

The Principles and Practice of Narrative Medicine

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CHAPTER 13

Clinical Contributions
of Narrative Medicine

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Rita Charon

Health is life lived in the silence of the organs.
—Réne Leriche, 1936¹

The clinical consequences of narrative medicine are the measure of the promise of our work. Although the conceptual and pedagogic dimensions of our work continue to grow, the North Star guiding narrative medicine has been, from the start, to improve health care. We have the benefit of on-going discerning dialogue about the contributions of narrative medicine to the clinical enterprise, as both critique² and confirmation of the dividends of narrative rigor in routine clinical practice.³ Our experience and the experience of others have demonstrated the potential of narrative practices to transform healthcare. Emergency medicine physician and fiction-writer Frank Huyler proposes the following reasons for providing narrative training in healthcare:

Studying the humanities . . . [helps us] . . . become more aware, more insightful, more reflective, and—ultimately—more influential in shaping the trajectory of healthcare. It's about encouraging the facility, willingness and ability to enter into the larger public debate in these cacophonous times, when collective silence will not serve. . . . And, finally, it is about providing an outlet for both emotional engagement and self-reflection in a culture that typically denies both, looks outward rather than inward, and too often ignores not only the personal costs but the personal rewards of medical work.⁴

This chapter gives examples of several forms of clinical narrative medicine practice that have developed since the 2000 emergence of narrative medicine,

catalogued into (1) interview/relationship techniques with individual patients, (2) clinician and healthcare team development, and (3) deployment of novel narrative practices in routine clinical care. This is not to be taken as an exhaustive list of procedures but rather as an invitation to conceive of, together, the affiliative road ahead.

Individual Interview/Relationship Techniques

An Open Beginning: We have learned through practice in many clinical disciplines and specialties to open a conversation with a patient with a broad, non-directive invitation to speak. The wider the first question posed to a patient the better the conversation ensues, the more one can learn about the patient, and the greater are the number of things the patient and clinician can do together. Many interview technique manuals endorse the “open-ended question” as a cardinal feature of a patient-centered interview; we have come to consider that openness as a feature not of the end of a question but rather as the beginning of the very posing of it.

In my own internal medicine practice, I often begin an encounter with a new patient with this invitation: “I will be your doctor, and so I need to know a great deal about your body, your health, and your life. Please tell me what you think I should know about your situation.” In beginning a conversation with patients I know well, I have learned to signal a similar openness to begin wherever the patient chooses to begin. Such linguistic practices invite the patient to frame the problems that require our attention and to include in our gaze whatever events or situations might be related to the present concern. The triad of body, health, and life seems wide enough not to exclude many things that might be on that patient’s mind.

I have trained myself to listen to the answer to this question without writing, typing, scanning the computer monitor—hands in lap, listening. The rolling of the office chair away from the computer monitor toward the patient as he or she sits in the other office chair is itself a meaningful physical action. Attentive listening is the core of the practice, far more important than exactly what words are used. It is here in the reception of the patient’s response that the narrative aspects of the healthcare encounter occur and that all the skills of narrative medicine are put into practice. Philosopher and activist Simone Weil writes, “The capacity to give one’s attention to a sufferer is a very rare and difficult thing; it is almost a miracle; it is a miracle.”²⁵ Never fully achieved, this state of attention is, nonetheless, what the nurse or social worker or chaplain or physician seeks to attain. Weil continues:

A quarter of an hour of attention is better than a great many good works. Attention consists of suspending our thought, leaving it detached, empty, and ready to be penetrated by the object; it means holding in our minds, within reach of this thought, but on a lower level and not in contact with it, the diverse knowledge we have acquired which we are forced to make use of . . . as a man on a mountain who, as he looks forward, sees also below him, without actually looking at them, a great many forests and plains. . . . Love for our neighbor, being made of creative attention, is analogous to genius.”⁶

An open beginning, met with however pure an attention one can achieve, lets the listener hear the patient uninterruptedly speak. This close listener, this reflexive listener, notices how he or she feels while listening, senses the shifts in mood like shifts in the weather, notices the questions generated in himself or herself by the listening, generates hypotheses while listening about what it all might mean. Here is where the rigorous training in close reading enters the clinical practice. The attentive listener who has learned how to get the news from stories, who has learned to pay attention, while reading, to both content and form, to be aware of genre, diction, metaphor, time and space, tone, and mood, can learn to follow complicated stories as they are being told. This “close listener” can hold in the mind all details, paradoxes, ruptures, feeling along with the teller as the account is being given. He or she rides the patient’s account in real time, curious—why this now, where might this be going?

