Narrative Medicines: Challenge and Resistance

By David B Morris, PhD

"Take two short stories and call me in the morning."
—Anonymous

Narrative medicine as a relative newcomer continues to attract serious attention among health care professionals, despite the puzzlement of medical insiders who wonder what this alien creature is. Rita Charon, MD, PhD, founding director of the new program in narrative medicine at the Columbia University College of Physicians and Surgeons, offers a clear description: she uses the term *narrative medicine* to mean medicine practiced with "narrative skills."[1] This usage, although it entails further inquiries into the nature of narrative skills, clearly raises the question of what constitutes narrative. In her 2001 groundbreaking article "Narrative Medicine,"[2] Dr Charon offers a definition that parallels the account by novelist-philosopher Richard Kearney, who immediately puts nonphilosophers at ease with his plain-talk claim that all narrative shares the common function of "*someone telling something to someone about something*."[3p5] Patients are always telling something to physicians, of course, and physicians are always telling something to patients—so maybe narrative isn't so alien to medicine after all. Lewis Mehl-Madrona, MD, reminds fellow physicians that their work, despite a biomedical emphasis on drugs and surgery, is saturated in narrative: "We may talk drugs while Bantu healers talk herbs. We may talk surgery while a Dene healer talks about a many-day Blessing Way ceremony, but there is a similarity: we are in dialogue. We are co-creating a shared story of healer and patients/families/communities wherever we go. We are immersed in the act of storytelling."[4]

Yes, but are power brokers in medicine actually *listening?* If listening, are they openly or secretly (in some inner sanctum of deep untouchable values) digging in their heels and *resisting?*

The Landscape of Resistance

It seems futile to deny that narrative medicine, despite impressive recent achievements, evokes strong resistance. Even if skeptics agree that both are telling stories, indigenous healers and science-oriented physicians engage in storytelling that proceeds from incommensurate systems of belief. Science-oriented physicians, that is, tell stories that resist identification as stories. Narrative medicine needs to understand the resistances it evokes, including a resistance to identifying standard biomedical practices as narrative. It also needs to examine its own acts of narration. Dr Mehl-Madrona, for example, constructs an *us/us narrative* in which a doctor addresses his fellow doctors ("we"). The article constructs a nonfiction space of like-mindedness distinct from the conflict-torn arena that Mr Kearney calls *us/them narratives:* human vs alien or cowboy vs indian.[3p79-121] As a writer-scholar affiliated with a medical school but without a degree in medicine, I am a semi-outsider, but as an outsider I feel a sharp dissonance between the fantasy of a medical consensus over narrative and the entrenched skepticism I meet when speaking to physicians about narrative medicine. "What you say about narrative is very interesting," I hear repeatedly. "Thanks so much for coming. But I have seven minutes per patient." End of story.

Medical resistance to narrative medicine taps into valid concerns about the management of time, but physicians are not the only resistors. Some patients say they prefer skilled technique to good bedside manner. A preference for brusque skill is not necessarily misguided, especially for well-informed patients as busy as their doctors, and many patients cling to the fix-it model of a no-nonsense physician who holds all the answers. A patient-centered resistance to dialogue reminds me of the comedian who complained that he went to his doctor for a sprained ankle and came out with diabetes. (Less talk equals less bad news.) Patients and physicians moreover meet within a system that defines their relation as asymmetrical—in power and knowledge—thus skewing a paradigm in which storytelling traditionally reduces the distance between narrator and listener. (Think of the bond reinforced when a parent reads a child to sleep or when suspense draws us closer: "Listen my children and you shall hear …"). Biomedicine may resist narrative medicine in part because narrative implies a threatening erasure of professional distance and authority. Meanwhile, some patients will reject any medical outreach that looks like bogus intimacy or veiled paternalism.

Resistances to narrative medicine are real, both among patients and physicians, and cannot be wished away

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in a dream of frictionless consensus. When George L Engel, MD, first recommended the new biopsychosocial model, for example, he subtitled his famous 1977 essay "A Challenge for Biomedicine."[5] Resistances to a biopsychosocial model were—maybe still are—in part a response to the serious challenge it posed to biomedical principles and power. The challenge of narrative medicine, however, extends beyond patients and doctors, beyond even biomedicine. It also challenges proponents to clarify their basic concepts and to demonstrate their basic claims. Narrative medicine has in fact attained enough prominence that the time seems right to face even its own internal disagreements. This self-confrontation promises not only to clarify principles but also to reveal benefits (beyond better patient care) that narrative medicine holds for doctors.

