Stories for life

Introduction to narrative medicine

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It is difficult
to get the news from poems
yet men die miserably every day
for lack
of what is found there.
W.C. Williams[1]

In honour of the 50th anniversary of the College of Family Physicians of Canada in 2004, then-President Dr Rob Wedel and Dr Ruth E. Martin conceived the Heartbeat Project, a plan to collect and publish a book of stories that had, as they put it at the time, "awed, encouraged, moved, inspired, provoked, troubled, humbled or worried us" in the course of their family practice careers.

Those of us who became involved in the Heartbeat Project helped to present storytelling workshops at the 2004 and 2005 Family Medicine Forums. Before the first of these workshops, we were somewhat apprehensive, but an amazing thing happened. Not only were the workshops better attended than we had hoped, but people stayed after the sessions to finish stories, exchange e-mail addresses, and thank us for brightening their days.

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Stories offer insight, understanding, and new perspectives. They educate us and they feed our imaginations. They help us see other ways of doing things that might free us from self-reproach or shame. Hearing and telling stories is comforting and bonds people together.

In scientific terms—if we make sense of the world by recognizing patterns and thinking in categories—being able to narrate a coherent story is a healing experience.[2,3] In psychological terms, stories keep us connected to each other; they reassure us that we are not alone.

Two qualitative researchers have been involved with the Heartbeat Project, examining the more than 200 stories collected so far. When we look at the recurrent themes they have identified—such as community, family, listening, relationships, and even love—we see confirmation of our need for connection.

Anatole Broyard, an editor and author who died of prostate cancer, wrote as follows:

> Physicians have been taught in medical school that they must keep the patient at a distance because there isn't time … or because if the doctor becomes involved in the patient's predicament, the emotional burden will be too great. As I've suggested, it doesn't take much time to make good contact, but beyond that, the emotional burden of avoiding the patient may be much harder on the doctor than he imagines. … A doctor's job would be so much more interesting and satisfying if he simply let himself plunge into the patient, if he could lose his own fear of falling.[4]

Broyard, without realizing it, was describing the new discipline of narrative medicine (NM), which holds promise as a remedy for the burnout, exhaustion, and disillusionment many Canadian family physicians are feeling.[5] Dr Wedel explains, "[the] active voice contains the real passion of the profession—the art component of medicine. … The stories really contain some of who we are. They rejuvenate the spirit. … Stories are how we talk to each other in the halls; learn from each other; teach our students."[6]

Rita Charon, an internist with a PhD in English literature, is credited with pioneering most of the innovations in the field of NM, including its adoption into the core curriculum at more than half of North American medical schools. (Dalhousie University's program was the first in Canada.[7]) Narrative medicine's underlying thesis is that not only can we heal physician burnout, we can teach empathy or, as some would say, at least preserve the natural empathy that medical school and residency all too often destroy.

It is exciting to think that there might be a way to address the often-voiced complaint that, while we're not bad at curing, we're dismal at truly caring. Psychiatrists call it "empathic failure." David Kuhl, a Canadian palliative care physician, calls the harm we do "iatrogenic suffering."[8]

Patients are still frightened, isolated, and in pain. And the harm we do has to do with language, with what we say and what we withhold. "Underlying … is the assumption that careful attention to the language and stories of medicine can enrich the doctor-patient relationship, improve patient care, and enhance doctors' sense of satisfaction with work."[9]

Cet article se trouve aussi en français à la **page 209.**

After years in practice, many of us are guilty of interrupting patients because we think we already know what is going on. Then we gently barrage them with questions in order to confirm our diagnoses.

Narrative medicine has helped me see that traditional phrases such as "chief complaint" need to evolve into "chief concern"[10] and that patients can only deny behaviours and symptoms if we make them feel accused. I've always disliked the word "noncompliant"; "nonadherent" is much more respectful.

Because so many patients are prone to self-blame, it's best to avoid asking a question that begins with "Why"; it's almost always perceived as judgmental. If we just listened to the patient's story, we would soon learn that there is always, from the patient's perspective, a good reason.

