Narrative based medicine

Stories we hear and stories we tell: analysing talk in clinical practice

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Even at its scientific best, medicine is always a social act.[1] For all the science that underpins clinical practice, practitioners and patients make sense of the world by way of stories.[2 3] Even the most evidence crazed doctors have to translate their perception of "biostatistical truths" into accounts that make sense to others. Studies of the consultation process, which have largely taken place in primary care, have focused on the structure of the meeting from greeting to closure.[4 5] The concepts of doctor centredness or patient centredness are described[6] and measured[7]; these concepts undoubtedly have a profound influence on professional practice.[8] These observations have led to an ongoing exploration of the effect that communication styles have on both patient satisfaction and clinical outcome.[9]

But there is much more depth to be explored in the process of communication, and the tools normally used are insufficient to examine the layers of meaning that lie within the text of exchanges.[10] The microanalysis of talk can inform the essence of medical practice, define principles for effective communication, attach meanings to a patient's story, as well as help doctors share ideas about fears and hopes for the future—in medical speak: communicate risks and benefits.[11] By deconstructing a piece of dialogue in this paper, we hope to illustrate the value of learning to listen carefully to the stories we hear.

Summary points

Conventional studies of the doctor-patient consultation tend to focus on structure rather than content and are therefore relatively superficial

The different interactional perspectives within the clinical encounter can be exposed using techniques of microanalysis that take account of text, tone, pauses, interruptions, and non-verbal communication

Through the detailed study of discourse in context, clinicians might learn to listen more constructively to their patients' stories

Discourse analysis

Discourse analysis is, essentially, the study of language in context.[12 13] There are many examples of analysis in which these techniques have identified valuable but previously hidden patterns and perspectives (for example, in outpatient clinics,[14] among health visitors,[15] and in transcripts of interviews conducted by HIV counsellors[16]). Discourse analysis has roots in linguistics, sociology, and psychology but despite these origins it is really no more than the examination of the processes of naturally occurring talk. For instance, how is one version of events selected over any other? How is a familiar reality described in such a way as to lend it an unquestionable authority? The one essential point about discourse analysis is that it follows the text which in many cases, like the following extract (box), is a piece of talk.

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The transcript in the box is of a meeting between a patient and a doctor in an inner city practice. The patient is a woman aged 52. Because she has an urgent problem she has been unable to see her usual doctor and has to consult with someone she has not seen before. She begins with a torrent of symptoms: puffy eyes and legs, burning on urination, pain in the back, and a sore throat. The doctor examines the urine sample, diagnoses a "water infection" (she gets recurrent cystitis), and asks if the patient is allergic to any antibiotics. At this point the consultation might well have terminated. But the patient lets out a cough: nothing extravagant, just a little cough.

Let us consider the transcript and apply the techniques of discourse analysis at first hand. The aim is to reproduce the dialogue down to the last "um." The symbols used can seem a bit off putting at first. Interruptions, pauses, overlapping speech, and intonations are all signified to gain access to the precise dynamics of the interaction. The extract begins 2 minutes and 30 seconds into a consultation which lasted 6 minutes and 45 seconds in total. The extract itself lasts 2 minutes.

The cough (at line 052), functions as a discourse marker signalling the speaker's wish not to terminate the interaction.[17] The doctor's next utterance ("Anything else?") is characteristic of doctors' preclosing moves in interactions with patients,[18] but leaves closure to the patient. The patient is in a position to allow closure or to shift to a new topic. She opts to respond (055) first with a pause then a request for "water tablets." The pause here indicates a new topic and precludes any accusation of indecent haste. The patient does not wish to be perceived simply as itemising a shopping list. The ritual of correct timing is necessary to maintain the necessary gravity accorded to the ceremony of consultation and

prescription. Although the pause lasts less than two seconds its significance should not be underestimated.

The patient makes her request for a repeat supply of Dyazide and links her diuretic treatment to her hormone replacement therapy, leaving the doctor seemingly bemused. She dismisses the water tablet topic while the doctor is still mulling it over—(071) a prolonged "mmm"—and she proceeds (072-3): "But I wanted the er Seroxat the antidepressant tablets please."

