

Narrative Medicine

What Is Narrative Medicine?

Narrative medicine is not easy to describe. The very terms “narrative” and “medicine” seem to fall in fundamentally different fields. But their fusion is critical to address some of the issues in our modern medical system that often diminish the human aspects of the clinical encounter.

Narrative medicine has the potential to be a powerful healing tool; in terms of the Circle of Health, it might be said to represent what could happen at the intersection of Mindful Awareness, Personal Development, Mind & Emotions, and perhaps even Spirit and Soul.

The art of telling stories and the art of deeply listening to stories used to be central to the relationship between patients and clinicians. Today, those arts are often undervalued in medical encounters that tend to “privilege the biology over the biography.”¹ This creates disconnection between patients and caregivers that can be repaired by promoting the role of telling and receiving stories as central in clinical exchanges. Patients have a story that needs to be heard, not just symptoms that need to be treated. Pain is often as much psychological as somatic: our emotions, thoughts, and stories influence our awareness of pain and its effect on our lives.

It is critical for clinicians to practice generous, attentive listening and to invite and facilitate storytelling from their patients, because often the story verbalizes things the body is trying to communicate through its ailments.

Practicing narrative medicine can facilitate better health care, because it restores value to the subjective experience of suffering that is often lost in the objective stance in which clinicians are trained. Narrative medicine has been deemed “one of medicine’s most important internal renovations,”² and is being integrated into the system in myriad ways.

How Was Narrative Medicine Started?

Narrative medicine emerged as a response to patients’ complaints that their clinicians did not listen to them, or did not seem to truly care about their suffering. Internist and literary scholar Rita Charon coined the term “narrative medicine” and launched the Program in Narrative Medicine at Columbia University in 1996. Her goal was to help health care professionals improve communication and collaboration with their patients and to bridge the gap between the humanities and the sciences. At the heart of her mission lies the belief that effective health care “requires the ability to recognize, absorb, interpret, be moved by, and act on the stories of illness.”³ Charon considers narrative medicine a basic science mandatory for medical practice.⁴ Though not always called narrative medicine, many endeavors in medical education and practice bring together literature and medicine, as well as the social and behavioral sciences, under this umbrella category.

Why Do We Need Narrative Medicine?

More than 2,000 years ago, Hippocrates articulated one of the founding principles of narrative medicine, stating, "It is more important to know what sort of person has a disease than to know what sort of disease a person has."⁵ In order for clinicians to provide truly effective health care, they need to care for people, not just cure diseases. They need to understand the meaning of the patient's experience, not just their symptoms. To do that, they need strong skills in both verbal and nonverbal communication. Narrative medicine equips clinicians with the tools to achieve these goals.

Address illness, not just disease

Medical anthropologist and psychiatrist Arthur Kleinman distinguishes "illness" from "disease." He depicts "disease" as the biological problem that science addresses and "illness" as the human experience of the disease. Good health care must tend to both, must attempt to cure the biological disease and care for the psychological and social experiences of illness. Biological science can tackle the disease, but a narrative science approach best addresses the illness. Kleinman writes, "Each patient brings to the practitioner a story. That story enmeshes the disease in a web of meanings that make sense only in the context of a particular life."⁶

As a first year resident at Columbia University, Yira De La Paz wrote a reflective narrative about a 30-year-old patient who came to the hospital having seizures, presumably due to alcohol withdrawal.⁷ De La Paz listened to the man's story, which involved being adopted, disconnected from his adopted parents, jobless, estranged from his young son, and bound to alcohol as his "best friend" since age 12. In his written reflections on witnessing this patient's suffering, De La Paz wrote:

He wept as he told us his story and how alone and depressed he was. Looking at him, I felt so helpless, thinking about how anything I say would sound like a sermon repeated over and over again, or shallow...we always bring our own prejudices into our questioning, but this time, I was ashamed of it because this person gave me a glimpse into his world and it could have been anyone, even myself, or my son.^{7(p354)}

De La Paz models how to recognize the way a disease is enmeshed in a "web of meanings" that can foster an empathetic connection between clinician and patient. Receiving a comprehensive story stirs a clinician to reflect on his/her own life story, whereas obtaining medical data for the patient's chart does not, and often leaves the patient bereft of the compassionate presence of the clinician.

