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Terminology and Praxis: Clarifying the Scope of Narrative in Medicine

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Until about thirty years ago, narrative and narrative theory were the province of those disciplines that have traditionally formed the accepted core of the humanities: literary, cultural, religious, and, to a lesser extent, philosophical studies. Researchers in these fields—whether hard-core narratologists or narrative ethicists—tend not to produce narratives, but to receive them. Their work involves commenting analytically on that reception, looking at the determinants, operations, and semantics of individual narratives or of narrative as a genus. Narrative theory now populates new and rather different territories—those fields that support narrative production as well as consumption, including history and historiography, ethnography, law, therapy, and of course, medicine.¹

Our interest lies specifically in the theoretical and practical uses of narrative in the medical field, and we began with a review of the relevant literature that generated some surprising results. We expected the influence of narrative in medicine, which had captured the interest of physicians and scholars, to be legible in medical and humanities publications. Moreover, we had observed the ways in which popular culture reflected that interest in media, ranging from print publications such as *The Atlantic Monthly* and *The New York Times* to television series such as *House, M.D.*² We were nonetheless surprised by the sheer volume of articles, essays, and editorials we discovered when we conducted a search in medical and humanities journals using the keywords “narrative and medicine.” Our search returned no fewer than 7,000 related writings, raising the question of precisely how narrative was being employed by its various proponents, for the remarkable quantity of this research alone does not give one a sense of the range

of approaches, methodologies, assumptions, and goals that the phrase “narrative medicine” has come to encompass (A more recent search in September 2011 using the same search terms but limited to the years 2009–2011 led to an additional 3,000 papers, though addressing the same array of issues as noted in the previous search). Many medical schools, for instance, have not only introduced the analysis of narratives—both fictive and non-fictive—but also the creation of narratives. Within the last twenty years, the study and teaching of medicine has, in short, embraced the entire realm of narrative theory and practice, as both consumers and producers.³

Theory

As Martin Kreiswirth puts it,

[at] every linguistic register, inside or outside academic or specialized discourse, in the marketplace, . . . [physician’s] office, or courthouse, narrative is inherently double; it points either to a kind of discursive performance—a telling, an ongoing method of organizing data (“*x* is a narrative, not an argument”; “the first words of his narrative fell flat . . .”)—or to that which has been performed—what has been told, a product, a conceptualized or reified content (“*x* is the most important narrative for that culture”)—or to both, indiscriminately. And the same holds true for the words *story*, *tale*, or *account*. Narrative by its very signification and cultural use is both presentation and presented; the narratological problematic, the basic formal relationship between the what and the how, is thus contained within the term itself and infects, to some degree, any attempt to define, legitimize, or criticize it.⁴

As well, for something to be labeled a narrative, it must stress sequence, causality, and even teleology. Through whatever media—linguistic, visual (static or dynamic)—narrative must place the represented phenomenon in a serially linked, temporally ordered chain, whose culminating end point is in a position to control what came before it.

The explosion of interest and the resulting proliferation of publications on medicine and narrative have not always concerned themselves with such definitional issues. Indeed the sheer range of such studies has, perhaps inevitably, led to a diffusion of concepts and terminologies—terminologies that are slippery enough in individual

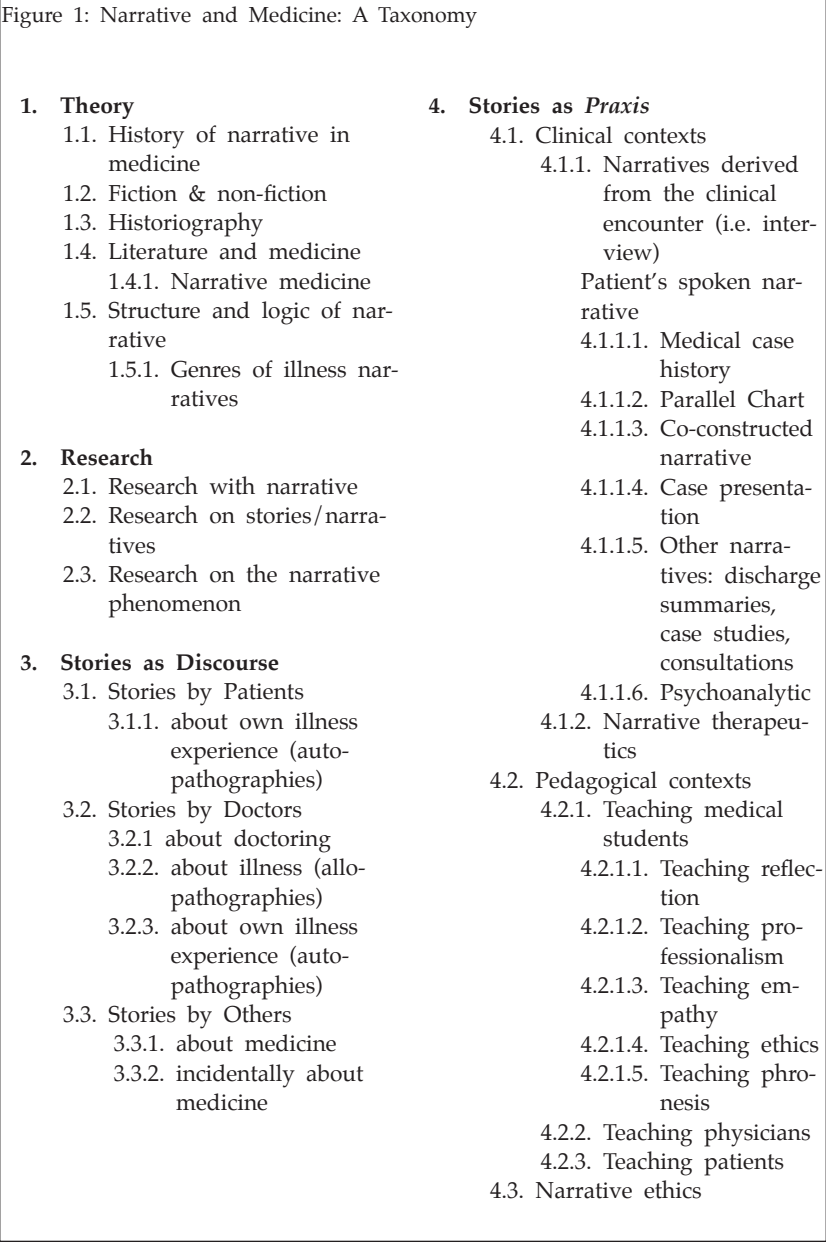
disciplines, let alone in a cross-disciplinary context. For example, in *The Routledge Companion to Historical Studies*, published in 2000, the entry on *Narrative* cites forty-three works for "further reading." Not one author among the forty-three listed corresponds to the roster of important narratologists or narrative theorists from the humanities: no Roland Barthes, Gerard Genette, or Gerald Prince, for example. As Mieke Bal notes, "the narratology that came to the attention of [non-fictional] narrativists was so narrowly based on fiction that they saw little point in it for their historiographic project. This is a major setback for both."⁵ Like the historians, a number of medical theorists, including Byron Good, Howard Brody, Rita Charon, Trisha Greenhalgh, Brian Hurwitz, Linda Garro, and Cheryl Mattingly, define what they mean by narrative in the medical arena in different terms. And they, too, are concerned not just with story as story but with storied forms of knowledge, with narratives whose epistemic status and discursive work are securely tied to facts and referentiality. To be sure, fictional narratives are often used in medical (and medico-ethical) pedagogy, but the medical narrative itself operates in the realm of truth-telling, rendering it amenable to terminological practices that are often distinct from those of the humanities. On one hand, therefore, we have a situation in which narrative theory outside literary studies "has had little exposure to [literary] narratology."⁶ On the other hand, however, Genette observes that narratology has devoted attention "almost exclusively to the behavior and objects of fictional narrative alone. And this has not been a simple empirical choice, implying no prejudice toward whatever might . . . have been explicitly excluded from consideration; rather it has involved the implicit privileging of fictional narrative, which has been hypostasized as narrative par excellence, or as a model for all narratives whatsoever."⁷