Narrative Knowledge or Narrative Therapy?

The most influential discussion of narrative medicine, Dr Charon's 2001 article in *The Journal of the American Medical Association (JAMA),* insists that narrative is above all a form of knowledge. Narrative knowledge, in her account, complements (although it differs from) what she calls medical "logicoscientific" knowledge.[2] She sees two main roles for this narrative complement. First, narrative is a *source* of knowledge. It provides physicians with information as medically relevant as numerical data about pulse and respiration. Second, narrative is an *instrument* of knowledge. As an instrument, narrative requires skillful technique for its effective use, like a scalpel, and Dr Charon invokes an academic tradition of testable skills when she describes narrative (in the lexicon of medical education) as a "competence." Narrative competence, in Dr Charon's summary, implies the skill and experience necessary so that physicians may exercise the knowledge crucial to their profession. Narrative competence serves professional functions beyond the treatment of illness, from inspiring trust to promoting empathy, but the cultivation of a good bedside manner (preferable, surely, to a bad bedside manner, cultivated or not) isn't among them.

Narrative knowledge differs significantly from narrative therapy. Clearly they can be related, and they are not inherently in conflict, but their differences matter. For example, Dr Mehl-Madrona tells several compelling stories—about Terry, cured after a 24-year history of irritable bowel syndrome, and about Bernard, a cancer patient now seven years cancer free—in which recovery accompanies both narrative intervention initiated by the physician/friend and life-changes initiated by the patient. Narrative, in these cases, seems therapeutic. It accompanies, advances, or accomplishes a healing that Dr Mehl-Madrona describes as unresponsive to biomedicine. He also describes narrative skills in doctors and patients as mostly automatic. As moviegoers, theater buffs, and natural-born talkers, we are all experts in the understanding and creation of stories. "We have been doing it," he writes, "for longer than we can remember."[4]

Dr Charon, by contrast, wants certified professional competence and medical training in narrative. In fact, her account draws upon decades of scholarly analysis in the field of narratology, where competing theories abound.[6-9] Narrative competence for Dr Charon implies that our native expertise is merely the starting point for extensive relearning: a process analogous to the relearning that occurs when medical students are taught professional skills at interviewing, even though they are natural-born questioners. Such learned and relearned narrative skills have uses extending far beyond therapeutic interventions that facilitate rare, if dramatic, recoveries or that indirectly improve quality of life. They encompass multiple everyday applications that provide doctors with medical knowledge—about behaviors and lifestyles and preferences—as vital as data on cholesterol levels or blood pressure.

The competence that Dr Charon recommends as indispensable for the professional use of narrative finds a clear illustration in the concept of *narrative situation.* A narrative situation shapes every story by governing who speaks about what, to whom, when, and where. Drs Charon and Mehl-Madrona, for example, both write to fellow doctors about narrative, but their narrative situations otherwise differ greatly. Dr Mehl-Madrona writing in *The Permanente Journal* is freer to pursue clinical storytelling in a memoir-like style. Dr Charon's claim that narrative knowledge *complements* logicoscientific knowledge, by contrast, is an effective strategy for an article appearing in the citadel of biomedicine, *JAMA.* Her argument for narrative knowledge as a "complement" to logicoscientific knowledge does not directly challenge biomedical principles but rather appears to buttress them and (in shoring up any weaknesses) to assure their dominance.

Knowledge, even narrative knowledge, is power, but Dr Charon's somewhat delicate narrative situation rules out the rude question of how far biomedicine, as a system of power, will accept a copartnership with narrative medicine. A new copartnership will change biomedicine, of course, much as yin changes yang, not least by redefining them as mutually incomplete and inseparable. A biomedicine possibly *changed* by nar-

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rative medicine is correct to see a threat to its identity and power. Dr Mehl-Madrona, in contrast to Dr Charon, writes from a narrative situation deeply informed by Native-American and indigenous traditions, within which stories (associated with knowledge and power) are not separable instruments of professional competence but rather inseparable signs of an entire worldview. This worldview understands health through concepts of living in balance with oneself and the world, including the local community and the spirit realm, and it understands stories as actively promoting or restoring balance. Here too a biomedicine that accepts or honors such a worldview, rather than simply adopting a few exotic therapeutic tools, is correct to see a threat to its professional identity and power.

