Narrative-based medicine: a passing fad or a giant leap for general practice?

LISTENING to the patient's story has always been at the heart of medical practice. So what should general practitioners (GPs) understand by 'narrative-based medicine'?[1,2] Is it any more than a fashionable catchphrase, pointing out the obvious need to balance evidence-based medicine with the other attributes of good doctoring, including attentiveness, imagination, humanity, and literacy? Does a 'narrative-based approach' offer any advance over 'patient-centred medicine' or the traditional teaching of good general practice? Could it make any difference to encounters between GPs and patients?

Narrative studies have caught up with medicine only recently. However, they have a long and distinguished history elsewhere in the academic world. In anthropology, sociology, psychology, and philosophy they have brought about a quite dramatic change of focus: from observing the content of people's lives to paying attention to the flow of words by which we all create meaning. Narrative research has shown how we create our own realities, and indeed our lives, with the same motives, the same themes, and the same structures, as fiction. 'To be in a culture', says Jerome Bruner, 'is to be bound in a set of connecting stories'.[3] The philosopher Charles Taylor goes further: 'We understand ourselves inescapably in narrative'.[4] So one argument for considering narrative as an important new conceptual framework, rather than just a passing fad, is that it brings medicine into alignment with the social sciences and the humanities.

As well as crossing many disciplines, narrative studies also reflect a wide range of contemporary intellectual influences. These include postmodernism, which challenges the idea that bodies of knowledge such as science and medicine are objective; and social constructionism, which argues that reality is something that we agree with other people, rather than being 'out there'. Feminism and anti-racism have also had a part to play, with their emphasis on the different stories that people hear or tell according to their own perspectives. So a further advantage of taking narrative ideas seriously is that they may provide medicine, and primary care in particular, with more appropriate intellectual grounding for the 21st century.

Now that narrative studies have started to pay attention to medical encounters, they have contributed to our understanding in a number of important ways. One is to demonstrate how we as doctors are continuously recreating and reinforcing the 'grand narrative' of biomedicine when we talk to each other and our patients.[5,6] They alert us to the way that we 'tell stories' in consultations; for example, each time we offer a description of an illness, an explanation for it, or a diagnosis. These may be special kinds of stories, professionally and culturally sanctioned, but they are stories nonetheless. Although we may believe in them as unshakeable scientific truths, in fact, they can be as transient or evolutionary as the stories that patients bring us about their own lives.

What is interesting about such studies is that they often stress the necessity for doctors and other health professionals to propose new and more useful narratives to patients. Rather than accusing us of paternalism for doing so, they suggest that we provide crucial opportunities for people to seek meaning for their experiences, to provide them with a temporal shape, or explore their moral significance.[7] Mattingly, in her close analysis of conversations between occupational therapists and severely disabled young adults, talks of 'the drive to create a compelling plot'.[8] She talks about the way that clinicians try to steer patients towards 'therapeutic plots'. She sees these as having a number of functions. One is to help patients to 'locate desire', often in circumstances where they may no longer know what, if anything, they want. Another is to help people to find ways of revealing themselves, not necessarily in a single coherent story but also 'in terms of discontinuity, instability and the like'. Analyses such as these give the social sciences a more constructive part to play in relation to medicine than has sometimes been the case in the past. They suggest ways in which we might start to see our core professional role as collaborative 'story-makers'.

Another area where narrative studies offer a practical direction is by modelling closer attentiveness to the precise language that patients use. While patient-centred medicine counsels a change in consulting behaviour, a narrative approach takes this further by drawing attention to the way that our beliefs, value systems, and cultures are always deeply embedded in the very language we use as doctors, and in what we hear or do not hear. As GPs, we may already use empathic patient-centred techniques, such as open questions and reflecting back what the patient has said, but we may still unwittingly ignore or disqualify people's realities by failing to catch many of the exact words, phrases, and metaphors with which they weave their stories — or by failing to track our own discourse and the beliefs it represents.

