The power of stories

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Man was a storytelling animal, the only creature on earth that told itself stories to understand what kind of creature it was. The story was his birthright, and nobody could take it away.

Salman Rushdie, *Joseph Anton*[1]

Stories are uniquely human—an extremely powerful means by which we communicate as human beings. I offer my sincerest congratulations to our 3 prize winners.* They demonstrate the power of the story, which is my theme, and the power of reflection. From "Wisteria" we learn of a garden of memory, where each plant is a reminder of a person known, a patient remembered, where ugliness is transformed into beauty. I will never look at wisteria in my garden without thinking of this story. From "43 Minutes" we identify with the physician's sense of helplessness in the face of inevitable death, and also the recognition of the importance of "being there," of bearing witness. I will not forget either the image of the powdery–blue eyes of the dying woman. From "Premature" I identify with that feeling of limitation that we have as generalists, the fear of failure, and the elation of successfully performing a life-saving maneuver. I certainly remember moments of terror during more than one delivery, but also the exaltation of a successful outcome, sometimes not fully experienced until the newborn entered grade 1 and successfully passed that first year of school.

All 3 stories are about death: 2 are about the inevitability of death and how we can find meaning, and 1 is about staving death off against the odds in a premature baby, allowing a new life to enter the world. I do not think it is an accident that many of the narratives physicians have written over the years are about death and dying, and the same is true of those narratives written by patients, because these are still the great mysteries.

Since I began to see patients as a medical student I have believed in the power of the story—the story of life, of health and illness, told by my patient. It is the word pictures that are painted by our patients, whom we walk alongside, that help us to understand the particular experiences of particular patients. As family doctors we are privileged to hear the life stories of our patients as they evolve over time; not only their narratives of illness, but also their narratives of resiliency—the contexts within which their illnesses are experienced. We listen to the stories in order to understand the particular patient within his or her particular family to make the right diagnosis and to determine the best treatment, sharing that process of decision making. But long before I became a doctor, and I suspect for many of you it was the same, I learned about health and illness from literature, from art, from film, and from music. I do not think that one can be a good physician in any branch of medicine without understanding and experiencing the rich depiction that artists bring to us of the human condition. Not only do I learn about health and illness, and how better to care for patients, but I learn about myself as a person who also faces unexpected illness and expected life aging. So, too, not only do I learn about my patient from their story, but I learn about myself.

We remember stories. It is rare for me to give a presentation without telling stories; I do not know how to talk except to do that—stories from my practice, stories from my personal and family experience, and now stories from my life as an academic administrator. If I ever do write *The Life and Times of a Family Physician Dean,* it will be a collection of stories and what I took away from the experiences as lessons learned. Those lessons are about me as much as they are about the other persons in the drama, just as we hear in the winning stories.

Untold stories

When I was Head of Family Practice at the University of British Columbia in Vancouver, I did a locum in a remote northern community. As I had been practising in an urban setting for the previous 20 years, and I had reduced my practice time substantially because of my university duties, my biggest fear was that several airplanes would fall out of the sky simultaneously and that I would be fogged in and have to deal with multiple trauma patients all by myself. So I hung out in the emergency department, practised my intubation skills, boned up on advanced trauma life support and advanced cardiac life support, and headed off. Well, in fact, during that 2-week period no airplanes fell from the sky, although I did see a number of complex patients who in Vancouver I would have passed on to an internist or at least a medical resident. But I correctly diagnosed the patient who seemed the most critically ill by sitting at her bedside and listening to her story.

An older woman was admitted to the emergency department with severe chest pain. The usual interventions were carried out very promptly, but the electrocardiogram showed only nonspecific changes. I sat down with her and began to ask her what she thought

La version française de cet article se trouve à www.cfp.ca dans la table des matières du numéro de janvier 2013 à la page e48.

was going on. She told me that a couple of days earlier, her grandson had been accused of sexually abusing a youngster in the extended family. It became clear that, rather than cardiac ischemia causing heart pain, she was suffering from heartache. Instead of shipping her out by helicopter, we kept her overnight, we connected her with a counselor, and life went on. Ironically, it was my special interest in sexual abuse and family violence that prepared me to see this patient, not my emergency medicine skills.

