Published in final edited form as:

Presse Med. 2013 January ; 42(1): 3–5. doi:10.1016/j.lpm.2012.10.015.

Narrative medicine in the international education of physicians

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The essay by Francois Goupy et al. entitled “L’enseignement de la médecine narrative peut-il être une réponse à l’attente de formation des étudiants à la relation médecin–malade?” prompts me to submit some thoughts in its shadow, both to add some background on the new discipline of narrative medicine and to examine the particular contributions of this educational research project [1].

The purpose of the study by Goupy et al. is to assess the feasibility and acceptability by medical students of an elective in narrative medicine newly offered at Paris-Descartes Medical School and to learn, in the students’ own words, what they think they derived from their narrative training. Narrative medicine is an emerging method of fortifying the capacity of the physician to reach, understand, and ally with the patient in care. As Goupy et al. eloquently note, medical educators have tried many different avenues to arrive at these capacities – through teaching the medical humanities, psychological dimensions of medicine, aspects of psychoanalysis, and medical ethics [2–4]. We all know how critical are such aspects of our doctoring selves as empathy and affiliation, and yet the means to achieve these for our students seem ever elusive. Were all students lucky enough to have role models for compassionate care, our problems would be solved. Alas, not all of us physician-teachers can, in fact, model that which we hope our students grow up able to do. The source of sadness or pique, such a recognition redoubles the efforts to find ways to develop these capacities, now not just for the youngsters but also for those who allegedly train them.

Narrative medicine emerged in 2000 as the unification of my practice in patient-centered general internal medicine and my doctoral training in English Literature. Based on the conviction that knowing how stories are built would improve my practice as a general internist, I immersed myself in the study of narrative theory and the structure of the novel. This narrative knowledge and practice influenced my clinical practice. Over years of disciplined study of story-telling, I learned how to pay attention to the “narratings” that occurred in my office and hospital ward. Slowly, my practice of medicine was transformed as I developed fresh skill in attentive listening, in writing full-bodied representations of what I learned about patients, in finding means of encouraging patients’ articulations of their situations, and in forming staunch clinical affiliations that devolved from such practice. I

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Disclosure of interest: the author declares that she has no conflicts of interest concerning this article.

came to realize that the very act of writing about my patients gained me access to knowledge that, had I not written, would have remained out of awareness and, hence, useless. When I asked patients to read what I had written about them, asking, “Did I get this right?” they were uniformly grateful that I had taken the time to write about them beyond the minimum required of the medical chart and, often, began to write themselves about their illnesses. Such writing enlarged the evidence available on which to base our clinical actions and the grounds for our therapeutic affiliation.

At the same time, colleagues and I were experimenting in a medical pedagogy that included creative work – reading fiction and poetry, writing in parallel charts or portfolios, and encouraging students to write about their own clinical experiences. As evidence accrued that such practices were helpful in clinical training [5], I drew together a group of clinicians and scholars from Columbia University’s medical school and School of the Arts and Sciences. Together, we tried to figure out through what mechanisms and intermediates such work helped students – was it the widening of perspectives? the privileging of voices of patients? the personal recognition possible in small-group teaching? the recruitment of the imagination into clinical training? The joy of art?

This group developed and then tested the conceptual framework of what is now called narrative medicine, founded on a triad of movements – attention, representation, and affiliation [6]. Attention is the state of availability of one person to the other, a donation of one’s single-minded concentration and focus to the needs of the other. It is what a close reader does so as to enter narrative worlds written about or told, thereby becoming able to seek out the meanings held within that world for those who inhabit it. Training in close reading, along with interpersonal training, can build habits of attention in doctors. When learners are asked to represent complex events or states of affairs in words, they confer form on otherwise formless situations. The very conferring of form – as a short story, a poem, an obituary, a love letter – makes visible an invisible situation, otherwise marooned in some chaotic memory. When one reads what one has written and has the advantage of readers who can, invariably, see things in a text that its writer cannot see, one begins to plumb the depths of one’s own knowledge of the situation represented. A relationship marked by attention and deepened by the mutual recognitions made possible by acts of representation leads to a sturdy clinical affiliation. This affiliation, of course, is required of effective care.

The effective physician by no means needs to be a gifted writer. Instead, he or she needs the capacity to recognize that a story is unfolding in an illness – in the words of the patient, the changes in the body, the natural history of the ailment, and the responses of the many health care professionals involved in the patient’s care [7,8]. Not all of us are skilled in “narrativizing” that which we hear and witness in a patient’s illness. But with practice, we can improve this native ability to enter others’ narrative worlds and to visualize others’ perspectives on these worlds. We do so by using the imagination to generate hypotheses, based on evidence, for what the patient is going through, what the body’s pathophysiological changes might signify, and what one’s own response to the patient means. These hypotheses can then be tested in reflective clinical practice. Gaining access to these levels of meaning – some of them beyond awareness – fundamentally adds to the extent that the clinician can be of help to the patient.

