I THE SOURCES OF NARRATIVE MEDICINE

Medicine has grown significantly in its ability to diagnose and treat biological disease. Doctors can be proud of their ability to eradicate once fatal infections, prevent heart attacks, cure childhood leukemias, and transplant failing organs. But despite such impressive technical progress, doctors often lack the human capacities to recognize the plights of their patients, to extend empathy toward those who suffer, and to join honestly and courageously with patients in their struggles toward recovery, with chronic illness, or in facing death. Patients lament that their doctors don't listen to them or that they seem indifferent to their suffering. Fidelity and constancy seem to have become casualties of the cost-conscious bureaucratic marketplace. Instead of being accompanied through the uncertainties and indignities of illness by a trusted guide who knows them, patients find that they are referred from one specialist and one procedure to another, perhaps receiving technically adequate care but being abandoned with the consequences and the dread of illness.[1]

A scientifically competent medicine alone cannot help a patient grapple with the loss of health and find meaning in illness and dying. Along with their growing scientific expertise, doctors need the expertise to listen to their patients, to understand as best they can the ordeals of illness, to honor the meanings of their patients' narratives of illness, and to be moved by what they behold so that they can act on their patients' behalf. Nurses and social workers have mastered these skills more fully than have physicians, but all can join in strengthening these capacities in health care.

Doctors, nurses, and social workers began turning for help in these areas to people who know about narratives, which can be defined as stories with a teller, a listener, a time course, a plot, and a point. Teachers of literature, novelists, storytellers, and patients who have written about their illnesses have become collaborators at our medical centers in teaching health professionals the skills needed to listen to narratives of illness, to understand what they mean, to attain rich and accurate interpretations of these stories, and to grasp the plights of patients in all their complexity.[2] These are narrative skills, for they enable one person to receive and understand the stories told by another. Only when the doctor understands to some extent what his or her patient goes through can medical

care proceed with humility, trustworthiness, and respect. I use the term *narrative medicine* to mean medicine practiced with these narrative skills of recognizing, absorbing, interpreting, and being moved by the stories of illness. As a new frame for health care, narrative medicine offers the hope that our health care system, now broken in many ways, can become more effective than it has been in treating disease by recognizing and respecting those afflicted with it and in nourishing those who care for the sick.

Years ago when I was just out of internal medicine residency training, I would sit in a little clinic room in Presbyterian Hospital, getting to know relative strangers who were to become my patients for more than 20 years. Most were poor, sick, elderly women of color—from the Dominican Republic, Puerto Rico, Central America, and the American South—who now lived in Manhattan's Washington Heights or Harlem. I realized slowly that my task as an internist was to develop the skills required to absorb my patients' multiple, often contradictory, stories of illness. I came to understand that what my patients paid me to do was to listen expertly and attentively to extraordinarily complicated narratives—told in words, gestures, silences, tracings, images, laboratory test results, and changes in the body—and to cohere all these stories into something that made provisional sense, enough sense, that is, on which to act. These narratives had many tellers—the patient herself or himself, as well as family members, friends, nurses in the emergency room, interns dictating hospital discharge summaries, social workers, therapists, and all the other doctors who wrote in the medical chart. What I was listening for and reading for were diagnostic clues to help identify a biological or emotional source of the patient's symptoms, autobiographical background to help me understand who it was who bore these symptoms, and grounds for personal connections between the two of us sitting in that little room.

In order to do all these things at once, I had to do what all doctors—ideally—do, whether they realize it or not. I had to follow the patient's narrative thread, identify the metaphors or images used in the telling, tolerate ambiguity and uncertainty as the story unfolded, identify the unspoken subtexts, and hear one story in light of others told by this teller. Like the reader of a novel or the witness of a drama—who naturally do all these things seamlessly—I also had to be aware of my own response to what I heard, allowing myself to be personally moved to action on behalf of the patient. I was the interpreter of these accounts of events of illness that are, by definition, unruly and elusive. I saw that, while I had very demanding "listening" tasks, the patient's "telling" tasks were even more demanding, because pain, suffering, worry, anguish, and the sense of something not being right are conditions very difficult, if not impossible, to put into words.