Often it is the privilege of a longitudinal relationship that allows us to hear from our patients the whole story—the untold story. I have written about my patient who told me her story about being abused as a child only after she had been my patient for many years.[2] When I asked her why she had not told me sooner—because I had asked many times—she explained that early on she could not disclose, even when I asked in a gentle and caring way, because she did not know if she could trust me. Then later, she said, she was afraid that if she told me, I would be disappointed and disgusted, and maybe withdraw from her, so she held back some more.

Within our relationships with patients we need to take the time to listen—to have our ears, minds, and hearts open to what is said. Even in a short visit the doctor can listen to the untold story, know that it is there, and invite the patient back when there is more time, and then wait. We must not forget that our many short visits in family medicine are additive. They are allowing us the time to build trust and to expand our knowledge and our understanding of the patient—if we ask the right questions, if we leave space for the answers, and if we attend to what is said and not said. Our trade requires that we make hypotheses very rapidly and rule in or out our provisional diagnoses by judicious questioning. I am pretty good at that; I have gotten very good at that over time, as many of us have over the years. Yet I have learned that by eliciting the untold story, I have made the diagnosis that otherwise would be missed, no matter what fancy tests I might do. A senior colleague once said to me, "If the story doesn't quite fit, think again about your diagnosis." Those physicians who "never see a case of …" are not looking or listening. I am reminded of the accusation leveled at me when I moved from my community practice to a university family practice teaching unit. I was accused of bringing my "Herbert patients" with me—that is to say, patients with complex social circumstances, including sexual abuse, family violence, sexual dysfunction, and the like. My partner in the practice at the campus said the practice had not had those patients before. Well, of course they had been there. I had been asking the questions of the existing patient population, and had been listening to the answers, painful and time-consuming as those interactions sometimes were.

Another sort of medicine

Much of the time, we physicians do mundane tasks, and in this era of evidence-based medicine, accountability, and quality assurance, we follow algorithms for diagnostic testing and for prescribing. But sometimes the algorithms are insufficient to meet the needs of a particular patient. As physicians we have the potential to be artists—to be creative and imaginative in our care to the extent that we expand our understanding of the persons who are our patients and the relationships that exist between us. It is the relationship of trust and respect that makes it possible for patients to expose their times of darkness, their failures and fears, as well as their hopes and dreams. And it is within that relationship that we might discover our capacity to approach what Leonard, in *Awakenings,* a wonderful book by Oliver Sacks, calls *another sort of medicine.* Leonard says,

> There is of course an old medicine, an everyday medicine, humdrum, prosaic, a medicine for stubbed toes, quinsies, bunions, and boils, but all of us entertain the idea of another sort of medicine of a wholly different kind. Something deeper, older, extraordinary, almost sacred, which will restore to us our lost health and wholeness, and give us a sense of perfect well-being.[3]

It is that kind of medicine that we reach for when we care for patients with chronic illnesses or with illnesses from which they will die or that we cannot cure but for which we can extend our caring beyond what is comfortable for us, where our compassion has the potential to allow a sense of healing, even when we cannot fix what is broken. It is that kind of medicine that patients yearn for. It is that kind of medicine that we hear about in "43 Minutes" and in "Wisteria."

Let me describe a personal example of what I am going to term *creative prescription,* that illustrates *another sort of medicine.* Years ago in practice in east Vancouver, I wrote what I would call my most unusual prescription. I had been seeing a woman for depression and marital unhappiness. She was married to a much older, very successful man, whom she described as wrapped up in his business, and she felt increasingly invisible and unheard. So after seeing her for several weeks individually and after seeing her with her husband, she disclosed to me that she had always wanted to play the piano. That day I wrote a prescription on my prescription pad for the purchase of both a piano and piano lessons, with the instruction that she give the prescription to her husband. She did. He bought her the piano. She learned to play, and her depression lifted and the marriage problems dissipated. What happened? We can speculate that her self-worth was enhanced as her husband supported her morally and financially to do something for herself; that she experienced a sense