Make meaning

A medical student on a pediatric rotation wrote the following narrative about an adolescent male patient with a neurological disease:

"I'd rather not talk about it," he politely responded. Did I cross the line? How often do I find myself wondering this in medicine? Because of what? My fear of knowing the intricacies of

my patient's life? But he did talk about it. He talked a lot. To be seventeen, a prisoner in the hospital and a prisoner outside of the hospital; this is unacceptable to me as his provider. I tried hard to see beyond. So I asked. I asked questions I would ask anyone. He shared how his disease affects life in the juvenile detention center.

Other providers criticized his admission, attributing his symptoms simply to his desire to get out of the detention center. But can you blame him? He quietly described his difficulties in the center. Balance difficulties made walking without assistance not only hard but terrifying. Without liberty to use the restroom when desired, his bladder difficulties worsened simply because of fear of losing control. I can't imagine the other inmates would take lightly to this situation.

I didn't understand until he explained. I didn't understand what his disease meant to him; a life of uncertainty and missed opportunities (A. Waldner, personal correspondence, 2014).

Human lives are woven out of intersections between story and biology. Psychiatrist and medical humanities professor Bradley Lewis asserts, "In addition to bodies, organs, and tissues, (humans) also live meaning-centered lives, and they have complicated emotional and historical relationships with their bodies."^{2(p11)} As such, health care practitioners must know how to help their clients make meaning out of their embodied and illness experiences. Narrative medicine endows clinicians with concrete skills and strategies to help patients make meaning.

Physician and literary scholar Howard Brody proposes two ways stories and health care engage with one another. First, he postulates *storytelling is healing*, which speaks to how the stories patients tell themselves about their illness experiences determine those experiences. Conversely, *healing is storytelling*, which refers to the narrative construction work clinicians do in an effort to understand and explain their patients' experiences.

But this medical authoring usually draws from scientific models of interpretation and organization, which results in many of the human aspects of the patient's story getting lost in translation, "Patient stories and the doctor stories often do not work well together."^{2(p16)} With narrative training, clinicians can better co-author stories of illness with their patients and foster collaborative partnerships imperative to holistic healing.

Improve communication

A third year medical student who took part in a narrative medicine rotation at the Washington D.C. VA hospital described how writing narratives of patients and reading the stories to them afterwards, "...led to new clinical insights about patients, deepened relationships between students and patients, and altered patients' willingness to comply with health care team recommendations for work-up and treatment."⁸ By understanding patients' stories, practitioners can deliver better medical care.

Narrative training equips clinicians as co-creators of illness stories. It enables them to heal the divide that often exists between patients and practitioners. This divide results from insufficient training in generous listening skills, differences in the languages spoken by sick people and scientists, and the default clinical communication techniques that often do more harm than

good. One study examined how clinicians can use narrative techniques to help brain injury patients through rehabilitation.⁹ The authors concluded that “a narrative approach can be an effective tool that informs clinical decision-making”—eliciting a patient’s full story proffers comprehensive information needed to steer the course of treatment. What’s more, listening deeply to patients’ full stories decreased patients’ sense of isolation and empowered them in developing new identities.

The relationship between clinician and patient is a narrative relationship, not strictly a scientific one. It is based in verbal and body language. It is semiotic; a clinician’s work is to decode a patient’s description of the illness experience—to translate a patient’s symptoms into medical meaning and significance. It is reciprocal; clinician and patient both play the roles of speaker and listener during the clinical encounter. To effectively decode, translate, and co-construct the healing stage of a patient’s illness experience, a clinician must master skills in narrative competency.