This has important training implications. In some of the psychological therapies, where narrative ideas have had great influence, learners are now being trained to follow their patients' verbal feedback from moment to moment. They are being taught how to respond in a way that affirms the linguistic world created by patients, and offers diagnoses, formulations or interpretations, not as a superior truth, but simply as a suggestion of a possible 'new story'. In a number of places in Britain, Europe and the United States, approaches along these lines are now being taught for primary care on postgraduate courses, by teams that include both family physicians and family therapists.[9-11] Although these courses were originally designed to bring ideas from systemic family therapy and biopsychosocial medicine into primary care, they have all to some degree taken a 'narrative turn', and now pay increasing attention to the way that professionals can learn to help their patients, whatever their gender or culture, to give voice to their current stories and to reconstruct

ones that they find more useful or meaningful.

Such approaches point to a new way of looking at primary care; as a place where patients bring 'broken stories'[12] and invite professionals to help fix them. Within the context of a long-term relationship (or even a shorter one), our task as GPs may be to help people to place their current experiences within a coherent personal or family narrative. Many patients will inevitably wish us to contribute elements of the scientific 'grand narrative' that we have brought from our medical training and professional knowledge, and they may need some practical and technical solution, such as a prescription, injection or hospital referral. However, they are unlikely to want a new narrative that is wholly constructed around a hierarchical doctor–patient relationship or a reductionist scientific understanding, nor will they be willing to accept anything we say or do unless it makes sense as part of a story that they can construct and own themselves.

In many ways, therefore, narrative-based medicine turns the conventional biomedical approach — and even the patient-centred one — on its head. Instead of listening to 'the patient's history' to determine what to do, it judges our actions by whether they contribute to an improvement in the patient's narrative. Philosophically, this is indeed a giant leap.

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References

1. Greenhalgh T, Hurwitz B. *Narrative based medicine: dialogue and discourse in clinical practice.* London: BMJ Books, 1998.
2. Launer J. *Narrative-based primary care: a practical guide.* Abingdon: Radcliffe Medical Press, 2002.
3. Bruner J. *Acts of meaning.* Cambridge: Harvard University Press, 1990.
4. Taylor C. *Sources of the self: the making of the modern identity.* Cambridge: Cambridge University Press, 1989.
5. Hunter KM. *Doctors' stories: the narrative structure of medical knowledge.* Oxford: Princeton University Press, 1991.
6. Atkinson P. *Medical talk and medical work.* London: Sage, 1995.
7. Bury M. Illness narratives: fact or fiction? *Sociol Health Illn* 2001; **23:** 263-285.
8. Mattingly C. *Healing dramas and clinical plots: the narrative structure of experience.* Cambridge: Cambridge University Press, 1998.
9. Launer J, Lindsey C. Training for systemic general practice: a new approach from the Tavistock Clinic. *Br J Gen Pract* 1997; **47:** 453-456.
10. Larivaara P, Taanila A, Huttunen I, *et al.* From biomedical teaching to biopsychosocial education: a process of change in a Finnish medical school. *J Interprof Care* 2000; **14:** 375-385.
11. McDaniel S, Campbell T. Training for collaborative family healthcare. *Fam Sys Health* 1996; **14:** 147-150.
12. Brody H. 'My story is broken: can you help me fix it?' Medical ethics and the joint construction of narrative. *Lit Med* 1994; **13:** 79-92.

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Are we downhearted?*

AS 2003 opened, *The Guardian* led with an article stating that one in five of all general practitioners said they were planning to retire from the health service, because of rising disenchantment with their job. To any of the remaining four-fifths, already struggling with the existing work, this was a story guaranteed to spread alarm and an even stronger sense of being abandoned in the trenches. However, even the careful *Guardian* is capable of exaggeration. The survey they were quoting tells a more complex story.