of improved personal efficacy and ability; that she felt seen; that she was reinforced by his approval of her new skill; and that their communication improved and she felt like and was treated as an equal. Did I perform a medical intervention? I think I did. It was a family medicine intervention. How did I know what to do with this patient? Where did I come up with the idea? Well, I had formal knowledge and skills in behavioural sciences and psychiatry; I had informal knowledge also from teachers and colleagues who were my role models; and I had read and heard stories of physicians who were able to help patients with long-standing problems by doing something creative, including wonderful stories told by and about Milton Erickson, the father of clinical hypnosis, who was renowned for his inventive, often paradoxical interventions. I think that what I did was I took my patient's story, I passed it through the sieve of my formal and informal knowledge, I added the salt of my personal and professional experience and the pepper of my intuition and creativity, and came up with a dish for the couple to try together, which apparently they enjoyed.

Recently there has been a resurgence of interest in training physicians to be reflective practitioners, with the incorporation of portfolios of reflective writing in undergraduate medical education and other mechanisms to encourage reflection. This is not new. Ian McWhinney wrote about the importance of the individual story of the patient more than 40 years ago, and it is instructive to read his early writings again. Ian Cameron was one of the pioneers at Dalhousie University in Halifax, NS, using published works to encourage reflection more than 30 years ago. *Academic Medicine* has had a special page for the humanities for a long time. Yet now we see the phenomenon everywhere. We see it in journals from *CMAJ* to the *New England Journal of Medicine*, with stories and reflections appearing. In recent years, Rita Charon at Columbia University in New York, NY, established a graduate program in narrative medicine to allow physicians and other health care professionals to pursue advanced education in this particular technique. I think it is interesting that this groundswell is occurring in parallel with the competency-based educational movement, which some are concerned could be applied in a way that is simplistic or reductionist, and not easily applied to relational aspects of our practice. But in fact there is an essential complementarity. To attain competency in patient-centred communication, I think it can be argued that reading, writing, and hearing stories is essential. To become a reflective practitioner demands this approach.

The Phoenix Project, the most recent project of Associated Medical Services, was initiated about a year ago and is led by Brian Hodges; it was set up to increase attention to humanity and compassion in medical care. The project is designed to build a cadre of health professional leaders in reflective practice, initially in medicine and nursing, but to broaden out across the health professions. Phoenix Fellows have now been appointed at each of the Ontario universities with medical schools, with the hope that a second round will expand that to include representation from other nursing programs in universities without medical schools. Fellows have undertaken to be change agents, to conduct programs of study and practice that will lead us to that other kind of medicine. As one of the Phoenix Project Fellows, Shannon Arntfield, who is a faculty member in obstetrics and gynecology at my own Western University in London, Ont, is championing narrative medicine in our undergraduate and postgraduate medical curricula. Her passion for educating physicians in this way has already led to the introduction of reflective portfolios, dedicated academic half-days, and a group of committed faculty from across the medical school who meet to read, to reflect together, and to write stories.

Power of qualitative research

I was drawn to qualitative research methods over the years because of the words—because it was a way for me to listen to participants' perspectives on a question, including their interpretation of the question, which in many cases was very different from what I had intended when I formulated it. Often it is stories that participants offer in research as answers to questions, just as our patients do. They provide thick and rich descriptions of their experience with life, health, and illness. In doing qualitative research I am able to reflect on the answers of participants and to draw out themes to enhance our understanding of the phenomenon of interest. Whether it is the experience of First Nations people living with diabetes or young surgeons trying to find work-life balance, some questions necessitate narrative answers and the ability of the listener to analyze and understand the story.