Around that time, the movement called "literature-and-medicine" was just starting to grow, and I was fortunate to be included in a National Endowment in the Humanities Seminar on Literature and Clinical Imagination in 1982. Joanne Trautmann Banks, editor of Virginia Woolf's letters and the first literary critic to be appointed to a medical school faculty, directed a monthlong intensive training program in literary theory, texts, and methods salient to medicine. Part of

the training was encouragement to write, in ordinary narrative prose, about our clinical practice. I chose to write about a patient I had just seen the week before the seminar started, because I was unhappy about how I had behaved toward her and it nagged at me that I had acted brusquely and dismissively without knowing her situation. So I wrote a story about this incident, filling in with fiction the gaps there were in fact.

I was picking up some papers from my office, in a hurry, and was stopped by a young woman patient who had dropped in to ask me to sign a disability form for her. I had seen her a couple of times in the office for the evaluation of headaches, headaches that I had not considered terribly worrisome and for which I had prescribed acetaminophen. I remember being irritated, not only that she thought she deserved disability on such slim clinical grounds but that she would appear, without an appointment, and expect me to make time to fill out the form. But I was late for a meeting and did not have the time to inquire about the situation, so, without even putting down the stack of papers in my arms, I quickly scrawled a diagnosis and signed the form, no doubt conveying my displeasure at the patient's request.

In my story, the patient—I called her Luz—had a chance at achieving her dream of becoming a fashion model. Her aunt in Manhattan had met a contact at a big agency and urged Luz to move in with her from Yonkers while preparing for auditions. The disability payments, in my story, would give Luz a needed income while she got a portfolio together and tried to make her dream come true. I wrote the story from Luz's point of view, and the story ends with Luz musing about how hurried her doctor was and how scornful she seemed to be.

When I next saw the patient in the office soon after the seminar concluded, I had been thinking about her a great deal and trying to inhabit her point of view. I had tried, in my imagination, to make sense of her unexplained behavior while realizing what my own behavior must have connoted. And so I asked her with great interest and regard about the situation, apologizing for having brushed her off so quickly the last time.

The stakes were much, much higher in fact than in my imagined fiction. Indeed, Luz *did* need the disability payments to tide her over for an emergency move to Manhattan. But it was not in search of a career in fashion. Luz was the oldest of five daughters, all of whom were being tormented by their father and uncle in their crowded apartment in Yonkers. My patient had been sexually abused since she was twelve, and now she refused to stand by and allow the same thing to happen to her younger sisters. She felt, at age twenty-one, that she could set up a safe house in Manhattan to protect herself and her sisters.

Once I learned all this, the social worker in the domestic violence project and I introduced Luz and her sisters to emergency shelters and support groups and gave them needed resources in facing the violence in her family. They did move to Manhattan, taking their mother, too, away from the abusive male relatives. Over the years, I have taken care of three of the five sisters and their mother. When the father became terminally ill, the women in the family asked me to be his internist too.

Luz taught me about the power of the clinical imagination. Although I did

not know what had preceded her visit that day, I had wordlessly registered her urgency and need to leave home. Until my impressions were expressed in language, I did not know what, in fact, I *knew* about the patient. My hypothesis about the modeling career was all wrong—in my story, Luz was running *toward* something, when, in fact, she was running *away*—and yet my acts of guessing at the patient's situation and trying, imaginatively, to make sense of her behavior had some profound dividends. The hypothesis acted like a prosthetic device or a tool with which to get to the truth, like a crowbar or a periscope will enable you to see under a rock or over a wall. Also, this narrative act helped me to get closer to the patient. My writing exercise *invested* me in learning of her true plight instead of blaming her or suspecting her of malingering. The effort, required by my storytelling, to reach for and visualize Luz's point of view helped me take care of the patient by bringing me to her side, seeking to understand her behavior, taking seriously her situation, and gaining access to the unsaid knowledge I had already developed of her strengths and desire.

In the ensuing years, I have come to realize that these narrative skills are deployed not only in the encounter between an individual patient and doctor but throughout the enterprise of medical practice: teaching, doing research, understanding and diagnosing disease, reflecting on one's life in medicine, interacting with professional colleagues, and fulfilling the public responsibilities of medicine.