Indeed, just as narratology has neglected the alethic potential of narrative, as Prince has put it,⁸ medicine's attempt to scrutinize story qua story has, until recently, neglected most other aspects of narrative theory. In the nineteenth century, "true" stories patients told were gradually subordinated to the "truer" physical data doctors could discover with the aid of technological devices and, more recently, to the statistical data of the epidemiologist.⁹ Though medicine is recuperating the patient's story and has therefore begun to embrace the immigration of narrative and narrative theory, it is still anxious about story's relationship to the states of affairs it is presenting (or representing). This could be linked to the tensions between the unique, idiosyncratic story an individual tells and the aggregated population data upon

which medical diagnoses and treatments have been based for roughly a century. It could also be based on the problematic truth value of the self-proffered narrative.¹⁰ The resultant evidence-based, positivist approaches to medical practice are only slowly becoming open to a more holistic approach, which takes the patient's idiosyncratic, anecdotal contribution—his/her story—into account.

Given this "narrativist turn" (perhaps "return") in medicine,¹¹ the medical field would benefit from a focused analysis and integration of narratological concepts, with an aim toward producing a shared lexicon for theoretical and practical discussions of the meaning and potential uses of narrative(s). We are now asking, therefore, how we might discern a taxonomy (see figure 1) of narrative terms as they apply to medical practice and treatment, which might then be employed in various practical settings to the benefit of patients and doctors alike. We start here by taking a broad view of the current state of medical writings—theoretical, clinical, and pedagogical—that feature ideas about narrative.¹²

Narrative medicine has taken various forms and shapes since the early 1970s when a number of medical schools introduced instruction in the humanities, generally as an elective course and in response to George Engel's call for a biopsychosocial model of doctoring.¹³ The subsequent evolution of narrative medicine is best traced through the writings of Rita Charon, a passionate advocate for the discipline in medicine and medical education. Some narrative theorists, Charon and Arthur Frank among them, have argued that analysis of fictional representations of illness can enhance a medical practitioner's treatment of patients. In 1995, Charon noted the two-decade-long history of teaching literature in medical schools, generally through the presentation of selected works of literature, often, though not necessarily, about patients, physicians, and illness. She noted five broad goals, including learning about the lives and stories of the ill, the power of the physician, medical ethics, and the "genres" of medicine, the aim of which was to "strengthen the human competencies of doctoring."¹⁴ Over the last thirty years, therefore, the creation and expansion of what was once broadly referred to as the medical humanities curricula in medical schools throughout North America and Europe has in varying ways and degrees included the study of literature as a constituent part. This approach principally is connected to the ethical reward and insight into human behavior enhanced by literary analysis, which is thought to improve one's capacity for empathy.¹⁵ It is a position that follows the path and uses the tools of analytic narrative consumption.



By 2000, Charon refers to literature and medicine as a “flourishing sub-discipline of literary studies” that signals the end of the reductionist emphasis in medicine and permits her to predict the advent of medicine that is “both technologically and narratively competent.”¹⁶ At this point in the history of the medical humanities, Charon and others herald the narrativist turn in medicine—though at the time, more as a commitment than an observation. In 2001, Charon introduced the term “narrative medicine” in an article title and described the varieties of writing about patients and medicine, positing that close readings of literature and novels will encourage attention to the plight of patients: in most instances, actual narratives by patients per se are not the object of the investigations.¹⁷ Later that same year, Charon defined narrative competence as “the ability to absorb, interpret, and respond to stories” and compared it in importance to “scientific ability.”¹⁸ She suggested that narrative competence enables the physician to practice with empathy, reflection, professionalism, and trustworthiness, all of which together constitute *narrative medicine*.¹⁹ Finally, Charon described narrative knowledge as understanding “the meaning and significance of stories through cognitive, symbolic, and affective means.”²⁰

A shift from the analysis of traditional literature to that of stories of illness as a way to provide effective, empathetic treatment was spurred by the widespread impact of Arthur Kleinman’s work on stories of illness written from the perspective of a clinician-ethnographer.²¹ Kleinman shifted the enterprise from narrative consumer to narrative producer. And Charon broadened the scope somewhat in 2005 to include among the benefits of a narrative approach the skills of “attention, representation, and affiliation.”²² In most instances, these skills are cultivated by the exercise of writing the story as learned (or read) from the patient and, at times, of sharing the document with the patient as a means of developing and deepening the clinical relationship. Narrative medicine would, if properly taught and practiced, lead to a Levinasian intersubjectivity between doctor and patient, producing the trust and clinical partnership necessary to the physician’s tasks. The most recent incarnation of narrative medicine is the elaboration by Charon’s group of narrative evidence-based medicine as a response to the presumed barriers to the translation of innovations from the laboratory to patients. On the pathway from research finding to clinical implementation, the last step is the change of behavior by a given physician and patient—in this setting, “a portion of the salient evidence will not be found in numbers but in language.”²³