How many times have we counseled patients to quit smoking or lose weight? It wasn't until I listened, without interrupting, that I could really hear what smoking or obesity meant to patients. One patient—and she was far from the only one—told me that smoking was one of her best friends. She wasn't self-destructive—she was lonely. Quitting smoking might be a triumph of will, but it would also be felt as loss. Another patient told me that her large size was a comfort to her; when curled up with a book or even sitting in a theatre or airplane, she felt she was hugging herself, caring for herself in a way no one else did or could.

In 2000, Charon wrote, "Together with medicine, literature looks forward to a future when illness calls forth, in witnesses and in helpers, recognition instead of anonymity, communion instead of isolation, and shared meanings instead of insignificance."[11] At a Toronto conference in 2004, she said that when she started to implement the philosophy of NM into her practice she had to sit on her hands while she let patients respond to the one and only question she asked during first consultations: "I have to learn as much as I can about [your] health. Could you tell me whatever you think I should know about your situation?"[12] Many of us fear that, even if we had the time to listen to the answer (research estimates range from 6 seconds[13] to 7 minutes[14]), we wouldn't be able to cope emotionally with what we might hear.

Narrative medicine suggests something revolutionary—that we need to stay in touch with our emotions and develop what Jack Coulehan calls "emotional resilience," which he defines as "being able to function in a steady or objective fashion, while also experiencing the emotional core of physician-patient interactions."[15] That is, we can only fulfil the promise of patient-centred care if we let down our defences.

> This makes doctors more emotionally vulnerable to patients' problems, but allows the opportunity to treat the patient by harnessing the emotional response. ... The doctors' mandate goes beyond clinical diagnosis. How far it goes depends on how far the physicians are along the road to self-knowledge; how wide their life experience is; where they are in the life cycle of developmental tasks and spirituality; how well they can empathetically witness, and how much they emotionally dare to care.[16]

To continue in practice and to appreciate the wonderful privilege of being able to do this work, we have to believe that we're having some effect, helping at least some of our patients, even if it means only listening and witnessing. Our acceptance of these limitations has to do with self-knowledge: "...in my thirties, I began to notice how far the authority granted me had outstripped my powers to use it wisely. There were moments of... snap judgment, laziness and plain indifference. ... These added up, looming larger than the good I could ever have dreamed of accomplishing in my youthful striving."[17]

John Stone, a cardiologist-poet, wrote:

> Literature will help lead a young doctor... to the proper sensitivity; it will help to find the proper words... even to place the doctor, vicariously, in the patient's hospital bed. Literature can provide for students of medicine something of what psychotherapy can provide for its patients: catharsis, personal insights, and supports. ... Literature becomes a vehicle for much-needed reflection.[18]

Lawyers assure us that patients are actually very understanding about mistakes we make. What makes them angry enough to litigate is our silence and avoidance, our failure to communicate, which leaves patients feeling patronized and demeaned.

Being emotionally detached or "well defended" is now contraindicated. We need to stay in touch with our emotions, because without them, we risk becoming the kind of doctors who go down the hall to see "the gallbladder in room 2." Diseases don't "present"; people become ill.

Perhaps it's exactly in this way that we family physicians differ from other specialists, whose main challenge is diagnosis and asking, "What's to be done?" Ours is more likely to be following patients with chronic illness and asking, "How are you going to manage?" Specialists see a snapshot of a patient in time. We're involved in watching the video—which brings us back to story.

If it's true that "stories are antibodies against illness and pain,"[19] then, with the insights of this new discipline, we have a chance to truly become physicians healing ourselves.

If you are interested in contributing a story to the Heartbeat Project, please e-mail it to **Janet Alred**, *at* **janetalred@gmail.com** *or fax to 604 485-0077. If you are interested in*

a theme-related select bibliography on NM, please contact **Dr Ruth E. Martin** *at* **ruth.martin@familymed.ubc.ca**. *For incorporating NM into teaching, see the impressive on-line database for literature, art, and medicine at* **http://endeavor.med.nyu.edu/lit-med**.

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Tell your story: call for papers

Narrative medicine is an emerging area of understanding and research in medicine and is particularly applicable to the practice of family medicine. It uses stories as part of the process of understanding, diagnosing, and treating illness.

Canadian Family Physician will have a special focus on the stories in family medicine in an upcoming issue. We welcome reflections on and research into narrative medicine for this issue. Please see **www.cfpc/cfp** (under "for authors") for article guidelines. The deadline for submissions is **May 15, 2007**.