What Are the Intentions of Narrative Medicine Training?

Narrative medicine seeks to influence health care in a variety of ways:

- To introduce the concepts of “narrative competency” into the delivery of health care
- To implement “narrative interventions” in clinical practice
- To enhance and broaden medical education
- To train clinicians to more effectively communicate with their patients
- To endow clinicians with skills to listen attentively to complicated and sometimes incoherent narratives that are told partly in words, but also in silences, gestures, test results, and body language
- To teach how to identify and unpack metaphors
- To open up, expand, and deepen medical practice, not provide an alternative to or distraction from it
- To explore how clinicians are touched by the stories they receive, so they will act with compassion and empathy on their patients’ behalf
- To offer clinicians a way to process what they themselves undergo in caring for their patients
- To investigate how clinicians’ own stories impact their ability to hear and interact with patients and colleagues
- To acknowledge the weight of witnessing patients’ sometimes intense and traumatic experiences
- To mitigate burnout, cultivate resilience, and support self-care

What Skills Does Narrative Medicine Offer?

The phrase “narrative competency” is used to describe the narrative skills that practitioners gain through rigorous training in narrative medicine. Medical sociologist Arthur Frank, explores the relationship between bodies and narratives in his book *The Wounded Storyteller*. He identifies the central skills needed as ones which enable a clinician “to learn to think *with* stories. Not think about stories ... but think with them. To think about a story is to reduce it to content and then analyze that content. Thinking with stories takes the story as already

complete; there is no going beyond it.”¹⁰ To think *with* a story, as resident De La Paz did with his 30-year-old patient whose disease he came to see entangled in a “web of meaning,” is to experience it affecting one’s own life and to find in that effect a certain truth of one’s life.”

The 3 primary skills taught in narrative medicine are called “Attention,” “Representation,” and “Affiliation”:

- **Attention** concerns how clinicians can be fully present with and listen attentively to their patients’ stories, *and* know their own stories. Attention is based in a reciprocal, intersubjective relationship.
- **Representation** concerns how clinicians can examine the meaning of the stories patients tell, and explore how they are, or are not, constructing meaning out of those experiences. Representations of patients to consider include how the patients are written and spoken about to four different groups of people: medical colleagues, the patients themselves, the patients’ families, and clinicians themselves.
- **Affiliation** concerns how clinicians can use the experience of telling and listening to stories of suffering to deepen their empathy and compassion in relationships with patients, as well as between fellow clinicians. Affiliations are the outcomes of narrative work, the collaborative actions and care-giving communities that result from the practices of attention and representation.

How Effective Is Narrative Medicine?

Research shows that narrative medicine is significantly impacting health care. Numerous articles published in a wide range of sources illustrate narrative medicine’s intentions and influence, which has helped confer narrative medicine credibility as a science. “Evidence of the usefulness of narrative practices, rigorous ethnographic and outcomes studies using samples of adequate size and control have been undertaken”¹¹ at universities and medical centers across the country to evaluate how narrative competence affects the delivery and resonance of health care over time. A central hypothesis being tested postulates, “The physician equipped with the narrative capacities to recognize the plight of the patient fully and to respond with reflective engagement can achieve more effective treatment than can the physician unequipped to do so.”¹¹ (p1900)

Three obstetrics and gynecology training programs participated in a study examining the correlation between narrative medicine session attendance with burnout and empathy measures.¹² The study found that participants who attended more sessions experienced decreased burnout on the Emotional Exhaustion scale. Another study explored the efficacy of narrative writing as a supplemental treatment to psychotherapy for PTSD.¹³ Findings indicated that patients tolerate the intervention well and report satisfaction, leading researchers to conclude it holds promise, but its efficacy still needs additional study. Outcomes from international research on narrative medicine’s impact acknowledge “recognition of emotion, perceptual sharpness, tolerating uncertainty, decreasing burnout, improving healthcare team function, and deepening individual clinicians’ knowledge of individual patients’ situations are all being demonstrated as consequences of narrative training.”¹⁴ Research on this burgeoning field ongoing.