That narrative medicine has employed both literary and actual narratives of illness foregrounds the fraught relationship between fictional narratives and lived experience. How, for instance, does a patient's experience and the story in which he attempts to encapsulate it compare to those of literary authors? According to Brody, "the idea that a major difference exists between 'real-life' and fictional or literary, first-person accounts of sickness must be challenged." In narratives of illness "it is far too simple-minded to assume that the writer of literature presents to us a world of fantasy that has never existed whereas the author of a nonfictional pathography [first-person 'true' accounts of illness]²⁴ has some special insight into the world as it really exists, even if the relevant world is nothing but his own subjective experiences."²⁵ The concern tacitly expressed here has to do with the problem of truth-value in fictional versus non-fictional accounts of "factual" experiences. Analytic philosophers and speech act theorists, such as David Lewis, Gregory Currie, and John Searle, who discuss questions of truth-value, generally agree that the truth-value of statements or claims made about fiction can be at least equivalent to that of statements made about non-fiction.²⁶ And within the fictional world itself, the truth-value of a claim made by a narrator or character, for instance, helps readers determine whether the speaker is reliable. Such a determination relies on the principle that truthful claims are indeed possible to make within the context of fiction. Indeed, in *The Literary in Theory*, Jonathan Culler implies that the truth-value of claims a fictional, omniscient narrator makes can have greater actual truth-value than those of historians, for instance.²⁷

The same question applies to patients in the actual world who tell their stories of illness to various audiences. If health is the ability to function in society and to carry out those activities that are meaningful to the individual, then well-being is also characterized by a coherent story with meaning and clarity. The endless narrative of quotidian existence simultaneously reflects and shapes an individual's identity. It supplies an anecdotal framework of causality in which antecedents have roughly predictable consequences and, in turn, provide roughly reliable prognostications for the future. It is these three features—identity, causality, and prediction—that give a story its meaning. Stories written for quasi-public consumption are generally retrospective, historical renditions and are presented after their meanings have, to a large extent, become clear. In contrast, the story crafted early in the clinical process is almost by definition not coherent.²⁸ In these different contexts, the content of the story, though it represents the same

experience, can change considerably. The truth-values of each version, however, do not necessarily differ, for each version iterates the experience in the manner in which the individual best understands both the events she describes and her ability to communicate them effectively to her current audience. Neither is fiction; neither is pure, objective fact, for pure, unmediated historical fact, as we now generally agree, is impossible to produce. With these concepts in mind, Frank's implicit assumption that fictional narratives of illness are useful, realistic representations of lived experience helps to explain why medical theorists uphold the value of studying literary alongside non-fictional narratives of illness. Moreover, these advocates explicitly or implicitly value the mode of detailed investigation and attention identified with critical literary techniques. A sufficient command of the critical techniques once identified primarily with literary criticism, we argue, would help the physician receive and effectively analyze the idiosyncratic stories her patients communicate.

Stories as Praxis

Clinical Contexts

Underlying the patient's narrative is a ubiquitous human desire to tell stories.²⁹ When life is interrupted by an unexpected and mysterious symptom or sign, the at least somewhat coherent life story an individual consciously or unconsciously composes for himself and others loses its explanatory power as it fails to accommodate the often abrupt, puzzling change. The individual is faced with an event that seems to lack a causal link to the past, and whose implications for the future are presently unknowable. This non-adherent narrative detail is an affront to the integrity of the story whose disintegration marks the transition from person to patient. The disjunction thus introduced into daily life permits only a fragmented tale whose explanatory features of causality and prediction have dissolved and whose narrative coherence is thus undermined. Hence, many authors, including Brody,³⁰ Laurence Kirmayer,³¹ and Shlomith Rimmon-Kenan,³² regard illness as the absence of a narrative explanation, an unfulfilled need for a story that makes sense. The universal desire, or need, for a story with temporality, causality, and some limited predictability for the future is thwarted by an impending illness, and part of the suffering that characterizes sickness is the result of living with a broken story. Indeed, it is one's awareness of the absence of a coherent narrative that marks the onset

of illness and its attendant threat to identity, though disease may have been present long before.³³

The emergence of a symptom or sign, whether physical, psychological, affective, or functional, adds an element that the quotidian narrative cannot incorporate, whether causally or prognostically. This element of mystery causes a breach in the story and, hence, in the daily life it subtends. The features of uncertainty and fear thus engendered are cardinal elements in the subjectivity of illness, and it is for their resolution that the patient seeks medical assistance.³⁴ The circumstances described above result in three phenomena, which occur on the path toward the patient's sense of (narrative) resolution. First, the patient tries to craft a story about her illness, even before seeking medical help. Thus, physicians may receive stories with strange attributions as a result of the patient's desire to connect events causally and temporally, hoping to repair the breach in lived experience. Second, the physician attempts to render a diagnosis, which she then shares with the patient. The mere act of putting a name to her patient's condition can be, for the patient, a source of relief and even joy, irrespective of the implications the diagnosis might entail. Finally, and most importantly for our purposes, the goal of the physician is to relieve the mystery and its attendant suffering by helping the patient craft a new or amended narrative that can explicate the symptom or sign, provide a plausible causal chain, and begin to demystify the future.³⁵

As part of the first phenomenon described above, patients will often link their new symptoms to otherwise innocuous events in order to provide present experience with a historically chronological anchor; thus, details that appear irrelevant to the clinician are aggregated to the story, while medically significant features may be omitted. This aggregation of seemingly irrelevant events may result in the physician's paradoxical skepticism about the validity of the patient's story. A barrier to clear communication between patient and doctor begins to take shape, and familiar linguistic signs mark the physician's skepticism: the patient "reported," "claimed," or "complained" of a given symptom. Of greater concern perhaps is the all-too-common medical observation that patients are "poor historians" or even "irrational" people simply because the reconstructed narrative lacks plausibility to the medical gaze, though it may lend coherence to the patient's idiosyncratic frame of reference. This is yet another source of miscommunication between patient and physician that is, at least in part, the result of the positivist and scientific influences in modern medicine. As Jerome Bruner notes, "[J]ust as our experience of the natural world

tends to imitate the categories of familiar science, so our experience of human affairs comes to take the form of the narratives we use in telling them."³⁶ The physician's object of inquiry is a reified disease within a human vessel; the patient, in contrast, seeks clarity about her afflicted body. This parallax way of seeing illness has sundered the clinical relationship and produced two discrete objects of attention: the physician tracks the natural history of the disease while the patient seeks a demystifying story of her illness. Thus, the contemporary clinical interview brings together two people whose epistemological comportments toward the encounter are challengingly distinct: a patient with a fractured and perhaps recently reconstructed story who is afflicted by fear of the future and whose question—"what does it mean?"—points to a convoluted plot of future events, and a skeptical clinician whose time allocations are imposed by a third-party payer (the new elephant occluding the examining table)³⁷ and whose question—"what is it?"—seeks a linear response.