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Drs Charon and Mehl-Madrona both write from personal stances that defuse the potential threat posed by narrative medicine, but their recommendations imply ways of thinking about knowledge and about its legitimate sources that are bound to inspire resistance. Unlike biomedicine, for example, narrative medicine utterly depends on the concept of intersubjectivity.

An Intersubjective Model: *Story* as a Verb

For decades American medical students have memorized the familiar acronym that identifies the patient as subjective and the physician as objective, or at least as the official agent of objective fact: SOAP *(subjective, objective, assessment, plan)*. Narrative medicine right at the start challenges this slippery assumption about a clean division between subject and object. True, common sense finds it hard to give up the reassuring binary division of the world into perceiving subjects and objects perceived. This ancient mind/body dualism—reinvented by Descartes to legitimize the body as a site for scientific knowledge—no longer coincides with what many patients understand about health and illness. (Their allegiance to conventional and alternative medicine—and to various mind/body practitioners—is well documented.) Quantum mechanics and narrative theory both renounce objective certainty as inapplicable to their fields of thought. Dr Charon, in this spirit of resistance, refuses to describe narrative knowledge as soft and subjective, in contrast to logicoscientific knowledge in all its glittering hard objective truth. Narrative medicine is not practiced in some spongy nebulous province of unknowable subjectivities. The knowledge that narrative produces is not subjective or soft—ie, scientifically invalid—as opposed to objective hard data. Narrative medicine instead challenges the false binary of knowledge that is soft or hard. It asks what buried sexual politics underlies medical metaphors of softness and hardness—and why doctors even *need* these worn-out tropes? It challenges biomedicine not to reject scientific method—it won't—but to rethink the concept of a knowledge that is neither purely objective nor purely subjective but, impurely and pragmatically, intersubjective.

Intersubjectivity does not translate into the moronic caricature that everything is relative. Everything *isn't* relative. Instead, it posits a knowledge constituted by a process of dialogue in which two or more subjectivities reach agreement (or reach a knowledge of their disagreement). Such knowledge, obviously, is not trouble free. Innumerable subjectivities once agreed that the world is flat, and they were flat-out wrong. Still, intersubjective knowledge is always open to change, and the process of change is far more complex than an intellectual morality play in which good science drives out bad science. From an intersubjective perspective, lab reports and numerical data both depend on multiple human subjects. They require consensus on methods for verification, on standard operating procedures, on legal and economic arrangements. Tests are open to false positives as well as to interpretation, fraud, or error. Yes, the truth claims implicit in lab reports don't resemble the claims of obvious fictions, such as, say, *Little Red Riding Hood*. To repeat, it *isn't* all relative. An intersubjective model nonetheless insists that its knowledge is constructed, and thus the grounds of its constructedness are always open for analysis. Despite its rejection of an illusory Cartesian mind/body split, which, incidentally, most pain specialists also reject, narrative knowledge is not cast adrift on a sea of relativism but navigates real variations among competing claims—patient, family, lab, intern, resident, attending physician, chief of staff, insurer, hospital attorney, and government agencies. The knowledge that emerges—provisional, inherently open to revision—embodies the dilemmas of an intersubjective model.

Over lunch, palliative care specialist Walter Forman, MD, and I tried to imagine an alternative to the medical-student indoctrination in SOAP. PLAN (*patient-lab-assess-negotiate*) is our new and improved SOAP. The patient/lab dyad replaces the misleading subjective/objective split, free from its loaded value-judgments. It does not label the patient as inherently less reliable than laboratory data. (The lab, on occasion, may be wrong and the patient right.) Both acronyms feature analysis and planning. Our strongest innovation was to add the imperative *negotiate*. The concept of negotiation recognizes that doctors do not plan alone, like a general laying out late-night strategy for tomorrow's campaign.

Wherever possible, patients must be consulted, but not simply as a matter of etiquette. Their bodies, their choices, their lives are at stake. They can undermine treatment with noncompliance, despite the best-laid medical plans, and they can aid recovery through a partnership that views medicine, like narrative, as inherently intersubjective.