How Is Narrative Medicine Practiced?

Narrative medicine uses a multidisciplinary approach to make space for comprehensive, unique life stories to be shared and received in medical contexts. Originally derived from narrative theory, autobiographical theory, phenomenology, psychoanalytic theory, and trauma studies, narrative medicine converges with many disciplines. It involves the study of literary texts, including classic novels and poetry, as well as autobiographies, films, performance, music, graphic narratives, visual art, oral history, psychology, autobiography, philosophy and ethics.

While traditionally taken up by small groups that do close reading and writing exercises, there are numerous ways to practice narrative medicine. Beyond the traditional classroom model, educational opportunities are increasingly available for practitioners, medical students, and patients. Refer to the tool, "[Exercises and Readings for Narrative Medicine Groups](#)."

Classroom model

In a traditional narrative medicine meeting, participants are guided by a facilitator through close reading, writing exercises, and group discussion. This model resembles hospital rounds, during which a medical team gathers to consider their patients' stories, examine their bodies, review information, and come to conclusions about their care.

A typical one-hour session in a medical setting often begins with a brief introductory didactic portion providing an overview of narrative medicine. The day's topic is then introduced and discussed briefly—for instance, "Managing Uncertainty" or "Death and Dying" or "Camaraderie." The participants then read a piece of literature together, or examine a piece of visual art. A short story, a poem, or one visual work are best suited to a limited time frame. If it is an ongoing group, they may choose to read a longer piece prior to the meeting. After reading, participants discuss what struck them about the piece, either as a whole group (or in dyads or triads, if it is a group larger than 15).

The facilitator then offers a writing prompt, to which everyone responds for approximately five minutes. Participants are then encouraged to share what they wrote with the larger group, or just with a partner. Listeners are encouraged to comment on the writing itself—the "craft," not the experiences—the "content."

Ground rules and safe space

The intention is to create an environment for people to talk about themselves and their experiences in a meaningful way. To do so, it is important to establish ground rules to assure participants they are in a safe space. Everyone must agree that what is spoken of and shared will be kept confidential. It is advised that during the writing portion of the session, participants write down their ideas as they will be read, not in note format. The feedback after someone reads her/his work should concentrate on the craft and expression in the writing, not therapeutic processing of the content. Facilitators should always pay attention to the emotional temperature of the room, and moderate the session if need be.

Participants

Groups can consist of health care trainees, practitioners, patients, or family members. Clinicians often form writing groups to share personal writing they do on an ongoing basis pertaining to their medical experiences, or to practice writing exercises together without incorporating close reading. The possible formations of narrative medicine are innumerable, and individuals are encouraged to create innovative manifestations tailored to their interests, skill-sets, and schedules.

Resources

While the traditional classroom model of narrative medicine practice usually takes up a literary source—book, short story, or poem—additional formats may include the discussion of a visual artwork, an article pertaining to narrative medicine or stories, a film screening and discussion, a theater outing, or other outside-the-classroom experiences. Refer to the tool, [“Exercises and Reading for Narrative Medicine Groups.”](#)

How is training in close reading beneficial?

Reading benefits us as human beings. When we read a story, we take ideas into ourselves, into our bodies and minds. What are we absorbing when we read? How does the story affect us? Medical humanities professor Arnold Weinstein compares a book to a pill; they both go into us and can have powerful effects. We read, and take medicine, for nutrients and nourishment.

At the heart of narrative medicine lies the belief that training in close reading makes better clinicians. As Rita Charon puts it, “Good readers make good doctors.”^{3(p113)} Clinicians are readers of complex, sometimes contradictory texts, e.g. multiple viewpoints told by the patient and family members depict various scenes. In addition, not all of the “text” of an illness narrative comes in words; the body speaks its own language, in words, silences, gestures, expressions, and lab results. Clinicians must be well versed in how to decipher and translate what a patient’s body and self-communicate in a medical experience in order to provide the most appropriate and comprehensive care.

