

### Editor's key points

► Narrative-based medicine (NBM) enables a more thorough exploration of the patient history, providing a deeper understanding of the patient, as well as the illness and its implications. Narrative skills are integral to the practice of NBM, and learning these skills takes time.

► This is the second in a series of 3 articles examining NBM. It outlines some of the skills required to practise NBM and presents a patient case example.

► Good communication skills are fundamental to the consultation. This article discusses some of the concepts GPs can use to build on the strong communication skills they already possess to begin to practise NBM: neutrality, circular questioning, and hypothesizing, as well as reflective skills.

### Points de repère du rédacteur

► La médecine narrative permet d'explorer plus en profondeur l'histoire du patient pour mieux comprendre celui-ci, la maladie et ses conséquences. Les compétences narratives font partie intégrante de l'exercice de la médecine narrative, et il faut du temps pour les perfectionner.

► Il s'agit du deuxième d'une série de 3 articles qui se penchent sur la médecine narrative. Il met en évidence les compétences requises pour pratiquer la médecine narrative et présente en exemple le cas d'un patient.

► Les consultations exigent fondamentalement de bonnes compétences en communication. Cet article traite de certains concepts dont peuvent se servir les omnipraticiens pour renforcer les solides compétences en communication qu'ils ont déjà afin de commencer à pratiquer la médecine narrative: la neutralité, le questionnement circulaire, la formulation d'hypothèses et les capacités réflexives.

# Narrative-based medicine and the general practice consultation

## Narrative-based medicine 2

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### Abstract

**Objective** To raise awareness of narrative-based medicine (NBM) as a valuable approach to the consultation, which, if practised more widely by GPs, would convey considerable benefits to both patient and doctor.

**Sources of information** Principally, this article draws on the perspectives of 2 of NBM's key proponents, John Launer and Rita Charon, and which are complemented by the perspectives of several other authors.

**Main message** This article examines NBM in relation to patient-centred care and the particular skills that are required to practise NBM. Narrative-based medicine brings together skills from other fields of practice—skills that are not beyond the capabilities of GPs—conferring benefits on patient and doctor. Narrative-based medicine's skills enhance the patient-centred method and an evidence-based approach.

**Conclusion** The literature speaks very loudly about the importance of narrative and of understanding the illness experience. What makes NBM stand out is the fact that it is a collaborative and mutually beneficial process, having the power to create a new narrative—a narrative that heals and transforms the patient and the doctor.

## La médecine narrative et les consultations en pratique générale

### Médecine narrative 2

#### Résumé

**Objectif** Mieux faire connaître la médecine narrative comme approche valable des consultations qui, si elle était pratiquée plus largement par les omnipraticiens, apporterait des avantages considérables tant aux patients qu'aux médecins.

**Source de l'information** Cet article se fonde principalement sur les points de vue de 2 des principaux partisans de la médecine narrative, Rita Charon et John Launer, auxquels s'ajoutent ceux de plusieurs autres auteurs.

**Message principal** Cet article examine la médecine narrative par rapport aux soins centrés sur le patient ainsi que les compétences particulières nécessaires pour l'exercer. La médecine narrative réunit des compétences empruntées à d'autres domaines de pratique, des compétences qui ne vont pas au-delà des capacités des omnipraticiens, et qui confèrent des avantages tant aux patients qu'aux médecins. Les compétences en médecine narrative enrichissent la méthode centrée sur le patient et une approche fondée sur des données probantes.

**Conclusion** La littérature scientifique accorde beaucoup d'importance à la narration et à la compréhension de l'expérience de la maladie. Ce qui démarque la médecine narrative réside dans le fait qu'il s'agit d'un processus

collaboratif et mutuellement bénéfique, qui a le potentiel de créer une nouvelle narration, une narration qui guérit et transforme le patient et le médecin.

