Chapter 5: The Visible Curriculum

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Visual-based Teaching

Sample visual arts-based curricula developed at the University of Toronto

1. "Looking Through Art": An example of using Visual Thinking Strategies (VTS) for group visual learning (contributed by Allison Crawford, MD MA FRCPC)

Learning goals:

- To allow learners to enlarge their skills and vocabulary for visual observation and communication (visual literacy)
- To demonstrate the importance of perspective-taking and multiple viewpoints, through an experience of looking as a group
- To introduce the social, historical, and cultural contexts of looking and of shifting representational practices, and to introduce critical reflexivity about medicine as having a visual culture (and norms) of its own.

Resources needed:

Time: Sessions are generally 1 hour or 3 hours

Resources needed: We have incorporated VTS into a lecture format, in which images can be projected as slides. We have also used art within a hospital collection. Our more formal lectures take groups of learners to the Art Gallery at the University of Toronto, or the Art Gallery of Ontario, for either one three-hour session, or a series of 6 one-hour sessions.

Process and tips:

Overview: Looking at art together using VTS is not an art historical exercise. It is an opportunity to look within a group-learning context, and to hone skills of observation, attention and description.

Process: As a group we gather around a pre-selected work of art. The group is encouraged to describe what they see in the painting, and to back up their observations with specific details of the painting, using standard VTS prompts and facilitation practices.

Works are selected so that we move from more realistic, narrative paintings, through to portraits, and on to greater degrees of abstraction or experimentation. We try to cover art across historical periods. We also include works in other media such as sculpture, photography, and installations. We purposely choose representations of gender, (dis)ability, and transcultural representations. We do not necessarily select art that has an explicit connection to medicine.

We have found it fruitful to expand on the VTS prompts in order to encourage reflection *across* works of art, and across historical periods:

- What story/ stories is this artist telling about the human body and human experience?
- Do you imagine that this perspective has changed over time or across cultures?

Finally, we have also made explicit connections between the period of art and advances in medical sciences at the time. We often prompt the group with:

- What was/is going on in medical sciences at this time that might relate

to this work (what do you see that makes you say that)?

- Does this act of looking have any relationship to your role as (a clinician, trainee, patient)?

2. "Fill In The Blanks": An example of a comics-making seminar prepared for learners in the Faculty of Medicine, University of Toronto

Learning goals:

- To use the tools of visual narrative to reflect on the spoken and the unspoken in interpersonal exchanges
- To practice perspective-taking through the "re-vision" of comics describing a clinical encounter.

Resources needed:

Time: 1 hour

Supplies: paper; pens/pencils; altered and unaltered photocopies of excerpts from published comics about healthcare/illness.

Space: each participant requires a writing surface; configuration of the space should be suited to group discussion.

Process and tips:

Overview: Comics convey narrative through a combination of text, images, and other graphic devices such as page layout; when used to tell stories of health, illness, and care, this combination of modes can capture situational ambiguities, subtleties of nonverbal communication, mixed messages in physician-patient communication, and other narrative complexities. Comics are multimodal, and thus require the reader/viewer to interpret, and

navigate the relationship between, visual and verbal expression. The exercise described here encourages participants to interpret a visual depiction of personal interactions in a clinical scenario, and to experiment with re-interpreting that scene by adding or altering text (e.g., speech balloons, thought bubbles).

Preparation: Choose a short excerpt from a work of graphic medicine (see Resources list, and consult www.graphicmedicine.org for examples). Using white-out or a digital application such as Photoshop, erase the words from the speech balloons and narrative text-boxes, so that only the visuals remain.

Process: Distribute these altered narratives to participants. Have participants, individually, "read" through the wordless narrative and then fill in the dialogue, based on their interpretation of the images (e.g., body language, facial expression, visual symbolism, etc.). Have participants share their results, and discuss as a group. What is going on in this scene? How did visual cues in the narrative influence interpretation of the scene? After this discussion, have participants take their analysis of the scene one step further by adding "thought bubbles"— i.e., in addition to what is being said, what is each character thinking? Are these thoughts congruent, or dissonant, with what is said out loud? Again, discuss as a group. How might subjective experience (as conveyed in thought bubbles) differ from or influence what is expressed outwardly in a clinical encounter? What factors influence subjective construal of a situation? How can we practice attending to the interplay of the spoken and the unspoken?

