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Cultivating an Embodied Interpretative Consciousness: Health Humanities Initiatives at the Montreal Museum of Fine Arts

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Abstract

Partnerships between museums and medical faculties have increased, with the majority focused on building aptitudes related to clinical reasoning or therapeutic use of self. We report on the results of a partnership between the Montreal Museum of Fine Arts and the Faculty of Medicine and Health Sciences at McGill University. The *Physician Apprenticeship* elective focused on aptitudes, such as *deep seeing* while the *Narrative Rehabilitation* initiative focused on *bodily sensing* and hermeneutic competencies, including reflexivity on how past experiences enter interpretive processes. Tracing the impact in a participant learner's detailed description of a clinical encounter suggests how these two programs result in, what we are calling, *embodied interpretive consciousness*. The chapter includes descriptions of, and suggests how, the museum educator's techniques running both programs may be essential for cultivating intersubjective and embodied professional reasoning competencies needed to understand what might matter most to those with whom health professionals work.

Introduction

Partnerships between art museums and health science education typically focus on aptitudes rather than interpretive outcomes, despite the role of the arts in developing hermeneutics as a systematic process of understanding meaning (Dilthey, 1923/1988; Gadamer, 1975/1989; see also, Ricoeur, 1981/2019). In a review of visual arts instruction in medical education, for example, key learning objectives include disease-oriented skills (diagnostic), relational competencies (empathy, communication, cultural sensitivity), and resilience (tolerance of ambiguity and decrease in emotional exhaustion and depersonalization) (Mukunda et al., 2019).

This chapter explores the outcomes of two health humanities initiatives at the Montreal Museum of Fine Arts (MMFA). Although the impetus for and explicit aims of the Physician Apprenticeship elective and Narrative Rehabilitation initiative at McGill University focused on disentangling clinical observation from inference—or interpretation, broadly speaking—medical and rehabilitation learners' reflections also heightened attention to the impact of their museum-based curricula on the interpretive process, itself. Thus, the purpose of this chapter is to trace, through the feedback of learner participants, how a collaboration between the MMFA and the Faculty of Medicine and Health Science at McGill worked to cultivate an embodied interpretive consciousness that could be accessed in clinical contexts.

The Context of the Health Humanities Initiatives at the Montreal Museum of Fine Arts

In 1999, the Education and Wellness Division at the Montreal Museum of Fine Arts (MMFA) opened its doors to community groups and social service agencies. For over 20 years, their award-winning program, *Sharing the Museum*, developed programs for and with diverse populations that led to partnerships with hospitals, clinics, and non-profit community-based organizations. In part inspired by the forum, "The Art of Examination: Art Museum and Medical School Partnerships" (Pitman & Woon, 2016), which she attended in June of 2016, Marilyn Lajeunesse, museum educator, artist and then Educational Program Officer for Adults and Community Groups in the Education and Wellness Division at the MMFA expanded the Division's focus to include the *Narrative Rehabilitation* initiative in the fall of 2016 and *Physician Apprenticeship* elective in 2017.

The express motivation of the McGill undergraduate medical education's *Physician Apprenticeship* elective was to enhance pragmatic skills in "deep seeing," grounded in cognitive research and consultation with an interdisciplinary range of visual literacy experts (D.J. Boudreau, personal communication/invitation to student groups, January 6, 2017; see also, D. J. Boudreau, Cassell, & Fuks, 2007). The overarching aim of the *Narrative Rehabilitation* initiative for the McGill professional graduate students in occupational therapy was to enhance their practical or narrative reasoning. In clinical contexts, narrative reasoning is essential when raising questions about the best good(s) of interventions and how to understand what really matters to particular persons in particular circumstances (Mattingly, 1998b). Informed by the philosophical resources used in a conceptual framework of narrative phenomenology (Mattingly, 2010, 2014), narrative reasoning is grounded in ethnographic research of clinical encounters with children with disabilities and their families (e.g., see Lawlor, 2003b, 2009; Mattingly, 1998a; Park, 2008). (Please see Table 1 for details of the format, objectives, and key theories used in both initiatives).