In this context, the goal of narrative medicine is to restore to clinicians a skill at and sensitivity to the narrative tradition that underpins all human discourse and intersubjectivities. To be sure, narrative medicine does not seek to eradicate the benefits that modern science affords medical practice. Rather, it works to understand that technology is powerless in the absence of a relationship between two human beings whose clinical encounter is both moral and instrumental.

The Patient's Narrative: Types and Genres

While patients may write the stories of their illnesses for their families or friends, the patient's tale in the clinical setting, albeit exploring the same subject matter, takes on a different genre and form, for its utilitarian aspect is responsive to and shaped by context, interlocutors, and specific purpose. For example, a patient in the waiting room may share her story with a fellow patient in order to share the misery of illness, seeking confirmation that at least one other person lives with the same ailment, or perhaps to fill the anxious time between her acknowledgment of the illness and the resolution she seeks. However, there is little expectation that her fellow sufferer will provide anything more than a friendly ear and a degree of patience in listening. These stories tend to be expansive and ornamented with those details of daily life that provide narrative depth and richness. They also reflect the cultural rootedness of stories and their social functions.³⁸ Again, these stories often attribute causality to antecedent life events that are

medically implausible yet are necessary to shore up sometimes long and ostensibly circuitous attempts at narrative coherence.

Despite the richness of the narrative outside the doctor's office, once the patient enters the interview room, the narrative tends to be "medicalized," i.e., shortened in ways that the patient imagines will accommodate the doctor's needs by providing him only with the information he would wish to know.³⁹ Yet, it is rare that the patient presents a story to fit the physician's preexisting, medicalized format, whether it is a printed form, electronic health record, or mental tabulation. It is thus no surprise that physicians interrupt their patients within seconds of the beginning of the narration. Those who have studied the discourse in physicians' offices note the presence of two individuals engaged in parallel, often non-intersecting conversations. Elliot Mishler and others have described this finding in phenomenological terms, as the voice of the lifeworld and the voice of medicine "with different structures of meaning" and a "discordance of voices."⁴⁰ The best models, by contrast, include a physician who listens without interruption and understands the interaction in narrative terms, namely, with important subtexts, plots, voices, affect, and unexpressed thoughts. In fact, we would argue that the stories produced during the clinical encounter ought to be co-constructed by the patient and physician, in order to devise an open-ended, mutually owned narrative that both parties understand, albeit from different perspectives. By aiding in the construction of a new narrative, the physician helps to fill the breaches and to provide meaning, thus allaying fears about the future. Some refer to this phenomenon as the elucidation of meaning,⁴¹ addressed in the next section.

But this is not the end of the story. The traditional medical description of the patient's narrative is an abstraction unrecognizable by the patient but suitable for medical needs of record-keeping, billing, legal obligations, and interactions with consultants and students. To be sure, the tentative conclusion the physician draws from the clinical encounter helps chart the course of investigation and therapy, and these hinge, at least in part, on diagnostic understanding. Furthermore, as one moves away from the direct patient encounter, the medical story becomes transformed as it is related to consultants, colleagues, other health care professionals, and perhaps even a medical journal as a case report.⁴² These are all various incarnations of the original narrative, but their relationship to the initial encounter, as well as their instrumental value, deserve some scholarly attention.

Narrative Therapeutics

Many authors have noted the putative therapeutic effect of narratives and some have hinted at the idea of narrative therapeutics.⁴³ This can have at least two senses: first, the attention by a skilled clinician who can listen to a patient's narrative in a sympathetic manner can itself provide healing. Indeed, institutions employ a number of tactics for enhancing their students' capacities for empathy, tactics which rely upon the assumption that imaginative reading and writing can result in "compassionate solidarity" and thus represent a sort of healing act.⁴⁴ Whether this effect reflects the "talk therapy" of traditional psychiatry, or, as Brody has suggested, it is simply a powerful placebo, is unclear.⁴⁵ Either way, reported benefits are common. In the second sense, the practice of all that narrative medicine entails decreases fear, anxiety, and uncertainty and hence contributes to healing. A frequent comment in this literature is that narrative medicine helps the patient derive meaning from the clinical encounter. In an appropriate dialogic interaction that also provides a conduit for clear communication, one can understand this meaning-making taking place on several registers. First, the assignment of a name to the patient's suffering can immediately reduce anxiety of a dire diagnosis and outcome. Indeed, it is intriguing that patients whose array of findings have puzzled clinicians over many weeks and months, report a sense of joy at being "given" a diagnosis, even one whose prospects are dismal. There is a sense of being recognized as an individual and being rescued from a liminal state of unnamable illness when a diagnostic label is assigned. There appear to be fine gradations of depersonalization in which it is apparently less demeaning to be demoted from person to patient with a diagnostic tag than to a state of patienthood, type unknown. A second source of meaning stems from the attribution of causality that demystifies the symptoms and signs and helps repair the breach in the patient's narrative. In one sense, the narrative of illness begins to align with and can help create a new and reshaped narrative of daily living. In another sense, a coherent story begins to offer some prognostic information, thus allowing the patient to begin comprehending the impact of the illness on his plans for the future. Finally, there is an affiliative dimension necessary to the clinical relationship that can transduce meaning, especially in narrative form.⁴⁶

Stories as Discourse

Autopathographies

Most autopathographies describe the social experience of the patient/author in a particular context, explaining why that experience and context warrant our interest as readers, and usually answering questions, if indirectly, such as "What is noteworthy about the illness?" or "How does my illness and its experience differ from commonly held assumptions about this illness?" Examples of autopathographies include testimonials to rare, dire, or dramatic conditions, such as Anatole Broyard's *Intoxicated by My Illness*, or Jean-Dominique Bauby's *The Diving Bell and the Butterfly*. They also include accounts of illnesses in which the patient's survival is the ostensible "plot" of the text, such as Frances Burney's harrowing 1811 account of her mastectomy in the era before anesthetics.⁴⁷ But as narrative theorists and social scientists agree,⁴⁸ even such stories have objectives beyond the legacy of the rendition: they serve a more process-oriented function, a working-through of a traumatic or anomalous experience. For instance, in his analysis of illness stories, Frank draws attention to the rhetorical function of autopathographies, emphasizing the curative potential of both the patient's expression of his illness and the reader's reception of it: "Giving accounts [of one's illness] is, both for experts and laypersons, part of that business of dealing with disease and its consequences. Health and illness have a double existence. They are the means by which we can maintain and define our fitness for society; [and] they portray a world of experience that we claim for ourselves alone."⁴⁹