Exhausting and replenishing, achieving this state of attention is perhaps the igniting act of humane healthcare. Attentive reception of the patient’s account of self then permits or even requires action taken on behalf of the patient, always within sight of the personal context that frames the clinical concern. As a result of the careful and creative attention, the listener can begin to understand what matters to the patient and even, over time, to learn something about how the patient’s mind works. When this encounter occurs within a setting of healthcare, it takes its direction toward the physical or mental concern that occasioned the visit. Once the clinician learns how the patient frames the problem that has brought him or her to seek healthcare, that clinician then fills in the narrative history with the more standard clinical interviewing questions about past health, family history, specific symptoms, and current conditions. As I reflect on my own experience with individual patients, I realize how pivotal and meaningful were those very first things I learned about a person as he or she exposed the “sounds of the organs” to a stranger.

Open-ended and nondirectional clinical conversations are by no means unique to narrative medicine and are recommended by many of the clinical interviewing textbooks.⁷ What becomes possible with narrative medicine training is to know what to do with the open-ended answers. When the listening

is accompanied by subtle awareness of narrative forms, temporal structures, invocations of space, and figural language in what the teller says, the listener squanders nothing that is said or that is even left unsaid.

Such listening routines have been adopted by persons trained in narrative medicine practicing in a variety of specialties. Malgorzata Nowaczyk, a medical geneticist who studied with us in narrative medicine workshops, recognized the subtlety and power of the stories she was hearing from her patients, her patients' terror, and the sense of rage at the cosmic unfairness that sent their families an unearned rare genetic disorder. She published an essay in the medical genetics literature introducing a form of attentive listening that acknowledges this terror in patients while exposing the listening clinician to its dread: "Many published first-person illness narratives contain elements of chaos; if we listen closely to our patients in clinic we may find chaos there as well."⁸ Sarah Chambers and Julie Glickstein, pediatric cardiologists at Columbia who worked closely with the narrative medicine team in our faculty development seminar for physicians, recognized the narrative complexities involved in first performing echocardiograms for fetuses thought to have serious cardiac abnormalities, then translating to the parents what the fetus wordlessly told them in the gray images, and then listening to the responses of the families while the doctors helped them to make decisions.⁹

These two studies are examples of recent publications using narrative medicine principles and methods in clinical encounters with individual patients. Narrative interviewing techniques have been adopted by others in multiple settings and specific clinical situations, including in caring for patients with Ehlers-Danlos Hypermobility syndromes,¹⁰ assessing decision-making capacity for inpatients,¹¹ caring for women who get pregnant after receiving liver transplants,¹² and developing therapeutic relationships with chronically ill hospitalized patients.¹³ In all these settings, the development and deployment of attention and the capacity to capture and act on the evidence of patients' narrative accounts promise more informed care for patients and, for clinicians, a heightened sense of having been of service.

Clinician and Healthcare Team Development

Clinicians Write As reflective and creative writing methods are adopted in health professions schools, clinician/educators themselves are exposed to the fruits of narrative work. As a dividend of Columbia's inclusion of creative writing for students in its curriculum, the faculty members engaged in this narrative pedagogy have learned to use the same methods in their educational and clinical practices.¹⁴ Their adoption of narrative methods in their own practice

and teaching outside of the medical student course has functioned as powerful role-modeling for their students, who witness their teachers using what they preach as serious components of their professional lives.¹⁵

Once the Program in Narrative Medicine was launched in 2000, groups of clinicians at Columbia requested some training in writing for themselves. As one example, the general pediatricians who teach courses including creative writing exercises formed a “Narrative Pediatrics” group, meeting once a month with a narrative medicine facilitator, sometimes with the residents and students, to join in close reading and creative writing. Over the course of the seminar’s few years perhaps 100 pediatricians have attended at least a few sessions, and a core group has attended each session religiously. Participants have reported that the seminar gives them perspective on their practice, increases their curiosity about patients, increases their readiness to “take the next chart out of the box,” and lets them see more of the world around them.¹⁶ Such narrative medicine seminars are underway with regularly scheduled meetings for fellows in palliative care, pediatric cardiology, and child psychiatry; for residents in obstetrics and gynecology, primary care medicine, family medicine, and radiology; for social workers; for chaplains; and for faculty from a variety of departments combined.

Similar narrative training is underway in a variety of clinical sites for physicians of many specialties, nurses, physical therapists, social workers, chaplains, and even prisoners and wardens at a maximum security prison, all facilitated by narrative medicine faculty and Master’s Program graduates in New York. The pilot study for a novel narrative medicine training program at a nursing home facility in New York has completed a feasibility study of narrative training among staff nurses and recreation therapists who work with long-term residents. Leaders of these groundbreaking efforts are now launched on the process of outcomes research with a range of variables chosen for testing and study.

