

The Whole Story: Narrative as a Clinical Tool

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Even the most comprehensive medical history cannot tell the whole story. Inevitably we have a main character—the patient. We also have a narrator—the provider. Descriptive details are relayed, although often in a rather cryptic narrative style. The tension derives from some aspect of ill health that has become sufficiently disabling so as to require medical attention. Information gained from the vital signs, lab tests, and physical examination may help to zero in on the immediate cause of the problem. A social history may reveal intriguing information about significant relationships and lifestyle factors that could be important both in understanding how the patient became ill in the first place and about mechanisms that may play a role in the healing process. Consider the following:

Mr. Ford, a 61 year old white male, complains of persistent cough and shortness of breath. No evidence of acute infection. Past medical history includes poorly controlled hypertension, gastroesophageal reflux disease. Blood pressure today 150/90. Previous alcoholism, has been sober for 7 years. Smokes 1.5 packs per day since age 20. Advised smoking cessation using nicotine patch.

There is something missing. If Dr. Rachel Remen is correct that “Stories are someone’s experience of the events in their life, they are not the events themselves,” then the above paragraph is more data than narrative. We know something about the physical condition of Mr. Ford’s body, and we can infer much about his lifestyle. Few would dispute his physician’s interpretation of the data. Chronic smokers often experience the kind of symptoms described above. But we know nothing about Mr. Ford’s experience, his story. We do not know whether he attributes his cough and shortness of breath to smoking. Has he tried to quit in the past? Does he want to quit now? In behavioral medicine, what

Mr. Ford wants matters; his beliefs and desires are as important in determining his final health outcomes as any amount of medical data.

Many professions require the ability to fix something when it breaks. When my water pipes rupture, I call a plumber. When my computer catches a virus, I call an IT specialist. If I start having migraines, I call my doctor. What sets medicine apart from these other professions in the repair business? Only patients can tell stories. The water pipe cannot describe the constant wear and tear, the increasing pressure, the erosion that eventually culminates in a small explosion. The computer cannot recall possible sources of exposure nor describe the course of the illness. While the water pipe and the computer are entirely incapable of contributing to their own healing, most patients present with some ability to tell the story of their sickness.

I would argue that this unique capacity for patients to share the way in which they experience illness is a defining characteristic in the practice of medicine. Consider the opposite—practicing medicine in the absence of story. Ann Fadiman, in her book *The Spirit Catches You and You Fall Down*,² writes about the challenges associated with providing medical care for Hmong refugees in Merced, California in the 1980s. Both patients and providers experienced frustration when language barriers and cultural differences made it almost

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impossible to communicate story and interpretation. When asked about his strategy for treating Hmong patients who did not speak English, one physician likened his approach to practicing veterinary medicine. This comparison is both provocative and compelling. Without story, something about what makes the medical encounter uniquely human is missing.

Recognizing the life story behind every medical history is a moral obligation that also has tremendous practical value. The human potential to participate in the process of care suggests that patients can act in ways that facilitate or hinder certain health outcomes. In this era of chronic disease, primary care physicians spend untold hours making recommendations for behavior change that often seem to fall on deaf ears. The physician's assessment of a health problem and recommendation for appropriate treatment may be absolutely correct and in accord with clinical practice guidelines. But in medicine, technical accuracy does not guarantee a good outcome. If the patient does not agree with the physician's interpretation of the condition, it is unlikely that he or she will comply with recommended treatment. We can diagnose Mr. Ford's nicotine dependence based upon his medical history, but we cannot help him quit without knowing his story.

Patient stories often challenge our assumptions about the causes of suffering and the best ways to alleviate it. This is

especially true when working in a cross-cultural context. In her book, Fadiman describes the attempts made by American clinicians to provide high quality Western medical treatment for epilepsy to the child of a Hmong family who believed their daughter Lia suffered from a spirit that caught her and made her fall down. The fundamental tension lay in the fact that the doctors wanted to treat Lia physically for what the Lee family viewed primarily as a spiritual concern. The stakes were as high as the chasm was wide. In the end, the best attempts to treat Lia medically left her in a persistent vegetative state and both her providers and her family grief-stricken and demoralized. Might a little more story have helped to bridge the gap?

We cannot expect to reach different places via the same path, so we might as well reconnoiter at the outset. The patient story informs the route and determines the final destination; it orients us to potential roadblocks and suggests maneuvers to overcome them. If we think that medical care can succeed apart from a shared understanding of the problem and the solution, we are fooling ourselves. Understanding the patient's perspective does not guarantee agreement between patient and physician about what is wrong or what to do about it. But at least it opens the door for real dialogue, ultimately making healing and wholeness possible. **NCMJ**

REFERENCES

- 1 Remen RN. *Kitchen Table Wisdom: Stories that Heal*. New York, NY: Riverhead Books; 1996.
- 2 Fadiman A. *The Spirit Catches You and You Fall Down: A Hmong Child, Her American Doctors, and the Collision of Two Cultures*. New York, NY: Farrar, Straus and Giroux; 1997.