*Narrative medicine provides healthcare professionals with practical wisdom in comprehending what patients endure in illness and what physicians themselves undergo in the care of the sick.*

Rita Charon<sup>1</sup>

**P**atient-centred care (PCC) is the accepted model for general practice<sup>2,3</sup> and is taught to GP trainees. Principal components of the model include exploring the disease and the illness experience; understanding the whole person and the context; finding common ground; and enhancing the patient-doctor relationship. Patient-centred care also encompasses the biopsychosocial aspects of illness, health promotion, illness prevention, and shared decision making. While narrative-based medicine (NBM) might focus on the narrative, it does not negate any of PCC's principles; NBM adds to the patient-centred method.<sup>4</sup> Texts on PCC<sup>2</sup> and consulting skills<sup>5,6</sup> now include sections on NBM and narrative skills, thus acknowledging the importance of the patient narrative. The narrative enables a more thorough exploration of the patient history.<sup>7</sup> It provides a deeper understanding of the patient, as well as the illness experience and all its implications.<sup>1</sup> This understanding, in itself, facilitates management, and change is effected through the creation of a new narrative.<sup>4,7-9</sup> Narrative-based medicine therefore facilitates information gathering, promotes understanding, and is the means for moving forward.

### Sources of information

Principally, this article draws on the perspectives of 2 of NBM's key proponents, John Launer and Rita Charon, and which are complemented by the perspectives of several other authors.

### Main message

**Narrative-based medicine: challenges and criticisms.** Narrative-based medicine has its sceptics and with valid reason. First, not all presentations call for a narrative exploration.<sup>9</sup> Second, there might be resistance to NBM from patients and doctors.<sup>8</sup> Patients, for example, might prefer skilled technique in a doctor over bedside manner<sup>8</sup> or they might not want to share their innermost feelings.<sup>9</sup> Also, there are doctors who prefer the biomedical model or an evidence-based approach.<sup>8</sup> Further, some doctors become overwhelmed by the emotions that certain narratives engender,<sup>10</sup> while others have particular habits that impede the narrative flow.<sup>4</sup>

In addition, NBM has been criticized particularly as being time-consuming<sup>8</sup> and that it opens up a host of problems.<sup>4,9</sup> Balancing narrative and normative

requirements is a dilemma when working under pressures of time.<sup>4</sup> However, studies have shown that allowing a narrative flow does not necessarily require a lot of time.<sup>9</sup> Time spent gaining understanding is also time well spent, and it is always better to draw out underlying issues because that is often where the real problems lie. Another criticism is that NBM is mostly about patients' psychosocial needs,<sup>11</sup> neglecting the biomedical aspects of illness. In this respect, when the cited case examples are predominantly psychosocially focused, the literature on NBM is not helpful. It is important to remember that from an NBM perspective, the biomedical is just as much part of the narrative as the psychosocial.

An important pitfall in the practice of NBM is not knowing one's limitations and becoming carried away by stories. Patient stories belong to real people with real problems. Care and caution must always be exercised<sup>4</sup> because pursuing the narrative for the narrative's sake is dangerous.<sup>4</sup>

Narrative skills are integral to the practice of NBM and learning these takes time.<sup>9</sup> However, they are not beyond the scope of GPs, as Launer points out in his book *Narrative-based primary care. A practical guide*.<sup>4</sup> Indeed, experienced GPs having good communication skills have found that patient management becomes easier over time because of the accumulated knowledge of their patients' personal and medical histories and because of the connection and understanding that develops. Without having been taught narrative skills, they have incorporated an NBM style into the consultation because they have discovered that listening to the patient has important benefits for both doctor and patient.