In all these settings, clinicians learn the skills of close reading as participants together read complex texts of poetry, prose, visual art images and objects, or performance arts. Through their own deliberations on the workings of the text, each participant comes to locate his or her own sense of what the text means. They are then invited to write to an expansive prompt in the shadow of the text, getting the chance to represent their own emerging perceptions aroused by it. Finally, when they each read aloud what they’ve written, their listeners/readers can join them in seeing what has been created.¹⁷

Parallel efforts in narrative faculty development are ongoing in a growing number of institutions in the United States and abroad in a range of departments and faculty teaching academies.¹⁸ Triangulating evidence for the utility in practice of the teaching of these skills is available from the development of

narrative training for practices other than healthcare. Judith Moran, a family lawyer and graduate of the Master of Science in Narrative Medicine graduate program, has replicated our practice at the University of Baltimore School of Law, on whose faculty she is appointed; the conceptual framework, pedagogy, and goals of improving practice and professional care for clients are identical in the two professions.¹⁹

Interprofessional Education and Practice: Since the mid-1980s, health professionals and national and international bodies advising them have called for improvements in the effectiveness of the healthcare team.²⁰ Although there are yet to be strong bodies of evidence supporting the hypothesis that strengthening healthcare teams improves the quality of the care, health education certifying boards and public and private providers of health insurance are requiring that students and clinicians be trained for interprofessional education and practice.²¹ Beginning in 2014 with a gradual roll-out, the health professions schools of dental, medical, and nursing schools are being required to provide interprofessional education for their students as a condition of certification by their licensing boards.

There are many reasons that healthcare teams are less than effective. As specialization in healthcare has accelerated and as healthcare roles have proliferated, an industrial assembly-line model hove into view, each member of a team completing his or her small part of the action with little appreciation of the whole. More sinisterly, the implacable hierarchy of healthcare, in which white male physicians continue to occupy the positions of power, replicates and even intensifies the biases and patterns of domination of its wider culture. An academic medical center stages drama after drama in which persons from many professions fight among themselves for small gains—classroom space, internal resources of money or time, influence on institutional policy, seats at tables of authority—while decisions are typically made in board rooms in which physicians predominate. Inevitably, the hierarchical divides widen and stiffen even among the ranks far from the power pinnacles. Within community hospitals or clinics, these patterns can be broken; it is from such places that models of effective healthcare teamwork are likely to arise.

In the face of such overdetermined dysfunction, many approaches to improve the healthcare team have arisen.²² One approach to improving the function of healthcare teams is a practical, task-based framework.²³ Typically, members of a team charged with accomplishing a particular healthcare task—in an operating room, emergency room, labor and delivery room, or general medical hospital ward—are gathered to practice the tasks they must together do. These training sessions use role-play scenarios, clinical vignettes, or simulations using dummies or actors portraying patients to demonstrate the task in question. Behavioral learning objectives are drawn up prior to the exercise.

In keeping with the mainstream educational methods used in health education, these objectives must be stated as observable behaviors. Checklists of the team-supportive behaviors on the agenda are used to assess the success of the individuals in the team and the team itself, sometimes as self-report by learners and sometimes completed by trained observers who attend the session with the learners.²⁴

More nuanced approaches to collaborative team development arise from social scientists, particularly in the fields of gerontology and end-of-life care—specialties in which effective teams of members of multiple disciplines are critical for effective care of patients. The field of Narrative Gerontology arose at the millennial turn to connect narrative theorists with clinicians and social scientists committed to improving care for the elderly.²⁵ Their scholarship and research have expanded to contribute to the conceptual and pedagogical work of healthcare teams in general.²⁶

The conceptual frameworks that guide their development and evaluation of interprofessional education include social science and psychology-derived relational theories, social identity theories, self-presentation theories, sociology of professions, and the discourse and power analysis of Michel Foucault.²⁷ Such factors as early professionalism into role, hierarchical status differences between professions, structural silos that divide professions from one another, and organizational structures that may permit or prohibit change are relevant to the fate of efforts to instill teamwork among healthcare professionals.

Narrative medicine brings contrasting and complementing conceptual frameworks to bear on these models to improve healthcare team effectiveness. Narrative training and practice guide members of interprofessional teams to find their common ground. This ground can be found *under* the distinctions that separate them, for they have all chosen their careers, at least in part, because of a commitment to patients and in answer to a calling to work with the sick.²⁸ Rather than focusing on the contrasts among professional identities of members of a team, narrative medicine methods illuminate the common values and desires of persons prior to their becoming members of a profession or in excess of their membership in a health profession. The expansiveness, creativity, and reflexivity of narrative medicine learning makes room for interprofessional groups of students or clinicians to see one another in fresh light, not in terms of turf or traditional roles but as colleagues facing always-new problems and opportunities in joining with patients in their care.

In practice, narrative medicine brings to interprofessional education and practice its signature methods of close reading, creative writing, and attention

to telling and listening as co-creators of narratives. Creativity, reflexivity, and reciprocity are as present in interprofessional pedagogy as they are in the clinical practice. In addition to the narrative theoretical frameworks from the social and behavioral sciences, we include the literary and aesthetic ways of knowing and doing. Through the intersubjective contact that can occur in narrative medicine teaching, participants from various professions meet as *themselves*—themselves as tellers and listeners, readers and writers—in the process exposing their own perspectives, imaginations, memories, and values. All that happens in the descriptions of seminar practice in earlier chapters of this volume can occur among these interprofessional learners. Participants are present not as healthcare team members with a particular task to do; they are present in their full, daring subjectivity.