THE NARRATIVE ROAD TO EFFECTIVE MEDICINE

Health professionals and patients are at a crossroads. Together, we have to discover means of sustaining the tremendous capabilities of our biomedical sciences while trying to ease the suffering and loss occasioned by serious illness. The price for a technologically sophisticated medicine seems to be impersonal, calculating treatment from revolving sets of specialists who, because they are consumed with the scientific elements in health care, seem divided from the ordinary human experiences that surround pain, suffering, and dying. Whether to protect themselves from the sadness of taking care of very sick people or to guarantee the objectivity of their clinical judgment, doctors seem to operate at a remove from the immediacy of sick and dying patients, divided from sick people by deep differences in how they conceptualize illness, what they think causes it, how they choose to treat it, and how they respond emotionally to its presence. Patients long for doctors who comprehend what they go through and who, as a result, stay the course with them through their illnesses. A medicine practiced without a genuine and obligating awareness of what patients go through may fulfill its technical goals, but it is an empty medicine, or, at best, half a medicine.[3]

Although they may not show it, doctors, too, long for a medicine different from the current fragmented bureaucracy that health care has become. Everywhere—in high-powered academic medical centers, in small-town hospitals, and in rural communities—clinicians seek out means by which to reflect on their practice, to talk to one another seriously and intimately about their lives around

sickness, and to grasp with as much accuracy and emotional clarity as they can what their patients undergo in serious illness.[4] On my many visits to distant medical centers, doctors, nurses, and social workers attend workshops where they can write about their lives with patients, ruminate together about their feelings and failures, and review with joy their triumphs. What the participants in my workshops understand urgently (although perhaps preverbally) is that the self is the caregiver's most powerful therapeutic instrument and that effective health care professionals have to find means toward self-knowledge, forgiving self-criticism, and inner nourishment.[5]

Doctors with long lives in medicine behind them know what has been disrupted by the recent economically driven changes. They join primary care physicians and proponents of patient-centered health care in their belief that doctors should grow with their patients, getting to know their bodies and their lives through decades.[6] They know how the knowledge doctors accrue about their patients' families, fears, and hopes and the trust they earn through dutiful attention are critical to their providing their patients with effective health care.[7] Not only the personal dimensions of disease but its biological dimensions become clear only over time: to understand what disease a patient might have requires schooled longitudinal curiosity about that person's state of health. Sicknesses declare themselves over time, not in one visit to the consultant. The doctor who has accompanied a patient over a prolonged period of time will have the bank of biological knowledge about that individual necessary for timely and accurate diagnostic vision along with the muscular therapeutic alliance necessary to engage the patient in effective care.[8]

If doctors seem divided from their patients and from themselves, they also seem divided from their students, from one another, from other health professionals, and from the society they are meant to serve. The personal mentorship and role modeling that was once the hallmark of medical education have been eroded by time and money pressures. The competitive—and deficit—environment of most teaching hospitals leaves little room for the dutiful raising of young professionals or the nurturing of those in full career.[9] Instead of committing themselves to the professional development of their members, professional medical organizations more often indulge in legislative lobbying or market positioning. Turf battles threaten to undermine respectful alliances with nurses, physician assistants, social workers, therapists, and psychologists, leaving many health professionals feeling isolated, distrusted, and struggling against one another instead of working together on behalf of the patient. The threat of malpractice litigation leaves doctors feeling they must practice a rigid, suspicious medicine. And, as medicine has had to round up on itself defensively, it is less equipped to initiate honest and consequential dialogue with the public about such grave issues as equity in health care, the limits of medical power, and the ideals of health care envisioned—and invested in—by this country.

