Listening with a narrative ear

Insights from a study of fall stories in older adults

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Abstract

Objective To determine the value of adding a patient narrative to the clinical assessment of falls in the elderly.

Design Qualitative study of interviews.

Setting A fall prevention clinic in Calgary, Alta.

Participants Fifteen older adults on a wait list for assessment by the fall clinic and the physiotherapists who assessed them.

Methods Participants' stories were audiorecorded and later transcribed and summarized. Stories were collected using open-ended questions, first inviting participants to tell the interviewer about themselves, and then the circumstances of their falls and their reflections on them. In a subsequent visit, transcriptions or summaries were returned to patients for member checking. Narratives were read and analyzed by all 4 investigators using a narrative approach and a close-reading technique. With the patients' additional consent, stories were shared with the fall prevention team for their insights and reactions. Interviews with physiotherapists were audiorecorded and transcribed.

Main findings The narrative analysis provided new insights into the attitudes about and perceptions of the causes of falls, their effects, and rehabilitation. Close reading exposed presentation of self, locus of control, and underlying social and emotional issues.

Conclusion The addition of patient narratives to clinical assessments offers clinicians an understanding of patients' perspectives, which can be used to better engage patients in rehabilitation.

EDITOR'S KEY POINTS

- Patients' and clinicians' understanding of the causes and implications of clinical events differ. Listening with a narrative ear can provide greater insight into the patient perspective and locus of control. This can enhance rapport and treatment decisions.
- Patients who might benefit from closer narrative listening are those who express hopelessness for the future, those reluctant to accept rehabilitation, and those who describe themselves as passive participants or tell a chaotic story.
- Attention should be paid to figurative language, as it might be conveying subtle messages that should be explored. Clinicians can leverage those images and such language in treating patients.

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Écouter comme si c'était un conte

Les leçons d'une étude sur les récits relatifs aux chutes chez les personnes âgées

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Résumé

Objectif Établir s'il est utile de tenir compte du récit des patients lors de l'évaluation clinique des chutes chez les personnes âgées.

Type d'étude Étude qualitative au moyen d'entrevues.

Contexte Une clinique de prévention des chutes à Calgary, en Alberta.

Participants Quinze patients âgés en attente d'une évaluation par la clinique de prévention des chutes et par les physiothérapeutes de la clinique.

Méthode Les récits des participants ont été enregistrés pour ensuite être transcrits et résumés. Ils avaient été recueillis à l'aide de questions ouvertes dans lesquelles on invitait d'abord les participants à parler d'eux-mêmes à l'intervieweur, et ensuite à décrire les circonstances de leur chute et ce qu'ils en avaient pensé. Lors d'une seconde visite, on remettait aux patients les transcrits aux fins de vérification. Les récits ont été lus et analysés par les 4 chercheurs à l'aide d'une méthode narrative et d'une technique de lecture attentive. Après avoir obtenu un deuxième consentement de la part des patients, les récits ont été soumiss aux membres de l'équipe de prévention des chutes pour obtenir leurs opinions et réactions. Les entrevues avec les physiothérapeutes ont été enregistrées et transcrites.

Principales observations L'analyse des récits a entraîné une façon différente d'interpréter les causes et les effets des chutes, de même que le processus de réadaptation. La lecture très attentive a montré ce que le patient pense de lui-même, son locus de contrôle ainsi que les composantes sociales et émotionnelles sous-jacentes.

Conclusion Le fait de tenir compte du récit du patient dans l'évaluation permet au clinicien de mieux comprendre l'idée que se fait le patient de sa chute, ce qui peut éventuellement amener celui-ci à accepter la réadaptation.

