Groopman |
| *Wit* | 2001 film directed by Mike Nichols |
| *Miss Evers' Boys* | 1997HBO film adapted from a play by David Feldshuh |