Narrative requires full-body immersion in an intersubjective model because—as Mr Kearney observes—it "takes two to story."[3] *Story* for Mr Kearney resembles an action-verb more than a noun. Stories are less the work of individual authors, even if individual authors write them, than plural, coauthored events that depend also upon readers or listeners. Slippage appears as soon as you open *Hamlet*. "O that this too too solid flesh would melt." Or: "… too too *sullied* flesh"? An editor decides. Experienced theater-goers may hear both adjectives in a ghostly duet. Moreover, *Hamlet* is rarely performed uncut. So *Hamlet* is the product of a collaboration among author, text, director, actor, audience, not to mention reviewers, critics, and scholars. This intersubjective matrix looks like the ninth circle of hell to orthodox proponents of the scientific method. Is it, however, really so alien to medicine? No physician could give a logicoscientific answer to the question of whether my father was an alcoholic. Chronic pain is notoriously hard to treat effectively. So too are depression and dementia. Doctors, to their credit, assist patients on this difficult, dangerous, uncertain ground—where the scientific method does not hold all the answers—but biomedicine resists (as if its life depended on it) the idea that such assistance involves narrative.

The verb-like quality of narrative is especially clear and troubling when stories change. Proponents of narrative sometimes speak about getting the patient's story—as if narrative were an extractable unchanging nugget of data. Stories change depending on the narrative situation. A 50-year-old African-American woman may not tell the same story about sexual abuse to a 20-year-old white male intern that she tells to a 60-year-old African-American female gynecologist. Stories may alter with each retelling, as a hilarious joke may bomb in unfriendly circumstances. The inherent variation of narrative raises serious questions about its validity and credibility. It is hard to trust a story that tomorrow may take a 90-degree turn. Still, lives are like that. In the metaphor drawn from books and narratives, people do turn over new leaves. Physicians do not expect fevers to remain unchanged. Cancer and depression do not continue in a steady state. The verb-like variations implicit in narrative would seem relatively unproblematic for physicians who deal every day with humans and diseases that unexpectedly change course. Narrative competence provides a framework for dealing even with certain stories that calcify into ritual recitations—like in-house myths about sickle cell patients and drug-seeking behavior—offering a way to identify and to critique troublesome sociocultural issues often invisibly at work in calcified medical behaviors or in static patient complaints. Stories, as Mr Kearney emphasizes about narratives of national identity, can trap as well as liberate. Illness narratives too can prove harmful or helpful, which is why they need to be examined. The variableness inherent in narrative includes, among its compensating benefits, the possibility to correct harmful illness narratives (such as the myths surrounding HIV/AIDS) and to replace professional narratives of identity that entrap physicians in a limiting conception of their own powers and competences.

Narrative competence, in short, offers guidance for negotiating the dilemmas of an intersubjective model. A biomedical corollary seems evident: "It takes two to doctor." Resistance to this corollary may recognize that narrative medicine and its intersubjective model constitute a threat to the biomedical model. Resistance may also signal that the time is drawing closer for the emergence of a philosophy of medicine that integrates apparently contrary impulses in a new synthesis (rather than cobbles them together under the victory banner of biomedicine). Can Western health care forever accept a dual track system in which logicoscientific knowledge dances the old subject/object two-step while its young partners (narrative medicine and mind/body medicine) tango away into the new world of intersubjective doctoring?

Narrative Constructedness: Patients *Are* Stories

Rachel Naomi Remen, MD—pediatrician, therapist, medical educator, author—puts it this way: "Everybody is a story."[10pxxvii] Not everybody *has* a story—in the sense that everybody has a nose or a mother or a suitcase—but rather everybody *is* a story. Pediatrician and novelist Perri Klass, MD, medicalizes the same point. "Every person is a story," she writes, "every patient is a story." Doctors too. As Klass adds: "When I admit a new patient to the hospital, I start writing the endings in my head."[11p323] Minus story, that is, doctors are technicians in the dark, without a clue beyond textbook natural histories of disease, and patients are no more than mute featherless bipeds bearing signs and symptoms. If stories make us human, a medical encounter that subtracts narrative might as well

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subtract liver, heart, and respiratory system. As philosopher Alasdair MacIntyre contends, "… we all live out narratives in our lives …" and "… we understand our own lives in terms of the narratives that we live out … ."[12p197] Other philosophers and neuroscientists now pursue good evidence that both human identity and human consciousness are fundamentally narrative constructions.[13] The relatively recent discipline of narrative psychology looks at all human life as inherently "storied."[14,15] In studying the life stories that people construct, psychologist Dan P McAdams, PhD, finds that these narratives guide behavior, framing how we see ourselves in the past, present, and future.[16]

Narrative medicine is not, from this perspective, a time-intensive luxury gumming up the works with needless chatter or at best feel-good talk but an extension of medical practice crucial to getting and using knowledge needed for the care of patients. The key point is that narratives, like personal identities or postmodern cities, don't just exist or arise: they are *constructed*.