Table 1

Format and objectives of the Physician Apprenticeship elective and Narrative Rehabilitation initiative

	PHYSICIAN APPRENTICESHIP	NARRATIVE REHABILITATION
Format	▪ 6-8 resident physicians and medical learners per session with 10-12 sessions offered per year ▪ These sessions are elective, and learners self-register their participation; they come from all four years of the undergraduate medical program. ▪ The sessions last about 1.5 to 2 hours: - Close observation of one artwork, where each learner makes descriptive comments about the artwork. This is followed by discussion (60 minutes); - Free period (30-45 min) structured by a written prompt, such as "Find an artwork that you might like to share with a depressed friend" (Williams, 2010) followed by each learner presenting the chosen artwork to the group.	▪ 65-70 learners/year, who are enrolled in the psychosocial stream in OT ▪ These sessions are mandatory, and include all learners in the Occupational Therapy Professional Master's program or by permission ▪ The sessions last 2 hours - Close observation of three artworks, where each learner makes descriptive comments about the artwork. This is followed by discussion (25 minutes per artwork); - Five different tours (6-8 learners/group) run in parallel across two days; - Large group discussion across 5 groups each day (20 min) about significant experiences and relevance to clinical practice.
Objectives	The objectives are consistent with the Osler Fellows Apprenticeship Program objectives (Steinert et al., 2010): ▪ Cultivate observational skills ▪ Foster reflection ▪ Develop tools for engaging in a formal analysis ▪ Practice interpretation using evidence (i.e. close observation) ▪ Create an atmosphere of respect and tolerance of other's opinions through discussion and sharing of individual perspectives of the art object ▪ Make connections between aesthetic observations (form), analyses, informed interpretations and clinical work ▪ Empathy and compassion	The objectives outlined are consistent with the critical and narrative-phenomenological conceptual framework used for the Narrative Rehabilitation Module in professional reasoning): ▪ Cultivate *participant* observation skills ▪ Foster reflection on historical inheritance ▪ Develop tools to identify significant experience (i.e., bodily-sensing, scene) ▪ Practice interpretation based on specific details ▪ Appreciate that multiple different perspectives on experience are equally valid ▪ Make connection between aesthetics as bodily-sensing of significant experiences in both museum and clinical contexts ▪ Intersubjectivity

Museum-based Curricula as an Everyday Hermeneutics

The museum-based gallery visits at the MMFA, under the guidance of Marilyn Lajeunesse, cultivated aptitudes more akin to an "everyday hermeneutics" (Park, Bonsall, & Fogelberg, 2021) or those aspects of clinical reasoning that focus attention on the meaning of illness and its impact on experience. The psychiatrist Arthur Kleinman (1988) first called attention to the meaning of illness experiences in his landmark book on "illness narratives," followed by his work to understand "what really matters" to particular persons (Kleinman, 2006). Yet, in anthropologist Cheryl Mattingly (1998a) ground breaking ethnography on clinical encounters, she described the type of narrative reasoning used to understand meaning as underground,

largely missing from charting (Mattingly, 1998b) and often considered illegitimate (Mattingly & Lawlor, 2001).

First used to decipher the meaning of religious texts, the philosopher Wilhem Dilthey (1923/1988, 1927/1977) proposed that hermeneutics, or the systematic science of interpretation, could also be used to understand the meaning of lived experience, whether through text or gesture, actions, or art. In clinical contexts, "everyday" hermeneutic practices focus on interpreting the meaning of gestures, actions and words of particular persons to understand what really matters to them and is, therefore, essential for person-centered or precision care. Yet, any focus on interpretive processes that centre upon understanding the meaning of another's experience is often missing from or remain unarticulated in biomedical curricula.

