Narrative Medicine

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Bearing Witness
by Michael Kaffman, MD

I clearly saw that her every attempt
to break out,
every attempt to explain
her pain
is like being trapped in a spider's net.
As if every additional symptom,
every sensation,
every treatment she had, and every specialist
she saw,
have increased her captivity
and now she is trapped
as if paralyzed
like a hunted fly who waits to be sucked
and dried out
to its death.
And I clearly saw that every attempt to help her
had only ensnared her the more.
I sat in the quiet that formed after
her long monologue of suffering, of helplessness.
I felt my neck muscles tense
the rigidity at my low back.
I took a deep breath and
waited.

Physicians have stories that demand to be told. It is no wonder, given their line of work. The air in clinics and hospital units buzzes with compelling life and illness stories – not only those of patients but of their lay and professional caretakers as well. Sometimes these are stories of relief and healing, but all too often they tell of pain, helpless struggle, frustration and defeat. Narrative Medicine, or medicine practiced with narrative skills, considers the stories of patients and their caretakers as integral to the experience of ill health and healing. In Europe, the United States, Canada, and Israel, NM researchers and facilitators have begun to investigate the development of physicians' sensibility to language and promote narrative competence as a teachable mode of practicing evidence-based medicine with the skills of active listening, close reading and narrative writing.

NM = narrative medicine

The underlying assumptions of connecting medicine and the acquisition of narrative competence are: a) efficient clinical judgment is case-based; it begins with understanding and interpreting the individual case and ends with action on the patient's behalf. b) understanding and interpretation are narrative skills; and c) narrative skills can be taught to medical students and health care practitioners by using learning methods from literary studies and the qualitative social sciences. This paper discusses the clinical rationale of Narrative Medicine, its efficacy and ethicality in producing more accurate and humane clinical decisions and relations, and the methodology of its teaching in medical schools.

Practicing physicians have always known that clinical medicine is a science of individuals. Rather than applying universal scientific truths to every patient in the same way, the experienced doctor exercises clinical judgment, defined here as the subjective application of scientific knowledge to the individual case at hand. Successful diagnosis, prognosis and treatment of diseases depend on the clinician's ability, first, to understand and interpret the particulars of the individual patient's complaints and malfunctions and, second, to compare these details differentially with many other case histories within the correct scientific category [1]. This is why the basic clinical – and educational – unit has always been the individual case. As Kathryn Montgomery Hunter puts it, "medicine is grounded in subjective knowledge – not of the generalized body in textbooks, which is scientific enough – but the physician's understanding of the particular patient" [2]. What researchers in narrative medicine realized is that in contrast to the clinical *ideal* of scientific certainty and simplicity that traces a direct line from cause to effect, *practical* medical reasoning is interpretive and narrative. The clinical diagnosis and prognosis require "[p]iecing together the evidence of the patient's symptoms, physical signs, and test results to create a recognizable pattern or plot" [3]. From a narrative point of view, this is the creation of the medicalized illness *story*, even though it is a story that enjoys high social status, cultural authority, and legitimacy [4].

In the process of creating the medicalized story, the wise

physician uses scientific knowledge as a tool which he or she recognizes as necessary but never sufficient. Prior to the application of any scientific generalization, the physician must engage in active listening to the patient's unique verbal and non-verbal elements in the illness story. The ability to listen, to interpret, and then to represent the patient's evolving story in medical terms lies at the heart of medicine's pragmatic and case-based form of reasoning. However, unlike the traditional, biomedical history taking, NM contends that the illness story must not end with the biotechnical model – nor even with the bio-psycho-social description of disease. The next and crucial stage in the process of exercising narrative rationality within patient-centered medicine calls for an affiliation with, or the co-creation of, patient and doctor illness stories [5,6]. This last stage merits some explanation since it goes against the grain of both the traditional hierarchy of patients' and physicians' status in society as well as the predominant reliance on the material and physical story of disease in medical schools and hospitals.