The use of the past tense ("I wanted") for a request in the present serves allows the speaker to remove herself from the here and now, a common feature of "negative politeness."[19] This is consistent with a reluctance to be perceived as too pushy or demanding, and is consolidated by the "please" at the end of the utterance. The doctor might be reluctant to bluntly ask the patient about the source of her depression but at the same time the seemingly unrelated sequence of her taking diuretics, hormone replacement therapy, and her request for antidepressant drugs, needs some substantiation. The doctor asks "You take those do you?" (the slight but unexpected emphasis on "take" indicating the doctor's momentary confusion). The patient replies with a simple "yeah" (075). The doctor follows up with a question formulated out of professional concern and framed in linear time: "How long have you been taking those?"

There is a pause, and then the patient chooses to respond not in linear time, but in event time (077): "Well my son was killed." This is the event which led to her being prescribed antidepressants. These opening phrases are interspersed by lengthy pauses: "(.) Uh well my son was killed (2.0) five years ago (2.0)."

Linear time (five years) is only relevant in relation to event time (her son's death). Mishler made the distinction between the "voice of medicine" and the "voice of the lifeworld."[10] The following excerpt is drawn from a consultation between a general practitioner and a young woman who is abusing alcohol.[10]

Doctor: How long have you been drinking that heavily?

Patient: Since I've been married.

Doctor: How long is that?

Patient: (giggle) Four years. (giggle)

Dismissing the importance of a biomedical time frame for clinical judgements, Mishler argues that the practitioner above, by insisting on a real time scale (four years) over a more meaningful, personal one subordinates the voice of the "life world" to the voice of medicine.

In our excerpt, the doctor does not interrupt the patient; he allows the voice of the life world to take precedence ("life meaning" comes before "time meaning"). By doing so he gives the patient the opportunity to fill in the kinds of linear detail which she thinks might be relevant and which she immediately does anyway ("five years ago").

In the transcript the introduction of biographical detail helps establish the narrative basis of the patient's depression and legitimises her continued use of antidepressant drugs. The account, with its litany of deaths, provides an idea of this patient's "sustaining fiction,"[20] of the explanatory causes that underlie her story. We are all continuously involved in the process of adding new stories to our own sustaining fictions. Stories are renewed, reconstructed, or abandoned but are

Extract from transcript of consultation

047 Doctor— I'm going to give you something called Augmentin
048 it's a little white bullet (.)
049 if you take them three times a day (.)
[
050 Patient— Mhm
051 Doctor— And we'll see if it helps you.
052 Patient— OK that's lovely. *[coughs briefly]*
053 Doctor— Anything else?
054 (.)
055 Patient— Uh (.) dya dya oh is it Dyazide (.)
056 the (.) water tablets I'm on?
057 Doctor— You take those regularly?
058 Patient— Yeah every day (.)
059 now I always take them in the morning but (.)
060 would it be all right to take them in the night? (.)
061 you know because oh *[sighing]*
062 it drives me mad you know
063 'cause I (.) pass water so much =
064 Doctor— = 'Course you do =
065 Patient— = And as I say if I'm on holiday I think well
066 I don't want to be running into the toilet all the time.
067 Doctor— Why are you taking (.) water tablets?
068 Patient— Because I'm on HRT?
069 Doctor— O yeah =
070 Patient— = Um (.) clif clif cilafin is it? Well I've got enough of those. (.)
[
071 Doctor— Mmm:mm.
072 Patient— But I wanted the er Seroxat
073 the antidepressant tablets please.
074 Doctor— You take those do you?
075 Patient— Yeah.
076 Doctor— How long have you been taking those?
077 Patient— (.) Uh: well my son was killed (2.0) five years ago (2.0)
078 just after that then (.) three months after (.)
079 my (.) granddaughter
080 three month old twin granddaughter died of meningitis (.)
081 then in the January (.) my son in law got uh
082 died of a heart complaint
083 twenty two so I refused to take anything you know
084 but then (.) doctor Y insisted (.)
085 and I have found them and I started work
086 after thirty years I'm a receptionist at the um
087 [names famous Welsh institution] (.)
088 and I have really found that that has (.)
089 been more of a help to me (.) *[breathes heavily]*
090 but doctor Y said she still wanted me to take those antidepressants
091 but I was thinking (.) would I be able to take one one day
092 leave one off the next day
093 to try and (.) would you know
094 would that be all right do you think or?
095 Doctor— Do you want to do that?