**Communication skills in NBM.** Good communication skills are fundamental to the consultation.<sup>12</sup> The first step in narrative is giving the patient permission to tell his or her story in his or her own words. Implicit to this is a genuine interest in the patient and willingness to listen. The narrative is explored with the patient, paying attention to his or her ideas, concerns, expectations, feelings, emotions, and reactions; following cues and observing body language; looking for connections and how the story fits in the patient's life; formulating new insights into the illness experience; and considering options for assisting the patient.<sup>4</sup> These are basic communication skills encompassed by Launer's 7 Cs,<sup>4,13</sup> as presented in the first article in this series, along with examples of useful questions.<sup>14</sup>

There is no prescribed way for incorporating narrative skills in the consultation.<sup>4,13</sup> It depends on the doctor's style and skills, while the context influences how deeply the narrative is explored. Certainly in an emergency, management of the presentation would take precedence over a narrative approach.<sup>4</sup> The case example of Nerida that is presented in **Box 1** demonstrates an NBM approach and the use of communication skills

**Box 1. Using narrative: Nerida's case example.**

Nerida is a 40-year-old single mother who has seen her GP several times over the past 2 to 3 weeks because of nausea and reflux. Her usual GP is not in today. She presents looking unwell.

Doctor: *How can I help you today?*

Nerida: *I've been very nauseated for a while now and I'm sure it's all due to stress, but now I'm having diarrhea and abdominal pains.*

Doctor: *Can you tell me more about your symptoms?*

Nerida describes her physical symptoms in more detail and doesn't say anything about her stress. Having explored these symptoms sufficiently, the doctor turns his attention to what has been happening in the preceding 2 to 3 weeks.

Doctor: *I see from your doctor's notes that you have been having problems with heartburn. You have been prescribed some medication for it. How is that going?*

Nerida: *The heartburn is much better but it's the nausea. I can't eat anything. I haven't eaten for 4 days. Last night my daughter made pasta for dinner. I had a mouthful but I brought it straight up. And now I have these pains and the diarrhea is like water. I have no energy at all. I'm really not well.*

In her narrative, Nerida keeps returning to how physically unwell she feels. She does look unwell. This creates a degree of urgency for the doctor to manage the physical problems. The doctor, however, chooses to ask about her stress.

Doctor: *You mentioned when you came in that you have been under a lot of stress and that you think that this stress is behind all these other symptoms. Tell me about this.*

The doctor allows Nerida to tell her story at her own pace, interrupting only to ask some clarifying questions and to empathize. The story is as follows: Nerida has 6 children with ages ranging from 7 to 18 years from 2 previous relationships. Her second husband died 2 years ago and she feels that she has only just gotten over her grief. Her 18-year-old son recently moved away from home, and from the tone in her voice it is clear that she is worried about this. Nerida lives with her partner, Kevin. He is a truck driver and is away from home for days or weeks at a time. Kevin has 2 children who live with his ex-wife, Diane. Diane refuses to speak directly with Kevin, and so Nerida acts as the go-between. Diane also makes things difficult for Kevin, such as access to his children, and periodically this results in arguments between him and Nerida. Recently Diane has accused Nerida of

seriously mistreating her children, and a court case is pending. Nerida is at a loss as to how all this came to be, let alone how it will be resolved. Her demeanour has been impassive throughout and her affect flat.

Doctor: *You certainly have a lot on your plate at the moment. [She smiles ironically and her demeanour lightens a little.] Of all of this, what is concerning you most?*

Nerida: *[She has difficulty putting this into words.] My partner, we get on alright and that, but he focuses on his children and the problems his ex is causing. That's all he goes on about. And right at the moment, I can't do anything. I can't even help myself.*

Doctor: *What would you like to happen?*

Nerida: *[She thinks a moment.] I just want to be able to look after my children. I just want to be able to be happy. I can't eat. I feel tired all the time and all I want to do is sleep. I can't keep going on like this.*

The doctor spends some time now trying to understand Nerida's feelings and emotions, the nature of the interactions among the 3 parties, and what has been tried to remedy the situation. The doctor doesn't attempt to solve any of Nerida's problems. When the story has been explored sufficiently, the doctor returns to the presenting problems.