Charon emphasizes the “parallels between acts of reading and acts of healing,”^{3(p17)} which both involve a story offered by a teller to a receiver who has to make sense of it. If one can learn to closely read a literary text, one can learn to closely listen to an oral narrative. Competency in close reading endows clinicians with clinical imagination, empathy, ethical awareness, and attention. Training in close reading enables clinicians to listen to their patients, read medical charts, and reread their own writing with acute awareness. A clinician skilled in close reading will be able to receive all of what their patient tells them, and then be able to represent and respond to the narrative in a comprehensive way that honors the patient’s story.

How Can Reflective and Creative Writing Be Used in Health Care?

Reflective and creative writing enables clinicians to be more fully represent what they learn about their patients and about themselves. Reflective writing surpasses the boundaries of the conventional medical chart—it allows a clinician to become an “I.” Writing narratively about a

clinical encounter demands attention in that present moment and makes the clinician more invested and attuned.

Fourth-year medical student Amy Waldner reflected, “Incorporating narratives as a part of my practice has been very powerful and cathartic for me. I find it particularly helpful with emotionally difficult patients...the difficulty is more so on my part. The patients have such strong stories that I find it hard for me to deal with emotionally. I find myself in situations, especially with patients who are palliative and/or dying, and patients who have significant mental health illnesses. I often leave their rooms feeling helpless and overwhelmed. Jotting down a few thoughts/reflections can really help me sort out my own emotional heaviness.” (A. Waldner, personal communication, January 22, 2014).

There are multiple settings in which clinicians can use ordinary language in narrative writing: in seminars, workshops and writing groups for health care practitioners, in “Parallel Chart” sessions, and in personal writing practices.

Patients, too, are encouraged to write about their illness experiences. Everyone—patients and clinicians—will write for different reasons and with individual outcomes. But there are several identifiable motivations, intentions, and results of writing in a narrative medicine context:

- To give form to experiences, thoughts, and feelings
- To make sense of what happened or is happening
- To provide a therapeutic release
- To get control of traumatic experiences and memories
- To remember and commemorate experiences
- To bridge the divide between writer and reader, patient and practitioner
- To challenge attitudes that difficult experiences shouldn't be talked about
- To find common ground and foster camaraderie.

In a [TEDxAtlanta talk in September 2011](#), Rita Charon described an experience she had in which writing reflectively about a patient of hers, and sharing that writing with the patient, positively affected her patient's well-being and brought the two of them together.¹⁵

Charon shared the story of a patient who was diagnosed with breast cancer 20 years ago. The woman had a lumpectomy, and was told she was cured. When the cancer returned years later, she had a mastectomy, from which she recovered uneventfully. However, she became deeply concerned that the cancer would return again. Charon described how she and her patient addressed this plaguing worry:

“She was in my office every week...We kept reassuring her, that's just how the tissues heal...She could not be reassured, she thought that we were deceiving her. Finally after another breast examination in the office...I told her I thought I understood what the fear was...that what she feared was that she would die.”

Charon could not tell her patient how her life would end, or assure her that she would not die. But she realized she could be with her patient in the midst of her fear, and promised her she

would. Charon credits her reflective writing practice for reaching that realization: “The way I knew that, the way I came to understand that is that I had been writing about her, and I had been showing her what I had been writing about her. And in that way, we made contact through her illness, through her fear.”

After Charon assured her patient they would face the fear together, “She said she felt much better, she felt much more relaxed, she wasn’t worried as she had been, and she was sure that I was right.” By connecting clinician and patient in a humanistic way through the act of writing, Charon observed, “Not only did we help the immediate problem with her own fear, but we made enduring, life-long contact, the two of us.”

How Can Clinicians Use Narrative Medicine?