In a 4-year project funded by the Josiah Macy, Jr. Foundation, the Program in Narrative Medicine at Columbia brought together first faculty and then students in Columbia's dental, medical, nursing, and public health schools to join in intensive narrative work. As is typical of our work anywhere, we introduced the group members to one another through creative acts. We read great texts, watched movies, wrote creatively, interviewed one another about complex questions. The texts and movies and interviews usually had little to do with healthcare, and we members of the group were not present as representatives of our professions. Instead, we had a chance to be present ontologically, epistemologically, and morally. In a matter of months, the groups of faculty or students came to know one another deeply and to be committed to improving the teamwork in our institution.

Our evaluation of the courses has included qualitative methods of focus groups, ethnographic interviews, and attention to emergent phenomena. The results of our evaluations point to deepening knowledge of one another and of each profession's concerns and perspectives in healthcare. The students learned what they do *not* know but can rely on their team members to know for them. Developing sustained contact with colleagues from the other schools was itself an accomplishment that led to loosening of the strictly professional lenses through which we all see our work. In effect, the narrative medicine work released individuals from their profession's restricted epistemologies and practice frameworks. Not just for the sake of improving the safety and quality of patient care, our interprofessional work sprung us from the inevitable traps of professional identity.

Whether in the classroom prior to joining healthcare teams in the hospital and clinic or on the site of the work itself, narrative medicine methods bring unique value to healthcare team development. Amid the dramatic changes in the structures and values of American healthcare that are driven by economic

and commodification priorities, concerns and worries mount. Clinic staff members rebel against the 12- or 15-minute office visit, wondering how anyone can deliver effective healthcare to persons with hosts of physical and social/economic threats to good health in so short a time. Hospital routines are governed by needs to document all activities (in large part by the economic need to bill for them), usually on remote computer terminals, taking the nurses and doctors and residents and therapists away from actual sustained contact with patients. Hospitals make major decisions about spending and saving without transparency, so that healthcare workers are surprised and saddened to see their units closed to make room for new money-making enterprises. The competition among major health systems for business, the greed of some of those who work among us, the health gaps between poor and well-off patients that are intensified by our stratified healthcare dishearten us, make us worry that we cannot deliver acceptably good care, drain our sense of community and self-regard.

In the face of these challenges, committed healthcare professionals are organizing—through interprofessional groups, professional societies, groups engaged in humanizing healthcare, political collaboratives for primary care, and issue-based associations—to build processes of egalitarianism and diversity into the power structures and organizational patterns of clinical work. As the drive to improve healthcare teams continues, we can envision growing roles for those equipped with narrative skills in clinical practice and clinical teaching. Despite the disillusionment engendered by the contemporary bureaucratic climate of major health centers, our narrative capacities can let us perceive the value of our work, can inspire us with means to counter the depersonalization of our institutions, and can guide us toward means to improve, always, the care of the sick.

In these settings, all the more necessary are the clearings that narrative medicine can open. Not only do these clearings accomplish intensive personal and small-group work. They are also the crucibles for social activism as peers and colleagues discover in one another—and then perhaps more forcefully within the self—rage, protest, and idealism silenced. This is the beginning of a critical inquiry; this is the birth of consequential social action toward change.

A unique and inspiring experiment in narrative healthcare team development is taking place in Göteborg, Sweden, and we include it here as an exemplar of the consequences of full narrative consciousness on healthcare team development in mainstream healthcare institutions. Inspired by the concepts of narrative medicine and patient-centered care, the nurses, nurses' assistants, and physicians in a large community hospital in Sweden instituted patient-centered and team-based work rounds. No longer does a patient being admitted to hospital meet sequentially with the different members of the professional

team. Instead, the patient is invited into the team's comfortable office to sit and speak with all members of the team at once. As the guest of honor, the patient is heard carefully by all members of the team. The patient, in turn, is assured that all professionals caring for him or her will hear the same story and agree among themselves on a plan of action.

Nurses, physicians, and nursing assistants describe the improvement in the care they can provide since they began team-based rounds.²⁹ Their work proceeds more quickly and smoothly, they feel more satisfied with the quality of their work, and they experience a closer relationship among themselves and with the patients. They experience new joy among themselves and with their patients thanks to this experiment.