Dr. Goupy and several of his colleagues received training in narrative medicine at Columbia and introduced an elective in this new discipline at Paris-Descartes. In the essay commented on here, they study the outcomes of the first round of seminars. Forty-one Paris-Descartes medical students participated in the twenty-hour elective, a combination of lectures and small-group seminars. The lectures covered such topics as empathy, autobiography, and the imagination. In small groups of eight students apiece, these protophysicians were coached by physician-teachers to write about their own experiences with illness, their own journeys toward medicine, and their fledgling clinical practices. All students were invited to read aloud what they had written, and many did. Those listening “listened for” both the content and the form of what was written, that is, what the story seemed to be about and how the story was told. The student evaluations rate the lectures as being moderately effective and the small groups as highly effective. They endorse the teaching methods and the salience of the material, suggesting that more sections be offered in the future; some students say the course should be mandatory for all medical students. Narrative comments written by some students report clinical consequences of what they learned in narrative medicine, as they credit their seminar with their development of powers of attentive listening.

The study is well conceived and designed to achieve the goal of initiating a purposeful tracking of an emergent phenomenon at this medical school. Although this is not a randomized control trial, although there is selection bias among study students who chose to study narrative medicine, and although it is cross-sectional and not longitudinal, it is, by necessity, where one starts in systematically and seriously studying one’s pedagogic practice. This group has done what many educators attempting something new forget to do – to study a new method from its very introduction. With these results in hand, the researchers can continue studying the students’ responses to future narrative medicine seminars, having a baseline from this study for comparison.

I am curious about what has happened to the faculty by virtue of their involvement in narrative medicine teaching. I was fortunate to work with three of the authors when they traveled to New York for training in intensive Narrative Medicine Workshops. With their grounding in narrative medicine’s conceptual frameworks, pedagogy, and clinical practice, I wonder if they, like their students, can point to differences in their own clinical practices that have unfolded as they develop stronger narrative skill. I wonder if their power as role models for compassion and affiliation for their students might be influenced by their training and then their teaching of narrative skill. I am suggesting that, unlike developing some less multi-dimensional and less interior clinical skill – like doing a lumbar puncture or examining a shoulder for rotator cuff injury – the learning of narrative skill alters many aspects of the learner’s self, leading perhaps to improvement in many arenas of performance. Goupy et al.’s study lends evidence to the proposal that narrative medicine is not a local, culture-bound phenomenon. Instead, the international adoption of narrative medicine’s methods suggests that something fundamental to the practice of medicine is reached by developing narrative competence and strengthening one’s sense of story in clinical practice. We are launching the International Network in Narrative Medicine in London in June 2013 as a locus to gather colleagues from throughout Western and Eastern Europe, UK, Asia, Africa, the Americas, and the Pacific engaged in this work. Its practice, like narrative itself, is gradually declaring itself to be transhistorical and transcultural.

A month ago, a medical student from Paris-Descartes visited me in New York. She had heard me lecture on narrative medicine in Paris and was eager to see the practice in person. During her visit, she came with me to my internal medicine office hours as a witness. With the patients' permission, she sat in on my consultations with patients in order to write as clear a representation as she could of the phenomenon of this doctor-patient visit, not the pathophysiology uncovered but the human interaction that took place. In her witness notes, she describes one visit: "An atmosphere of compassion, understanding, confidence and acceptance on the both sides is set. Listening to the patient makes me feel like disease isn't apart, it belongs to a story, somebody's story and you can't completely heal when you don't get the story hidden by the disease. The disease is a sort of expression of a story. Your relationship is an exchange which enriches both of you" [9].

Such is the reach of this practice. I am grateful that my colleagues at Paris-Descartes Medical School have undertaken this outcomes research to learn with rigor how these new practices both bring fresh equipment into the practice of medicine and renew the age-old capacities that have always deepened the care of the sick and grounded the healers in their art.

Acknowledgments

Funding: NIH NHLBI R25HL108104, 2011–2016, PI. Supported by: NIH NHLBI R25108104.

I thank the faculty and students at Paris-Descartes for their transnational collaboration and my faculty and student colleagues in the Columbia's Program in Narrative Medicine for their on-going discovery work.

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