Doctor: *Can we come back now to your nausea and the abdominal pains? I would like to examine your stomach. Then we can talk about what might be going on there and what can be done for it.*

Nerida consents. The doctor examines her and the physical problems are managed. The doctor empathizes. He tells Nerida that while she might be experiencing a protracted viral infection, he agrees that the stresses that she has been dealing with could very well be contributing to her physical symptoms. The doctor emphasizes the importance of maintaining open lines of communication with her partner and of supporting each other through the difficulties. Nerida leaves looking much more at ease than when she came in. The doctor makes a mental note to ask Nerida to continue with her story when he next sees her. Following the consultation, the doctor reflects on what has transpired and wonders whether the case had been managed appropriately. The doctor comes to the realization that Nerida's impotence in the psychosocial domain is mirrored by her physical inability to function.

with a patient who has what initially appears to be a straight-forward biomedical problem. With Nerida, the doctor chose to explore the physical symptoms first and the patient's stress later. If Nerida's problem required urgency, the doctor clearly would not have explored her background in such detail. Nevertheless, the doctor would still have been mindful of Nerida's concerns, her possible fears, and the implications of her illness for her and her family. From an NBM perspective, Nerida has been allowed to relate her troubles in her own way and without being hurried. Certainly the consultation has gone longer than perhaps initially expected;

however, the illness has been placed in a context that provides a more complete understanding of the patient. Nerida's emotional burden has been eased, her concerns addressed (the physical symptoms, the consequences of continuing to be unwell), her supposition that it is "stress related" has been validated, and empathy has been expressed. All this has been done using communication skills that are familiar to all GPs.

**Narrative-based medicine and the talking therapies.** Narrative-based medicine's specialized skills, which also form part of the 7 Cs,<sup>4,13</sup> come principally from

family therapy<sup>4</sup> but are not unknown to the other talking therapies (eg, psychotherapy, counseling). These skills are neutrality, circular questioning, and hypothesizing.<sup>15</sup>

Neutrality,<sup>15</sup> generally speaking, goes against the grain for many GPs who have learned to problem solve. Neutrality is about being objective and mindful, focusing on the task at hand without being fixated on specific outcomes, and being cognizant, as well as tolerant and nonjudgmental, of differing points of view. This is not dissimilar to the principles of motivational interviewing with which most GPs would be familiar: providing information, establishing readiness for change, exploring options, encouraging but not forcing change, and working with the patient.

Circular questioning<sup>15</sup> follows the patient's train of thought and facilitates the unfolding of the narrative. This is done by picking up on words or phrases in the narrative and reflecting them back to the patient or using them in some way to clarify or encourage responses. This creates a loop of question-response-question (hence the concept of circularity) that keeps the narrative flowing. Circularity requires good listening skills and the ability to pick up on cues. It also requires the listener to be comfortable with following the narrative rather than trying to direct it.

During a conversation, the GP will formulate certain notions about the patient. However, it would be wrong to assume that they correspond precisely with the patient's reality without checking and clarifying. Hypothesizing<sup>15</sup> achieves this by asking questions based around "How do you explain ...?," "Suppose ...," and "What if ...?" Hypothesizing, in conjunction with circularity, is also a powerful way of assisting patients with considering realistic possibilities for change and how these might occur.

There are 2 important elements to NBM. One is having a greater awareness of complexity.<sup>4,12</sup> This encompasses such things as the ways in which people connect, the possible outcomes that might result from their interactions, and how one event can have many consequences. The other element is having an open mind for all sorts of possibilities<sup>15</sup>—possibilities that arise as a result of formative experiences with important others and past and present relationships. The patterns of relationships provide clues as to why these patterns keep recurring and why people repeatedly make the same mistakes, reinforcing the fact that events in a person's life do not occur randomly or in isolation. The GP does not need to have knowledge of psychological theory in order to be able to explore these things.

With Nerida, the GP resisted the temptation to treat the biomedical problem early in the consultation. A different perspective on Nerida's illness was gained, one that reaffirmed the mind-body association or what might be better described as *mind-body unity* or the *mind-body continuum*.<sup>16</sup> In using these specialized skills, the GP is not seeking to take over the role of counselor or

psychiatrist. Rather, the GP is seeking new insights and meanings and an understanding of the patient that goes much deeper than a simpler exploration of the narrative.