Two books by Frank amplify this tension between the idiosyncrasy of any illness and its simultaneous potential to tap into collective experience. In his autopathography, *At the Will of the Body*, Frank writes about having cancer and a heart attack and concludes with the observation that all members of society are in "remission" of some kind.⁵⁰ He expands this observation and the scope of his personal story in *The Wounded Storyteller*, which figures a variety of patient experiences to argue that the transformation of an illness into a story has palliative, if not curative value, for the storyteller and, by proxy, for the readers, all of whom have or will face illnesses.⁵¹

Writers and scholars differently account for the therapeutic nature of autopathography, but many of them propose that narrative design symbolically corrects the disintegration or disorder represented by bodily illness. For Frank, the illness narrative has three primary narrative modes: restitution, chaos, and quest. Restitution narratives

anticipate cure and give prominence to curative technologies, chaos narratives portray illness without meaning or end, and quest narratives describe the illness as a process of transformation.⁵² For Alan Radley, the coherence offered by the aesthetic creation of an illness-story is a symbolic reconstitution of the patient's threatened existence; the writing or telling of one's illness "provides the necessary conditions for . . . the re-establishment of a sense of direction and coherence."⁵³ Readers, too, benefit from the illness story through a form of vicarious liberation, for "illness accounts are always more than 'stories about': they are also ways of 'seeing as,'" a perspective which has a public/collective reach, even when the story itself is intricately idiosyncratic.⁵⁴ Shlomith Rimmon-Kenan writes about her own remission from illness as well as other illness narratives to theorize how life stories are reconstructed in relation to life-threatening conditions. Illness, according to Rimmon-Kenan, disrupts the chronological linkage between past, present, and future and traumatically destabilizes an assumed sense of coherent narrative identity.⁵⁵ She notes that illness narratives tend to cope with disruption by creating a new kind of continuity that narratively restructures past memories and future expectations in light of present circumstances. In Western societies, moreover, the desire to create narratives that support coherence and transformation is conditioned by social and cultural expectations of wellness, normality, control, and self-sufficiency. Rimmon-Kenan challenges Frank's assertion that written narrative and chaos are incompatible and that writing and telling are triumphs over disruption. She argues instead that "while narration may lead to a working through and mastery, it may also imprison the narrative in a kind of textual neurosis, an issueless reenactment of the traumatic events it narrates (or fails to narrate)."⁵⁶ Ultimately, Rimmon-Kenan seeks not to reject phoenix narratives or narratives that strive for coherence, but to make room for those narratives structured more around chaos than epiphany or continuity.

The Physician's View: Stories Written about Patients

Many doctors have theorized about the links between writing and healing, including Charon and Richard Selzer, who maintain that the process of writing both imitates (Selzer)⁵⁷ and aids (Charon)⁵⁸ the administration of medical treatment. For Charon, when doctors write narratives about their patients' illnesses they achieve a better understanding of the patients' emotional and psychological experiences and, importantly, provide better treatment on an empirical level.⁵⁹ Noted

above, Charon attributes this improved treatment to the attention and empathy that narrative writing generates. By giving form to the patient's illness, the practitioner can better perceive the illness in all of its dimensions ("form" can mean "diction, genre, figural language, narrative situation, focalization, allusion, temporal scaffolding").⁶⁰ Sayantani Das Gupta argues that when medical students write "personal illness narratives," they cultivate an understanding of their (real or imagined) patients' illnesses by using their own experiences to shape their narratives.⁶¹ And finally, in "Storytelling in Medicine," Brody argues that stories clarify and substantiate scientific claims, as well as give meaning and form to illness in a manner similar to the healing effects claimed by religion.⁶²

The doctor-as-witness to the isolating and traumatic effects of illness has been prominent in many memoirs by practitioners treating HIV/AIDS. In examining a series of physician memoirs, Katrien DeMoor argues that they reveal the doctor's often fraught transition from conventional curing to caring and the alleviation of pain. In so doing, DeMoor also proposes that the process of "taking care of" dying patients extends, by way of these written accounts, to memorializing them in narrative form.⁶³ Like doctors who treat HIV/AIDS patients, palliative care physicians and nurses often cultivate a medical voice that stresses compassion and the integrity of the patient over medical technology or treatment.⁶⁴

For Kleinman, current medical practice more generally breeds a climate of alienation between patient and physician, and he proposes narrative-making as an antidote. Kleinman studies the way in which the meaning of an illness is culturally inscribed and claims that the construction of an illness (by the patient, the family, or the physician, as well as by a specific culture) profoundly affects its outcome, which invests great power in the shape and form of the illness narrative itself. In their accounts of illness, physicians are especially apt to seek coherence and try to contain seemingly arbitrary signs or symptoms: the process that yields diagnosis is thus akin to the process of narrative-making. But this "art," to Kleinman, has been under-acknowledged in medical training, and in the Western understanding of medicine as an empirical rather than subjective field.⁶⁵

Pedagogical Contexts

Narrative medicine has permeated the world of medical education at multiple levels and plays varying roles in different programs.

Institutions usually make use of narrative approaches to education and treatment with three objectives in mind: (1) to reveal patients' perspectives, helping students become better attuned to suffering, improving their capacity for empathy, and making them better healers; (2) as a catalyst for self-reflection; and (3) as a strategy to provide emotional support to harried health professionals. Narrative approaches are generally built into the existing program and serve as vehicles for meeting more narrowly defined educational objectives, particularly those in the domain of "medical humanities."

A broad range of approaches is used to foster humanism in medical schools, including the study of the humanities (such as classic literature),⁶⁶ communication skills training (with an emphasis on "cultural competency"), service learning (which generally refers to volunteer work among disadvantaged populations), and stimulating self-reflection.⁶⁷ The idea that humanism can provide medicine with the context necessary to understand the individual, idiosyncratic patient corresponds closely to our understanding of one of the key benefits of narratological approaches to medicine.⁶⁸ Regardless of where individuals or institutions situate narrative medicine, a unifying theme is the belief that understanding and working with narratives can help to humanize medical practice. In reviewing the literature, we have discovered the ways in which stories become instrumental within pedagogic contexts, and have identified four separate and complementary teaching domains, reminiscent of those defined by Charon: ethics, empathy, reflection, and professionalism.

