

The Use of Narrative in the Doctor-Patient Encounter

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This article considers the value of narrative in the doctor-patient relationship. The goal of storytelling as a therapeutic enterprise for both doctor and patient is examined. Special attention is paid to the physician's role as narrative facilitator, and the article suggests guidelines for fulfilling this function in a way that is respectful and potentially transformative. The article concludes by offering some possibilities for evaluative criteria to be used in determining the trustworthiness of a given narrative exposition.

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HISTORICALLY, listening to patient stories has been an integral part of medicine (17). It was from the illness story of the patient that the physician constructed a diagnosis and prognosis. However, the biomedical revolution that transformed the practice of medicine has not looked kindly on patient narrative (5, 32). High-tech procedures, test results, and lab values frequently appear to overshadow the patient's story, which may seem excessively imprecise and insufficiently technical. The danger exists that the skills of understanding, recognizing, and eliciting narrative may fall into disuse. More and more, patient narrative is judged to be alien, confusing, or even irrelevant (9). Yet the importance of narrative cannot be

overcome by exclusive reliance on the biotechnical aspects of medicine. Many psychologists and philosophers have asserted that stories are our primary means of organizing and making sense of our world, our best solutions to problems-in-living, a major way of coping with human experience (23). If this is the case, they cannot reasonably be omitted from the realm of patient care. More than ever, we need to learn how to facilitate, encourage, and respect, rather than demean and cut off, the stories of our patients.

The Narrative Mode in Medicine

The classic example of narrative in medicine is the patient history, or medical interview. This is the opportunity for patients to present an account of their illness through the prism of personal experience and values. However, the medical interview has become so structured and analyzed that it runs the risk of becoming simply one more mechanistic tool in the armamentarium of the contemporary physician. Nevertheless, it is through the interview (and subsequent followup dialogues) that the physician has the best opportunity to access the subjective, idiosyncratic context in which the presenting symptoms occur.

The genogram also has the potential to facilitate the telling of a patient's story (20). Ideally, the structured approach of the method provides a measure of psychological safety for the teller, and enhances its narrative, self-revealing potential (27). Yet, when time is short and anxiety high, a

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temptation exists for both physician and patient to hide behind the technique of genogram, and to avoid its narrative basis (29).

Storytelling as Healing

Despite a diminishing facility to be sensitive to narrative in the doctor-patient encounter, stories have the power to heal lives and relationships (34). Various writers in family medicine have described storytelling as “restoring a disrupted connectedness” (3), reducing anxiety and guilt, and giving coherence to the self (30). It is also possible to differentiate between pathogenic and therapeutic stories (15). The former diminish, harm, and alienate both patient and physician. Therapeutic stories, by contrast, promote competence and well-being, and are transformative and healing (33). One goal of storytelling in medicine is thus to transform patient narrative into stories of healing.

Hannah Arendt, a social philosopher (see 21), and G. Gayle Stephens (31), a family physician, have both observed that stories do not literally recreate experience. Rather, they are always inventions or discoveries. Thus, to paraphrase Stephens, what is required in narrative is the mutual construction of a coherent, convincing, and shared account of how things came to be as they are, and what might be done to ameliorate their debilitating effects. Further, as Oliver Sacks (22) observes, it is not only the patient whose healing is enhanced by narrative. In his own field of clinical neurology, he intimates that the physician who is deprived of patient narrative experiences a reduction in his or her understanding of the world and, ultimately, in the sense of self. Through careful attention to the eliciting and construction of the patient’s story, healing becomes a potentiality not only for the patient, but for the physician as well.

Dimensions of Literature

Classically, four elements of literature have been identified: character, plot, theme, and style (12). While these may not, on the surface, seem of importance in patient history-taking, nevertheless they have profound implications for our understanding of the patient. In terms of character, a knowledge of patient psychology and motives is the key to interpreting the information they present. Central to the plot are human predicaments and their attempted resolutions, of which disease and its cure or amelioration are merely specific subsets. The theme, or definitive message, insight, or organizing purpose of a story, provides us with a context in which to understand specific disease-oriented complaints. Finally, style, or the manner in which narrative is presented, yields significant clues about the person of the narrator. How does the patient tell his or her story? How do patients use detail, language, and dramatic climax? Where does their story become obscure, confusing, or unbelievable? These questions all help us assess potential areas of confusion and miscommunication in the doctor-patient interaction.