Medical schools, residency training programs, and professional societies have, in the past two or three decades, responded to the need to humanize medicine. In addition to equipping students and doctors with sophisticated technical knowledge and skills, medical educators are working hard to enable physicians

to practice with empathy, trustworthiness, and sensitivity toward individual patients. Such developments as biopsychosocial medicine, primary care medicine, bioethics, and professionalism in medicine have arisen since the 1960s to widen doctors' narrow focus on biological disease and to encourage them to take stock of patients' emotional, social, and familial needs.[10] These movements have led to several major advances: training in communication skills in medical schools, research and teaching in the social and emotional dimensions of health and illness, awareness of ethical aspects of health care, and attention to doctors' own well-being and personal awareness.[11]

Until recently, however, these efforts have not had much impact, because no one knew very well how to describe the traits lacking in medicine nor how to teach them. Most agree that medical schools and training programs cannot train adults to be empathetic, respectful, altruistic, and ethically responsible, for such traits are developed and nurtured from infancy onward. Indeed, it is charged that doctors' innate empathy, respect for the suffering of others, and ethical discernment *diminish* in the course of medical training and that doctors become hardened against the suffering they witness through their education.[12] How, then, are we to advance beyond the uncomfortable state of knowing what the matter is but being unable to fix it?

Even if medical educators cannot require a student to respond to a patient's suffering with compassion, they might be able to equip students with compassion's *prerequisites:* the ability to perceive the suffering, to bring interpretive rigor to what they perceive, to handle the inevitable oscillations between identification and detachment, to see events of illness from multiple points of view, to envision the ramifications of illness, and to be moved by it to action. Those who espouse professionalism have learned already that, however highly medicine might prize altruism and accountability, doctors cannot be forced to practice with these traits unless they are helped to develop the antecedent skills required to reflect on their work, to recognize the duties incurred on them by virtue of being doctors, to feel rewarded by the humble intimacy afforded by trustworthy medicine, and to unite with their colleagues in swearing to uphold medicine's ideals. And, however urgent seems the national need for frank discourse and consensual decisions about our health care system, one cannot expect doctors and other health professionals to take the lead in opening the complex and risky discussions that must take place without providing them with the skills of respecting multiple perspectives, hearing and mediating competing voices, and recognizing and paying heed to a multitude of contradictory sources of authority.

To provide to medicine what it lacks today, we have to conceptualize the problems in terms global enough to envision the whole and practical enough to suggest workable solutions. I think it helps us to see that many of the failures of contemporary medicine are concentrically widening consequences of the same set of fundamental problems. Whether enacted in the situation between an individual doctor and patient, within the doctor himself or herself, among medical and nonmedical colleagues in the health professions, or in dialogue with the larger society, medical practitioners often seem isolated from authentic engagement, unused to recognizing others' perspectives and thereby unable to develop

empathy, and at a loss to understand or to honor the meanings of all that they witness.

To know what patients endure at the hands of illness and therefore to be of clinical help requires that doctors *enter* the worlds of their patients, if only imaginatively, and to see and interpret these worlds from the patients' point of view. To reach accurate diagnoses calls for the kind of lived-in, tacit knowledge of disease and health available only through immersion in the natural history of diseases and scrutiny of the changes in individual patients' bodies over long periods of time. To take stock of the costs and rewards of a life lived around sick and dying people entails reflection and self-examination, while to make oneself available to patients as a therapeutic instrument demands risky self-knowledge and personal awareness. To fulfill one's duties toward colleagues and students, to admit mistakes and to lessen the chance of their occurrence, and to commit oneself to medicine's ideals flows from one's fidelity to an affirming yet disciplined (and potentially disciplinary) professional community. And to bring about meaningful decisions with the public regarding matters of health requires the sophisticated communication powers to open fear-laden discussions without triggering defensive anger and to illuminate, despite multiple clashing perspectives, common goals and shared desires.

