

What to do with stories

The sciences of narrative medicine

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Before her death last year, Dr Miriam Divinsky and I corresponded about storytelling in medicine. Her work introduced readers of this journal to narrative medicine¹ and paved the way for this special issue of stories and reflections from practice, joining widespread developments in this young discipline in North America and worldwide. Her essay “Stories for life”¹ eloquently describes the personal insight and active affiliation physicians derived from telling one another stories from practice. Here I want to extend this affiliation with her, no matter if she is on the other side of mortality, and with readers and writers summoned by her, to give voice to these stories that saturate our practices and our lives.

Development of narrative medicine

I first used the phrase “narrative medicine” in 2000 to refer to clinical practice fortified by narrative competence—the capacity to recognize, absorb, metabolize, interpret, and be moved by stories of illness. Simply, it is medicine practised by someone who knows what to do with stories. My colleagues and I have conceptualized and put into practice some basic tenets of narrative medicine. To acknowledge our cocreation of these ideas, I must introduce my team, for our work could not have been done without us all: Sayantani DasGupta, Craig Irvine, Eric Marcus, Maura Spiegel, Patricia Stanley, and me. I will rely on work published by each of us to point readers toward the intellectual and scientific bases of our emerging theory and practice.

Methods

At Columbia University in New York, NY, we provide narrative training (ie, rigorous training in close reading, attentive listening, reflective writing, and bearing witness to suffering) to doctors, nurses, social workers, psychoanalysts, therapists, literary scholars, and writers who attend our intensive training workshops. We also provide such training to students of medicine, nursing, physical and occupational therapy, pastoral care, oral history, social work, literary studies, and law. Our research projects are accruing evidence that students and clinicians who have undergone narrative training with us strengthen their therapeutic alliances with patients and deepen their ability to adopt or identify others’ perspectives.²

Narrative medicine curricula and projects are proliferating throughout the United States, Canada, Europe,

Great Britain, Latin America, the Middle East, and Australia. We take this explosive growth of interest and practice as evidence that capacities that are currently *lacking* within clinical practice and for which clinicians and patients yearn—singular recognition of patients and authentic use of the self by clinicians—can be developed through our emerging practice of bringing narrative knowledge and skill to bear on the care of the sick.

We have proposed a conceptual framework for understanding why narrative skills matter for clinicians and for patients and have proposed intermediates and mechanisms by which narrative training bestows its benefits on clinicians. The science of our practice gradually revealed itself as we struggled to articulate what we observed in our narrative teaching in medical settings.

Adopting a method of concentrated and closely observed and recorded teaching of one another in a 2-year intensive seminar followed by self-conscious teaching in a selected group of clinical settings (humanities seminars for second-year medical students, writing seminars for staff members on in-patient wards, literature seminars for physicians, creative writing workshops for health care professionals, and writing seminars for mixed groups of clinicians and patients), we generated and then tested hypotheses about the sequelae of fortifying narrative skills in these settings. What emerged as our science derived chiefly from narrative theory, autobiographical theory, phenomenology, psychoanalytic theory, trauma studies, and aesthetics.

The following discussion will review our current thinking about each of the 3 movements we have identified in narrative medicine—attention, representation, and affiliation—and will cite the sources of our evidence for each one.

Attention

The clinician caring for a sick person must begin by entering the sick person’s presence and absorbing what can be learned about that person’s situation. A combination of mindfulness, contribution of the self, acute observation, and attuned concentration enables the doctor to register what the patient emits in words, silence, and physical state. Contemplative practices, aesthetic appreciation, and Freud’s evenly hovering attention all have something to teach narrative medicine about the attainment and use of attention. By becoming a recognizing vessel, the doctor can “receive”

the patient, acting as a container for a flow of great value or, with a different image, registering a transmitted radio signal from far away.

Pediatrician Sayantani DasGupta invokes Buddhist learning and what she has coined “narrative humility” to describe the stance of the clinician who would hope to pay narratively competent attention to patients, embracing patients as teachers and recognizing ourselves as lifelong learners who always begin to know how to listen to, and surrender to, the other.³ DasGupta has also applied concepts and methods of oral history to clinical work, reasoning that the oral historian’s nonjudgmental acceptance of the testimony of the sufferer adds to our understanding of the attentive presence required of the doctor. Seeing these similarities between clinical practice and both contemplative states and oral history not only gives intellectual clarity to our practice, but also enhances clinical training by suggesting for our use some of the techniques used in preparing trainees for these other practices.

In addition to being a psychological or interior state, attention in clinical practice is a peculiarly narrative state.

However material its concerns with flesh and bone seem to be, medicine attends to words—the spoken language of patients, the dictated language of discharge summaries, the scrawled longhand of intern progress notes, the increasingly keyboarded “sign out” onto the electronic medical record, the messages of love and loss given and received near death.

Philosopher Craig Irvine brings the philosophy of Emmanuel Levinas to bear on our narrative medicine theory, suggesting that Levinas’s ethics of the face—accepting the moral duties incurred by virtue of a humble facing up to the otherness of the other—orients clinicians toward patients with fresh vision and ethical strength.⁴ For Levinas, only discourse has the capacity to unite 2 distinct “others,” and so the serious study of discourse between persons, whether in clinical conversation or in literary text, is essential to the task of attending fully to the other. We find that by teaching trainees the skills of close reading (and generally we ask them to read literary texts of prose or poetry), we are conveying the basic skills of clinical attention, by which doctors, nurses, and social workers can absorb all that their patients and colleagues have to tell.