Myths and Metaphors

Perhaps the classic narrative pattern of the Western world, as identified by Joseph Campbell (6), is the prototypical myth of the heroic journey from which all other stories are derived. Narratively, it has been argued that we continually create through our stories myths that then determine, and at times overdetermine, our lives. In listening for narrative exposition, it can be useful to identify those elements of narrative that have assumed a mythic quality in the patient’s life. The healing goal of storytelling is to emerge from the mythic structure one has created, and shift to more advanced, more psychologically useful, mythic structures (10).

Several psychologists have stressed the developmental primacy of metaphor (11), arguing that metaphor is a fundamental category of human thought, required to reflect on and understand all human experience (19). In eliciting a patient narrative, we should be sensitive to the use of metaphor for what it reveals about the patient's understanding of his or her illness. When a patient says, "I feel so trapped by this disease," we must not ignore his or her need for liberating strategies. To adequately respond to such patient concerns, we must be prepared to "work within the metaphor" (24), explicitly exploring metaphorical language as a way to help the patient develop feelings and associations that otherwise might remain hidden.

Language

The above discussion suggests the primacy of language in the construction of narrative. Several authors (for example, 16) have noted that patients use a markedly different language from that of physicians in attempting to recount their illness stories. The task of the physician is often inappropriately defined as one of translation: to take the fear and suffering of the patient's language and transform them into the antiseptic and technical structure of the chart note. The point here is not that one language is "better" than another. The chart note, for example, efficiently and succinctly communicates a certain medical "story" to whomever peruses it. It is also an effective and successful story in terms of obtaining insurance reimbursement and warding off litigious actions (2). However, when one language (in this case, the medical language) is chosen to the complete exclusion of another language (the words and way in which the patient chooses to couch her or his story), or when the patient story is "discarded" as superfluous and irrelevant after the process of clinical translation, then an irreparable

loss of richness, viewpoint, and understanding has occurred.

The Need for Alternative Stories

Several authors have pointed out the need to help patients develop alternative stories, stories that more honestly and completely represent their lived experience (3, 10, 13, 15, 34). In what Howard Stein (30) has labeled "the official story," significant and vital aspects of the patient's life are omitted because they contradict the dominant narrative. A patient conceals her fear of breast cancer because she wants to appear competent and courageous in the eyes of her physician. A primary goal of narration, then, is to resurrect the "subjugated knowledges" (34, p.25) of the patient in order to bring into narrative form those parts of the story that have been rejected as too painful or too self-revealing.

Co-Creation of the Story

Storytelling is always a collaborative, conjoint endeavor. Sometimes this collaboration is sought out, sometimes imposed (21). Regardless, stories must be tested on others, and at times the storyteller must accommodate to the views of others. Howard Brody (3) posits an innate human need to tell one's story to someone, and, certainly, all people have told and listened to stories in all cultures throughout time (14). Sometimes patients need to tell their story more than once. In this repetition, there seems to be the urge to tell it "till we get it right," and narrative thinking moves from a poor, unconvincing story to one that is compelling and good. This analysis suggests that, in medical stories, the patient needs the physician as the recipient and co-creator of his or her narrative.

We may consider narration to be a reciprocal exercise, consisting both of the act of telling the story and the act of responding to it. In this mutual, interactive approach, the physician does not

simply “take a history,” but is also prepared to see the patient narrative grow and change over time, and to participate in that process. In this interpretation, the act of co-creation of patient narrative must be mutually negotiated between physician and patient. Such an approach assumes the intrinsic value of patient narrative, although it does not conform to biomedical rules and formats, and does not attempt to dismiss this narrative once the essential “biomedical” aspects have been extracted (16).

Although I am arguing that the very act of telling of one’s story has therapeutic properties in itself, acting as a release and a validation, nevertheless, in the role of “editor” or “co-author” of patient narrative, the physician acquires several responsibilities. First, there is the responsibility not to abandon the patient, not, so to speak, to shut the book half-way. In this regard, it is well to keep in mind the qualities considered necessary in effective textual interpretation (26). Here, the one approaching the text first must be intimate with that text; second, be willing to immerse himself or herself in the world created by the text; third, must care about the text, and not do intentional violence to its meaning; and, finally, must have a commitment to cultivate and harvest the meanings contained within the text.

In apprehending patient narrative, physicians might similarly be guided by such principles of respect, regard, and caring. Perhaps most interesting is the claim from the field of literary analysis that intimacy and immersion are required for successful textual interpretation. The physician who eschews involvement in patient narrative is no more likely to succeed in achieving insight and understanding of the patient than the dispassionate critic is likely to reach rapprochement with a text.