In Truth and Method, the philosopher Hans-Georg Gadamer (1975/1989) extended the study of hermeneutics by inquiring into the conditions that make interpretation, and thus understanding, possible. For him, interpretive processes were inseparable from historical situations precisely because persons are historical beings living under the influence of traditions. Foreknowledge, which is produced by the past, becomes the starting point of interpretation. Pedagogically then, a focus on interpretive consciousness requires a methodological slowing down and awareness of how both past experiences (i.e., practical knowledge) and acquired biomedical knowledge (i.e., technical knowledge) color interpretive acts. Given this anticipatory nature of understanding, Gadamer cautioned against overly hasty interpretative acts that submit blindly to the authority of the past. Instead, the "truth" of what one seeks to understand requires being attentive to the present moment while being conscious of the influence of past experiences and acquired knowledge upon judgment itself. Successful medical education programs that partner with local museums are led by arts educators (Mukunda et al., 2019). A constant in both MMFA initiatives was the design and modeling of how to conduct the gallery visits by Lajeunesse. Although loosely based on Bonnie Pitman's ground-breaking work and research on visitor engagement (Pitman & Hirzy, 2011), Lajeunesse's particular approach facilitated an interpretive consciousness. First, she began with the request to look at the art for a minimum of ten minutes to up to thirty minutes, in silence. This provided the opportunity to sink into the space and temporality of the gallery spaces, which are vastly different from the performance-oriented pressure in academic and clinical environments. Second, she provided biographical details on the artist and the context of the artwork to help situate the learner relative to the artwork historically. Third, she designed reflective questions that positioned the learner experientially in relation to the art. One notable example was the Canadian-Algonquin artist Nadia Myre's video installation of a paddler in a canoe (Myre, 2002) and her reflective question, "Do you think she is paddling towards or away from you?" By inviting learners to place their bodies and experiences—lived

and imagined—in relation to an artwork, Lajeunesse drew learners into the stance described by Gadamer (2004) as fundamental to the task of interpreting something; that is, of being "prepared for it to tell [them] something" (p. 282) rather than guiding interpretation towards some directed goal.

Deep Seeing: Details in Context

In the *Physician Apprenticeship* elective for clinical observation, medical learners engaged in an intentional and disciplined movement between description and interpretation. Based on consultations with experts in observation representing a broad range of fields (art history, veterinary science, law enforcement training, cinematography, and clinicians in pathology, dermatology, endocrinology, rheumatology, and child psychiatry), Boudreau, Cassell, and Fuks (2008) developed a teaching module reflecting eight principles of "deep seeing" that moved through "levels" of observation grounded in cognitive experience (e.g., whole person, part, personal and environmental contexts, behaviours and interactions, emotional and esthetic responses of the observer, the medium). Although the role of philosophy is acknowledged, the authors underscore the importance of embedding observational activities directly within situations from the clinical world; for example, by asking learners to describe faces and notice changes of particular clinical signs across time (e.g., colour changes in a healing bruise) through images and videos of patients in healthcare settings.

The focus on "deep seeing" of particulars helped to disrupt habitual ways of paying attention often dominant in clinical contexts. As one learner remarked:

> Too often we are "programmed for pattern recognition," which in itself isn't wrong. But sometimes it happens that we can miss small details that could tell us a lot about what we have in front of us (undergraduate medical learner).

One of the more profound comments was made by a medical resident after an hour-long session observing the painting, "The Raising of Jairus' Daughter," by the 19th century painter Gabriel Max (1878). During the final discussion, the resident recounted a recent experience evaluating the symptoms of a young patient who had a terminal illness. Struck by the expression and comportment of the Jesus figure in the painting, the resident deeply regretted not paying more attention to the woman's suffering. The honesty in the moment impressed the resident's peers, sparking a discussion on how the organization of healthcare delivery and the lack of time within clinical settings can compromise the human elements of healthcare.

Participant Observation: Bodily-Sensing during Significant Experience

The philosopher John Dewey (1934/1994) wrote about art as "an" experience; that is, the moments that stand out from "mere" experience. The *Narrative Rehabilitation* initiative

guided attention on the emergence of significant experiences from multiple first-person perspectives (i.e., I, we), which are often powerful intersubjective moments of conflict or connection (Jackson, 1998) that signal what is at stake for particular persons (Jackson, 2005). To capture these heightened moments, learners were provided with a participant observation template to handwrite a "thick description" (Geertz, 1973) of the artwork, its context and their own responses with a separate column to check if they experienced moments as significant.

Participant observations as an ethnographic method in which knowledge of one's own body and its experiences become an additional medium for understanding (Jackson, 1983). Participant observations, in contrast to clinical observations, also requires a different mode of being-with others (Lawlor, 2003a). As occupational scientist Mary Lawlor notes, participant observations require a vulnerability and an openness to being absorbed into the events, words and daily lives of others, whereas a clinical gaze is directed towards being helpful in ways that mask, limit or minimize vulnerability. Thus, the participant observation template also included cues for learners to notice and describe shifts in their own bodily-sensing. Bodily-sensing is a term that foregrounds the aesthetic aspect of experience that pertains to the senses (Park, 2008). This embodied approach was further prompted by asking learners to reflect upon the impact of the social and built environment on their interpretive acts, such as by asking, "What is your bodily-sensing experience of luminosity versus darkness? Attune to all the sounds. How do you experience the presence of the art and others around you?"