Key

(.) indicates a pause of less than two seconds; numerals in round brackets indicate the length of other pauses in seconds
[ ] contain relevant contextual information or unclear phrases
[ ] describe a non-verbal utterance
[in between lines of dialogue indicates overlapping speech
underlining signifies emphasis
= means that the phrase is contiguous with the preceding phrase without pause
: indicates elongation of the preceding sound

always central to the individual's presentation of self and sense of personal identity.

We find that the patient's son did not simply "die." He was "killed" (077), that is died as the victim of a particular agent or set of circumstances. Implicit in the pauses is an opportunity for the doctor to ask how her son was killed, an opportunity that he chooses not to take. The pauses act as a rhetorical device allowing the gravity of her loss to sink in and gives an accounting for the prescribed drugs. But that is not all. Seeing that the doctor does not request further information about the circumstances of her son's death (a request which would be highly threatening to both doctor and patient), the patient then enumerates two other losses in her family: the death of a baby granddaughter from meningitis and the death of a son in law from a heart complaint. The fact that the causes of death and the ages of the dead are enumerated in both these other cases only draws attention to the lack of explanation regarding the killing of her son.

By emphasising within a short space of time the extent of her losses, the patient avoids the possibility of being categorised as somebody requesting antidepressant drugs without good cause. Hanging over every patient is the potential accusation of malingering[21] resulting in an obligation to prove that a malady is not contrived and to express a wish to get well. Moreover, in this transcript, the patient insists that it was her doctor who "wanted her" to take the tablets (reinforcing her own passivity in this decision despite their effectiveness). Then (as if further evidence of her good intentions were needed) she states her wish to reduce the dose, thus maintaining her contractual responsibilities to recovery. This wish to lower the dose is shown as her choice, a choice unaided (indeed hindered) by her practitioner ("but doctor Y said she still wanted me to take those antidepressants"), which strengthens the representation of herself as a responsible member of society; she states later in the consultation: "I wouldn't like the thought of being on them forever."

Reflective thoughts

For the doctor, the narrative appeared out of the blue. He records: "I hadn't expected this: three deaths and a request to withdraw from antidepressants during a routine repeat prescription. Would that be all right? To participate in a shared decision about the end of grief, about a symbolic farewell to a son, killed five years ago. I attempted to give her autonomy over her decision, hoping not to abandon her.[22] But it wasn't enough.[23] How could I tell her that I didn't know. That if I had lost a son I can't imagine surviving at all, never mind coming off tablets."

Discussion

This transcript reveals intricate communication strategies, informs us how patients construct their roles within consultations, and opens up a new way of listening to the signals which so often pass unnoticed; this analysis gets us that step nearer to reconstructing "the imaginative universe in which human acts are signs."[24] Mishler objects to mere code-category assessments of consultations (that is, ascribing coding formats to subunits of the interaction) and argues for a more eclectic approach using detailed textual assessment. There is also a need to capture the thoughts of both patients and clinicians. As more studies show that patients' perceptions of what happens within consultations are probably more valid than measures based on coding structures,[25–27] and that "finding common ground" is more of a perceived event than a quantifiable finding, those who are interested in this sort of analysis need methods that will illuminate the subtext—the white space that signifies thoughts, disagreements, distress, and indecision. Evidence suggests that patient participation in decisions reduces costs for the health service and emphasises the critical, but almost neglected, part that the patient-doctor interaction plays in the use of health resources.[28]

Clinicians may have to go beyond the superficial assessment of the consultation to examine the perceived messages that patients take away into the longitudinal discourse of their own lives.[29] By becoming interested in talk, clinicians might be able to listen more constructively to their patients' stories[30] and might be able to allow a more "democratic arrangement of voices."[31] Lest we forget, for countless patients it is the telling of their stories that helps to make them well.

The articles in this series are adapted from *Narrative Based Medicine*, edited by Trisha Greenhalgh and Brian Hurwitz, and published by BMJ Books.

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