

Humanity before Science: Narrative Medicine, Clinical Practice, and Medical Education

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A patient saw a physician for the first time. The physician wanted to learn everything about the new patient, and listened attentively without interruption. The patient paused after a while and wept. When asked why, “No one let me do this before,” was the response.¹

There is growing public opinion that the current medical care has lost its human aspects, widening the gap between patients’ expectations and physicians’ performance. Many forces today restrict physicians’ ability to reflect on their clinical experiences and relationships. The marketplace speeds up medical work, interrupts continuity with patients, and erodes the autonomy of the physician-patient relationship.² The current revolution in technology of medical informatics complicates matters further. The *cut-and-paste* functions of electronic medical records undermine the psychological and therapeutic value of face-to-face personal and compassionate encounters between physicians and their patients.

This transformation in the physician-patient relationship did not take place overnight. Modern American medical education in charge of preparing future physicians was transformed by Flexner’s report in 1910. Flexner was chosen by the Carnegie Foundation for the Advancement of Teaching to head up a commission to assess medical education in the US.³ Flexner narrowly defined the proper goals of medicine as the “attempt to fight the battle against disease.”⁴ He argued that the future of pathology, therapeutics, and medicine depends upon those trained in the methods of natural science. Clinicians must be “impregnated with the fundamental truths of biology,” ignoring the human aspects of the disease in favor of biology and natural science.

But we know that patients are not just bodies, organs, and tissues. They live meaning-centered lives, and they have complicated emotional and historical relationships with their bodies.⁵ Flexner’s vision of medical education created physicians richly sophisticated in biologic variables and interventions, but all too often they lost

touch with the human aspects of health care and the basic tenets of clinical encounters with their patients.⁵

To understand the gap between patients’ expectations and physicians’ performance, one must make a distinction between *disease* and *illness*.⁶ Medical philosophers turned to “phenomenology” to better understand the meaning of illness and the moral core of healing.⁵ Illness is the innately human experience of symptoms and suffering, whereas disease is the clinical perspective of the problem. Flexner’s model addresses the alteration in biologic structure and/or function, ie, *disease* without addressing the psychological and social variables of a disease, ie, *illness*. This fact was already well recognized in the 1970s when resistance to the Flexner’s report started to surface.

Wounded Humanity

As such, illness, as explained by Pellegrino, is an altered state of existence arising out of an ontologic assault on the humanity of the person, resulting in the “*wounded humanity*.”⁷ An ill person suffers four elements: the loss of freedom to act because of bodily impairment, the lack of needed knowledge to make rational steps toward recovery, the loss of some degree of autonomy resulting in more dependence on others, and the transformation of self-image to adapt to the new situation. The patient’s wounded humanity, rather than being a secondary aspect of the clinical encounter, must become the cornerstone of the healing relationship. The only way the physician can legitimately enter into a healing relationship is through the understanding of wounded humanity. Tending to biologic variables is one, and only one, part of it. To Pellegrino, “if the professional does not consciously remedy the four deficiencies that impair the patient’s expression of humanity, his ‘profession’ is inauthentic.”⁸

The wounded humanity is the core of any healing relationship between physicians and their patients. Physicians have recognized the need for patient-

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centered care, which they have attempted to address through various forums. The Schwartz Center Rounds is one example that fosters enhanced communication, teamwork, and provider support.⁹ The impact on measured outcomes increased with the number of rounds attended. Such rounds may enhance relationship between physicians and their patients.⁹ Another example is the Balint group, which probes into what evokes unexpected feelings among patients such as anger, fear, frustration, irritation, etc. Such discussion may facilitate an understanding of the physician-patient relationship.¹⁰

Narrative Medicine

Narrative Medicine on the other hand, is born through contemporary efforts to rehumanize medicine; to counterbalance the many problems of Flexner's model; and to recognize, absorb, interpret, and be moved by stories of illness.¹¹ The human capacity to understand the meaning and significance of stories is being recognized as critical for effective medical practice. Both patients and physicians find some comfort in storytelling. Patients find words very helpful to contain the chaos of illness and enable them to endure it better.¹² Physicians, on the other hand, find writing about patients and themselves confers on medical practice a new understanding that is otherwise unobtainable.¹³ No wonder Narrative Medicine has been thriving over the past several years and is currently reflected in many genres. Stories from medical practice published in reputable medical journals such as "On Being a Doctor" in the *Annals of Internal Medicine*, and "A Piece of My Mind" in the *Journal of American Medical Association*. Other genres include writing exercises of medical training, medical fiction, lay exposition, and medical autobiography.²

But does Narrative Medicine hold the answer to the current crisis in the physician-patient relationship? Does storytelling really work? What evidence, if any, supports the positive impact of Narrative Medicine on patient care, clinical practice, and medical education?