To accomplish all these goals—empathic and effective care of individual patients, candid reflection, professional idealism, and responsible societal discourse about health policy—requires a unified set of skills. To do all these things requires what psychologists and literary scholars call narrative knowledge, that is, the kind of knowledge that Luz taught me years ago. If narratives are stories that have a teller, a listener, a time course, a plot, and a point, then narrative knowledge is what we naturally use to make sense of them. Narrative knowledge provides one person with a rich, resonant grasp of another person's situation as it unfolds in time, whether in such texts as novels, newspaper stories, movies, and scripture or in such life settings as courtrooms, battlefields, marriages, and illnesses. As the literary critic R. W. B. Lewis writes, "Narrative deals with experiences, not with propositions."[13] Unlike scientific knowledge or epidemiological knowledge, which tries to discover things about the natural world that are universally true or at least appear true to any observer, narrative knowledge enables one individual to understand particular events befalling another individual not as an instance of something that is universally true but as a singular and meaningful situation. Nonnarrative knowledge attempts to illuminate the universal by transcending the particular; narrative knowledge, by looking closely at individual human beings grappling with the conditions of life, attempts to illuminate the universals of the human condition by revealing the particular.[14]

Medicine can benefit from learning that which literary scholars and psychologists and anthropologists and storytellers have known for some time—that is, what narratives are, how they are built, how they convey their knowledge about the world, what happens when stories are told and listened to, how narratives organize life, and how they let those who live life recognize what it means. Using narrative knowledge enables a person understand the plight of another by participating in his or her story with complex skills of imagination, interpreta-

tion, and recognition. With such knowledge, we enter others' narrative worlds and accept them—at least provisionally—as true. Our genuine curiosity and commitment toward the truth enable us to peer through the twilight of another's story as we try to see the whole picture and as we reflect on what it might mean. We recognize what parts we play in one another's lives and how entailed we are in our shared creation of meaning. We get to know ourselves as a result of the vision of others, and we are able to donate ourselves as instruments of others' learning.[15]

This form of knowing about the world that makes sense of the told predicaments of others—risky, demanding, self-defining, horizon-opening—seems to be at least part of what medicine today is lacking. Narrative medicine—or medicine practiced with narrative competence—is at once attuned to the individual patient, replenishing for the individual professional, dutiful in generating and imparting medicine's knowledge, and cognizant of the responsibilities incurred by the public trust in medicine.[16] Narrative medicine can help answer many of the urgent charges against medical practice and training—its impersonality, its fragmentation, its coldness, its self-interestedness, its lack of social conscience.

Narrative medicine not only describes an ideal of health care but also provides practical methods to develop the skills needed to reach that ideal. Narrative medicine recognizes that some of the skills currently missing from medicine are, in fact, narrative skills, that we know what narrative skills are, and that we know how to teach them. Literature departments, creative writing courses, anthropology and ethnography departments, and psychotherapy training programs, among many others, have developed well-tested methods of teaching students how to read, write, and interpret texts; how to systematically adopt others' points of view; how to recognize and honor the particular along with the universal; how to identify the meaning of individuals' words, silences, and behaviors; how, as a reader or a listener, to enter authentic relation with a writer or a teller or a text; and how to bring one's own thoughts and sensations to achieving the status of language. We know how to educate students in these skills. We just have not been doing it in medical schools or nursing schools. By recognizing these skills as fundamentally narrative competencies, medicine is beginning to know how to provide them.

How Narrative Competence Enters Medicine

An 85-year-old woman with bad asthma comes in to see me. I've know her for almost 20 years. We have managed to decrease her hospitalizations and emergency room visits dramatically over the years, and so she is grateful and I am proud. Today she sits and weeps. I know that her 28-year-old grandson just last week drowned in the ocean off Miami. I know that her son, this dead man's father, was shot to death on the streets of Harlem at the age of 36. She sits next to me and she weeps. Her English and my Spanish enable us to reach one another. Her pain is unbearable. Suffering again the loss of her son by virtue of the loss of her

grandson, she is overwhelmed by her grief. Yes, she prays to a God she still feels near; yes, she is comforted by the presence of her daughter; yes, she allows herself to talk about her two lost men. She knows that time will heal her pain, and she knows to wait. I weep with her, unable to fathom her agony but able to honor her bereft state. I listen as she tells of her anguish, knowing that her telling of it is therapeutic. I will see her next week, and the week after that, not to fix anything but simply to watch with her, to listen to her, to behold, in awe, her faith and power and love.