POINTS DE REPÈRE DU RÉDACTEUR

- Patients et médecins n'ont pas la même compréhension des causes et des conséquences des événements cliniques. Écouter ce que le patient raconte peut nous renseigner davantage sur sa façon de voir et sur son locus de contrôle. Cela peut entraîner une amélioration du rapport et du traitement.
- Les patients qui pourraient bénéficier d'une écoute plus attentive de leurs récits sont ceux qui se disent désespérés face à l'avenir, ceux qui sont réticents à faire de la réadaptation, et ceux qui se décrivent comme des acteurs passifs ou qui racontent une histoire chaotique.
- Il importe d'être attentif au langage figuratif, car il peut être porteur de messages subtils qu'on pourra explorer. Le clinicien pourra s'en servir dans le traitement du patient.

Cet article a fait l'objet d'une révision par des pairs.
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A common lament among patients is "The doctor didn't listen." Doctors listen, but with a clinical ear. The patient's illness story is transformed by the clinician to develop a diagnosis and treatment plan.[1] This transformation typically involves interrupting the flow of the narrative by interjecting clarifying questions, editing out "irrelevant" data, and choosing clinical terminology. This process might eliminate aspects of the narrative that reveal patients' beliefs, values, fears, and expectations, all of which can assist clinicians in finding common ground when negotiating therapy.[2] This might be magnified by shifts in today's health care delivery, such as the use of the clinical history as a shared document by the health care team, constraints on clinician time, and the evolution of electronic health records in which the narrative might be structured and reduced to a series of checked boxes.[3]

More than one-third of adults older than 65 fall each year.[4] Falls can be important and frightening experiences. In the elderly, falls raise concerns about injury, disability, helplessness, and dependency.[4] These fears are often reflected in the narratives they create about their falls.

In 2012 we undertook a study to capture and analyze elderly patients' fall stories. We used a narrative approach, as story telling is how patients communicate with clinicians.[5] We believed that by listening to their stories we would capture the nuances of their fall experiences. We hoped these insights would improve their treatment course.

METHODS

With ethics approval from the University of Calgary in Alberta, a convenience sample of 15 seniors was recruited from a wait list for a fall prevention clinic (which defines seniors as those aged 65 years and older) in Calgary. Patients who had language difficulties or cognitive impairment were excluded. After the patients were recruited by the fall clinic coordinator, the investigators contacted the patients, explained the study, and set times for an interview, which usually took place in the patient's home. After obtaining informed consent, stories were audiorecorded and later transcribed and summarized. Field notes captured the interviewers' impressions about each person's deportment and living situation. Stories were collected using open-ended questions; patients were first invited to tell the interviewer about themselves, and then to describe the circumstances of their falls and their reflections on them. In a subsequent visit, transcriptions or summaries were returned to patients.

Interviews lasted between 15 minutes and 1 hour. Which authors interviewed which patients depended on the availability of the former; L.P. interviewed 4 patients, R.J. interviewed 7 patients, and L.N. interviewed 4 patients, and T.R. subsequently interviewed all patients for member checking[6] by offering the verbatim transcriptions for validation. Member checking was later altered by providing a narrative summary to reduce participants' stated discomfort at reading their verbatim comments.

With the patients' additional consent, stories were shared with the fall prevention team for their insights and reactions. Interviews with physiotherapists were audiorecorded and transcribed. Narratives were read and analyzed by all 4 investigators using a narrative approach[7] and a close-reading technique.[8]

To ensure the validity of our study we audiorecorded the interviews to capture what participants actually said and we returned summaries or transcriptions to them for validation.[9] All investigators read and analyzed the interviews independently and came to a consensus on the interpretations presented here. In addition, the physiotherapists read the stories and reflected on whether these stories confirmed their own assessments.

RESULTS

Fifteen seniors, aged 65 to 91 years, comprising 5 men and 10 women, were recruited and interviewed. One patient withdrew from the clinical assessment at the fall clinic but consented to our interview.

In analyzing the stories we purposely listened for perceptions and attitudes about the cause of the fall, the effect of falling, change, and rehabilitation. We listened for language devices used, including narrative structure, narrative voice, figurative language, and what was not said.