There is a growing body of literature, though mostly qualitative, suggesting that Narrative Medicine does affect patient care. When a physician practices medicine with narrative competence, s/he can quickly and accurately hear and interpret what a patient is trying to say. Such a physician uses the time of a clinical interaction efficiently, wringing all possible medical knowledge from what a patient conveys about the experience of illness and how s/he conveys it. Also, as physicians describe the emotional and personal aspects of the

care they deliver to particular patients, it helps them to comprehend their patients' ordeals as well as their own lives with the sick.^{1,14}

In the effort to help physicians understand what they and their patients experience in the presence of illness, medical educators have been paying increasing attention to narrative competence, defined as the set of skills required to recognize, absorb, interpret, and be moved by stories. Unfortunately, as early in medical training as anatomy class, students learn that patients are predominantly defined by their bodies whereas physicians are defined by their scientific minds. It is also in the training process that such attitudes as professional detachment are learned. Although the field of medicine is dedicated to the examination, diagnosis, and treatment of bodies, the relationship of physicians to their own physicality is poorly understood, if not willfully ignored.¹⁵

DasGupta and Charon argue that traditional medical training teaches students that what lies below their white coats is irrelevant to their physicianhood.¹⁵ Furthermore, a physician whose body becomes relevant may risk losing his or her identity as a physician. In the case of physicians who are themselves struggling with illness, "the dichotomy of being both a doctor and patient threatens the integrity of the club. To this fraternity of healers, being ill is tantamount to treachery."¹⁶ Physicians' literature is rife with descriptions of physicians continuing to perform medicine while ill themselves. Yet, there is an alternate literature of physicians' transformations through personal illness in which these physicians' experiences were not only because of the physical reality of illness itself but also to the role-reversal that forcibly thrust the hitherto mind-defined physicians into their very real bodies. In the process of witnessing, interpreting, and translating their own illness experiences, these physicians become better able to listen empathically for the stories of their patients.¹⁷

Empathy

One of the most challenging tasks of medical education is teaching empathy. Empathy consists of three distinct components: a cognitive component in which the physician "enters" the perspective of the patient, an emotional component in which the physician puts himself or herself in the place of the patient, and finally, an action component in which the physician communicates understanding by checking back with the patient.¹⁷ In a small study involving medical students, DasGupta and Charon demonstrated that writing "personal illness narratives" allowed participants to benefit from reflec-

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tive writing in a new way. Rather than maintaining a clinician's point of view, or adopting the point of view of an "other," such narrative writings allow medical students to explore subjective experiences of illness. Furthermore, such experiences may critically inform the nature of students' professional caregiving.¹⁵

Pearson et al tested the value of narrative writings during surgical residency. They demonstrated in a small study that the use of a narrative-based approach in surgical resident education has the potential to capture and measure the general competencies of system-based practice, practice-based learning, communication skills, and professionalism.¹⁸

Levine et al explored the value of prompted narrative writing in internal medicine residency. They concluded from a small study among interns that writing throughout the year resulted in reflection and encouraged interns to reconsider their core values and priorities. Some found that the exercise promoted greater self-awareness and provided an emotional outlet. Writing about difficult experiences coupled with reflection motivated some interns to want to improve.¹⁹

It seems from the available literature that Narrative Medicine is promising in addressing some of the flaws of Flexner's model of medical education, and may be the answer to the current crisis in the physician-patient relationship. Its impact extends beyond empathic and compassionate delivery of care to patients; it extends well into physicians' own wellness. Medical educators should consider incorporating narrative writings as early as medical school education and all the way into residency and fellowship education. ♦

Disclosure Statement

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Indivisible

Body and soul cannot be separated for purposes of treatment,
for they are one and indivisible. Sick minds must be healed as well as sick bodies.

— C Jeff Miller, MD, 1874-1936, American gynecologist