Why bother listening to patients?

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An anecdote for narrative medicine

Rita Charon's seminal paper in the developing field of Narrative Medicine begins with the following anecdote (1).

Ms Lambert (not her real name) is a 33-year-old woman with Charcot-Marie-Tooth disease. Her grandmother, mother, 2 aunts, and 3 of her 4 siblings have the disabling disease as well. Her 2 nieces showed signs of the disease by the age of 2 years. Despite being wheelchair-bound with declining use of her arms and hands, the patient lives a life filled with passion and responsibility.

"How's Phillip?" the physician asks on a routine medical follow-up visit. At the age of 7 years, Ms Lambert's son is vivacious, smart, and the center—and source of meaning—of the patient's world. The patient answers. Phillip has developed weakness in both feet and legs, causing his feet to flop when he runs. The patient knows what this signifies, even before neurologic tests confirm the diagnosis. Her vigil tinged with fear, she had been watching her son every day for 7 years, daring to believe that her child had escaped her family's fate. Now she is engulfed by sadness for her little boy. "It's harder having been healthy for 7 years," she says. "How's he going to take it?"

The physician, too, is engulfed by sadness as she listens to her patient, measuring the magnitude of her loss. She, too, had dared to hope for health for Phillip. The physician grieves along with the patient, aware anew of how disease changes everything, what it means, what it claims, how random is its unfairness, and how much courage it takes to look it full in the face.

What is narrative medicine?

Narrative medicine is a movement, part of the broader umbrella of medical humanities, and one of its pioneers is Dr Rita Charon, a physician from Columbia University who also holds a PhD in English literature.

Charon argues "that a scientifically competent medicine alone cannot help a patient grapple with the loss of health or find meaning in suffering – along with scientific ability, physicians need the ability to listen to the narratives of patients, grasp and honour their meanings and be moved to act on the patient's behalf" – she terms this ability *narrative competence* (1).

These ideas may seem distant and difficult to relate to, but they begin with the clinical history. In today's climate of a dizzying array of blood tests and increasingly sophisticated imaging, it is easy to forget the humble history in a patient's workup. It is in the clinical history that rapport with the patient is achieved (or not), where the therapeutic relationship begins and the scene is set for the patient's medical journey.

History-taking and the skill of talking to patients

We first start taking histories in medical school - it is ironic that medical students routinely find being on the wards and talking to patients in their clinical years invigorating (many junior doctors will groan about the drudgery of talking to patients!). Being exposed to the extraordinary variety of patient narratives is one of the privileges of being in medicine and beginning to comprehend the vast array of cultures, societies, histories, and illness is certainly breathtaking. However, the key difference of course is that medical students often have the time to take a thorough and detailed history and it is a joy to be able to take the time with a patient and really understand their background, the reasons for admission, and the ways their illness has impacted on their life.

As we progress from medical student to intern to registrar, the histories become more concise and targeted in eliciting the relevant clinical symptoms to arrive at a diagnosis.

But why continue to bother with the careful listening, understanding and building empathy we practised in medical school?

The importance of the patient-doctor relationship

It is common to see registrars being short and somewhat rude with patients in the knowledge that they have limited time to arrive at a diagnosis in order to provide a similar level of care to their other patients. But what are the problems with this?

1. Patients need to be able to tell their entire story for accurate diagnosis. Failing to engage with the patient and not taking the time to listen can result in inappropriate investigations, inappropriate management and ultimately poor clinical care. A patient may reveal a crucial part of the history that can change their provisional diagnosis and management (e.g. I used to be able to sleep flat, but now I sleep on 5 pillows in a patient who has presented with cough and dyspnoea).
2. Much of medicine rests on a therapeutic alliance with the patient so that they can become engaged in their own health care. One of the most powerful interventions in medicine is smoking cessation (in many cases, more vital than medications and procedural interventions) – how do we effectively influence patients to do this? It's obviously not just a matter of asking patients to stop smoking – what if we tried to understand their reasons for smoking, what smoking means to them, what their life means to them, and engaging the patient in this tradeoff?
3. Despite technological advances in medicine, there are still vast tracts of medicine where there are no solutions and the best thing a physician can offer is to bear witness to "unfair losses and random tragedies" (1). Many conditions in medicine we are powerless to influence and as doctors we like to often "cure" but unfortunately we can only provide "care" sometimes. Being with patients and their families is a vital part of being in medicine, and in the ongoing automatisation of medicine, its more vital than ever to be the human face breaking the bad news or letting a family know that their beloved parent needs to go to a nursing home.

Cross-cultural narrative competence

Narrative medicine is a fascinating field. However, it has its critics, and one of the concerns arising in Australia is how do we build narrative competence with patients who are not from our cultural background? The metaphors, illness models and collective memories in Western culture are entirely different to those from another culture. I think working as a junior medical officer in Australia, it is critical to remember the enormous power and knowledge asymmetry those of culturally and linguistic diverse and indigenous backgrounds face in Australian hospitals. I believe part of the solution to this is cultural competency training, judicious use of family members, and regular use of medical translators.

You can read more about narrative medicine at the following sources

1. Intima: A Journal of Narrative Medicine
2. Pulse - voices from the heart of medicine
3. Narrative Based Medicine by Trisha Greenhalgh and Brian Hurwitz, BMJ Books (1999)

And you can watch Dr Rita Charon talk about the importance of honoring the stories of illness in her TEDx talk

References

1. Charon, R. 2001. Narrative Medicine: A Model for Empathy, Reflection, Profession, and Trust. JAMA: The Journal of the American Medical Association, Volume 286 (15), 17 October 2001, pp. 1897 - 1902

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