Medicine is joining other disciplines such as anthropology, history, psychology, social science, law, and even mathematics in recognizing the elemental and irreplaceable nature of narrative knowledge.[17] A narrative shift has taken place across these many fields of human learning, challenging scholars and practitioners from religious studies to psychoanalysis to police work to concentrate on not just the facts but the situations in which these facts are told.[18] Although narrative is defined somewhat differently by literary scholars, psychologists, autobiographers, and historians, each of these narrative-users shares fundamental ideas—that narrative knowledge and practice are what human beings use to communicate to one another about events or states of affairs and are, as such, a major source of both identity and community. The narrativist turn that has overtaken many fields exposes the centrality of storytelling in many human activities from teaching kindergarten to enacting religious faith. Telling stories, listening to them, being moved by them to act are recognized to be at the heart of many of our efforts to find, make, and honor meaning in our lives and the lives of others.

Narrative is a magnet and a bridge, attracting and uniting diverse fields of human learning. The Ozark storyteller knows something that helps the lawyer in the courtroom. The police officer interviewing the crime victim adopts methods developed by the anthropologist in the field. The richness and exhilaration of narrative studies today, whether in the social sciences or in journalism or in a class on Henry James, arise from our recognition of our common concerns and shared goals. In an age of specialization and fragmentation, how satisfying to discover the deep, nourishing bonds that hold us together—storytellers all, bearing witness to one another's ordeals, celebrating our common heritage as listeners around the campfire, creating our identities in the stories we tell.

As an enterprise in which one human being extends help to and shares knowledge with another, medicine has never been without narrative concerns. Like narrative acts, clinical practice requires the engagement of one person with another person and realizes that authentic engagement is transformative for all participants. Narrative competence permits caregivers to fathom what their patients go through, to attain that illuminated grasp of another's experience that provides them with diagnostic accuracy and therapeutic direction. And, as has more recently come into view, this same narrative competence increases the power of all health professionals to come to grips, through reflection, with what being a caregiver means in their own lives and the lives of their families. It makes them all better teachers, better researchers, better colleagues with all other health professionals. It equips them to more effectively enter serious con-

versations with the public about the choices medicine forces upon us and gives us the privilege to consider those choices.

By no means a replacement for scientific competence, narrative competence allows all that a professional knows to be placed at the service—now—of this patient who suffers from asthma and grief. It allows the doctor or nurse or social worker to provide care that strengthens and does not belittle, care that deepens and does not blunt the patient's search for meaning in the face of illness. Most important, medicine practiced with narrative competence can bridge some of the divides between the sick and the well, enabling all to recognize their common journey. Using narrative competence, caregivers can do what anyone who witnesses suffering does—in a family, among friends, in the news, on the stage, in fiction, on the street, in the hospital—one knows, one feels, one responds, and one *joins with* the one who suffers.[19] It is as if the heads of the teller and listener are bowed over the suffering that happened in the attempt to interpret and understand it.

A young man came in to see me, referred by his wife who had been my patient for some time. She said that he had been enduring bothersome symptoms for years but had not wanted to subject himself to a medical evaluation. The patient, a muscular man of serious demeanor and stiff carriage, described severe abdominal pain, terrible difficulty with digestion, and bowel symptoms that interfered dramatically with his work performance and his leisure time. I wondered at his stoic acceptance of these intrusive symptoms for many years, and I noticed the pressure with which he held himself in during our conversation.

It was then time for the physical examination. Instead of changing into the cotton gown as I had asked him to, my patient stood hunched over the stainless steel sink near the examining table, fists clenched, head bowed, his back to me, motionless. I knew not what was happening, but I knew not to move. I sat at my desk, quarter-turned away from him, gaze slanted down, arrested by the force field of his stillness. We were part of a tableau, wordlessly enacting what, it came to me, must be an old truth.

When he spoke, it was to say, "It's because of what happened the last time I was at the hospital." And so I knew to use great caution, slowness, and gentleness in touching him, so that performing the physical examination could be not an assault but an effort to help.

To call this medicine narrative medicine brings to health professionals and patients critical knowledge and practice from many other fields of human learning and actions. What Luz and I did in marshaling the clinical imagination forms a part of what has become an international movement toward incorporating narrative studies into medical education and practice. By now, medicine is beginning to acknowledge the requirement for narrative knowledge and skills in the care of the sick. In the same way that medicine can do more today by virtue of all that it has learned from the scientific disciplines, medicine can do more today by virtue of all that has been learned from the narrative disciplines.