The best way to understand narrative medicine is to use it. To incorporate it into medical practice, practitioners can practice it not only with their patients, but also with their colleagues and themselves. Clinicians are encouraged to build the narrative dimensions of their practices through these interactions in order to strengthen relationships, hone care-giving skills, and glean fresh insights into the profession of medicine.

Patients are not the only ones who have stories to tell; health care practitioners also have stories that need to be heard. It is crucial to create spaces and opportunities for practitioners in which they feel comfortable, encouraged and equipped to explore and share their experiences, while connecting with others undergoing similar experiences, in an honest, uninhibited way. Practitioners can use personal narrative writing about their patients and work for self-reflection as well as to challenge themselves to be better practitioners based on the things about which they have written.

The culture within which practitioners work must also be considered. Practicing narrative medicine with a group of medical professionals who make up a medical community can strengthen the collegial atmosphere, shed light on how they construct medical knowledge within that particular community through the analysis of how the participants write and speak about their work, and illuminate the greater meaning of clinical practice.

Narrative medicine groups

Colleagues interested in cultivating the exploration of their own stories and practicing narrative medicine can form a narrative medicine group that meets weekly, bi-monthly, or monthly. Groups may find it convenient to meet during the lunch hour. They can select pieces to read beforehand which they come together to discuss, or select short pieces to read together, followed by a writing prompt, sharing, and discussion in the traditional classroom model. Refer to the tool, [“Exercises and Readings for Narrative Medicine Groups.”](#)

Reflective writing

Clinician reflective writing practice aims to expand detached, clinical records of patients into personal, narrative accounts of clinical experiences. The writing can be done privately, for personal processing, healing, and self-understanding. Or it can be shared with other clinicians, as a contribution to medical education and as a means of fostering camaraderie and collaboration among colleagues. A fourth year medical student pursuing emergency medicine

who regularly practiced reflective writing commented, “Because I’m going into emergency medicine, it’s not easy to write a narrative on a busy ED shift, but it’s something that I try to do after a shift if I’ve had a particularly memorable patient...it is a great tool for reflection for me.” (A. Waldner, personal correspondence, January 22, 2014). Ideally, regular reflective writing results in better patient care and enhanced knowledge for medical professionals.¹⁶

There are several intentions of reflective writing for clinicians:

- To describe patients and clinical interactions in rich detail
- To engage in self-observation based on personal experiences and opinions
- To pose and ponder questions that may be unanswerable
- To examine and decode experiences in order to inform future behavior
- To hone analytical skills and strengthen critical thinking
- To glean insights that will influence how medicine is practiced
- To reflect on and validate both challenging and victorious experiences.

The “Parallel Chart”

Rita Charon created a narrative writing practice for clinicians and medical students called the “Parallel Chart.” Intended to augment the patient’s objectifying medical chart, it does not contain test results and blood pressure readings but rather, the clinician’s subjective responses and concerns written in ordinary language. It allows for authentic exploration of a patient’s experience and a clinician’s reactions. Even if a clinician only has two minutes to write, these narrative notes significantly expand the perspective of a patient’s experience. It is not intended to serve as a diary, but an ongoing part of clinical training, “in the service of the care of a particular patient.”^{3(p157)}

As a first-year resident at The University of Texas Medical School-Houston, Chieu Foo participated in a four-session close reading and narrative writing curriculum conducted with 48 residents to evaluate the effects of narrative medicine.^{7(pp352-353)} During one of the sessions, residents were asked to write a story about one of their patients whose suffering affected them, and then contrast that narrative with the case report they composed for the patient. Foo wrote this story:

I remember having a 27-year-old girl who suffered from congenital toxoplasmosis on my service. She had the mentality and behaviors of an 18-month-old infant. She was admitted to the hospital because her parents felt that she was not herself. She had been experiencing diminished appetite for a month but no definite acute illness was identified. I was touched the moment I entered her room. What I saw was a pair of extremely caring parents who have taken care of her meticulously for the past 27 years despite her disability and as though she was an infant. I could hardly keep my tears back when the chief doctor brought up the issue of end-of-life decisions. Her parents were asked if they had considered what they want for their child if she stopped breathing. Her parents teared up but were able to reasonably and logically provide an answer. They said they did not want her to suffer. I teared up myself. What will I do if I have such a child or know that my unborn fetus will end up this way?