As the written feedback shows, learners remarked that some of their most memorable experiences occurred when they became aware that a certain anticipated or projected meaning was at play in their own or others' interpretations. As one learner wrote in their reflection paper:

> Why did the painting make me feel sad? Why did the blue colors evoke gloomy feelings? I began reflecting on my experience and wondering whether it was possible that I was projecting my own emotions and thoughts onto the painting. Was I seeing what I was feeling, allowing my own biases to influence someone else? […] It was here that I really understood the concept of ambiguity. We all saw different things (occupational therapy graduate learner).

Following the gallery visits at the MMFA, learners were asked to envision how the museum experience might impact on their future clinical practice:

> When working with our clients, I need to recognize that I come into a session with innate prejudice; my feelings, past experiences, values and beliefs will inevitably shape the way I see my client and connect with them. [I]f I can understand what

> they see and feel, I will be more successful in helping them accomplish their goals their ways (occupational therapy undergraduate learner).

Over the years, the explicit focus on bodily-sensing was more explicitly taught to the learners prior in a workshop created by Keven Lee based on his explorations of "moving-with" (e.g., see Lee & Park, 2021).

A Clinical Encounter: *An* Experience

Jiameng Xu participated in the *Physician Apprenticeship* elective as a medical learner and the *Narrative Rehabilitation* initiative as a PhD candidate conducting an ethnography (Xu, 2019), which used a narrative phenomenological lens supplemented by additional scholarship based on Heideggerian (1962) and Gadamerian (Gadamer & Bernasconi, 1986) resources on hermeneutics. The following case study is an exemplary illustration of how the structures of healthcare systems and technical pedagogy can impinge upon the capacity for attending to the particularities of patients and their situations. The discussion that follows reflects on how MMFA-McGill initiatives in the museum space cultivated what the authors are calling: an *interpretive historical consciousness in the clinical context*.

Clinical Observation and Procedures—Jiameng Xu's Account

In the Emergency Room, patients with complex needs have fleeting, initial encounters with multiple specialists. Those whose clinical statuses are deemed to be unstable or uncertain are placed on a stretcher in the resuscitation bay, a room of about three by four metres. As a medical learner assisting the Acute Care Services team, there I meet Mrs. E,[1] an elderly woman having delirium and extreme abdominal pain. Traversing the floor of the crowded Emergency Department to get to her, I pick up on information relayed to my clinical supervisors by nurses, unit clerks, and other specialists. Their phrasings are telegraphic—compressed packets of demographic, observed, laboratory, and other details collected since the moment of Mrs. E's arrival at the hospital:

> "She's 90-years-old."
> "Imaging shows she has a gastric perforation."
> "Vital signs stable since arrival but with fluctuating level of consciousness."
> "She's guarding her abdomen. She requires emergent surgery."

These details, rendered in a clinical vernacular, already create an image of Mrs. E's situation

[1] Mrs. E is a pseudonym.

before I even see her with my own eyes, Mrs. E is facing a life-or-death situation.

> As I draw near her room, I am already anticipating the kinds of further details that would enable me to complete my next clinical task: ascertaining the direness of her physical status. Even as I pull open the sliding door, I recall encountering patients housed in the post-surgical ward upstairs just earlier that day. Surrounded by technology—by monitors, IV fluid poles, a portable cabinet of medications—her face remains hidden. I open the sliding glass doors of the resuscitation room and step inside.

The precipitousness of Mrs. E's situation is being discussed; with each passing hour without surgical intervention, the probability of her survival steadily declines:

> "I am ready to die," she says. Physician after physician ask her to answer "yes" or "no" to whether she wants surgery and if she understands the procedure's benefits, risks, and alternatives. She responds each time with, "I am ready to die."

Protocol, however, requires that before she can undergo the operation, she must clearly state her consent.

