PROFILE

A clearing for narrative practice

We meet in a forest clearing in downtown Toronto, and she tells a story. Of a girl who habitually took 10 books out of the library at once and read them before their due date. Whose French–Canadian grandfather and father, both family doctors, spent their days listening to patients' stories. Who grew up in Providence, Rhode Island, hearing a sad story of the death of a newborn sister, named and mourned. My storyteller was the chosen one of five surviving daughters. The one chosen by her father to be a doctor.

Pre-med was interrupted by Vietnam, tear gas and the protest imperative. She taught reading to poor children and drove a school bus; she finally returned to school. She became a doctor in New York City, but was driven to earn a doctorate in comparative literature. Stories were important. She wondered if she could meld the two: storytelling and medicine. Or if one was the key to practising the other.

Dr. Rita Charon's story has shaped her life's work as the founder, in 2000, and current executive director of Columbia University Medical Center's Program in Narrative Medicine — a phrase she coined,[1] an art of which she is the doyenne — and author of eight books and more than 100 articles.

Beginning this article with a short form of Charon's narrative is apt. Consider what it reveals: a love of literature, a background in medicine, knowledge of death, a belief in social justice.

In 1981, when Charon began practising at a clinic for poor, mostly Dominican patients at Presbyterian Hospital, New York City, she had an epiphany:

"I came to this shocking realization that my job was to put things together that [everyone] was telling me. These scattered, contradictory stories: the mother says one thing, [the] father something else, the intern says something else, the psychiatrist. I knew I couldn't disregard them just because they were contradicting one another. My job was to be that central person who got all the stories and made them make sense."

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Dr. Rita Charon.

Charon decided to nurture narrative by telling new patients two things: "I will be your doctor, so I need to know a great deal about your body, and your health and your life. Please tell me what you think I should know about your situation."

The first time she said this, she put her hands in her lap: no writing, no typing, just listening. In effect, she created a clearing — a safe place in which her 36-year-old patient with joint pain could talk. He told her that his father and brother had died from kidney problems, his father 20 years ago, his brother 10 years ago. Now his 21-year-old son was acting out and giving him so much trouble.

"And then he started to cry," says Charon. "I had to break my silence and ask: 'Why are you weeping?' And he said, 'No one ever let me do this before.' To talk. Right from the beginning, I said this is an important thing, and it's missing in medicine." She wrote about that experience for the *New England Journal of Medicine* in 2004.[2]

Sometimes, patients told her medical details, but often, she learned early in the clinical relationship about losses, deaths, stillbirths — vital life events. After a patient left, Charon would write down what she'd heard and at the next appointment show it to the patient and ask if this was what had been said. "One said we left something out. That's when she told me there was violence in the family. Someone else told me about a stillborn child from decades ago."

Charon pauses to hear a house sparrow's song at the Toronto Music Garden in the clearing by Lake Ontario. "It's incredible," she marvels.

Charon had discovered the triptych of narrative competence: attention to the story, through close listening; representation through a creative act, such as writing, to reveal the story; and affiliation, by entering the patient's world — at least imaginatively — to see it from that point of view.[3] Narrative competence bridges the razor-sharp divides between doctor and patient, sick and well, powerful and powerless, dying and not dying. It allows doctors to see underlying causes and their patients more clearly. The differential diagnosis is narrative medicine in practice, Charon says.

"There are technical improvements in practice. When I invite someone to tell me what I should know about their situation it lets me learn so quickly what was important. A woman read what I wrote and said: 'You left something out: I grew up being raped by my uncle.' I would not have learned that for years, if ever, while taking care of her. And suddenly I have this given to me. It's so easy if you seek to establish yourself as trustworthy.

"I don't think it can be faked, but this is what's missing in practice. Patients have not stopped complaining: 'My doctor doesn't listen to me. My doctor seems indifferent to my suffering.' What we know is simply that patients aren't going to put themselves in your hands if they don't trust you.

"We want patients to do what we tell them to do and we get real angry … if they don't take insulin or their cholesterol medicine … We have nasty words for it like noncompliant. Noncompliant.

"I know that my patients do what I tell them to do. … The difference is being skilled in this domain. It's not only for the sake of being nice or having a good bedside manner. It's that you learn things that are critical for you to know as you take care of that person. And it's more likely that they will do what you think is important for them to do. It's [of] incalculable benefit to the patient to feel they are heard and understood.

"[There is] a dividend for the doctor, because you feel you have been present. You are using yourself in a powerful way. You are not despairing with the patient, but you witness her despair. And that gives something … that is needed."

Charon fully acknowledges that practising narrative medicine is challenging given the 8 or 12 minutes typically allotted per patient. She knows that convincing skeptics will require research-fuelled evidence. "It's a new field. It's not self-evident."

A major obstacle is the reluctance of general medical journals to accept qualitative research. Charon is heartened by a recent letter in *BMJ* from 76 academics in 11 countries who challenged editors to "reconsider their policy of rejecting qualitative research."[4] "Not all *BMJ* readers know what to do with qualitative data, and isn't it time for them to find out?" asks Charon. "We're happy to write methods papers on how to read qualitative data."

After 35 years of practising at Presbyterian Hospital, Charon recently stopped seeing patients to focus on research and ramping up the Program in Narrative Medicine. Workshops and seminars morphed into a master's program in 2009; there are now 150 graduates, many of whom teach. A distance program will begin in January, and *The Principles and Practice of Narrative Medicine,* a book written by Charon and other experts, is due in 2017.

"Googling 'narrative medicine' nets thousands of hits, though Columbia's program remains first. There's a lot of interest in this story business. I feel very strongly … that it's hard to do, and if somebody tries to teach it and doesn't know how, they will do it badly. … It can be very dangerous. Damaging. We all feel an obligation to keep teaching the difficult skills of doing it well."

Charon hopes the textbook sets a standard. "We're in a clearing now. We often use that word 'clearing.' Narrative medicine makes these clearings. It's protected and safe."

We sit on a cool granite stone, a dwarf erratic from the Canadian Shield, carefully placed along a twirling path. Cars roar by mere metres away, on Queens Quay West, yet they are overpowered by the twittering birds, muffled by the green that surrounds us. It is a good place to talk about the future of medical practice.

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Dr. Charon recently presented at the first joint Family Medicine–Psychiatry Grand Rounds at the University of Toronto and taught in the Narrative Healthcare Atelier & Certificate Program offered by the Mount Sinai Psychotherapy Institute and the Program in Health, Arts and Humanities, University of Toronto.