According to the American neo-Aristotelian philosopher, Alasdair MacIntyre, "the chief means of moral education is the telling of stories."⁶⁹ And deciphering, understanding, and respecting patients' stories, particularly by foregrounding the patient perspective, may equip physicians with the cognitive and even affective tools with which to manage ethical dilemmas.⁷⁰ In the 1970s, the favored entry for humanism in medicine was the teaching of ethics in courses that relied on a principled or rule-based approach to bioethics,⁷¹ but the courses had only minimal influence on the development of virtuous physicians.⁷² In response, educators explored other approaches to teaching ethics, and narrative ethics—based on the fundamental premise that story-telling enables human beings to attach meaning to lived experience—offered a viable alternative. Anne Hudson Jones has traced the development of various movements within the field of narrative ethics.⁷³ She describes four approaches: clinical casuistry, narrative competence, relational ethics, and shaping a physician's participatory and moral comportment

toward the story-teller.⁷⁴ Casuistry has a checkered history, and although Albert Jonsen and Stephen Toulmin have championed its contemporary rehabilitation,⁷⁵ there are no reports of its explicit inclusion in health sciences education. As we describe above, Charon has championed narrative competence.⁷⁶ Relational ethics, also described previously, pertains to the patient and physician's joint construction of the narrative.⁷⁷ Finally, Frank articulates the moral and empathetic engagement with patients in his phenomenologically framed call to "think with" stories rather than simply to think "about" them.⁷⁸

All narrative ethics approaches to medical treatment claim to contribute to the teaching and provision of ethical care. According to Barbara Nicholas and Grant Gillett, "A narrative ethics asks: Whose story is being told, and by whom? Whose interpretive framework is being given authority? And how do those of us with social or institutional power respond to narratives with which we are uncomfortable or which challenge our position?"⁷⁹ As educators and students seek answers to these questions, they build the narratological framework these programs employ, thus shaping research agendas. For example, this version of narrative ethics has served as the scaffolding for a semi-structured interview template used in qualitative health research, where patients' modes of reasoning about symptoms are given priority over medicine's traditional "causal attributions" for illness.⁸⁰

Our research suggests that the concept of empathy, and the related phenomena of sympathy and compassion, are critical to medicine. Empathy is rooted in the German word, *empathie*, or "feeling into," which implies that intellectual and/or emotional effort is involved in one person's relationship to another. Despite considerable semantic confusion and the paucity of validated tests or scales, the teaching of empathy has nevertheless been the subject of numerous educational interventions.⁸¹ The most frequently used strategy to promote empathy is founded on the premise that an engagement with narratives requires, among other skills, an appreciation of different perspectives. It is based on the idea that both the teller and receiver have intentionality, anchored in unique socio-cultural contexts and in desires, beliefs, and values that are particular to the individual. Working with narratives of different types and origins would thus seem to present a natural vector for "feeling into" another's life and thus nurturing one's capacity for empathy, or, as Kleinman puts it, for fostering "empathic witnessing."⁸²

Working with narratives in order to enhance one's capacity for "empathic witnessing" has taken a number of forms. Some programs use first-person narratives, for example, by inviting students to write

stories of their own illnesses or to make use of narratives received during medical students' conversations with patients.⁸³ Another tactic is to ask students to rewrite a patient's narrative from a first-person perspective.⁸⁴ This last approach is particularly effective in encouraging identification with the ill person, even as it catalyzes self-reflection in the student. Some institutions apply classic literature to clinical settings to teach narrative and ethics, and have experimented with creative writing to promote reflection.⁸⁵ Indeed, most programs that employ narrative techniques, in an effort to reduce the emotional distance between doctor and patient, also claim to stimulate critical insight and reflection. A report by Micheline Louis-Courvoisier and Alexandre Wenger is a practice-oriented description of the benefits medical humanities afford a medical curriculum that reveals an implicit application of narrative theory. For these authors, the human sciences produce a "distancing" effect that the study of history and literature helps to produce and maintain, and their definition of "distancing" corresponds to what narrative theorists typically identify with post-structuralism: "the awareness that one natural way to describe a given situation does not exist and that any point of view—scientific or not—is context dependent and culturally shaped."⁸⁶

Reflection implies a conscious and deliberate effort to understand and appreciate events deeply, exploring experiences both intellectually and affectively. Many programs depend on narratives to promote this elusive quality of self-awareness or mindfulness, generally using combinations of (creative) writing, reading, and listening. An innovative exercise is the so-called "parallel chart," which refers to a process whereby students are asked to contemplate and write, in ordinary, everyday language, about their inner lives as they concurrently compose the formal notes in the medical record. Specifically, students are expected to consider the patient's plight as well as their own responses as they care for patients.⁸⁷ Patient-generated narratives, focused on their interactions with students, have also been used in the assessment of learner performance.⁸⁸ Although there is little evidence that creative writing will, at least as a sole intervention, result in an enhanced ability to reflect or to empathize, the concept of the "reflective or mindful practitioner" is now firmly entrenched in the medical education lexicon.⁸⁹ Finally, publications on narrative/reflective writing are an integral part of the medical literature and appear in a variety of journals.⁹⁰

A preoccupation in current medical education is the drive to reinforce professionalism and to reaffirm traditional virtues of the

physician-healer.⁹¹ Medical programs now widely use stories and other literary devices, whether generated by novelists, patients, physicians, physicians-become-patients, or physician-novelists, in order to promote and uphold professionalism.⁹² Students are invited to immerse themselves in narratives that portray physicians as ideal (or less-than-ideal) role models in order to foster discussions about the core attributes of professionalism, namely, altruism, competence, honor, and integrity. Indeed, narrative has in some ways superseded more conventional approaches to the promotion of professionalism. Jack Coulehan, for instance, suggests that rule-based approaches, as exemplified in charters or oaths, may be insufficient to cultivate an ethos of professionalism, arguing instead that in order to shape the behavior of physicians in training, professionalism “must be formulated as a metanarrative—a summation of, and reflection upon, many thousands of actual physicians’ stories, from different times and cultures”⁹³ He calls this “narrative-based professionalism.”⁹⁴

We have seen how pathographies and other narratives, and narrative theory in general, can serve to stimulate reflective thinking, foster empathic responses, and provide a scaffolding for the teaching of principle-based ethics and professionalism. There is an additional species of narrative in medicine that places stories precisely where they are (co)-created, namely, at the heart of the patient-physician dyad. Narrative represents a critical element of the clinical method, and it is the clinical relevance of narrative theory that we consider a crucial area of scholarship. By clinical method, we mean the toolbox of skills the physician requires in order to accomplish the clinical tasks of diagnosis and treatment. In this toolbox are the skills of listening, communicating, and observing; the techniques of the physical examination; and the aptitudes for clinical reasoning and wise judgment. Narrative understanding has, with some exceptions, not been traditionally considered an integral feature of the clinical method.⁹⁵ For us, it is an indispensable device—perhaps even a unifying leitmotif.