Explaining the fall

Telling their stories allows participants to make sense of their experiences. Participants attributed their falls to external or internal causes that often reflected their loci of control. Some common external causes were ice or poor footwear: "I thought it might be my shoes, getting different shoes, but when I wear boots I don't think I have a problem." (Patient 10)

But for some the fall was just a mystery: "[I] just fell," "[I] don't know," and "I can't remember why."

Falls were often attributed to internal causes: "I am sick," "[I am] weak," or "I have always had poor balance."

Effect of falling

A fall was seen as either a disruption or something that could be accommodated. Falls were either exclusively in the past or omnipresent, looming in the future. Falls that were described as in the past were not seen as relevant to the present or future; the effect was minimized and the stories were brief and factual with no emotional

content. The falls were accidents: "I've had 2 very minor falls with no injury and really no consequence at all. I tripped and fell very heavily on my left side and shoulder, hit my head, and required assistance to get up." (Patient 11)

Stories often reflected denial. There were delays in seeking medical treatment and no mention of the effect on their lives and the associated pain: "That happened on a Saturday. I went Wednesday afternoon to have [an] x-ray and they put a splint on it and phoned me back later that night to tell me it was broken." (Patient 3)

In contrast, the falls forced others to reconsider their current life circumstances or need for assistance.

> Maybe I do need something in my bath or shower but other than that .... But it got me thinking, maybe I should be moving out of here, yeah—but then I come home, I look around, and say, "Where am I going to go?"(Patient 3)

This participant also canceled her golf membership.

Others worried about a loss of independence: "They could put you in a home but that is a no-no." (Patient 2)

Travel for some was curtailed or seen as too risky: "I thought I would go to New York with a little group that goes from Toronto and I thought I could do that but I—I was afraid, so I canceled. I was afraid I might fall." (Patient 13)

Attitudes toward rehabilitation and change

We were interested in participants' perceptions of their future visits to the fall clinic and any changes that might entail. Some perceptions were positive.

> I'm going to the fall clinic because I really need to find out what the heck and I honestly don't know what I can do. Well, I'm hoping they might be able to identify why I'm falling, which would be a really good thing. If not, I'm hoping they can give me some exercise programs or whatever that will—that will strengthen my legs, my core, or whatever needs it. (Patient 15)

Others were more guarded and were not sure of the benefit or whether they wanted to make any changes.

> There was somebody on the phone from home care to offer a walker and I said, "Honey, thank you very much, but ... I've got a cane." (Patient 7)

> "Would you like to do a group exercise with the 'sit and get fit' group?" And I said, "No, J., I'm working pretty hard here on my cross-trainer." ... And I said, "Someday I will probably need it but right now, it doesn't fit today, right now." (Patient 7)

Narrative structure

In most stories, there was a beginning, a middle, and a future. In some cases the stories were stalled in the sense that the patients found themselves unable to narrate a future. Instead, they found themselves mired in their present predicament.

> I do commercial real estate on a spasmodic basis ... just [to] kill time as much as anything. I'm interested to see what this assessment will do for me and the ultimate [outcome] being hopefully that I will get some assistance to bring this shoulder ... back to the point where I can be of some use to myself and the family. (Patient 11)

Story structure varied from very organized (almost rehearsed) to chaotic jumping from one thought to another. Participants with chaotic stories inserted health or social issues that had adversely affected them.

Voice and presentation of self

We listened for the voice the participants used in the belief this reflected the participants' locus of control. Some participants preferred to tell their stories as seen through others' eyes (eg, "the doctor said," "my daughter thought") or asked their family members to relate the story. While some spoke in the first person (eg, "I tripped," "I slipped") others spoke of being a passive participant.