There are, as bioethicist Tod Chambers, PhD, summarizes the consensus among narratologists, "no artless narrations."[17p25] Every narrative, without exception, is *constructed*—through conscious or often largely nonconscious choices about what to include, exclude, highlight, or downplay. This *constructedness* is at issue (not aesthetic value) in the claim that no narrative is artless. Even nursery tales reflect choices about what is valued, marginalized, and excluded: *Little Red Riding Hood* exists in at least 17 different English versions since the 17th century.[18] Even a typical children's book, then, embodies a principle of constructedness, which is easy to confirm by imagining a 21st-century version in which Little Red Riding Hood actually possesses a name, tells her own story, dispatches the wolf, restores her grandmother, and ditches the trademark red cloak for outerwear with some style and attitude—like Princess Di in a Philadelphia Eagles jacket.

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Every narrative, even absent an identifiable narrator, proceeds from a specific point-of-view or, as often in film, from multiple points-of-view. Screenwriters in scripts abbreviate the inescapable hyphenate as POV.[19] Although medical studies prefer a POV that aspires to seem impersonal, impersonality in language (like Swiss neutrality in geopolitics) is clearly a mode of constructedness. Television and newspaper reporters openly use the term *stories* for work that they regard as unbiased, impartial, balanced, or objective. Findings from randomized double-blind experiments regularly end up as teaser headlines. Even meteorological data, as novelist EL Doctorow observes, are reconstructed on television with attention to narrative elements such as conflict (high-pressure areas *clashing* with lows) and suspense (tomorrow's prediction coming only *after* the commercial). "I am thus led to the proposition," he writes, "that there is no fiction or nonfiction as we commonly understand the distinction: there is only narrative."[20p26]

Narrative theorists claim that there is no God's-eye POV. Every text constructs the inherently limited standpoint from which it speaks, even when it ignores, confuses, or multiplies point-of-view. A specific POV necessarily entails blind spots, since a linear narrative can't see or say everything at once. A specific POV also embodies silent assumptions that influence not only what a narrative says but also, just as important, what it *can't* say. Western democracies, for example, silently assume that adults desire good health and personal autonomy, despite abundant evidence to the contrary. American media simply cannot say that the US health care system is not the finest in the world.[21] Stifled or silent speech similarly marks many Western medical encounters. Patients routinely withhold facts that they regard as irrelevant or shameful. Surely most physicians can think of statements they didn't make or deliberately withheld. Narrative medicine thus encourages physicians to consider not only what is said but also what is not said: what is silenced, excluded, marginalized, unsaid, or unsayable.[22] There is even evidence that POV influences health. When experimental subjects were asked to recall unpleasant memories, third-person scenes were significantly less upsetting than bad memories recalled in the first person.[23] Psychologists studying the use of pronouns found that the ability to change perspectives is a potent indicator of how well the act of writing will predict improvement in health.[24] All patients are stories, true, but their constructedness differs in ways that narrative competence helps to unfold. The patient as story contains fragments, inconsistencies, gaps, and shifts in POV that challenge the physician, above all, not just to listen, or listen actively, but to listen for significant elements of narrative.

Words Matter: One-Way Listening vs Two-Way Dialogue

Narrative (from Latin *narrare*—to tell) refers not simply to fictions, as we have seen, but to various forms of telling. These tellings include coherent narrative genres from epic poems to realist novels but also disjointed shards of discourse: TV sound bites, overheard phone sex, random blogs, you name it. While novels tend to lick up the social languages and speech genres that surround them, contemporary non-novelistic narratives equally absorb the fluid, shifting lingo and

fractured consciousness of channel surfers, iPod-ites, and multitaskers. Narrative tellings are not necessarily verbal. Visual, musical, kinetic, and mixed-media forms of storytelling spin their familiar sagas from country songs and are-you-ready-for-some-football to *The Nutcracker Suite*. The body language that accompanies many spoken narratives is sometimes indispensable to full understanding. Narrative medicine nonetheless stresses—and it is hard in a medical context to overemphasize—that words matter.