In this view, the ability to hear, read, analyze, and construct narratives registers both as a skill and as a particular comportment toward the practice of medicine. In Kathryn Montgomery’s terms, clinical reasoning, concerned with the application of rules (universal, invariable, and immutable) to singular and timely events or circumstances (effervescent, inexact, and ambiguous), is fundamentally a type of practical reasoning. “The first,” she explains, “is law-like and generalizable, the second inescapably particular and narratable.”⁹⁶ As habitual behavior, clinical reasoning can be best understood as a feature of *phronesis*, the

Aristotelian notion of practical wisdom. Phronesis is an intellectual virtue refined and strengthened through habitual practice under the guidance of an appropriate role model and mentor. Indeed, Daniel Davis and his mentor, the physician-philosopher Edmund Pellegrino, have proposed phronesis as a paradigm for clinical reasoning.⁹⁷ We argue that the *phronimos*—a person endowed with phronesis—ought, *inter alia*, to be equipped and inclined to recognize the text of a patient's disease, as well as the subtexts, contexts, and pretexts of his illness. In his discussions about "thinking with" stories, Frank describes the practice as a kind of phronetic inquiry, implying that stories can assist in teaching phronesis and contributing to sound, effective clinical methodology.⁹⁸ The amalgam of narrative medicine, phronesis, and the clinical method help to reconstitute the clinical relationship as the space of healing, the pursuit of which arguably triggered this invigorating resurgence of protean and generically diverse stories in medicine. We hope that our proposed taxonomy of stories-in-medicine, based on a functionalist approach to the field, will assist in its development and help clarify its ramifications and deployments.

Notes

1. See Kreiswirth, "Merely Telling Stories?"
2. A provocative article, published in *The New York Times Magazine*, explored several controversies, such as narrative's efficacy in teaching empathy, the role of parallel charting in promoting student self-knowledge, and the need for medical content and context in analyzing literary texts (Thernstrom, "The Writing Cure"). An NPR transcript of a program broadcast on November 17, 2009, features the relationship between medicine and writing, especially literary medicine. The article cites Terrance Holt, author of *In the Valley of Kings* and professor of medicine at the University of North Carolina School of Medicine, who describes the eminence of narrative in medical practice as follows: "Patients bring us stories We drop into the middle of patients' stories and try to change the plot for the better. First we have to understand it, however . . . to figure what it means" (Neary, "Story Specialists").
3. Some theorists, such as Tod Chambers and Kathryn Montgomery, view the study of doctor stories and narrative in general as a primary mode of exploring bioethics (Chambers and Montgomery, "Plot"). For an introduction to narrative production and pedagogy in medicine, see "Pedagogical Contexts" in this essay.
4. Kreiswirth, 302–03.
5. Bal, *Travelling Concepts in the Humanities*, 11.
6. Ibid.
7. Genette, "Fictional Narrative, Factual Narrative," 755.
8. Prince, "Narratology, Narrative, and Meaning," 543.
9. Leder, "Clinical Interpretation."
10. See Kreiswirth, 312–14, and Kreiswirth, "Tell Me a Story."
11. Kreiswirth, "Tell Me a Story."

12. In view of the growing use of narratives in medicine, additional research undertakings are needed—they are not, however, the major focus of this manuscript.

13. Engel, "The Need for a New Medical Model."

14. Charon, et al. "Literature and Medicine: Contributions to Clinical Practice," 599.

15. Another advocate of this position is Ronald Carson, who holds that "being versed in a broad range of moral experience" means engaging with imaginative literature (Carson, "Teaching Ethics in the context of the Medical Humanities"). The relationship between reading fictional narratives and enhancing empathic engagement has long been a source of scholarly interest in areas outside of medicine as well, ranging from its relevance in legal settings (One thinks of Nussbaum's work on empathy and law in, for instance, *Poetic Justice*) to its general relevance in daily life. The latter has been a subject of interest for literary critic and narrative theorist, Suzanne Keen, who has argued that reading fictional narratives encourages readers to feel empathy for characters, ideally spurring readers to voluntary acts of "prosocial" behavior in the actual world. For Keen, readers can respond with greater empathy to fiction due to freedom from "obligations of self-protection through skepticism and suspicion" felt in everyday life, but they can "still internalize the experience of empathy with possible later real-world responsiveness to others' needs" (Keen, "A Theory of Narrative Empathy," 220). Imagining the doctor as the analogue to the reader, Drew Leder describes the default structure of this relationship as follows: "It is as if a reader studied a book's style and meaning with the goal of taking over its authorship" (Leder, "Clinical Interpretation," 18). Narrative theorists in the humanities who discuss questions of voice in fictional narratives include James Phelan (see especially *Living to Tell About It* and *Narrative as Rhetoric*) and Susan Lanser (see especially *Fictions of Authority*). Mentioned below, in philosophical terms, this ability to hear the patient's voice calls up ideas about the appreciation of alterity about which Emmanuel Levinas writes (see especially *Alterity and Transcendence*). In the medical field, see the work of Carson.

16. Charon, "Literature and Medicine: Origins and Destinies."

17. Charon, "Narrative Medicine: Form, Function, and Ethics."

18. Charon. "Narrative Medicine: A Model for Empathy, Reflection, Profession, and Trust."

19. *Ibid.*, 1897.

20. *Ibid.*, 1898.

21. Kleinman, *The Illness Narratives*.

22. Charon, "Narrative Medicine: Attention, Representation, Affiliation."

23. Goyal et al. "'A Local Habitation and a Name,'" 733.

24. Hawkins, *Reconstructing Illness*.

25. Brody, "Storytelling in Medicine," 3.

26. Lewis, "Truth in Fiction"; Currie, *The Nature of Fiction*; Searle, *Expression and Meaning*.

27. Culler, *The Literary in Theory*, 190–91.

28. Launer, "The Narrative Practitioner at Work"; Brody; Leder.

29. Epstein, "Story, History, and Diagnosis"; Bruner, "The Narrative Construction of Reality."

30. Brody, "'My Story is Broken'"

31. Kirmayer and Garro, "Broken Narratives."

32. Rimmon-Kenan, "The Story of 'I.'"

33. In fact, the differential impacts of disease and illness on the personal narrative is one of the cardinal distinctions between the two concepts. See Kleinman, "The Cognitive Structure of Traditional Medical Systems"; Eisenberg, "Disease and Illness Distinctions."