Foo’s case report of her 27-year-old patient read as follows:

S: No complaints. No overnight events. Tolerates sips of water. Refuses food.

O: Undistressed. Awake. In bed. Temp 98.6. BP RR PR

A: Condition stable.

P: 1. Attending Dr. K discussed end of life issues with parents, for example, whether to apply resuscitation in times of cardiac arrest. Parents wished to keep pt comfortable and deny resuscitation in times of cardiac arrest. Appropriate forms were computed.

2. Continue with current supportive management.

3. Add Ensure twice a day.

The residents were “struck by the differences between depiction of the human experience versus documentation of the medical data, even when both were done by the same author.”^{7(pp352-353)} In reflecting upon the effects of narratively writing about their patients, many noted that “their identification with patients’ situations” moved them to change the connections they make with their patients: make more eye contact, spend a few extra moments to comfort, ask more about their family life. They “saw that their degree of connection with patients directly affects care.”^{7(p355)}

Mindful Awareness Moment: Write A Patient’s Story

Review Dr. Foo’s story above. Think about a patient you have seen in the past day or so, and give yourself five minutes to write a narrative about him or her.

- What do you notice yourself feeling as you do this?
- How does your narrative compare to how a visit note would look?

How would encounters be different if you communicated with patients with the intention of being able to recount their narratives?

Health care practitioners who adopt this practice are encouraged to read their entries aloud with colleagues on a regular basis. When sharing writing with colleagues, Charon advises abiding by the following principles:^{3(p159)}

- Focus on the text, not the content. Consider its frame, form, time, plot, and desire.
- Encourage the writer to read their words as they were written, not reiterate them in conversation.
- Listen for the writer’s unique style and voice.
- Invite responses and questions from the listeners.
- Offer positive feedback about the writing.

Students, residents, and clinicians who have used the Parallel Chart reported that through the writing and sharing they came to understand their own emotions and their patients more fully, conduct better medical interviews, perform procedures more efficiently, and feel greater confidence in their care-giving.^{3(p173)} Residents who participated in the four-session narrative medicine unit in close reading and narrative writing identified learning “the importance of

listening to my patients' stories," "not to prejudge the patient," "the importance of my feelings toward my patients," and that "narration helps process difficult situations and emotions that traditional theoretical discussion can't."^{7(p356)}

How Can Narrative Medicine Be Used with Patients?

The following examples offer ways clinicians can utilize narrative medicine practices one-on-one with their patients in order to strengthen the clinical relationship and thereby provide better care.

Unconventional clinical interviews

When first meeting a new patient, Rita Charon advises clinicians to open the interaction by saying: "I will be your doctor, and so I must learn a great deal about your body and your health and your life. Please tell me what you think I should know about your situation."^{1(p122)} Then sit attentively to listen to the story the patient tells, without taking notes or typing. Witness the patient's self through the narrative telling *and* the patient's body. In the same amount of time it takes to conduct a conventional clinical interview, more information may be obtained when a patient frames their illness experience within life events. Furthermore, sharing an intimate narrative exchange fosters greater unity and trust between patient and practitioner. Clinical and reflective narrative notes can be written after the interaction.