Narrative medicine has come to understand that patients and caregivers enter whole—with their bodies, lives, families, beliefs, values, histories, hopes for the future—into sickness and healing, and their efforts to get better or to help oth-

ers get better cannot be fragmented away from the deepest parts of their lives. In part, this wholeness is reflected in—if not produced by—the simple and complicated stories they tell to one another, whether in medical interviews, late-night emergency telephone calls, or the wordless rituals of the physical exam. Without narrative acts, the patient cannot convey to anyone else what he or she is going through. More radically and perhaps equally true, without narrative acts, the patient cannot himself or herself grasp what the events of illness mean. And without telling about or writing about the care of a patient in a complex narrative form, the caregiver might not *see* the patient's illness in its full, textured, emotionally powerful, consequential narrative form. It remains to be proven—although it appears a most compelling hypothesis—that such narrative vision is required in order to offer compassionate and effective care to the sick.

Not so much a new specialty as a new frame for clinical work, narrative medicine gives doctors, nurses, and social workers the skills, traditions, and texts to provide nuanced, respectful, and singularly fitting clinical care to the sick while also achieving genuine contact with their own and their colleagues' hopes and ideals as health professionals. As a result, the health care they practice is focused on the fully envisioned plight of each patient, of each caregiver, of each institution of health care, and of the whole society that suffers and that tries to heal.

NOTES

1. See Norman Cousins, *Anatomy of an Illness as Perceived by the Patient;* Anatole Broyard, *Intoxicated by My Illness;* Anne Fadiman, *The Spirit Catches You and You Fall Down;* and Simone de Beauvoir, *A Very Easy Death* for clear statements, by patients, families, and their allies, of the health care system's failures to care.

2. Joanne Trautmann, *Healing Arts in Dialogue,* and Delese Wear, Martin Kohn, Susan Stocker, eds., *Literature and Medicine: A Claim for a Discipline* document the beginnings of these practices.

3. Many of the pathographies written by patients or their families about their illnesses document these problems. See William Styron, *Darkness Visible;* Reynolds Price, *A Whole New Life;* or Nancy Mairs, *Waist-high in the World: A Life among the Nondisabled.* Health professionals, too, are deeply troubled by the emptiness of contemporary medicine. See Melvin Konner, *Medicine at the Crossroads;* Arthur Kleinman, *The Illness Narratives;* Rachel Remen, *Kitchen Table Wisdom;* and Bernard Lown, *The Lost Art of Healing.*

4. See the regular features entitled "A Piece of My Mind" in the *Journal of the American Medical Association,* "On Doctoring" in the *Annals of Internal Medicine,* or "Narrative Matters" in *Health Affairs* for examples of reflective writing, published in professional medical journals, that testify to doctors' growing desire and need to tell of their lives in medicine and to struggle to understand what their patients go through.

5. The British psychoanalyst Michael Balint made the observation that the self is the most powerful therapeutic instrument in his 1957 book, *The Doctor, His Patient, and the Illness.* Dennis Novack et al., "Calibrating the Physician: Personal Awareness and Effective Patient Care," survey and summarize recent work done in the field of reflection in health care. Diane Meier and Anthony Beck apply these concerns to individual clinical decision-making in "The Inner Life of Physicians and the Care of the Seriously Ill."

6. See Christine Laine and Frank Davidoff, "Patient-Centered Medicine: A Profes-

sional Evolution"; William Branch, *Office Practice of Medicine;* Thomas Delbanco, "Enriching the Doctor-Patient Relationship by Inviting the Patient's Perspective"; Eric Cassell, *Doctoring: The Nature of Primary Care Medicine;* and Laurence Savett, *The Human Side of Medicine,* 163–71.

7. Recent examples include William T. Close, *A Doctor's Life;* Jerome Groopman, *The Measure of Our Days;* and John Stone, *In the Country of Hearts.* See review of evidence-based studies of the consequences of continuity of care in Richelle Koopman et al., "Continuity of Care and Recognition of Diabetes, Hypertension, and Hypercholesterolemia." I thank Peter Watkins for helping me to understand this fundamental point.

