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Foreword

Inspiration and Instruction from Narrative Medicine Role Models

Patients have two stories to tell their physicians, one of facts and one of truths. Although facts and truths are equally important, some physicians choose to concentrate on listening to just the facts. This book presents the careers of clinical pioneers who choose to listen to both stories that patients tell. These practitioners provide inspiration and instruction as they explain how they listen for two stories. First, they concentrate on the story told by the patient's body in the language of signs and symptoms – the body never lies as it speaks of disease and pain. Clinicians *listen to* the facts portrayed as the patient performs the story of disease and then they summarize that story in a diagnosis. Second, they *listen for* the story of illness to understand the truths that shape the patient's psychological experience of biological disease.

The pioneering clinicians in this book maintain the importance of biotechnical competence in listening to stories of disease, but they add psychosocial sensitivity to the patient encounter in listening for narratives of illness. They appeal to their colleagues to join them in taking a balanced approach to curing and caring. For example, Coulehan urges that illness narratives not be discounted as *just psychosocial medicine.* Understanding illness actually helps physicians to make more accurate disease diagnoses and to formulate better treatment plans. For Coulehan and the other pioneers in this volume, the process of medicine comes to life in narratives.

These practitioners narrate their own stories to describe and demonstrate the importance of hearing the narratives of illness and suffering told by patients and to use this to impose meaning on their experiences of disease and pain. Given the interest that these practitioners have in stories and given their sensitivity to words, I was surprised that no one explicitly distinguished disease, illness, and sickness. Disease is a malfunctioning of biological processes; illness is how the patient perceives and interprets disease (this meaning-making is socially

constructed by cultural forces); sickness is the way of acting ill in the patient's social world. Obviously, how the patient manages sickness will be influenced by clinical intervention into an illness narrative or by the meaning that the patient places on disease. This opportunity to influence outcomes explains why the practitioners in this book care so much about patients' stories of illness. Together, the career stories of these clinical pioneers make the case for the centrality of illness narratives in the contemporary practice of medicine.

As a beginning, Brody instructs readers that a healing person must concentrate on more than just curing disease. Healers use narratives to liberate a patient's capacity for self-healing. Brody helps patients to tell their stories of illness in a form that enables them to gain a sense of control of, and maybe even mastery over, disease. A transformed illness narrative can reduce suffering and reshape sickness. Connelly asserts that clinicians begin to help patients transform their illness narratives simply by showing up. Clinicians can only support patients in their illness if they have met the illness. DasGupta adds the idea that transformation accelerates when the clinician serves as a witness who validates the story of suffering. Davis asserts that clinicians may do even more than validate a story; they may stay with the story as the patient takes the journey.

Buckley explains that illness stories contextualize the disease and locate it in the social space of a life in progress. Recall that the prefix *con* is from the Latin *cum*, meaning *with*, so con-text adds that which surrounds the patient's text or story. Buckley reminds readers that it is important for patients to have an opportunity to tell their whole story, especially those with chronic disease. Listening for the entire narrative helps physicians to identify what is most important to the patient. Through an illness narrative, patients educate physicians about what they need and how they want it delivered. Connelly explains that physicians may use the narrative to understand how best to manage the patient-physician relationship as an instrument of healing. Writing from personal experience, Connelly explains that relationship-centered medicine must attend to how much of oneself clinicians should put into a relationship, when they should do so, and for how long.

The novelist Eudora Welty* distinguished *listening to* a story from *listening for* a story. Listening to a story of disease means absorbing it by being receptive. Listening for a story of illness means actively discerning it and collaboratively shaping it. Charon moves readers to the topic of listening for a story by discussing narrative competence. She emphasizes the importance of identifying the

* Welty E. *One Writer's Beginnings*. Cambridge, MA: Harvard University Press; 1983.

narrative thread that runs through a story and then adopting the governing images and master motives to communicate with the patient. This discernment requires competence in listening for key metaphors and thematic ideas. Narrative competence enables clinicians to better understand the process by which a patient lives with disease, experiences illness, and acts sick.

Launer addresses the process of medicine by explicitly adopting a social constructionist perspective from which the primary goal of narrative medicine is to help people make sense of what is happening to them. He encourages clinicians to let the patient do what the patient needs to do. He helps patients explore their stories and create new meanings, whether they involve biomedical facts or biographical truths. Patients are never the sole authors of their illness narratives; the stories are co-constructed through the patient-physician interaction. Practitioners of narrative and relationship-centered medicine position the patient as collaborator and coinvestigator, sometimes preferring the metaphor of patient as author and physician as editor, while always realizing that only the patient has the power to authorize the story. To foster the healing power of collaboration, physicians must be willing participants in dialogues that help patients understand their own experiences of disease. Greenhalgh illustrates how revising illness narratives through dialogue, not a monologue, can create a new sense of self and a more adaptive, better way of acting sick.

When physicians engage patients in dialogues that co-construct meaning, these engagements do more than *something for* the patient; they do *something to* the clinician. Throughout the book, readers will learn what a narrative-centered approach to medical practice may do for the clinician as a professional and as a person. Each contributor to this volume has used their own narratives to articulate the preoccupations and thematic issues that direct their lives and shape the meaning of their medical practice. For example, Litzelman quotes her mentor, Dr Joe Mamlin, to illustrate the outcome of attending to and narrating her own story: "I have tried as hard as I can to anchor myself in clarity of what my ultimate concern is. And . . . the answer to that question is love. Period."

Each clinical pioneer in this book bravely reveals the ultimate concerns around which they have designed their lives and constructed careers in medicine. As the editors note, readers can follow each pioneer's footprints along a career path. Although the editors assembled a diverse panel of practitioners who articulate a wide variety of personal preoccupations and life themes, I did notice a striking commonality in the first footprints of their childhood and adolescent career interests: for most of them it was teaching, psychology,

philosophy, or writing. This tells me that their original interest or first calling remains alive in the way they practice medicine. Narrative and relationship-centered medicine enables them to sustain their original interest in the humanities. Each practitioner explains how they have integrated a core self and early interest into the way they interact with patients. In addition to early interests, readers may benefit from considering the lingering power of role models in the lives of the practitioners. Readers may also turn this attention inward to consider the models and mentors they have incorporated into the design of their own lives.

The editors have made an important contribution to advancing the practice of narrative and relationship-centered medicine. The book they have crafted provides information about the core principles and procedures of narrative medicine. If readers apply this information to their own practices, then the book will be a success. However, the editors invite readers to engage in something more. They invite you to listen for the truths of your own story as you hear the voices of colleagues speak from the pages in your hands. Please engage in a dialogue with these pioneers who divulge their own stories so that you may co-construct with them deeper meanings for your professional life and, more important, for your personal life. As your own story becomes more coherent, comprehensive, and credible, you will be positioned even more securely to create a safe space in which you may work with patients to transform their stories of illness. Reflecting on the ultimate concerns that move you will enable you to more fully inhabit your own life story and become more authentic and vital as you heal others.

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