34. While pregnancy or vaccination is not feared per se, neither are they illnesses.

35. Sinclair, "Disease Narratives."

36. Bruner, 5.

37. Greenhalgh and Hurwitz, "Why Study Narrative?"

38. Good, "The Narrative Representation of Illness"; Morris and Montello, "Narrative, Ethics, and Pain"; Kleinman and Kleinman, "Suffering and its Professional Transformation."

39. Morris and Montello.

40. Mishler, *The Discourse of Medicine*; Radley et al., "Time, Space and Opportunity in the Outpatient Consultation"; Barry et al., "Giving Voice to the Lifeworld."

41. Leder.

42. Charon, "Medicine, the Novel, and the Passage of Time."

43. Hartman, "Narrative and Beyond"; Charon, "The Self-Telling Body"; Poon, "Narratives and Therapy."

44. Coulehan, "Compassionate Solidarity."

45. Brody, "Storytelling in Medicine"; Crawford, "The Politics of Narrative Form."

46. Charon, "Narrative Medicine: Attention, Representation, Affiliation"; Schafer, "Narrating, Attending, and Empathizing"; Solomon, "Epistemological Reflections."

47. Burney, *Journals and Letters*, 431.

48. Berlinger 2003; Mishler, *The Discourse of Medicine*; Kleinman, *The Illness Narratives*; Charon, "Narrative Medicine: A Model for Empathy."

49. Frank, "Enacting Illness Stories," 31–49.

50. Frank, *At the Will of the Body*.

51. Frank, *The Wounded Storyteller*.

52. Frank, *At the Will of the Body*.

53. Radley, "The Aesthetics of Illness," 782.

54. Ibid., 791.

55. Rimmon-Kenan. See also Bury.

56. Rimmon-Kenan, 23.

57. Selzer, *The Exact Location of the Soul*.

58. Charon, "Narrative Medicine: Form, Function, and Ethics."

59. Charon, "Narrative Medicine: Attention, Representation, Affiliation."

60. Ibid., 266.

61. DasGupta, "Reading Bodies, Writing Bodies."

62. Brody.

63. De Moor, "The Doctor's Role of Witness and Companion," 220.

64. Cundiff, *Euthanasia is Not the Answer*.

65. Kleinman, *The Illness Narratives*.

66. The idea that literary study supports medical work in ethical and observational ways is a primary concept behind the development of "medical humanities," an interdisciplinary field that applies the arts and social sciences to medical science. The medical humanities database developed at New York University, for instance, includes a mission statement in which the insights and historical perspectives provided by the arts and humanities are held "to develop and nurture skills of observation, analysis, empathy, and self-reflection—skills that are essential features for humane medical care" (Aull, "Mission Statement").

67. The Arnold P. Gold Foundation defines these categories in a recently funded project aimed at elucidating the scope of such educational interventions prevalent in America (Stern, "Teaching Humanism," 497).

68. Bardes suggests that the humanist approach provides medicine with its "z axis" (i.e., the dimension which adds subjectivity and context to the universal truths and principles upon which biomedicine is believed to rest). For Bardes, nar-

rative medicine exists on a spectrum: at one pole it provides an epistemological framework, and at the other it symbolizes an invitation to physicians to attend to patients' individual stories. Bardes, "Is Medicine Flat?"

69. MacIntyre, *After Virtue*, 114.
70. Brody, "Storytelling in Medicine."
71. Pellegrino, "Altruism, Self-Interest, and Medical Ethics."
72. Coulehan et al., "'Let me see if I have this right. . . .'; Stempsey, "The Quarantine of Philosophy."
73. Jones, "Literature and Medicine."
74. Ibid., 1244-45.
75. Jonsen and Toulmin, "The Abuse of Casuistry."
76. Charon, "The Self-Telling Body."
77. Brody, "My Story Is Broken"; Eggly, "Physician-Patient Co-Construction of Illness Narratives."
78. Frank, *The Wounded Storyteller*; others have since expanded on the concept. See Morris and Montello.
79. Nicholas and Gillett, "Doctors' Stories, Patients' Stories," 297.
80. Groleau, "The McGill Illness Narrative Interview."
81. In contrast, sympathy is generally assumed to be spontaneous and to possess a more affective quality (Hemmerdinger et al., "A Systematic Review").
82. Kleinman, *The Illness Narratives*, 10.
83. DasGupta and Charon, "Personal Illness Narratives"; Kumagai, "Diabetes Stories," 200.
84. Marshall and O'Keefe, "Medical Students' First-Person Narratives."
85. Memorial University, for instance, has had some success, although the authors describe it as "a continuing saga with many challenges, disappointments, and frustrations" (Pullman et al., "Narrative Means to Humanistic Ends," 283).
86. Louis-Courvoisier and Wenger, "How to Make the Most of History and Literature," 51.
87. Clandinin and Cave, "Creating Pedagogical Spaces."
88. Liu et al., "Use of Unstructured Parent Narratives."
89. Epstein.
90. Clandinin and Cave; Levine et al., "The Impact of Prompted Narrative Writing"; Alcauskas and Charon, "Right Brain"; Wear, "Face-to-Face with It."
91. Cruess, "Teaching Medicine"; Swick, "Teaching Professionalism."
92. Wear and Nixon, "Literary Inquiry and Professional Development in Medicine"; Weisberg and Duffin, "Evoking the Moral Imagination."
93. Coulehan, "Written Role models," 106.
94. Ibid.
95. Shapiro's "Words and Wards: A Model of Reflective Writing and Its Uses in Medical Education" (233) for instance, counts narrative competence among the necessary patient care skills. Others have argued that narrative can guide clinical reasoning and catalyze inferential thinking—most notably abductive logic. See Mattingly, "In Search of the Good," 284 and Shleifer, "The Logic of Diagnosis." And we have elsewhere posited narrative understanding as a necessary complement to teaching attentive listening to medical students (Boudreau et al., "Patients' Perspectives on Physicians' Roles").
96. Montgomery, "Sherlock Holmes and Clinical Reasoning," 303.
97. Davis, "Phronesis, Clinic Reasoning, and Pellegrino's Philosophy of Medicine," 184-87.
98. Frank, "Asking the Right Question about Pain," 210.

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