> Then they took me to the hospital and after the MRI [magnetic resonance imaging], they put me with extended care, so I spent—2 months?—2 months in extended care on mostly pain pills, and then they sent me home. (Patient 6)

Presentation of self revealed degrees of self-sufficiency or disability: "I don't want to be asking, if I can do it myself" versus "I am tired [and] my body is not strong enough now." Or it revealed a state of change:

> So I guess I just need to accept the fact I'm getting older and can't do what I used to do as before. (Patient 5)

> I've been in management all my life and usually I'm interviewing you, not you interviewing me. And it's a different role for me. It's not one I want to get used to. (Patient 11)

Figurative language

Allegory[10] was present in the story told by an elderly man with renal failure who used an allegory to open up a discussion about end-of-life issues. When he was asked about a photograph of 2 cats, he took the opening to talk about their deaths: one of his cats had died

a "hard" death in a veterinary clinic, while the other had an "easy" death at home. He used his pets' deaths as an allegory that revealed his own preferences, fearing he would have a hard death, and end up in a "home" like his mother.

Another patient's unusual choice of words proved to be prescient. This patient's story was a chaotic narrative and she struggled to pull together a coherent account of her falls. In a non sequitur near the end of the interview, she said she had the feeling that something was "accumulating." She was later found to have a chronic subdural hematoma.

The use of similes was revealing in the narrative of family dysfunction told by an elderly woman who was estranged from her family. When she was asked what it was like to tell her story, she replied that it was "like peeling an onion." Her use of this domestic simile locates the source of her grief and tears in the family home. Her simile is especially appropriate in that it replicates both the layered structure of her narrative and the tears that accompanied her telling. As she peeled the layers of her narrative away, she revealed her self-image as that of a helpless bystander to the family members' difficulties; yet, the content of the narrative contradicts this image, exposing her pivotal role in her family's pain. So, in both the presence of layers and the absence of a centre, the narrative structure mimics the onion's structure, and because an onion has no centre, this simile that she chose reveals her failure to acknowledge her place at the centre of her narrative.

Missing elements

Because we also had clinical assessments done by the physiotherapists, we were able to assess what was missing from the participants' stories. Important missing clinical conditions included recent stroke, hospitalization, and alcohol abuse. Many participants did not mention emotional effects.

Feedback from the physiotherapists

Physiotherapists noted that elements in the patients' narratives were missing from their clinical notes because they did not inquire or they inquired but did not record the answer when they considered it to be information that was too sensitive. They found the narratives most helpful in complicated cases, where they thought they were missing something or were stymied.

DISCUSSION

Stories serve multiple functions. In the case of fall stories, they explain the event and create meaning for the teller and the listener. A patient's understanding might differ from the clinician's understanding. A narrative collected outside of a clinical encounter might provide additional insights into patients' perspectives.

Perceived causes and effects of a fall might have important therapeutic implications. Validating the patient's perspective is the first step in negotiating a treatment plan.[11] Reasons given for a fall often reflected a patient's locus of control. A common belief among patients is that falls are outside their control.[12] Patients who think the fall was an accident or had an external cause will need to be approached differently than patients who believe they need physical conditioning or balance training. Locus of control affects outcomes. Patients who attributed their hip fractures to an external locus of control had poorer outcomes.[13] Similarly, patients who perceive that the cause is poor health will require a slightly different approach. That patients are "too old" or "getting old" is a commonly voiced sentiment that needs be challenged before interventions can be entertained.[14]

The perceived effect of the falls varied. Some participants denied the effect of even serious falls to the interviewers. Participants who minimized their falls in our study were less likely to see the need for interventions. Denial might reflect a desire to maintain independence and not make changes.[15] Yet it can be self-protective; patients in denial have fewer falls despite being at greater risk.[16]

Attitudes toward change and rehabilitation are important to tease out because resistance to interventions, particularly exercise, is common. The acceptance or rejection of exercise programs might be influenced by social and cultural norms.[4] Our participants' reasons were often given in their narratives. Many see interventions as a threat to their autonomy.[14,17] One common recommendation, the use of a mobility aid, was resisted by some of our participants for reasons in keeping with what others have observed (eg, mobility aids can symbolize aging and fragility, and threaten self-perception).[12] Clarifying views and expectations about rehabilitation might be an important first step in the treatment process. One approach is to focus instead on developing mastery or self-management over the falls.[12,15] McInnes and Askie suggested it is important to negotiate what a person is willing to modify to reduce his or her fall risk.[14]

Narrative structure is an important consideration.[18] Fall stories that were chaotic or stalled reflected the emotional and social situation of the person telling the story. It is important to attend to these issues before any meaningful rehabilitation can begin. This was affirmed by the physiotherapists' experience with these participants.