Beauty beyond

At a recent meeting on health policy, I heard a person representing patients with chronic illness make some powerful remarks. I will paraphrase his words: "First of all, I'm not very articulate, and you're all so learned—I feel a bit awkward in speaking to you. I've been living with HIV for 25 years and I didn't know it was a chronic illness because I thought chronic illness was heart disease, and lung disease, and maybe cancer; but I guess I have a chronic illness. There are a lot of medical things that you can do for me, but mostly those get done. Let me tell you my worst problem: loneliness. I'm lonely. I'm very lonely. What I really want is for people to listen to me and I want to have choices. You're not all the same. The doctor in the clinic on Wednesday is not

the same as the doctor on Friday. I want to be able to choose whom I see, the person who will listen, and with whom I will feel less lonely."

And I think that is what Leonard tells us in *Awakenings* when he says,

> I have no exit. I am trapped in myself. This stupid body is a prison with windows but no doors .... I am what I am. I am part of the world. My disease and my deformity are part of the world. They're beautiful in a way, like a dwarf or a toad. It is my destiny to be a sort of grotesque.[3]

In a way we are all grotesques who can find and feel our beauty in relationship to others who are willing to listen, reflect, and bear witness to our humanity. It is our challenge as physicians to see the grotesque, to look beyond it, and to see the beauty. That is what our award-winning storytellers have modeled, and I thank them for it.

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Competing interests
None declared

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*This article is based on a presentation by Dr Herbert at the awards ceremony for the winners of the 2012 AMS–Mimi Divinsky Awards for History and Narrative in Family Medicine at Family Medicine Forum in Toronto, Ont, on November 16, 2012.

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THE COLLEGE OF FAMILY PHYSICIANS OF CANADA | LE COLLÈGE DES MÉDECINS DE FAMILLE DU CANADA

AMS Making a Healthy Contribution ASSOCIATED MEDICAL SERVICES

Stories in Family Medicine
Récits en médecine familiale

These stories were collected as part of the Family Medicine in Canada: History and Narrative in Medicine Program, an ongoing project of the College of Family Physicians of Canada (CFPC), supported by donations to the Research and Education Foundation by Associated Medical Services (AMS). The program collects stories and historical narrative about family medicine in Canada for a publicly available online database. The AMS–Mimi Divinsky Awards honour the 3 best stories submitted to the database each year. Information about the AMS–Mimi Divinsky Awards is available under "Honours and Awards" on the CFPC website, **www.cfpc.ca**. The Stories in Family Medicine database is available at **http://cfpcstories.sydneyplus.com**.

Récits en médecine familiale

Ces récits ont été présentés dans le contexte du programme Histoire et narration en médecine familiale, un projet que poursuit le Collège des médecins de famille du Canada (CMFC) sur une base continue, grâce à un don versé à la Fondation pour la recherche et l'éducation par Associated Medical Services Inc. (AMS). Le programme recueille des récits et des narrations historiques au sujet de la médecine familiale au Canada qui sont inclus dans une base de données en ligne accessible au public. Les Prix AMS-Mimi Divinsky sont décernés aux rédacteurs des trois meilleurs récits présentés chaque année. Pour en savoir plus sur les Prix AMS-Mimi Divinsky, rendez-vous à la section du Prix et bourses dans le site Web du CMFC à l'adresse **www.cfpc.ca**. La base de données sur les récits en médecine familiale se trouve à **http://cfpcstories.sydneyplus.com**.

Best English story by a family physician

Premature

J.P. Caldwell MD CCFP FCFP

A 2:30 AM phone call; pregnant, only 28 weeks, cervix fully dilated. "Come quickly!"

I jolt out of bed, downstairs and outside, just remember to go back inside to void. It's a warm August night in our small town, moonless, with empty streets. I'm impatient at the red lights—all 4 of them—between me and the hospital, and I wonder if I can go through them. My heart races as I wait for the lights to turn, tapping on the steering wheel to hurry them up.

Twenty-eight weeks—it's impossible. This baby can't survive—no matter what you do. I park in the special spot by the OBs' door, although the hospital is deserted. I race up the stairs.

Our obstetrician is already there. We have no pediatrician in town, so I am the one looking after the infant. It's a young mother, only 17, and she's had pain since

La version française de cet article se trouve à www.cfp.ca dans la table des matières du numéro de janvier 2013 à la page e52.