Practical strategies for practising narrative-based medicine

Allan Peterkin MD

Family physicians have become intrigued by what Rita Charon has called *narrative medicine* and what her colleagues in the United Kingdom have called *narrative-based primary care*.[1,2] My own experience in offering narrative workshops to doctors is that they agree with the principles, but wonder how they can realistically incorporate strategies into a busy office "without opening up a whole can of worms." There are ways to improve your narrative competence—that is, your capacity to receive, interpret, co-construct, and bear witness to the stories your patients bring you.

Here are some simple, practical strategies to try and then integrate into your doctoring style.

Ask open-ended questions. Charon starts her first patient visits by asking, "What would you like me to know about you?" before jumping into questions about symptoms. Try asking an open-ended question like this in a new assessment. You can allow a few minutes for the patient to present his or her concerns and then move into a more systematic, structured inquiry. If you need to contain the story, you can use your usual time management strategies, but make a point of telling the patient that you want to pick up the thread next time.

Do not interrupt. The average doctor interrupts a patient within 15 seconds. Make a point of letting the patient finish her thought before launching into the next question or comment.

Ask patients to write about their illnesses. Consider asking your patients to write a 1-page "Impact of My Illness" document, which you will read and discuss with them and keep in their charts. This might be the first time your patients were ever asked about the effect of illness on their lives. How did illness change or interrupt the stories they had imagined for themselves?

Allow patients to discuss their concerns. Add a final *S* to your SOAP notes—for *Suffering*. You do not have to write this down, but ask yourself if you have allowed room for patients to talk about their distress or real concerns in each visit.

Learn your patients' stories. Find out 1 thing you did not know about your patients' stories in every visit. Who are they when they are not ill? What are their interests, their hobbies, the names of their grandchildren? Did you know that the man with Alzheimer disease used to be a composer?

Look for a metaphor or key word. Look for a metaphor or key word that emerges in your meetings that is unique to your working alliance. It might be found through a humorous exchange, but it can become a symbol of the story you are constructing together over time.

View noncompliance as a blocked narrative, not as patient stubbornness. Get the real story. Noncompliance has a differential diagnosis like every other problem in medicine. You are definitely a character in that plot. Spending the time now will save you both time later.

Record encounters with patients. The next time you are troubled by a patient encounter, take 3 minutes to write down what happened. Write it the way you would tell a colleague—as a story with a beginning, middle, and end. Writing it down on the page will give you the distance to see how your own story (expectations, time pressures, unresolved grief) has collided with your patient's. Most people are surprised by how much of a story emerges in only 3 minutes and how it can facilitate personal reflection.

Be aware of your body language. In a time of high-tech record keeping, make a point of maintaining eye contact and not typing while the patient is speaking. Your body language conveys (or annuls) your receptiveness to a story. Think of other barriers to storytelling in your office; eg, where or how chairs are placed, whether you answer nonurgent calls during appointments. Change what you can!

Examine your assumptions. The next time you feel bored with a patient, think about the question you have not asked. Ask yourself what your unexamined assumptions about the patient are and revisit the moment in your shared story where the assumption took hold.

Examine stereotypes. Regarding assumptions, give yourself a writing prompt: "People with tattoos are..." "Obese people are..." "Single mothers are..." Stereotypes are the unexamined stories we tell ourselves without realizing it.

Ask "What do you think is going on?" When you are not sure what is going on with a patient, ask "What do you think is going on?" This reveals the story he is telling himself over and over about his symptoms. It might not give you a clue about the cause of the symptoms, but at the very least it will enlighten you about his fears and worst-case plot scenarios.

Ask "How would others describe you?" Patients tell stories differently to doctors than they do to anyone else. Ask "How would others describe you?" If what they tell you does not match what you are seeing in your visits, then you have missed something important in their stories.

Ask "What's the one thing you haven't asked or told me?" From time to time, ask your patient, "What's the one thing you haven't asked or told me?" Chances are you will hear the story that matters most.

Review your patient's chart. Before you see your next patient, take a moment with his chart. Take a deep breath. Ask yourself, "Where did we leave the thread of our story the last time?" A symptom is not a story. A laboratory result is not a story. They might be the punctuation, but there is always more.

Dr Peterkin is Associate Professor of Psychiatry and Family Medicine at the University of Toronto in Ontario, where he heads the Health, Arts and Humanities Program.

Competing interests
None declared

References

1. Charon R. *Narrative medicine: honoring the stories of illness.* Oxford, UK: Oxford University Press; 2006.
2. Greenlagh T, Hurwitz B. *Narrative based medicine.* London, UK: BMJ Books; 1998.

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