Words are often slighted in a justified concern for larger narrative structures or patterns within medicine.[25-27] Sociologist Arthur Frank, PhD, in *The Wounded Storyteller,* for example, sees narrative as the sign of a historic shift.[28] Until the 1950s, modern medicine was dominated by what he calls *the doctor's story:* tales of cure that feature physicians as heroes in the scientific conquest of disease. Contemporary postmodern culture, by contrast, celebrates *the patient's story:* tales that feature patients (wounded storytellers) reciting *chaos narratives* about lives falling apart or *restitution narratives* about the unexpected benefits that accompany illness. Today physicians too are wounded storytellers, such as Oliver Sacks, MD, recounting his severely injured leg or David Hilfiker, MD, breaking the physician's code of silence to describe his own professional fallibility.[29,30] What matters most here is that individual stories—no matter how closely they resemble larger narrative patterns circulating within a culture—cannot be disentangled from the actual specific words in which they are told.

Narrative medicine in its attention to language promotes a shift from passive processing to (as the cliché goes) active listening, but it does more. Competence implies skills not only to recognize large narrative patterns (a disability narrative? a family-crisis narrative?) but also to focus on the fragmented, hesitant, half-coherent words that patients bring to physicians. Inside or outside larger narrative patterns, it implies an attention to even apparently innocuous words, words such as *soft* or *hard,* with their potent metaphoric implications about whose data matters, and why. Even a single word may function like a metaphor and constitute a compressed mini-narrative, such as the very unofficial crypto-acronym GOMER (Get-Out-of-My-Emergency-Room). GOMER reduces multiple troublesome patients to a single stock figure—a dim-witted sitcom character?—as if lifted from a private scripted medical revue. Attention to language equips doctors to identify such reductive mini-narratives, to critique them, and to pre-empt their possibly damaging impact upon treatment. An attention to words also holds out the promise of a more open dialogue between doctor and patient. Dr Charon actually shares with a patient her written narrative of their initial encounter, asking for feedback in order to correct errors, to flesh out omissions, and to spark additions, so that patient and physician meet in an open-ended intersubjective narrative space where words matter because they constitute the ground (stable and shared but also changing and elusive) for improved understanding and continued exchange.

The importance of words in the medical encounter finds an embodiment in bilingual translators, whose role in medical communication goes beyond merely transposing words from, say, Spanish to English. Narrative knowledge implies a rejection of the error made in reducing words to transparent panes: an invisible medium through which meaning appears. This error encourages listeners to skip over words and leap directly to interpretation. Narrative medicine, by contrast, understands words as inescapably imprinted with sociohistorical contexts that alter meaning and trump interpretation. "This baby is poopy," said medical student and young mother Perri Klass as a member of the neurology consult team called to examine a newborn, whose diaper stank. The otherwise all-male team ignored her. She adds: "I had used the wrong vocabulary. I tried again. 'This baby has apparently had a bowel movement,' I said."[31p161] No response. She finally elicited a response when she offered to change the diaper. The all-male physicians shook their heads no. The offer—like her earlier choice of "poopy"—indicated a descent from professional standards of behavior. Words matter in the same way that unprofessional actions matter. Too often, however, an interest in narrative remains fixed at the level of actions or events and ignores the equally powerful subdrama of language. Speech, from this point of view, is action. Spoken or written words, no matter how idle they appear, perform work in the world that is only more obvious when, in certain circumstances, we say "I do" or "shove off" or "so help me God."

Words for narrative medicine belong to what anthropologists call thick description and local knowledge. Like a dialect or like stuttering, certain words in their thickness, opacity, cloudiness, or pure obfuscation may prove most significant when they temporarily stand in the way of meaning. Why, just here, do words fail the patient? Or fail the physician? Narrative, in short, is constructed out of words, multilayered in their significance, not interchangeable ciphers or synonyms. How does a patient hear the word *cancer?* Does the patient return to the physician who says that chronic pain is often *incurable?* Narrative medicine reminds physicians that patients *hang* on a doctor's words.

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Physicians' words are remembered, repeated to family and friends, analyzed for nuance like sacred writ. Narrative medicine prepares physicians to deal with words (speech-acts) as intrinsic to the medical encounter. It makes language—in addition to stories and disease states—a matter of professional competence.