Representation

Narrative medicine is by no means the first or only discipline to turn to narrative writing for help understanding complex events or states of affairs. While the dividends of clarity and comprehension for the writer in a clinical setting are becoming widely understood today, our hypotheses about *why* writing helps clinicians and

patients offer particular illumination for medicine. Unlike the feeling ascribed to Freud that one writes about an unpleasant experience in order to *rid* oneself of it, we have come to realize that narrative writing in clinical settings makes audible and visible that which otherwise would pass without notice.

In our writing sessions, we invite participants to describe complex clinical situations, in effect taking a chaotic or formless experience and conferring form on it. What emerges as a written text might be a prose paragraph, a poem, a scenic dialogue, an obituary, an encomium, or a love letter (one nurse once wrote a recipe for us), which, when examined closely by readers or listeners, conveys its meaning by both its content and its form. Even unpractised writers find themselves surprised by the discovery process of writing, and often

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the most striking discoveries are made not in *what* is written but in *how* the text is configured. Our students learn to examine their texts’ genres, figurative language, temporal structures, the stance of the narrator, and allusions to other texts—the narrative features that a literary scholar would consider in the study of any written text.

Novelist Henry James and literary scholar Roland Barthes both remind us that “expression” connotes putting sensations and perceptions into words and also the muscular process of delivering the essence of something into view—like expressing juice from a lemon or milk from a nipple.⁵ Hence, the meaning of what gets expressed comes simultaneously from the one writing and the subject of that writing. The representational act requires the expressive force and creativity of the writer along with the contained meaning of that which is now in view, unifying seer and seen in the creation of the text.

When patients or family caregivers write accounts of their illness experiences, readers have an intimate and urgent role to play in response. Neither casual nor coy, these texts are *asking* something of their readers—asking for witness, for presence, for answer. Health advocate Patricia Stanley proposes that the patient simultaneously suffers isolation from loved ones, from his or her healthy body, and from the self. Representing the events of illness offers hope that others can heed the isolated ones and reconnect those people by hearing them out fully.⁶ Whether sick or well, the reader of an illness narrative is summoned by the author to join with the teller—to form community that can combat the isolation of illness.

We see coming into view, then, the high stakes and urgent tasks of narrative writing in clinical settings. Not merely reports against forgetfulness or solipsistic diary-making, these narrative reflections take on the force of both creation and clinical intervention. The writing renders the doctor audible, the patient visible, and the

treatment a healing conversation between them. Until the writing, there are 2 isolated beings—the doctor and the patient—both of whom suffer, and both of whom suffer alone. By virtue of the writing, there is hope for connection, for recognition, for communion.

Affiliation

The movements of attention and representation spiral together toward the ultimate goal of narrative medicine: affiliation. It is *this* that we are after—the authentic and muscular connections between doctor and patient, between nurse and social worker, among children of a dying parent, among citizens trying to choose a just and equitable health care policy. The affiliation extends inward, too, to join doctors or nurses with themselves in a sustained habit of clinical reflection or to allow the suddenly ill patient to recognize the same self who existed before illness came. Instead of lamenting the decline of empathy among medical students or the lack of altruism among physicians, narrative medicine focuses on our capacity to *join* one another as we suffer illness, bear the burdens of our clinical powerlessness, or simply, together, bravely contemplate our mortal limits on earth.

The science undergirding this movement of narrative medicine examines what happens when human beings contemplate pain and suffering. We turn, for one source of clarity, to aesthetics and cinema studies, which illuminate the state of affairs when a witness sees a scene of pain. Literary scholar Maura Spiegel's pioneering work in the narrative permeability of film and dreams reconceptualizes empathy to suggest not only an internal state of virtuous self-negation and other-direction, but also a creative and *active* state of absorption and cocreation of story in which the viewer, too, is permeable to remaking of experience and thought.⁷ We, the viewers, are mobilized in witnessing others' suffering, be it in an intensive care unit or a darkened movie house, not only to comprehend what that suffering might mean to the patient or the subject of the film, but also to witness and comprehend what such suffering might mean or might have meant to ourselves. And so the interpenetration of self and other—the goal of affiliation—is seen within the very seat of the observation.

Such discoveries unite film—and by extension any creative and textual product—with dreams. Psychoanalyst Eric Marcus enriches our narrative medicine theory with his evidence of the thematic struggles toward selfhood undergone repeatedly by hundreds of students and trainees.⁸ By mobilizing psychoanalytic theories of Freud, Winnicott, and Lacan, and bringing them to bear on our work, Marcus deepens the theorizing possible in narrative medicine to probe intrapsychic economies and therapeutic goals of care. Any form of care of the sick shares some aspects of the analytic situation—its transferences, its formal intimacy, and its privileged and dutiful experience of another's inward states. More practically, the

care of the sick requires the analyst's creativity in *inhabiting* without colonizing the lived experience of the one who suffers.

Narrative medicine training is, as a result of Marcus's insights, recognized as a form of analytic supervision, requiring candidates to examine and undergo their own affective experiences and requesting trainers to make sustained commitments to trainees. As a result of Spiegel's insights, we see that such training requires the willingness to creatively "think *with* stories" toward personal and public meaning.⁷

Conclusion

This short review of the conceptual foundations of narrative medicine is offered in a spirit of exploration and as an invitation to think with us about the phenomenon of narration in medicine. As we health care professionals and patients delve into the challenges and rewards of serious storytelling in illness, we see with new clarity deep aspects of the illness, the sick person, the situation of care, and the person who cares for the sick. We see, too, newly opening avenues toward the human affiliations that alone can ease suffering, those bonds that indeed unite us with Divinsky, wherever she now is, and with all who have been and who have suffered. ❁

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Competing interests

None declared

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