8. I thank Peter Watkins for helping me to understand this fundamental point.

9. Kenneth Ludmerer, *Time to Heal.*

10. George Engel, "The Need for a New Medical Model: A Challenge for Biomedicine"; John Stoeckle, ed., *Encounters between Patients and Doctors;* Albert Jonsen, *The Birth of Bioethics;* and P. Reynolds, "Reaffirming Professionalism through the Education Community." The transformations in these areas within medical education and practice are, indeed, most startling and impressive, even as they seem not to have had very much impact on the routine medical care that patients experience. For summary overviews of the developments in humanistic medicine, see Moira Stewart et al., *Patient-Centered Medicine;* Jeremiah Barondess, "Medicine and Professionalism"; Eric Cassell, *The Nature of Suffering and the Goals of Medicine;* and Rachel Remen, *My Grandfather's Blessings.*

11. Mack Lipkin Jr., Samuel Putnam, and Aaron Lazare, eds., *The Medical Interview: Clinical Care, Education, and Research;* David Mechanic, *Medical Sociology;* Tom L. Beauchamp and James F. Childress, *The Principles of Biomedical Ethics;* C. P. Tresolini and the Pew-Fetzer Task Force, *Health Professions Education and Relationship-Centered Care;* and Ronald A. Carson, Chester R. Burns, and Thomas R. Cole, eds., *Practicing the Medical Humanities.*

12. Jodi Halpern, *From Detached Concern to Empathy;* Susan Phillips and Patricia Benner, eds., *The Crisis of Care: Affirming and Restoring Caring Practices in the Helping Professions;* and Fred Hafferty, "Beyond Curriculum Reform: Confronting Medicine's Hidden Curriculum."

13. R. W. B. Lewis, *The American Adam,* 3.

14. For useful and nontechnical descriptions of narrative knowledge, see Jerome Bruner, *Actual Minds, Possible Worlds* and *Making Stories: Law, Literature, Life.* See also such seminal works written by literary scholars and narratologists as Seymour Chatman, *Story and Discourse;* Shlomith Rimmon-Kenan, *Narrative Fiction: Contemporary Poetics;* W. J. T. Mitchell, ed., *On Narrative;* Paul John Eakin, *How Our Lives Become Stories: Making Selves;* and Wallace Martin, *Recent Theories of Narrative.*

15. See the recent works by physicians and nurses that endorse the use of narrative in their practices. Trish Greenhalgh and Brian Hurwitz, eds., *Narrative Based Medicine;* Kathryn Montgomery Hunter, *Doctors' Stories: The Narrative Structure of Medical Knowledge;* Rita Charon, "The Narrative Road to Empathy"; Melinda Swenson and Sharon Sims, "Toward a Narrative-centered Curriculum for Nurse Practitioners"; and C. Skott, "Caring Narratives and the Strategy of Presence: Narrative Communication in Nursing Practice and Research."

16. Rita Charon, "Narrative Medicine: A Model for Empathy, Reflection, Profession, and Trust."

17. For narrative's influence in psychology, see Theodore Sarbin, ed., *Narrative Psychology;* Jerome Bruner, *Acts of Meaning;* and Karen Seeley, *Cultural Psychotherapy.* John Paulos describes the relationship between statistics and stories in *Once upon a Number: The Hidden Mathematical Logic of Stories.* Hayden White outlines history's reliance on narrative processes in *The Tropics of Discourse.* Alasdair MacIntyre recognizes the narra-

tive nature of ethical thought in *After Virtue.* There are just a few examples of this very widespread intellectual current toward narrative modes of thought and practice.

18. See Martin Kreiswirth detailing what he has called the narrativist turn in the social sciences and the humanities in "Trusting the Tale."

19. Eric Cassell, "The Nature of Suffering and the Goals of Medicine"; Charles Aring, "Sympathy and Empathy"; Patricia Benner and J. Wrubel, *The Primacy of Caring;* and Louise Rosenblatt, *Literature as Exploration.*