Applications: Ask the Patient / Heal the Physician / Write Write Write

Narrative medicine is no panacea, nothing is, certainly not penicillin. Within medicine, narrative is an instrument suited to particular tasks, and its inability to meet hyperexaggerated expectations does not make it useless. As a tool, it must be matched to the tasks it performs well, so that we do not blame a stethoscope for its failure to turn a screw. Like any instrument, narrative must answer to questions of cost-effectiveness, but costs must be calculated fairly, with an awareness of externalities (or costs borne by parties not directly involved in the transaction). Medical economics cannot ignore costs associated, for example, with litigation, error, unneeded diagnostic procedures, and futile end-of-life intervention. Fairly calculated, an ounce or two of narrative prevention might pay big dividends. The economic language here, as narrative medicine would argue, is significant. Pragmatist philosopher and physician William James, MD, deliberately employed the metaphor "cash value" when appraising concepts.[32p31-2] A Jamesian pragmatist philosopher focuses on practical consequences and asks about a concept not *is it true?* but *what work does it do? what is its cash value?* The cash value of narrative medicine may involve not only its benefit to patients but also (as crucial figures without whom there are no patients) to physicians.

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First, however, a not-so-artful delay, recapitulation, and mark of constructedness. The strong version of narrative medicine entails several related claims: there is always story; the medical facts are not the whole story; the most important story may not be the story you hear. These claims bear qualification and discussion, but they add up to a significant change in medical thought and practice. When a patient presents to a physician, there may or may not be disease, but there is always story. The story is not identical with medical facts—virus, bacterium, or failed organ—because facts never speak entirely for themselves. They need a "storied" human voice. The most important story, in fact, may not be the story you hear because multiple stories often overlap. All the story-talk may serve as a screen to protect what is hidden in silence. Moreover, because stories change in the retelling, patients offer differing narratives depending on the narrative situation or even on the location (home visit, grand rounds, private office). Truth is not the crucial feature of stories, as even false or misleading narratives offer useful evidence and do a certain kind of work. A patient narrative about drug-free living, if directly contradicted by a lab report, raises serious questions bearing on treatment and on the intersubjective physician-patient relationship. Narratives are sometimes pure fantasy, but not all fantasies are equal. Confabulation in fact is a symptom of significant brain damage.

Narratives are also vehicles of belief, and there is surely economic benefit in identifying and replacing counter-therapeutic beliefs about illness. A study of 100 patients, for example, showed that patient beliefs about pain correlated directly with treatment outcomes.[33] Some patient narratives expose beliefs that research proves to be truly harmful, such as beliefs about chronic pain that result in catastrophizing. A physician with skills in narrative medicine can help patients identify their commitment counter-therapeutic narratives that promote harm and prevent healing. The next step: to help patients replace harmful narratives with new narratives suited to a patient's culture and beliefs that promote health and sustain wellness. There are good reasons why physicians might want to share with patients (after a careful evidence-based review) a few individual "success stories."[34p269-85] Patients, as cancer-survivor and Tour de France champion Lance Armstrong attests, want to hear how he beat the odds.[35] They want a narrative model for hope.

The economic benefit of narrative intervention may be even more basic and direct. Tests are expensive, often inconclusive, and sometimes downright unnecessary. Suppose a cheaper, surer method allowed doctors to collect certain kinds of relevant data. In a classic medical study of suffering, Eric Cassell, MD, confronted the difficult question of how a physician can know when the patient is suffering.[36] Dr Cassell, a pioneer in the study of physician-patient communication as well as an unusually wise clinician, offers a brief, sane, iconoclastic answer: "The only way to learn what damage is sufficient to cause suffering, or whether suffering is present, is to ask the sufferer."[36p643]

Asking the patient, as Cassell knows, does not always supply correct, complete, or infallible data. Patients don't always tell the truth—especially if drugs or abuse are at issue—and sometimes they reply confidently despite false, flawed, or limited knowledge. They may repeat what they believe the physician wants to hear, or what the culture instructs them to say ("I'm fine").

Asking the patient, however, is never without value. In addition to whatever information it produces, the question initiates a communicative process that may prove its value later. Like a serve in tennis, the physician's question launches a dialogic encounter whose outcome is (if not unpredictable) unknowable. A genuine inquiry—as distinct from a pro-forma checklist item—already implies that the physician has abandoned a detached, impossible God-like POV for a position of engagement that opens up a flexible space for human verbal interaction. It moves the physician, for however long the exchange continues in its narrative authenticity, off the script.