The physician also has the responsibility

to challenge automatic or conventional elements of the patient’s story, in effect, to say to the patient, “It seems to me there is much more to tell here.” In this guise, the physician’s responsibility is to help the patient’s tale gain momentum and depth, to draw out the story in hiding. In a similar vein, the physician commits to scrutinizing each patient’s story in order to find new meanings that may more accurately reflect the reality of the storyteller and, in so doing, help the storyteller see where the story wants to go (35). Thus, the task of the physician interested in patient narrative is both to help the patient retrieve meanings about oneself in relation to one’s illness, meanings that have been lost, and to facilitate a more honest appraisal of the implications of the patient’s illness.

The physician can also attempt to recognize and/or encourage conditions that facilitate the creation of meaning (8) during the process of patient narrative. In eliciting a patient narrative, the physician must encourage the patient to be emotionally engaged in his or her story, in other words to acknowledge fears, hopes, and expectations. Further, the physician needs to create conditions in which patients feel safe enough to be willing to challenge personal myths that may impede an accurate narrative (28): a patient whose mythology says, “I’m healthy as a horse,” may be unable to disclose persistent chest pain. Finally, to facilitate a meaningful patient story, the physician must help patients take the risk of confessing those aspects of their story that are confusing and full of gaps. When we demand certainty, patients oblige with fictive information that conforms to our logico-scientific criteria, but distorts the patient’s reality. When we allow ambiguity and mystery their place in the treatment room, patients have permission to offer narratives with those qualities as well.

Pitfalls of Co-Creating Stories

Howard Stein (27, 30) has pointed out the importance of paying attention to what we allow and do not allow to emerge as "acceptable" narrative material in the patient's story. Elsewhere, this practice has been referred to as narrative smoothing (25) whereby, in our role as facilitator and listener, we guide the storyteller to omit data and to make the story fit our preconceived model. We unconsciously censor our own and others' stories, translating what they say into what we can tolerate to hear.

In this regard, Zuckerman and Weidman (36) refer to narrative failures, and identify the inability of narrator and listener to connect or to form a therapeutic alliance; the failure of the listener to elicit more than fragments of a story; and the inability of both narrator and listener to resolve their conflicts about the essential nature of the story. We must conscientiously ask ourselves if our translations of the patient's story tend toward the official version, in line with our own theories and observations. Do we make leading suggestions to elicit a narrative that supports conclusions we have already drawn? At times, writes Stein (30), we confuse our stories with the stories of our patients, superimpose them, then try to treat and cure them under the guise of curing the patient. In the end, we risk depriving our patients by denying their stories.

Is It a Good Story?

One might reasonably argue that we should be reluctant to evaluate any patient's story, that is, to apply trustworthiness criteria (18). Such an act of judgment has the potential to stifle narrative creativity. However, in some way, we need to make sense of what we have heard, and it is from this perspective that the following criteria (30) are offered.

In listening to a patient narrative, we may ask if it is life-like—its verisimilitude (4). This criterion does not necessarily imply realism in a literal sense but, rather, whether the story provides a recognizable representation of life on some level.

Second, we can ask if this story is capable of generating multiple interpretations—its narrative indeterminacy. A story is richer and deeper if its meanings are not predetermined but, rather, are multiple, not preexistent, able to be constructed and reconstructed with each telling.

Third, does the story make sense? Is it credible—its narrative fidelity? In the light of one's own experience, and in light of previous stories one has accepted, is this story believable?

Fourth, is the story helpful to the patient, and possibly to others? Is it capable of deepening understanding? Does it produce change? Can a patient's story evolve or be written to transcend "narrative stuckness," whereby each chapter pathetically reiterates: "I just can't change my diet," or "I'll never quit smoking."

Finally, is the story capable of emotionally moving both patient and physician—empathic resonance? Does it facilitate a caring response in others? G. Gayle Stephens, talking about the doctor-patient relationship, wrote, "Woundedness makes the difference" (see 7), suggesting that it is only when we feel deeply that we are capable of caring greatly.

Levels of Interpretation

Traditional biblical exegesis teaches that there are four levels of interpretation possible in any text (1): the literal, which examines the literal facts of the story; the moral, which teaches a lesson of how we should behave; the allegorical, which reveals hidden meanings in the story; and the anagogical, or spiritual, which addresses how the narrative answers questions about the nature of humanity and

the nature of the universe. In the doctor-patient encounter, all levels of interpretation eventually should be satisfied, from the gathering of laboratory data to an exploration of the emotional and spiritual ramifications of the patient's condition. When this occurs through a mutual dialogue developing over time between physician and patient, the potential for both revelation and healing exists. In the receiving and co-creation of patient narrative, it is this goal we should strive to achieve with our patients.

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