Novel Narrative Practices

Clinical Charts: The emphasis narrative medicine places on representation extends to the institutional and legal records kept of healthcare work. The rise of the electronic health record has transformed the reporting routines in the United States and elsewhere. While promising gains in patient safety and integration of clinical information, use of the computerized record often leads to faceless care, patients greeted not by the faces but the backs of their now-typing clinicians.³⁰ Because the electronic health records were tailored from platforms used in patient accounts and billing, they do not allow the writer to “think like a clinician.” Instead, the electronic records are geared primarily toward diagnostic and procedural coding, in part to enable optimal billing.³¹ Formats of most electronic health records require writers to register data by choosing items from drop-down menus or placing check-marks in boxes. As a result, clinicians lose the opportunity to think systematically through a clinical situation as they do by writing the note sequentially and organically. However, despite many of the mechanized aspects of the current electronic medical record, clinicians maintain the opportunity, in most electronic platforms, to write freely within the chart, although time to do so is usually extremely limited.

The quest to restore the narrative to the medical record has become a rallying cry for many clinicians committed to their own narrative practices, while the time constraints of an increasingly economically driven healthcare system raise a barrier against the full use of writing as discovery of one's own clinical thoughts and one's awareness of the patient's situation. To restore the narrative will require not only a rigorous justification of the importance of writing in clinical decision making and in developing therapeutic alliances. It will also require solid evidence that the time devoted to narrative practices of writing,

on the part of both clinicians and patients, is repaid in improvement of the clinical outcomes of our practices. Such research is now beginning to get underway in ambulatory care settings, end-of-life settings, and clinical training settings. This research imperative is one of the most urgent commitments of narrative medicine today.

One way to preserve the value of the health record is to invite the patient into it. An ambitious project called “Open Notes,” arising from the Beth Israel Deaconess Hospital in Boston, has studied the consequences of allowing patients to read their physicians’ notes.³² Although there was reticence on the part of physicians at the outset, there were beneficial outcomes when patients read what their doctors wrote about them, including an increased sense of control for patients, increased knowledge about their health situation, and increased fidelity to taking prescribed medicines. Around a third of the patients had privacy concerns, and a very small percentage felt worry or confusion upon reading what their doctors wrote. At the end of this ambitious outcomes research, all patients and physicians opted to continue using Open Notes. This exploratory study heralds important shifts in the written communication in healthcare, suggesting the power of the written narratives of even routine primary care.

Increasingly, patients are given access to portions of their electronic health records by their healthcare institutions. Through patient-accessible portals, patients can retrieve test results, diagnostic imaging interpretations, and reports generated at visits with clinicians anywhere in the institution. Still in its testing phase, patients’ access to clinical electronic charts raises new and sometimes troubling questions about the lack of agreement among clinicians on the meaning of diagnostic testing results, and diagnostic suspicions held by the clinician but unspoken to the patient. Patients’ access to their own records necessitates a new level of attention for both accuracy and discretion among those who write in the chart—which, in retrospect, will likely be seen as an improvement in the documentation and in the care itself.

More and more clinicians routinely give the patient a copy of what they have written after the encounter. The simple practice of giving the patient a copy of what one has written is consequential. With the paper copy of what the nurse or therapist or physician has written in hand, the patient can more easily recall events of the clinical encounter, can show the note to others for help in understanding the proceeding, and can identify questions that escaped asking. Patients keep track of these notes and consider them valuable aspects of their health work. I have been in the habit of providing my patients with a plastic binder with the name of our hospital and the legend, “Patient-Held

Medical Record” on its face as a reminder that the patient “holds” the history of care himself or herself. Knowing that the patient will read what the writer writes also acts as a potent reminder to write in words and not numbers and acronyms, and to write in a style that the patient will be able to read and comprehend. More powerfully, the practice reminds the clinician that the office or hospital visit contains not only what the clinician values but also what the patient might value. The summary of the visit needs to include all that was discussed, not only the things the clinician considers salient to the care. Hence, this simple practice of giving the patient a copy of the note helps to emphasize that *all* that transpires in a health encounter matters—not only the test results and medication dosages but also the conversation about the death in the family, the worry about a child, or the triumph of landing the job or graduating from college—and contributes to the creation of the book of care.

The practice of asking the patient to contribute to the medical record, as described in Chapter 12 in this volume, is one component the next stage in this work. The boundaries between clinician and patient are, perhaps, becoming more permeable as we develop increasing awareness of the damaging divides between us. A vision of the future of narrative medicine includes movement toward equalizing the power of voices within the care and the representation of that care. A talisman as well as a reality in healthcare, the clinical chart occupies a pivotal space in the always evolving processes of care. Despite its being embroiled in—some would say highjacked by—the electronicization of healthcare, we can seize the power of writing and use it for the sake of equality, justice, and truth within the work we do.

Bearing Witness in Healthcare: Narrative medicine has developed a practice of witnessing in clinical settings. Before describing this clinical method, a summary review of bearing witness in contexts of health and social justice seems called for.