Here's the payoff for physicians. Physicians can be as frustrated as patients by the failures of biomedicine played out amid the maze of medical bureaucracies, insurance carriers, and multi-national pharmaceutical corporations. Physicians, in fact, bear a double load as they seek to treat increasingly frustrated patients. "Wherever I lectured," writes surgeon Lori Arviso Alvord, MD, "people would come up to me afterward and tell me stories of their impersonal treatment by doctors, of problems getting appropriate treatment through managed care programs, and of doctors or hospital staff who had treated them insensitively. They felt powerless, often miserable inside hospitals, stripped of their dignity."[37p190] These are the stories that physicians would rather not hear, but there is worse. Physicians face unusually high rates of burn-out, alcoholism, and suicide.[38,39] The highest suicide risk awaits women physicians.[40] What are the economic costs, even beyond personal tragedies, entailed in the loss of so many highly trained professionals?

"It's the humdrum, day-in, day-out, everyday work" explains pediatrician William Carlos Williams, MD, "that is the real satisfaction of the practice of medicine … ."[41p356] Dr Williams was certainly overworked, given his second job as the inventor of modern American poetry, but what sustained him through 40 years as physician to a poor immigrant community was not financial gain. As he continues: "I have never had a money practice; it would have been impossible for me. But the actual calling on people, at all times and under all conditions, the coming to grips with the intimate conditions of their lives, when they were being born, when they were dying, watching them die, watching them get well when they were ill, has always absorbed me."[41p356] The demise of the house-call and the rise of the computer screen have separated physicians from patients, and it is worth speculating whether the separation has anything to do with physician discontent. Narrative medicine clearly isn't for everyone. Its role may be more important in certain specialties. Nonetheless, stories reopen a space—flexible but not unbounded—where physician and patient may participate in an engagement that transforms the humdrum day-in/day-out diagnostic encounter into a source of truly sustaining, restorative satisfactions.

Writing has its satisfactions, not to mention frustrations, but its benefits radiate in some unexpected directions. Psychologist James Pennebaker, PhD, has shown across varied populations that the act of writing about traumatic experience provides measurable health benefits.[42] The trauma, it turns out, need not be personal or even actual for writing about it over several days to produce measurable health benefits.[43] A research team unaffiliated with Dr Pennebaker has replicated his results among arthritis and asthma patients, for whom writing about trauma correlates with a measurable reduction in symptoms.[44] Dr Pennebaker has established that the benefit does not derive from mere "venting"—defined as the oral expression of feeling—nor is writing interchangeable with forms of nonverbal communication, such as dance. The health benefits seem to require the specific neural organization distinctive of writing, both syntactic and semantic. Nor is mere writing sufficient. "Using our computer analyses as a guide," Pennebaker explains, "we realized that the people who benefited from writing were constructing stories."[42p103] Physicians not only treat trauma but also experience it as caregivers, and there is at least a possibility that, through narrative, they might just help to write themselves well.

Finale: Authorized Narratives vs Narrative Resistance

Narrative medicine, in order to merit space in *JAMA,* may need to emphasize its claims to knowledge. It may need to reaffirm the standard medical thumbnail case-study ("Mr X is a white male age 40 years"), which has its uses. The fact remains, however, that physicians are beginning to recognize the value of what's left out or neutered by the authorized biomedical narrative forms. New medical narrative forms are in development exploring new modes of engagement with patients, as the work of Dr Remen and Paul Farmer, MD, suggests. The therapeutic possibilities sketched by Dr Mehl-Madrona need to be explored seriously. Narrative medicine may prove most successful, however, because it offers some physicians a return to what drew them to medicine: something beyond facts, procedures, or logicoscientific knowledge. Such benefits include the restorative experience that Dr Williams found in a narrative-based immersion in the everyday lives of patients: "As I say, often after I have gone into my office harassed by personal perplexities of

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whatever sort, fatigued physically and mentally, after two hours of intense application to the work, I came out at the finish completely rested (and I mean rested) ready to smile and to laugh as if the day were just starting."[41p357] Such daily restoration seems indispensable to a professional labor as difficult, demanding, and dangerous as medicine. The national bean-counters might consider it money well spent if narrative medicine proves effective in promoting, as seems likely among the other benefits that it offers to patients, the long-term wellness and professional restoration of a growing subset of health care professionals receptive to the claims of story. ❖

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