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In the clinical setting, the narrative framework invites both physicians and patients to conceive of themselves as collaborative performers in the process of making a better illness story [5,7-9]. This means that physician and patient enter a process of negotiation through which they establish an ongoing dialogue by (re)telling and responding to an evolving mutual story. Here the physician does not hold a privileged position of power by "extracting," "distilling," or "translating" the patient's illness story into the biotechnical language of disease. Rather than impose the medicalized illness story as objective and superior to the patient's illness story, physicians who practice NM perceive it as a narrated professional *response* to the patient's presenting story. The physician's narrative becomes, in turn, available to the patient's response and retelling of the illness story [10,11]. It is offered not as a self-evident scientific truth but as a useful and indispensable component in the mutual construction of a better, more compelling, and therapeutic story over time. In other words, the joint story that physician and patient construct should carry enough persuasive power to convince both of them to undertake mutually agreed-upon actions on the patient's behalf [12]. A striking example for combined Narrative and Evidence-based Medicine is offered by a case report constructed by the second author, his patient, and two colleagues [13]. The report describes a clinical dilemma concerning a syncope due to paroxysmal atrial fibrillation in a patient with multiple problems. The patient narrated her various medical experiences and encounters with doctors, and shared her narrative with her physician Shmuel Reis. The report shows how the act of mutual narration levels the field of clinical relationships, humanizes the clinical encounters, and, in this case, fostered a dialogue between the patient's story of viewing anticoagulation as a sign of the incapacity she wished to avoid and the doctor's story of the clinical evidence and his fear of not preventing a stroke in his patient. The narrated dialogue between physician and patient unfolded for over a year before a shared process of decision making resulted in a compromise between the two stories.

The core insight of narrative medicine is that medical knowledge is stored in narrative schema while medical care is a narrative mode of making sense of, and being moved to action by, an individual's predicament

The dialogic nature of the narrative framework stands in alliance with contemporary understanding of patients' legal rights while expressing professional respect for the patient's autonomy. It also implies a broader conception of medicine itself. The core insight of NM is that, behind its positivist scientific outlook, medicine is located in a thoroughly constructivist position: medical knowledge is stored in narrative schemas while medical care is a narrative mode of making sense of, and being moved to action by, an individual's predicament [6,14,15].

Whether they are called patient-centered care, sustained partnership, or relationship-centered care, the changed doctor-patient communication models demand an increasingly more complex conception of clinical practice from health care professionals [16,17]. If, until recently, doctors learned to approach a patient as "a person in a role," and to treat this "person," in turn, as an organism that was analyzed wholly in terms of functions [18], today such a biomedical concept has given way to include the physician's understanding of *this patient's* predicament, *this person* who is not only embedded in particular social and familial circumstances but also embodies specific fears and hopes, cultural and group identity, and an individual existential plight.

A historical example of fundamental significance is J. Medalie's famous story that launched the construct of "the hidden patient" [19]. Medalie, a young rural general practitioner in Israel in the 1950s, was making regular home visits to a post-myocardial infarction patient in an agricultural community, supporting the patient's recovery and return to work. In spite of an uneventful course, recovery did not occur. Medalie noticed that the patient's wife was dominating the house calls by prolonged lists of questions, whereas the patient himself seemed passive and almost content. When called for an emergency in this household in the middle of a stormy night, he reviewed en route his case management and all the possible catastrophes he may encounter upon arrival. To his surprise, the door was

opened by the patient himself, who summoned the doctor to the couple's bedroom where his wife lay dead after having committed suicide. Medalie, who eventually became the first Chair of Family Medicine in Israel and a world leader in the discipline, shared his narrative reflection on this story with colleagues in Israel and abroad. The story has gained mythical status, propagated worldwide by word of mouth until published 45 years later. It manifests the power of illness narratives to drastically change medical perspective and management by identifying hitherto unheard of diagnostic constructs, such as the hidden patient.

Narrative medicine answers the overwhelming challenge of understanding the patient's unique illness story *and at the same time* expertly treating patients' diseases. It does so by introducing narrative as a consistent conceptual framework through which physicians can think of all the levels of health care, including a self-reflexive interrogation of their own values and beliefs [10]. The underlying premise of using narrative as a way to connect individual illness stories and evidence-based clinical practice is that it is through stories that we humans understand ourselves and our lives. Indeed, human life itself is a social, cooperative story or collection of stories. The stories we tell about our culture and our narrative versions of who we are shape our expectations, possibilities and identity in significant and dynamic ways [20]. Health crisis situations demand that people revise their life narratives to incorporate the overwhelming presence of illness. For the time being, their thickly layered illness stories become the persons they are [21,22].