Enormous events and events of enormity require witness. Acts that surpass reason, whether they be acts of nature or faith or good or evil, demand formal acknowledgment even while they may exceed the observer’s capacity to acknowledge them. That which requires witness is, by definition, that which cannot be subsumed within an explanation. Beyond fact, beyond history, that which requires witness remands the participant and the observer into the hermeneutics of presence. Lyric poetry, music, dance, and works of visual art are some of the means that have been used to mark the witnessing or memorializing of a grave event that cannot be represented in ordinary language.

The chorus of classical Greek drama fulfills the role of the witness to events that the protagonists in the drama cannot fully perceive for themselves. Not

only, “This *happened*,” say the members of the Chorus in Euripides’s *The Trojan Women* but “This matters”:

The sacrifice is gone and the sound of joy,
 The dancing under the stars and the night-long prayer:
 The Golden Images and the Moons of Troy,
 The Twelve Moons and the mighty names they bear:
 My heart, my heart crieth, O Lord Zeus on high,
 Were they all to thee as nothing, thou thronèd in the sky,
 Thronèd in the fire-cloud, where a City, near to die,
 Passeth in the wind and the flare?³³

Here the Chorus functions as the collective voice of Troy from outside the action. The Chorus is present in the play as witness to the sacrifice of Troy, lamenting—in the name of the whole city—to the gods who allowed the destruction and despairing at the passing of their beloved city into “the wind and the flare.”

We can distinguish between the eyewitness of an event and the one who bears witness to it.³⁴ This double meaning of the act of witnessing alerts us to its conceptual complexity, underlining the tension between fact and meaning. The eyewitness might testify at a court proceeding as a provider of historical fact—he or she might deliver a presumably verifiable account of a crime in a trial or identify a perpetrator in a police line-up. The one who bears witness—as a participant, observer, or marker of an event—is charged with the more significant duty to stand, personally, as one who recognizes the meaning of the event. The Quaker practice of collective silent standing for peace in public places, displaying signs declaring the subject of concern, accomplishes the complex task of both attesting to the standers’ own commitment to peace and bringing to the attention of passers-by *their* need to concern themselves with the war in the Middle East, the threat of nuclear war, or the dying of the planet. The mothers and grandmothers of children disappeared in South America’s dictatorships reversed decades of indifference and denial by their risky and permanent state of personal physical witnessing—not to a set of facts they could assert but to the state of “factlessness” surrounding the loss of their children.

Warning against the too-facile acceptance of either the reliability of witnessing or the impossibility of it, historian Hayden White notes that “we must not take the naturalness of seeing for granted.”³⁵ White studies the records of the Holocaust written by Primo Levi, both a survivor of Auschwitz and the documenter of its atrocities. A chemist who asserted that he used his scientific skills of observation and analysis to document life in the camps, Levi in fact transmutes his report of the Final Solution in poetic texts of paradox:

“It is us again, grey and identical, small as ants, yet so huge as to reach up to the stars, bound one against the other, countless, covering the plain as far as the horizon; sometimes melting into a single substance, a sorrowful turmoil in which we all feel ourselves trapped and suffocated; sometimes marching in a circle, without beginning or end.”³⁶

White points out that “[t]he most vivid scenes of the horrors of life in the camps produced by Levi consist less of the delineation of ‘facts’ as conventionally conceived than of the sequences of figures he creates by which to endow the facts with passion, his own feelings about and the value he therefore attaches to them,” suggesting that even the eyewitness requires representational forms that can handle both fact and meaning.³⁷

Literary scholar Geoffrey Hartman and psychoanalyst Dori Laub founded the Fortunoff Video Archive for Holocaust Testimony at Yale University, giving survivors of the camps the opportunity to add their testimonies to the archive of the atrocities. The videotaped interviews are spare close-ups of survivors recounting their memories, gently and unobtrusively guided by the interviewer’s perceptive comments. These interviews are not held as historically verifiable fact but as the means by which those who lived through the Holocaust are afforded a setting in which to express and therefore to know what they underwent.³⁸ The authentic report—not the same as the verifiable factual report—is described by Hartman as both a witnessing to what happened and a witnessing of the person to whom it happened: “If authenticity is to prevail, the survivor as witness to the traumatic event will be at once a first person and a second person: one who is able, despite everything, to say ‘you’ to the self that has remained, one who seeks an ‘I-Thou’ relationship with a disappeared or damaged self.”³⁹

Bearing witness is a powerful dimension of religious life, offering the self as one-who-testifies, sometimes at one’s own risk, to the truths and values of a faith. Religious witnessing may be accomplished wordlessly with garb, ritual, or ordinary daily habits that mark the person as a person of faith. Widespread political traumas and injustices can be faced with collective bearing of witness to atrocities not in trials of blame but in search of futures. Truth and Reconciliation rituals, most powerfully achieved in South Africa as apartheid was challenged, provide public opportunities for the wrongs to be exposed toward the strengthening of the post-trauma society.⁴⁰