Attending to Contextual Details

Medical training teaches a particular way to ask for a patient's consent, to conduct an *assessment of capacity*. Within this framework, Mrs. E's reply does not fit in a clear-cut way. Her statement, "*I am ready to die*" stands out as neither a refusal nor assent to treatment:

> I experience this moment as significant. My focus shifts to other contextual details, drawing my attention towards the person in the room who has been silent: Mrs. E's son. He turns toward me, breaking out from his previously unmoving stance as I approach his side. His eyes begin to shine with tears as he speaks: "Whatever she wants, I will follow. I won't decide for her—do you understand? I won't impose my wishes upon her. But I can't watch her suffer like this. I don't want her to be in pain. When my father was dying from cancer, he spent three months at home. We watched him go through chemotherapy. It almost killed me. We can't go through something like that again."

In the above scenario, Mrs. E's statement can be understood in a larger temporal context as a reflection of her own lived experience watching her husband's experiences with cancer. The bioethical principles that health professionals learn by rote—*beneficence*, *duty to treat*, *autonomy*, and *to not prolong suffering*—would direct the healthcare team to operate. Yet,

they cannot expediently ask a family member for a proxy decision to do so, given that Mrs. E's son had already stated his desire to act in accordance with his mother's wishes. The health professionals are at a seeming impasse:

> The senior surgical resident says, "We will come back." As he and I leave the resuscitation bay, I notice his shoulders slump and his gaze fall to the floor. I feel a heavy weight in my chest and abdomen.

Typically, when health professionals leave a patient's bedside, they have an idea, however faint, of what the problem might be and how to help. At this moment, neither know how to proceed.

Attending to Bodily-Sensing—Commentary

Xu's bodily-sensing awareness of the resident's "*shoulders slump*" and her own "*heavy weight*" bring awareness to the present moment rather than to any future prognosis. In this moment, Xu begins to realize how past experiences and larger sociocultural ideas about aging may foreclose attention to the present moment. As Xu and the supervisor walk to the nursing station, another surgical resident's question provides an exemplar of how this foreknowledge can enter into clinical decision making—"*But she is so old. What are we doing? Operating on her? She's over ninety*."

> Although nothing had been explicitly said, I was having trouble shaking the feeling that those around Mrs. E had reached the unspoken agreement to not proceed with the operation. Were we interpreting Mrs. E's "I am ready to die" as "please let me die" or "I do not wish for surgery"? In the absence of a certain "yes" or "no" at this time, have we already decided to let her go? (Xu)

The attention that the second resident drew to Mrs. E's age posed the question: Was Mrs. E's age, frail appearance, and being in pain and delirium steering the staff away from engaging with her further? Had Mrs. E been younger and less physically vulnerable, would the health professionals comport themselves differently around her?

> I begin to fear that the possibility of surgical treatment was being prematurely foreclosed by our assumptions that she was too old and too frail to benefit from it. With a shifting sensation in my abdomen, I turn to the surgical resident:
>
> Xu: Is this a complicated surgery?
>
> Resident: (Eyes brightening) No, it's a simple one. It's called a Graham patch. People tend to recover well.
>
> Xu: Does her age matter?

> Resident: No. She's actually really healthy. She doesn't have any co-morbidities. She's not taking any medications. People do well after, even when they are older.
>
> I feel a tug in my body to return to Mrs. E's bedside to ask her more questions.

Xu's question to the resident shifts their attention to remembering how the son confirmed that, contrary to their expectations given her age, Mrs. E neither took any medications nor had any concomitant illnesses. Attending to the "*tug in my body*" is equally a bodily-sensing signal to Xu to return to Mrs. E to understand what might really matter in her "*I am ready to die"* from Mrs. E's own first-person perspective rather than any third-person interpretation.

A Wider Range of Meanings

One resident's mention of "*she is so old*" underscores how prognosis and subsequent decisions can be made based on past clinical experiences or assumptions about age. Xu's bodily-sensing awareness in the moment interrupts or disrupts this potential prejudgment about age, allowing them to return to Mrs. E to ask a more open-ended question.

> Xu: What would you like to happen, Mrs. E?
>
> Mrs. E: If I do not get surgery, will I still get chemo?