Acquiring the skills of a good reader, i.e., "narrative competence," is essential to the physician's daily job of listening to the patients' stories and making sense of their often messy accounts

Narrative medicine practitioners are deeply aware that "a scientifically competent medicine alone cannot help a patient grapple with the loss of health or find meaning in suffering" [23]. Rita Charon, Chair of the Program in Narrative Medicine at Columbia University and a prolific NM researcher, maintains that without serious engagement in the narrative basis of the clinical encounter, communication between physician and patient is bound to be reductive and the quality of medical care can be critically compromised [24]. For Charon, acquiring the skills of a good reader, what she calls "narrative competence," is essential to the physician's daily job of listening to the patients' stories and making sense of their often messy accounts [25]. Other medical educators and physician-writers have emphasized the physician's own role as a storyteller, not just in terms of taking patients' histories but on the more profound level of recognizing that, in treating their patients, doctors invariably fall back on their own "human nature" or, more precisely, on their narrative grasp of the world [26]. It is their narrative grasp, or narrative capability, that directly affects doctors' interpersonal skills and ethical sensibilities. This is why, in order to achieve patients' empowerment in the clinical encounter, physicians themselves must be first empowered by enhancing their narrative feelers and knowledge of the personal, cultural and historical forces that bind the doctor-patient relationship in a narrative situation. The great bonus for practitioners of NM is a renewed sense of the meaningfulness of their commitment to medicine and success in combating burnout, as attested by numerous reported experiences of physicians' personal and professional development [27,28].

Moreover, practically all NM practitioners and researchers remind health care professionals that specific instruction on how to talk to, listen to or interact with a real human patient is an evidence-based desirable practice. Seasoned practitioners of evidence-based medicine see such narrative intervention as a welcome increase in clinical rationality that fosters emotional honesty about the inherent uncertainty of medicine and life itself [29]. NM educators and practitioners, while still supporting the standard, textbook way for writing the history in charts, are promoting a listening, conversational style and a self-reflective stance that continually serves to remind the physician that the stakes are high for both patient and caregiver and getting the story right is an absolute necessity [30,31]. While each NM facilitator and educator informs workshops and courses with his or her own "human nature" or narrative grasp of the world, all of them are geared toward closely reading literary and orally delivered narratives, class discussions rather than lectures, and writing exercises in small groups, expressing clinical experiences and dilemmas, in response to structured prompts or diverse literary, cinematic, dramatic, photographed and other means of telling illness stories. The growing theoretical materials in NM educational research may be summarized by the facilitator in introductory comments or provided in a collection of texts that supports the learning process. Either way, the emphasis in NM workshops is on promoting reflective practices, which as recent research shows drastically improve health care professionals' diagnostic capacities in complex situations [33].

Our own work in directing NM workshops for health care professionals creates the space to reflect in reading and writing, and thereby also enhances physicians' ability to engage in acts of witnessing and compassion. We believe that the development of self-reflection and self-awareness is instrumental in the establishment of a clinical reality that supports both patient and physician empowerment. Reflective practice, in this sense, is the constant self-awareness that recollects moments of practice, with all their intricacies, limitations, strengths and vulnerabilities, in a circle of questioning and testing that assures an evolution of practice, theory, and the lived experience of care [34]. The increase in the practitio-

ner's self-knowledge is in fact a prerequisite for meeting the patients' predicament – the ideas, concerns and expectations about health and treatment that comprise each patient's (and doctor's) unique narrative about reality.

Michael Kaffman's poem cited at the opening of this article was written in one of these NM sessions. It embodies another NM salient feature: engaging in the expectation of both patients and individual physicians that doctors should connect with care and feel empathy for their patients. The duty to bear witness to human pain and suffering is too often discarded under the stressful daily demands and impoverished resources of our health care system. Nonetheless, for the patients and their relatives the physician always *is* a witness, and his or her ability to enact this role with compassion can make or break the coherence of their illness stories, even, indeed especially, at their most chaotic moments. The physician-speaker of this poem receives his patient's suffering and can share in it at once viscerally, in his own tense body, temporally, by the extended act of waiting, and rhetorically through the pain and helplessness that he witnessed and imaginatively recreated. The poem as a whole manifests what has become the ethos of the NM clinical experience: "that one must tell of what one undergoes in order to understand it and that, as a consequence, the health professionals who accompany one through illness have a responsibility to hear one out" [35].

NM is by no means a mainstream movement in medicine or medical education at present. While becoming quite visible in the literature, it still forms "islands" rather than "bridgeheads." Its further propagation seems to await both more empirical work demonstrating clinical benefits and the maturation of different educational and practical approaches. And yet, NM education emerges as a pragmatic method of ensuring efficient implementation of evidence-based care precisely because it is the best bridge we have to date between the generalizations of scientific knowledge and the practical requirement of constantly adapting these generalizations to clinically unique situations.

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