Acts of witness occur not only in the face of large historical events of terror and war but also in the intimacy of personal relationships. The acts of recognition that transpire between mother and infant are, some assert, foundational for the lifelong capacity for address and response in the intersubjective relations with others that lead directly to personhood.⁴¹ Therapeutic relationships provide powerful scenes of witness, where the witnessing indeed constitutes

the therapy. Psychoanalyst Warren Poland describes witnessing in analytic treatment as a reciprocal state with transference engagement:

By witnessing, I refer to an analyst's activity, that of "getting" what the patient is saying without doing anything more active about it. . . . It is the analyst's functioning as a patient's other who maintains an actively observing presence, who recognizes and grasps the emotional activity in the mind of the patient at work. . . . Witnessing as an analytic function refers to the analyst as beholder, grasping and respecting both the patient's meanings and the meaningfulness of those meanings from a position of separated otherness.⁴²

In the innovative form of family therapy they have named narrative therapy, Michael White and David Epton have introduced "outsider witnesses" to attend therapy sessions with a client and his or her family. The outsider witnesses are chosen on the grounds of some similarity with the client so that the client's story will in some way resonate with their own experience. The witnesses can then, in conversation with the therapist while the client is present, demonstrate how listening to the story has aided or inspired them in their own lives.⁴³ Not unlike the members of a Greek chorus who contextualize the events being enacted, the outside witnesses' presence nests the situation of this family within wider spheres of social or interior experience, reducing the isolation of the suffering family while offering company and affirmation as they struggle toward health.

Narrative medicine has developed a tradition of witnessing within practices of individual patient care. A combination of the eyewitness and the bearing of witness, narrative medicine witnesses attend clinical encounters in order to give to their participants a finely perceived written representation of the events of their meeting.⁴⁴ With permission from both patient and clinician, the witness attends a visit, takes field notes as would an anthropologist, and writes from those notes a portrait of what occurred during the contact. Because the witness is not participating directly in the encounter, he or she can view and register much that, being embroiled in the event, neither participant can see. Clinicians have been grateful for the added dimensions of knowledge, available in the witness notes, about the encounter and about themselves, often including the witness notes in their own private files about patients. The Witness Notes are at times offered to patients as well, not as a transcript but as a portrait of their efforts toward their health.

Narrative medicine's form of witnessing achieves several simultaneous goals. The gravity of the clinical encounter is recognized and perhaps heightened by the formal act of witnessing it and by producing the resultant document capturing the event. Even routine clinical encounters spent largely in

discussion of symptoms, maneuvers of the physical examination, review of laboratory test and imaging results, and decisions about treatment can be recognized as complex subtle social events saturated with powerful emotion and bespeaking power relations, agreement or conflict regarding beliefs about health and illness, efforts to exhort or appease, evidence of attachment or indifference. Both participants in the encounter are witnessed. The observer pays attention to the patient's situation and the clinician's situation, silently asserting the reciprocity of effort, the potential for contact, the shared awareness of the importance of what they do together. The witness himself or herself, often unused to clinical settings, has the opportunity to contribute to the gravity of the proceedings, saying through his or her silent *amanuensis* that this event happened and this event matters.

Clinicians See

Beyond the dividends of narrative work and skills development, narrative capacities let individual clinicians see. I close this chapter by returning to Frank Huyler's testimony to the world of perception and activism aroused by the narrative skills of attention and representation.

Huyler describes a middle-of-the-night encounter with a woman in the midst of a large and perilous heart attack. She was homeless, living on the streets, and schizophrenic, and this combination of social factors had made it impossible for her to keep up with needed treatments for her heart disease, leading to this big MI. Huyler realizes that the \$7,000 spent on the coronary artery stent placed in the woman's circulation could have been better spent on housing, pills, and a bus pass (and why do stents cost \$7000 apiece anyway?, he asks). In defense of giving clinicians the narrative gifts of the humanities, Huyler writes:

I can hardly remember any of the thousands of lectures I've attended. . . . What I do remember are the patients I've seen over the years; the many moments, dramatic and small alike; the many colleagues and residents and students and nurses I've worked with; . . . the pleasure of coming home to clean sheets after a night shift; the flash of dread when the trauma pagers go off; the black, excoriating feeling of making a big mistake; the distinct aesthetic satisfaction of suturing a laceration; the intense stillness when a code is called and everyone stops; the occasional, silent glory of being right; the grief of the consultation room and the relief of the consultation room; the sounds and lights; the radio, the sirens; the screaming drunks and the quiet drunks; the brave and the cowardly. . . . Somewhere in the impossible mix is the sense that all of us in [health-care] are doing work, however imperfectly and at times despite ourselves, that counts.