Trustworthy listening

A Vietnam Veteran who participated in a writing program told one of his care practitioners, "Well, I guess it's something that I can even talk to you like this, and you not even a 'Nam Vet and all. Remember how long it took me to say anything? I just had to watch until I could trust ___ and ___ and you. It was almost three years till I started to open up."^{17(p19)} This Veteran's reflections depict the importance of cultivating trust and practicing patience in the healing process. To establish a relationship built on trust requires time and a willingness and capacity of the clinician to invite forth the patients' full stories and support the telling. Patients can then begin to narrate their history in a safe way, to trustworthy listeners. To be a trustworthy listener

- Listen to the story with an open mind. Do not deny or invalidate the teller's experiences.
- Respect the narrator and refrain from judgment. Be ready to be changed by the narrator.
- Experience and have emotions about the story. Understand it with your heart. In other words, receive the story through compassion.
- Be prepared to cope with potential triggers a patient's story may provoke in you.

Witnessing project

No one person can see everything that happens. A technique Rita Charon developed in an effort to enhance her practice as an internist involves inviting a non-clinician into the clinic room to witness her encounters with patients. The witness records perceptual observations of the patient encounter that may go unnoticed by the practitioner: what both the patient and clinician communicate in words, body language, tone, etc. The notes are later shared with clinicians, which can result in them changing unhelpful routines and habits, and provide insights into their patients and themselves. From her use of this practice, Charon attests,

“Already in a few months, I have changed basic routines in my office practice as a result of what my witnesses have shown me. More importantly, I have learned things about my patients and myself that I would never have learned on my own.”^{1(pp126-127)}

Reversed rounds

A graduate student of English who attended ward rounds with Rita Charon questioned the typical order of first presenting the patient’s history and then meeting the patient, “I couldn’t help but wonder how things would be different if it were done the other way around. What if the team went in to see the patient knowing nothing about all those numbers and medications, nothing about the prior history, knowing only that giant leg and that sweet, sad face?”^{1(p129)} Charon’s team took her suggestion and reversed the order of their rounds routine.

Clinicians who participate in rounds can try to reverse the order of that routine. Meet as a team with patients first, inviting them to tell their story and share themselves, before discussing the technical aspects of treatment in the presentation portion. This allows the foundation of patient care to be built on story, not lab results.

The graduate student who inspired the change in clinical routine joined Charon’s team when they first tried this and observed, “Care filled the whole room. The power of that was undeniable and intoxicating. There was nothing but care in that room for those few minutes...To care for each other, to tell each other our stories and try to understand them and then to try to help each other to heal.”^{1(p129)}

Group work

Narrative medicine lends itself exceptionally well to interventions focusing on healing trauma in community. Jonathan Shay, a noted neurologist and psychiatrist at the forefront the field of narrative medicine, asserts that to debrief with people who feel an affiliation and identification restores trust to the survivor, which “will have healthy biological effects, of comparable or greater magnitude than successful medication.”^{17 (p186)} The communal healing he advocates for is inherently a narrative project; he asserts that “peer recognition, which allows survivors of trauma to grasp that they are not freaks and ‘do not have to go through it alone,’ usually leads to communication of experience in words.”^{17(p192)}

Safety needs to be prioritized when giving and receiving stories in a group. Trauma survivors must also be helped to strike a balance between speaking in unity, the “we all went through the same thing” narrative, and telling their individual accounts. Shay stresses, “Major recovery...requires that personal narrative be particular, not general.”^{17(p. 192)} Facilitators must help participants feel comfortable enough to speak freely about their particular experiences, and ensure that in doing so, they do not lose the support that comes from the solidarity that arises in story-healing community work. It is also important to encourage participants to avoid making comparisons and constructing “hierarchies of suffering.”

Clinicians can orchestrate group healing opportunities for patients by offering narrative medicine workshops or ongoing groups. The features and resources outlined in this curriculum can offer structure for a group to embark on “story-healing.” Graduates of Columbia University’s Narrative Medicine Master’s Program are available to do on-site workshops to train clinicians in facilitating communal healing or to work directly with patients.

Is There a Narrative Medicine Program Near You?

At the close of this overview, take a few minutes to find out if any healthcare organizations in your area have narrative medicine programs. If so, consider dedicating some additional time to learn more about them. If there is not one in your area, do you know anyone who could successfully start one?

Authors(s)

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