Mrs. E's question echoes the earlier statement of her son about his late father: "*We watched him go through chemotherapy. It almost killed me. We can't go through something like this again*." Mrs. E had also watched her husband go through chemotherapy and then die at home. Witnessing her husband's gradual decline following medical treatment might have "*almost killed"* her too. Her query—"*Will I still get chemo*?"—opens up a wider range of meanings to their initial interpretation of her statement, "*I am ready to die*" and, thus, a new avenue for Xu to discuss:

> "The problem that you have is not like the cancer that killed your husband," I reply. "It is not cancer. But your stomach is like a balloon and there is a hole in it. We have to patch up the hole, and that is why we are recommending surgery." I then explain that should she choose to not receive surgical repair, she would likely die sometime in the next three days but could receive palliative care for pain.

The healthcare professionals' conception of what could be a good future for Mrs. E had been intertwined with cultural narratives about old age, disability, loss, and pain. Viewed through this narrower lens, it had made sense for the health practitioners to question the benefit of surgery. Yet, afterwards, on the post-surgical ward, Xu would learn of even more

particularities about Mrs. E that confirmed the "good" of attending to both contextual details and one's own bodily-sensing in clinical contexts.

> During my visits, Mrs. E would often refer, with a wide smile, to the beauty of the sunlight entering her window; or the clock hanging on the wall facing her bed, saying that it reminds her of her son's regular visits at suppertime, and explain she has cherished this event every day. These observations led to an understanding of what Mrs. E had stood to preserve: What was truly at the heart of it all was the relationship with her son.

Discussion

At the beginning of the clinical encounter, the health professionals' understanding was overshadowed by the projected meanings that had arisen from previous clinical observations of similar patient cases and sociocultural assumptions about the probability that frail elderly persons may not get better, have a good quality of life to anticipate, and-or do not have the capacity to make well-informed decisions on their own. While Gadamer (1975/1989) was concerned with outlining the historicity of hermeneutic experience, prejudice was simply an unavoidable aspect of human experience. Although he cautioned against allowing prejudgments to take up too much space in the foreground of understanding, prejudice, itself, also makes it possible to *have* an experience of understanding more grounded in the thing itself. For example, when projected meanings are shifted to the background in ways in which one is also conscious of them, this also allows that which one is seeking to understand to be seen more clearly on its own terms.

Deep Seeing as Historical Interpretive Consciousness

Humans are never without history, even when only minutely aware of the sphere of nascent meanings—foreknowledge, past experiences, culturally inherited expectations, and other habitual ways of being—that are brought to an encounter. These are labelled biases, often carrying a pejorative connotation. Often unconscious, these assumptions and projected meanings can have dire consequences in clinical encounters. On one hand, awareness of clinical observations as *a* historical condition—as a set of procedures, focused on symptoms and signs—is required to withstand overhastiness and the pressure to conform to institutional standards of efficiency or standardized procedures to assess a person's capacity to make their own decisions. On the other hand, "deep seeing" can bring conscious awareness back to the contextual details in a present moment during clinical encounters as a powerful check and counterbalance to the power of tradition.

For example, in the illustrative example, Xu observes a person sitting away from the circle

of clinicians in the corner, looking alone despite the cramped nature of the resuscitation bay and excluded from the discourse and action. This observation leads Xu to break away momentarily from the circle of clinicians to speak with whom she learns is the patient's son to try and understand his perspective. What Xu gains in the conversation is later taken up to inform a more inclusive decision-making process that includes both the mother's and son's perspectives. Reminiscent of the "deep-seeing" experiences felt in the museum—for example, when a resident announces regretting a lack of empathy during the evaluation of a terminal patient in grand rounds—Xu's ability to attend to contextual details while remaining open to being absorbed into the everyday life of family members in the moment underscores how levels of observation that include one's own emotional response in the clinical context is central to the process of clinical decision-making. Philosophical resources, particularly hermeneutics, can be used to question who and what is "shared" in clinical decision making (Thomas, Kuper, Chin-Yee, & Park, 2020), while also guiding learners to understand, and thus appreciate, the particular experiences of another in the moment. The statement, "*I am ready to die,"* is an existential statement that reflects the lived experience of a wife and mother to a son who witnessed what a husband and father had to endure during a different treatment. Understanding that statement from this experiential perspective opens up new avenues to ask an open-ended question that leads to a wider range of meanings that, as Xu later commented, "was the fruit of a historical interpretive consciousness lived in the moment."