It is precisely this sense of significance, of stakes that actually matter, of work with larger meaning, that drives the rigor and discipline of medical culture, the physical exhaustion, the endless phone calls in the middle of the night, all those pages both read and written, and all those lectures both given and received. . . . So much of medicine is . . . anonymous, thankless, faceless, and uncertain but necessary nonetheless. This necessity bears reminding, in part because it affirms our better natures, the good we sometimes do despite our indifferences.⁴⁵

The practices described in this chapter can add up to a deepening of the realization of the sublime in healthcare. Narrative skills enable one to fully perceive and to represent what occurs in healthcare. Through rigorous routines of capturing in words and text that which occurs in care settings, narrative medicine moves clinical practice toward its ideals of creativity, reflexivity, and reciprocity. Whether inviting a patient to co-construct the clinical record or bearing witness in the clinic, these routines establish the singularity and gravity of clinical events. They donate a sense of the high stakes of healthcare, letting both patient and clinician acknowledge the moment of what they together do.

Notes

1. Leriche, cited in Canguilhem, *Normal and Pathological*, 91.
2. See Mahoney, "Against Narrative Medicine"; Woods, "The Limits of Narrative."
3. See Lewis, "Narrative Medicine and Healthcare"; McKechnie, "Anxieties of Communication"; Vannatta and Vannatta, "Functional Realism"; Gold, "Narrative Medicine"; Launer, *Narrative-Based Primary Care*; Greenhalgh and Hurwitz, *Narrative Based Medicine*.
4. Huyler, "Woman in the Mirror," 919.
5. Weil, *Waiting for God* (2001), 64, as quoted by Schweizer, *Waiting*, 88.
6. Weil, *Waiting for God* (1973), 111–12, 149.
7. See Lipkin, Putnam, and Lazare, *Medical Interviewing*; Fortin et al., *Smith's Patient-Centered Interviewing*; Newell, *Interviewing Skills for Nurses*; Coulehan and Block, *Medical Interview*.
8. Nowaczyk, "Narrative Medicine in Clinical Genetics," 1946.
9. Chambers and Glickstein, "Making a Case."
10. See Knight, "Role of Narrative Medicine."
11. See Mahr, "Narrative Medicine and Decision-making."
12. See Donzelli, "Role of Narrative Medicine in Pregnancy."
13. See Rian and Hammer, "Practical Application of Narrative Medicine."
14. Amiel et al., "Narrative Medicine."
15. Devlin et al., "Where Does the Circle End?"
16. Martinez, "Feeding the Soul."
17. Winkel et al., "No Time to Think"; Charon, "Our Heads Touch"; Charon, "Why Read and Write?"; Olson, "Narrative Medicine."
18. For examples of faculty and resident development training in narrative medicine, see Branch et al., "Good Clinician"; Singer et al., "Four Resident's Narratives"; and Liben et al., "Assessing a Faculty Development Workshop."

19. Moran, "Families, Law, and Literature."
20. World Health Organization, *Learning Together*; World Health Organization, *Framework for Action*; Institute of Medicine, *Crossing the Quality Chasm*; Josiah Macy, Jr. Foundation, *Annual Report 2012*.
21. Reeves et al., "Interprofessional Education"; Interprofessional Education Collaborative Expert Panel, "Core Competencies."
22. Greer, "Status of Interprofessional Education"; Ho et al., "Making Interprofessional Education Work."
23. Weaver et al., "Anatomy of Health Care Team."
24. West et al., "Tools to Investigate"; Graham, West, and Bauer, "Faculty Development."
25. Kenyon, de Vries, and Clark, *Narrative Gerontology*; Kenyon, Bohlmeijer, and Randall, *Storying*.
26. Clark, "Narrative in Interprofessional"; Clark, "Emerging Themes."
27. Thistlewaite, "Interprofessional Education"; Reeves et al., *Interprofessional Teamwork*.
28. Sands, Stanley, and Charon, "Pediatric Narrative Oncology"; Charon, "Writing in the Clinic."
29. Lövrup, "Here Is the Patient"; Baathe et al., "Physician Experiences" <http://wardround.net/research/>.
30. Reis, Visser, and Frankel, "Health Information and Communication"; Bates and Gawande, "Improving Safety."
31. Cimino, "Improving the EHR."
32. Delbanco, "Inviting Patients to Read."
33. Euripides, *Trojan Women*, 65.
34. Oliver, "Witnessing," 80.
35. Hayden White, "Figural Realism," 113.
36. Levi, *Survival in Auschwitz*, 62.
37. Hayden White, "Figural Realism," 119.
38. Laub, "Testimonies"; Hartman, *Scars*.
39. Hartman, *Scars*, 19.
40. Ross, *Bearing Witness*.
41. Cavarero, *Relating*; Butler, *Giving an Account*; Arendt, *Human Condition*.
42. Poland, "Analyst's Witnessing," 21.
43. White, *Working with People*.
44. Charon, "Narrative Medicine as Witness."
45. Huyler, "Woman in the Mirror," 920.