

## Narrative and Medicine

Rita Charon, M.D., Ph.D.

A 36-year-old Dominican man with a chief symptom of back pain comes to see me for the first time. As his new internist, I tell him, I have to learn as much as I can about his health. Could he tell me whatever he thinks I should know about his situation? And then I do my best not to say a word, not to write in his chart, but to absorb all that he emits about his life and his health. I listen not only for the content of his narrative, but for its form — its temporal course, its images, its associated subplots, its silences, where he chooses to begin in telling of himself, how he sequences symptoms with other life events. I pay attention to the narrative's performance — the patient's gestures, expressions, body positions, tones of voice. After a few minutes, he stops talking and begins to weep. I ask him why he cries. He says, "No one has ever let me do this before."

More and more health care professionals and patients are recognizing the importance of the stories they tell one another of illness. As my colleagues and I in the Program in Narrative Medicine are discovering, not only is diagnosis encoded in the narratives patients tell of symptoms, but deep and therapeutically consequential understandings of the persons who bear symptoms are made possible in the course of hearing the narratives told of illness. Such fields as medical interviewing, primary care, literature and medicine, and relation-centered or patient-centered care have revolved around these "tellings" — whether the patient's private account in the office, the intern presenting on visit rounds, or the physician dictating a death summary after decades of now-ended care.<sup>1</sup> In turn, doctors have learned about therapeutic listening from practitioners of oral history, trauma studies, autobiography, and psychoanalysis. Only in the telling is the suffering made evident. Without the telling, not only treatment but suffering, too, might be fragmented. We have only to read the masterly accounts of illness written by patients — Jean-Dominique Bauby's *The Diving Bell and the Butterfly*, Christina Middlebrook's *Seeing the Crab*, John Hull's *Touching the Rock* — to grasp the power

of the telling of illness and to accept our obligation to learn how to receive these stories.

Like their patients, some doctors have learned that it helps to represent, in words, what they go through in practicing medicine. More and more doctors write about their practices not in scientific reports but in narrative records of meaningful human interactions. In books and essays for medical and lay audiences or in private notes for themselves, doctors describe the emotional and personal aspects of their care of particular patients. Some authors report that such writing helps them to comprehend both their patients' ordeals and their own lives with the sick.<sup>2</sup> By rendering whole that which they observe and undergo, doctor-writers can reveal transcendent truths, exposed in the course of illness, about ordinary human life.

In the effort to help doctors understand what they and their patients experience in the presence of illness, medical educators have been paying increasing attention to narrative competence, defined as the set of skills required to recognize, absorb, interpret, and be moved by the stories one hears or reads. This competence requires a combination of textual skills (identifying a story's structure, adopting its multiple perspectives, recognizing metaphors and allusions), creative skills (imagining many interpretations, building curiosity, inventing multiple endings), and affective skills (tolerating uncertainty as a story unfolds, entering the story's mood). Together, these capacities endow a reader or listener with the wherewithal to get the news from stories and to begin to understand their meanings.

When a doctor practices medicine with narrative competence, he or she can quickly and accurately hear and interpret what a patient tries to say. The doctor who has narrative competence uses the time of a clinical interaction efficiently, wringing all possible medical knowledge from what a patient conveys about the experience of illness and how he or she conveys it. Not only the story of an illness, but the illness itself unfolds as a narrative. A disease has

a characteristic time course, a complex mixture of causality and contingency, singular differences from and generic sameness to related diseases, a textual tradition within which it can be understood, and even a metaphorical system that reveals it (consider, for example, the complex metaphorical meanings of the word “immunity”). Narrative competence gives the doctor not only the means to understand the patient, but fresh means to understand the disease itself.

To enter a story is to make room for its teller, and the doctor with narrative skills habitually confirms the patient’s worth in the process of attending seriously to what he or she tells. Such a doctor will demonstrate concern for a patient while concentrating on what the patient says and, as a result, can achieve the genuine intersubjective contact required for an effective therapeutic alliance. Narrative competence includes an awareness of the ethical complexity of the relationship between teller and listener, a relationship marked by duty toward privileged knowledge and gratitude for being heard.

What was once considered a civilizing veneer for the gentleman physician — reading literature, studying humanities, writing in literary ways about practice — is now being recognized as central to medical training for empathy and reflection.<sup>3</sup> Capacities that medicine now sometimes lacks — attunement to patients’ individuality, sensitivity to emotional or cultural dimensions of care, ethical commitment to patients despite fragmentation and subspecialization, acknowledgment and then prevention of error — may be provided through a rigorous development of narrative skills. Perhaps strengthening the narrative competence of doctors might help them to achieve such elusive goals as humanism and professionalism by providing them with graduated skills in adopting patients’ points of view, imagining what they endure, deducing what they need, and reflecting on what the physicians themselves undergo in caring for patients.<sup>4</sup>

Narrative skills that are important to medical practice have been identified, and methods of teaching them have been developed. Programs are emerging in “narrative medicine” or “narrative-based medicine” to teach specific aspects of narrative competence. Such training efforts encourage health care professionals and students to write

about their patients in nontechnical language, helping them to uncover and understand their implicit feelings toward and knowledge of their patients. These programs provide rigorous training in reading literary texts to supply health professionals with the equipment to interpret and make sense of the stories of others. Clinicians who receive such training often encourage patients to write — or, as with the young man in my office, to tell — in uninterrupted narrative flow about their illnesses, demonstrating the therapeutic benefit for patients of such narration.

The mechanisms and processes by which narrative training benefits health professionals are currently under active investigation in federally funded research projects. Research on the outcomes of narrative writing in medical schools is under way in a number of settings, and the consequences of narrative training for multidisciplinary health care teams are just now being tracked. Investigators are examining the outcomes of therapeutic narrative practices in the ongoing care of the chronically ill.<sup>5</sup> The potential costs of these new narrative practices, including the increased time it may take to meet with new patients and challenges to patient confidentiality, are being recognized and addressed.

Many previous efforts have been made, from Francis Peabody on, to listen to patients and to care about what happens to them. My patient with back pain — actually a composite of several new patients I saw recently — revealed to me the connections among his symptoms, his illiteracy, his failures as a breadwinner, his familial losses, and his life in an alien culture. Armed with such knowledge, available to me most expediently through his personal narrative, I confirmed the gravity of all he told me and shared my optimism that things could improve for him. Together, we made a plan to investigate his educational needs and to evaluate his musculoskeletal symptoms. The more medicine understands the complexities of illness, the better clinicians can formulate their roles with respect to patients, both in technical dimensions and in dimensions of meaning. Narrative studies, many physicians are beginning to believe, can provide the “basic science” of a story-based medicine that can honor the patients who endure illness and nourish the physicians who care for them.

From the Program in Narrative Medicine, College of Physicians and Surgeons of Columbia University, New York.

1. Hunter K. *Doctors' stories: the narrative structure of medical knowledge*. Princeton, N.J.: Princeton University Press, 1991.
2. Verghese A. The physician as storyteller. *Ann Intern Med* 2001;135:1012-7.
3. Halpern J. *From detached concern to empathy: humanizing medical practice*. New York: Oxford University Press, 2001.
4. Greenhalgh T, Hurwitz B. *Narrative based medicine: dialogue and discourse in clinical practice*. London: BMJ Books, 1998.
5. Pennebaker JW. Telling stories: the health benefits of narrative. *Lit Med* 2000;19:3-18.