***Narrative-based medicine and the doctor's self.*** Schön<sup>17</sup> and others<sup>18</sup> speak of reflection on the consultation as being quite powerful for enhancing consultative skills and suggest that this reflection should be on the self, the patient, and the interaction. The Balint method<sup>19-21</sup> similarly promotes reflection on the patient's feelings and reactions, and considering possible explanations for what the patient is experiencing. It also promotes reflection on the self, increasing awareness of one's feelings and emotions and the part he or she plays in the consultation.<sup>19</sup> In this respect, narrative is no different. Certainly reflective skills are something that Charon focuses on particularly; whereas for Launer, reflective skills improve as narrative experience grows.

It is also valuable for doctors to reflect on times of personal illness and vulnerability. This type of reflection, where the self is referenced to gain insight into someone else's experience, is termed *reflexivity*.<sup>22</sup> It promotes a more empathic understanding<sup>9,23-25</sup> as a result of increased awareness for and understanding of one's own feelings and experiences. Self-reflection and greater self-awareness can only lead to a greater concern for self-care and, ultimately, the development of resilience. As Launer says, "Narrative ideas can also provide practitioners with the skills to help patients and colleagues alike to question, re-evaluate and change their own narratives."<sup>4</sup>

When caring for patients and their families over the long term, strong doctor-patient relationships develop and patients become more aware of the doctor as a human being, not simply as a professional, and they might even teach the doctor aspects of their illness and its management that the doctor might not have considered.<sup>24,26</sup>

***Narrative-based medicine and clinical practice.*** In this age of consumer medicine, doctors are frequently criticized for their lack of caring and for not addressing patient concerns.<sup>27</sup> The rise in hospital medicine, the growth of medical technology, the incursions of government and medical insurers into health matters, and evidence-based medicine (EBM) have all had negative effects on the importance of the patient narrative.<sup>28</sup> General practitioners are finding it difficult to manage patients who are more complex,<sup>29-31</sup> who are more informed, and who have greater expectations than in the past. Comorbidity is increasingly prevalent, presenting considerable challenges. Care is often fragmented; PCC is made difficult; there are difficulties with respect to shared decision making<sup>31</sup>; and EBM does not work well for patients with multiple conditions.<sup>29</sup>

While PCC has been proposed as "especially relevant" for managing comorbidity,<sup>32</sup> NBM is also relevant. Narrative skills (**Box 2**) enhance PCC<sup>4</sup> because of the

## Box 2. Narrative skills

Strong narrative skills include the following:

- Good communication skills (for eliciting a good history, exploring the patient narrative, and effecting change)
- The particular skills of ...
  - neutrality
  - circular questioning
  - hypothesizing
- An awareness of complexity and interconnectedness
- Insight and a broad awareness
- Imagination
- Reflective skills ...
  - on action and in action
  - with respect to the patient, the self, and the doctor-patient interaction
  - of reflexivity
- Self-awareness
- Self-care

focus on the illness experience and what matters for the patient and this encompasses understanding not only of the patient perspective but also the perspective of the relatives and carers. Further, narrative skills do not detract from evidence-based practice.<sup>9,33</sup> After all, evidence-based practice comprises part of the narrative that the doctor brings to the clinical encounter, and there is an argument that NBM and EBM are complementary.<sup>8,9,34</sup>

## Conclusion

*On the seventeenth day Ellen still lay in her room.*

*No one had told her a story to bring her back to life.*

Murray Bail<sup>35</sup>

Narrative-based medicine, PCC, and EBM can work together, and a doctor's style of practice reflects what he or she has been taught, as well as who he or she is. The literature, however, speaks very loudly about the importance of the narrative and of understanding the illness experience. What makes NBM stand out is the fact that it is a collaborative and mutually beneficial process, having the power to create a new narrative—a narrative that heals and transforms the patient and the doctor. 🌿

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### Competing interests

None declared

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