The use of language is important. It has been recognized that patients are more accepting of counseling when clinicians use words and phrases that mirror those used by patients.[11] Symbolism and metaphors in stories

need to be noted. These will have substantial meaning for the patient; the challenge is interpreting them in the patient's context.[19] Using the same metaphors or allegories but with a slightly different twist when counseling patients can open up new ways of thinking for patients.[20,21] Appreciating one participant's allegory of the death of his cats provided an opportunity to explore what a good death and a bad death were to him.

Narratives offer an opportunity for storytellers to project an image of themselves to the listener. In our study we have 2 divergent kinds of presentation: patients who are self-sufficient and patients who perceive themselves as disabled. Patients often presented themselves as self-sufficient despite disability. Other investigators have noted similar findings and speculate that it allows patients to maintain an independent, autonomous self-image.[4,12,16] Patients who presented themselves as self-efficacious were more amenable to and responded better to rehabilitation.[22]

Being attentive to and exploring what is not said can provide greater insight into the patient's situation. In this study the narratives complemented the assessments and raised questions that can be explored. Why is there no future in some stories? Why are important health conditions, such as stroke, depression, heart disease, and alcohol abuse, left out of their stories—do patients not believe these conditions are contributing to their falls?

Limitations

Stories are not fixed entities with one truth. They are edited and viewed through a lens of the past, the present agenda, and expectations for the future.[19] They are co-constructed.[23] The interviewer has an effect on the story the patient tells, and although we used open-ended questions, it seems likely that the stories were edited for us.[7] It is difficult to assess exactly how this affected our study findings.

An individual narrative cannot be generalized to other patients but, when the stories are taken as a collective, they reveal common patterns of how patients understand themselves and falls. It is similar to clinical encounters, where treatment and diagnosis must be presented within the person's worldview.

We collected these stories outside usual clinical assessments. It would be difficult to capture all the nuances of the stories while conducting a typical clinical assessment. How might our methods be integrated into practice? In the team-based approach to family medicine, other members of the team could be employed to capture relevant stories. Audiorecording the stories might be the best approach for the elderly, although a younger population could write their stories. One advantage is that the story can be read or listened to again later if necessary. However, narrative listening can be applied to any clinical encounter. What clinicians learn from patients' use of language, presentation of self, and their worldviews as expressed in their explanations and expectations can be used to develop a patient-centred treatment plan. Narrative analysis can take time but the skills can be easily learned and are transferable to other clinical encounters.

While a single screening question might not be available to determine which patients' stories warrant more careful collection and analysis, clinicians might want to listen more closely to patients with chaotic or stalled stories, or patients who use negative self-descriptors, such as "I am a klutz" or "I have always been clumsy," or denial.

Future research should examine the degree to which eliciting patients' narratives could result in patients' improved adherence to negotiated therapeutic plans and might also look at how to add patients' stories effectively to an electronic health record. Perhaps voice recording could be employed.

Conclusion

Understanding patients' perspectives by listening with a narrative ear will help clinicians develop rapport and negotiate interventions that are more acceptable and effective for patients. Such interventions deserve validation through further study.

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Contributors

Drs Pereles, **Jackson**, **Nixon**, and **Rosenal** all participated in the patient interviews. **Drs Pereles** and **Nixon** interviewed the physiotherapists. All researchers reviewed and analyzed the transcripts and agreed upon any conclusion drawn from them. The manuscript was mainly prepared by **Dr Pereles** in collaboration with **Drs Jackson**, **Rosenal**, and **Nixon**.