Bodily-Sensing as Embodied Interpretive Consciousness

In the Emergency Department, on the cusp of turning away from Mrs. E, Xu performed an everyday hermeneutic movement. Reminiscent of the bodily-sensing significant experiences felt in the museum, the emergence of such significant moments in clinical contexts provides opportunities to revisit, (re)observe details, and revise initial interpretations. In the illustrative clinical encounter, attending to bodily-sensing—particularly disruptions of expected experiences ("*shoulders slumping, gaze falling, heavy weight"*)—announces a disruption to typical clinical procedures. For Xu and the senior resident, this signals the type of emergent significant experience that can check overly hasty judgements in clinical contexts and prompt reflection on underlying assumptions. The conscious awareness of this disruption in the present moment demands of Xu the suspension of any foreknowledge about frailty or age alone and encourages her to raise a new question to the supervisor ("*Is this a complicated surgery?"*) that leads to a wider range of meanings and, thus more hopeful, alternatives. The bodily-sensing disruption also signals the opening to an ambiguous stance that is more vulnerable than a clinical lens, type of "gazing anew" (Lawlor, 2003a) that marks a shift from clinical to participant observations.

Listening to the "*tug in the body*," in turn, marks the beginning of a reinterpretation of the meaning of "*I am ready to die."* Yet rather than taking an aversive stance towards prejudice or judging oneself and the other healthcare professionals negatively for being inseparable from either clinical procedures required during assessments of capacity or normative ideas about aging, Xu ventured to (re)interpret clinical traditions and sociocultural prejudgements to see the situation in a different light. In the *Narrative Rehabilitation* initiative, the integration of participant observations of bodily-sensing in the context of the gallery spaces, alongside visual inspection of artworks provided an opportunity for learners to reflect on the sensations arising within their body when making and revising their interpretations. Xu's bodily-sensing "*heavy weight in chest and abdomen"* signaled a significant moment that indicated that a prejudgment was at play and an interpretation needed to be revised. The difficult-to-articulate non-cognitive and embodied experiences in the health humanity initiatives in the museum thus provide a type of simulated space to practice (and methodologically slow down) interpretive conscious in the moment. Cultivating such moments of embodied interpretive consciousness might mean the difference between the choice of an appropriate treatment or not, between the creation of a healing moment or its nullification.

Conclusion

The two health humanities initiatives at the MMFA provided the opportunity for learners to engage in slow and detailed observation of artwork. Drawing from phenomenological and hermeneutical resources can catalyze learners to become more aware of the fluidity of interpretations and the influence of their own historical situations. The format of small groups also allowed for multiple, and sometimes starkly contrasting, perspectives in which museum-based workshops are akin to medical simulation centres in which learners can practice navigating between, and integrating diverse observational, interpretive, reflective, and relational registers and capacities before entering the fluid and sometimes conflicting intersubjectivity of actual and time-pressured clinical encounters. This chapter has aimed to also illuminate a deeper pedagogical role for museums in bringing learners to examine the embodied interpretive processes by which they come to understand.

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Jiameng Xu graduated from the MD-PhD program at McGill University in 2021. She completed her PhD dissertation, "Practices of Being Near: An Ethnographic Study of Family Members and Persons with Lived Experience of Mental Illness," in the department of Rehabilitation Science within the *Connected Narratives Lab* led by Professor Melissa Park. She completed undergraduate studies in life sciences, concentrating in neuroscience, at Queen's University in Kingston, Ontario. She has been involved in initiatives to create a space for the arts and humanities within health professional training and settings of health-care delivery, including *Journeys Through Health,* an exhibition of artworks by persons with lived and living experience of illness that was displayed within the halls of two teaching hospitals in Montreal. She helped found the *McGill Humanities and Arts in Medicine* student interest group and was nominated by her medical school classmates to deliver the valedictorian speech. Currently a psychiatry resident at the University of British Columbia, she aims to dedicate her career to working with patients and their families.

Marilyn Lajeunesse has worked in the museum field for over 30 years, namely at the Montreal Museum of Fine Arts (MMFA) in the Education and Wellness Department. Her expertise includes how arts can contribute to well-being, accessibility, and inclusion. She initiated the award-winning *Sharing the Museum* program in 1999, co-designing progams with community

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