The paper, published in the *BMJ* of 4 January, reported surveys of general practitioner principals in England in 1998 and 2001, assessing their intention of retiring in the next five years and their overall job satisfaction. The overall population intending to retire in the next five years had increased from 14% in 1998 to 22% in 2001, with large increases in the age groups 46 to 50 and 51 to 55. Job satisfaction, measured on a seven-point scale, had decreased from a mean of 4.64 to 3.96. The change in job satisfaction was responsible for most of the increase in intention to retire, with some contribution coming from an increase in the age of the sample.[1] The authors are careful to qualify the results: general attitudes towards retirement age have changed dramatically, and stated intentions may not 'translate into action'. They quote research to support the notion that, at least in this field, stated intention is a strong predictor of retirement. This should not surprise: many or most of those planning to retire at age 55 or 60 would most probably have been making financial provision for many years (which would in itself suggest that less should be ascribed to changes in satisfaction over only three years). Finally, the authors acknowledge that some doctors may be leaving NHS general practice to pursue careers elsewhere, and perhaps we should welcome any such trends towards more varied career pathways.

The purpose of the survey was to inform NHS workforce projections, and the authors have to be right to say, with magisterial understatement, that 'If as few as half those reported here actually leave, this would still be cause for concern given the current shortage of general practitioners.' They conclude that the NHS should try to focus on improving job satisfaction in order to improve retention.

Does the Sibbald paper have more significance, emphasising how demoralised the whole profession is? This would be a much less reliable conclusion (which the authors themselves don't state). Compare, for instance, the paper published in the *BJGP* last year, which reported that very few NHS general practitioners had low job satisfaction (measured as low, medium or high), although here too there was a trend towards lower satisfaction with age.[2] One of the problems with the substantial literature and discussion around demoralisation of the profession is that it can so easily become self-fulfilling. Simply by indulging in the much-loved national pastime of whingeing we can demoralise ourselves. The modern therapist would prescribe a dose of collective cognitive behavioural therapy, so that when we meet colleagues we focus on all the good things about our lives. Or is that, in turn, simply offensive wishful thinking?

One of the problems here is that the evidence base is so weak. Even in the Sibbald paper, there is the nagging doubt

that job satisfaction and intention to retire are associated, not as independent entities but as items that are linked in the responders' mind to justify each other. Just as we have known for years that general practitioners apply the diagnostic label to justify the treatment decision that has already been taken, rather than the other way round, it is quite possible that the responders in this survey were happy to overstate their job dissatisfaction because they had already made the decision to retire from the job. While there is such a negative climate among colleagues, individuals may even be wary of expressing openly any positive feelings about their job. At this point there is only very soft anecdotal and personal experience to go on. Most of my colleagues continue to enjoy the clinical work and find it very fulfilling. It is working with patients that provides the interest, the stimulus, and the rewards that keep us going. But so much of the rest of the job is difficult, frustrating, and deeply unrewarding: the endless directives from other bodies; the numerous administrative reorganisations; the feeling that, despite the rhetoric, primary care is barely valued by the Department of Health ministers and mandarins; above all the lamentable state of secondary care services that makes it impossible for us to care for our patients to a standard that we or they would find acceptable. Beyond that, we feel for colleagues who find it difficult to replace retired partners, or to recruit or retain ancillary staff. We know there are areas of the UK where there is a horribly worrying workforce crisis looming, and where it may be difficult for patients to get access to any sort of primary care in the near future.

To understand this, the key is to grapple with the small extra complexity that it is not 'either/or', but 'both'. Trying to work in general practice at present in the UK is both hugely rewarding and endlessly frustrating. The human brain can easily accommodate two apparently conflicting ideas simultaneously. And if we get a little more sophisticated then we might be able to engage the managers in sensible discussions about the very real grievances and fears about the state of the NHS without denying to ourselves, or to them, the real rewards we get from our commitment to our patients.

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References

1. Sibbald B, Bojke C, Gravelle H. National survey of job satisfaction and retirement intentions among general practitioners in England. *BMJ* 2003; **326:** 22.
2. Lambert TW, Evans J, Goldacre MJ. Recruitment of UK-trained doctors into general practice: findings from national cohort studies. *Br J Gen Pract* 2002; **52:** 364-372.

*The full quote is cited in the Oxford Dictionary of Quotations, appositely: 'Are we downhearted? No! Expression much taken up by British soldiers during the First World War.'