Competing interests

None declared

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References

1. Hunter KM. *Doctors' stories: the narrative structure of medical knowledge*. Princeton, NJ: Princeton University Press; 1993.
2. Charon R, Wyer P; NEBM Working Group. Narrative evidence based medicine. *Lancet* 2008;371(9609):296-7.
3. Rosenbloom ST, Denny JC, Xu H, Lorenzi N, Stead WW, Johnson KB. Data from clinical notes: a perspective on the tension between structure and flexible documentation. *J Am Med Inform Assoc* 2011;18(2):181-6. Epub 2011 Jan 12.
4. Child S, Godwin V, Garside R, Jones-Hughes T, Boddy K, Stein K. Factors influencing the implementation of fall-prevention programs: a systematic review and synthesis of qualitative studies. *Implement Sci* 2012;7:91-100. Epub 2012 Sep 14.
5. Kleinman A. *The illness narratives. Suffering, healing, and the human condition*. New York, NY: Basic Books; 1988.
6. Creswell JW, Miller DL. Determining validity in qualitative inquiry. *Theory Pract* 2000;39(3):124-30.
7. Reissman CK. *Narrative methods for the human sciences*. Thousand Oaks, CA: Sage Publications; 2008.
8. Engel JD, Zarconi J, Pethtel LL, Missimi SA. *Narrative in health care. Healing patients, practitioners, profession, and community*. Oxford, UK: Radcliffe Publishing; 2008.

9. Morse JM, Barrett M, Mayan M, Olson K, Spiers J. Verification strategies for establishing reliability and validity in qualitative research. *Int J Qual Methods* 2002;1(2):13-22.
10. Eagleton T. *How to read a poem*. Oxford, UK: Blackwell Publishing; 2007.
11. Stewart M, Brown JB, Weston WW, McWhinney IR, McWilliam CL, Freeman TR. *Patient-centered medicine. Transforming the clinical method*. 2nd ed. Abingdon, UK: Radcliffe Medical Press; 2003.
12. McInnes E, Seers K, Tutton L. Older people's views in relation to the risk of falling and need for intervention: a meta-ethnography. *J Adv Nurs* 2011;67(12):2525-36. Epub 2011 Jun 1.
13. Furstenberg AL. Attribution of control by hip fracture patients. *Health Soc Work* 1988;13(1):43-8.
14. McInnes E, Askie L. Evidence review on older people's views and experiences of falls prevention strategies. *Worldviews Evid Based Nursing* 2004;1(1):20-37.
15. Miller JM. *Perception and psychological effects of falling of elderly people living in the community* [doctoral dissertation]. Chicago, IL: University of Illinois at Chicago; 1995.
16. Delbaere K, Close JCT, Brodaty H, Sachdev P, Lord SR. Determinants of disparities between perceived and physiological risk of falling among elderly people: cohort study. *BMJ* 2010;341:c4165.
17. Howse K, Ebrahim S, Gooberman-Hill R. Help-avoidance: why older people do not always seek help. *Rev Clin Gerontol* 2004;14(1):63-70.
18. Frank AW. *The wounded storyteller. Body, illness, and ethics*. Chicago, IL: University of Chicago Press; 1995.
19. Randall WL. Memory, metaphor, and meaning: reading for wisdom in the stories of our lives. In: Kenyon G, Bohlmeijer E, Randall WL, editors. *Storying later life. Issues, investigations, and interventions in narrative gerontology.* New York, NY: Oxford University Press; 2011. p. 20-38.
20. Barker PA. *Using metaphors in psychotherapy.* New York, NY: Brunner-Mazel; 1985.
21. Burns GW, editor. *Healing with stories. Your casebook collection for using therapeutic metaphors*. Hoboken, NJ: John Wiley and Sons; 2007.
22. Borkan JM, Quirk M, Sullivan M. Finding meaning after the fall: injury narratives from elderly hip fracture patients. *Soc Sci Med* 1991;33(8):947-57.
23. Williams G. The genesis of chronic illness: narrative re-construction. *Sociol Health Illn* 1984;6(2):175-200.