Unaltered copies of the excerpt may be distributed at the end of the exercise, so that participants can reflect on differences or similarities between their interpretation(s) and the original work.

3. "The Ugly Picture", An example of a mark-making seminar adapted from an inter-professional education seminar offered as a collaboration between the Health, Arts, Humanities Program at the University of Toronto, and the Trauma Therapy Program of Women's College Hospital.

Learning goals:

To explore the dynamics of the doctor-patient relationship—particularly the vicissitudes of asking for and offering help; various manifestations of struggle, self-protection and empathy; styles of response in the face of uncertainty; and the chance to appreciate a multiplicity of (neither right nor wrong) approaches to being in the role of a patient and in that of a doctor.

Resources needed:

Time: Minimum 45 minutes, to two hours.

Supplies: paper (at least two pieces per participant), and basic drawing material (may include colored pencils, pens, markers, pastels, crayons).

Space: Preferably a central table to work at, with the materials available to all.

Process and tips:

Overview: The art-making exercise provides learners with a technically simple, low-stakes framework for exploring, in an embodied way, the complex feelings and thoughts inherent in the roles of both physician and patient. Letting artwork serve as a safer stand-in for exploring aspects of oneself (a form of indirect self-presentation which art therapy capitalizes on), the exercise leverages the "[p]aintings as patient surrogates" (Braverman, 2011: 345) benefit. The artwork allows variable degrees of revelation from the learners, as it "serves an

important modulating function to simultaneously achieve depth of discussion and emotional safety." (Gaufberg and Williams 2011, 549)

The exercise places emphasis on developing literacy in non-verbal communication. Group members are guided to create art that serves as proxy for expressing an ambiguous problem (in the patient role), and for responding to it (in the doctor role), all without the use of words. All participants get to engage in both roles with one another.

Process:

1. The educator begins by telling learners that there is no need to know how to draw, and that there are no right or wrong responses. She asks them not to talk until the activity is over, but to take notes on their experience if they wish. She gives this prompt: "Take a piece of paper and make the ugliest picture you can with the materials here. It doesn't have to represent anything—simply make marks on paper. We'll take 10 minutes to do this."

2. Participants make marks on a page. After the allotted time, the educator gives the following direction: "Hand your ugly picture to the person to your right."

3. Participants hand their ugly picture to their neighbor. The educator says: "And now that you have an ugly picture in front of you, take a new piece of paper and make a response on it to the ugly image you got from your neighbor. Again, this doesn't need to represent anything—simply make marks on paper. We'll take 15 minutes for this."

4. When the response pictures are done, the educator engages the group in discussion by asking if someone would like to talk about the experience of responding to an ugly picture.

Each participant in turn gets to speak about responding, and about making their ugly piece:

Questions about making the response image can include:

- How did it feel to make a response to an ugly picture?
- What did you first notice about it?
- Is there anything you didn't want to look at or respond to in it?
- What do you hope your response conveys?
- Did you leave anything out of your response?

Questions about making the ugly image can include:

- Was it hard or easy to make an ugly picture?
- What do you notice first about the response picture?
- How does it address the ugliness of your ugly work? Does it miss anything?

Participants are guided to notice aesthetic elements (see Table 1) in both the ugly and the response pictures which can be associated with thoughts, feelings and sensations. These are linked with learners' reflections on the thoughts, feelings, sensations, responsibilities, choices and motivations they experience in each role, and their reflexes in communicating these.

The conversation may touch on issues of exposure/vulnerability/anger in showing one's ugly picture—and how these may characterize one's experience as a patient having to present one's trouble/pain/need to the doctor. It will also elicit reflections on one's reflexes in addressing such encounters—which can illustrate a spectrum of mirroring, empathy, confusion, and/or a wish to distract, fix, educate, or cheer up the patient, in the role of

physician. (Up to this point it may not have been clear to participants how the exercise is related to the clinical encounter; allowing for this realization to emerge naturally from the conversation can make the exercise specially memorable.)

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