(Adam's) Narrative Medicine

We seek to remove barriers, to view healthcare not as physicians and patients—separate classes—but as members of the same medical community.

April 11, 2017 By Adam Hayden

Tomorrow, Wednesday, April 12, I will pull a chair up to a table in the Medical History room in the IU School of Medicine, Medical Library. I join ten others—nine students and the professor, who are studying Narrative Medicine this semester. Consider this the preamble. In this post I rehearse my talking points, and I emphasize the importance of storytelling in medicine

Many of you following my journey recognize that I have been sharing my story for several months by way of social media—Facebook Live, this blog, monthly twitter chats (#BTSM), speaking in community settings, in academic venues—Marian University College of Osteopathic Medicine; this upcoming public lecture hosted by IUPUI Religious Studies Department on April 19, and perhaps more important than each of these are my regular coffee conversations with close friends and former colleagues, sometimes one-on-one, sometimes in groups.

Here are two theses, hypotheses maybe, which have always been there, just beneath the surface of my areas of interest, motivating continued study.

1. Story telling is a long-honored and integral piece of our human experience. The content that comprises our stories vary widely by cultural traditions—and with respect to our friends who study myths and tropes, perhaps the content across cultures is not tremendously different, after all (consider flood and creation stories traced easily to many cultures to emerge from the Mesopotamia), but the point I wish to make here is more broad. The act of sharing our experiences, framing our narratives, and contributing to an oral tradition is a defining feature of our collective humanity, at large, and certainly features of our identification with a community or, more abstractly, a peoplehood. But this stands against the following, second hypothesis.

2. We seek an objective worldview, so far as we think it is possible to achieve. The Western academic tradition employs the language of mathematics to describe the world on purely objective terms, purportedly void of subjective interpretation; physicists seek, through reductionism, the outlook that meaningful explanations are sought after only at the bottom-most level of the explanatory target: the level of fundamentality. That at some most primitive level the discrimination of distinct objects dissolves and what remains are, well, not even objects at all, but a collection of attributes, charge, mass, spin, and so on that stand in relation to one another.

These theses stand in seemingly stark contrast to one another: on the one hand, the anecdotal, narrative, story telling accounts, passed from family to family, friend to friend, peer to peer;

multigenerational. These stories contribute the to a sense of community and the reinforcement of values indicative of exemplars borrowed from the community who now live on as the subjects of their celebrated narratives.

On the other hand, the objective, quantified worldview has little concern for the subjective reinforcement of values drawn from a community of origin, and instead is concerned chiefly with predicting outcomes from a set of initial conditions and governing principles. Given reductionism, determinism, and fundamentality, the evidence presented to us by contemporary physical theories are, by definition, stripped of subjective identity.

Where does the physician find herself? Her patients, flesh and blood; her recording of their symptoms locked behind a protective wall erected from the scaffolding called HIPAA. Our office visits call out for personal connection. Our medical record keeping warns against privacy breaches.

Is this the space—the gray area between the practice and the policy, that we find narrative medicine? Between the stories and the statistics? The physicians and the patients. Medical history gathering is the pathway through which the two may become connected. Especially for the chronically ill, the cancer survivor, the terminally diagnosed, that more so than in any other space physicians and patients are presented with the opportunity to recapture the first of my two hypotheses. That storytelling is attachment to a community, through that which medical school may drive a wedge; may serve to detach physicians from their patients; detach specialists from the bodies on which they specialize. The community can be rebuilt when we seek to remove the barriers that lead to detachment. When healthcare is viewed not as physicians and patients—two separate classes—but as members of a medical community, where medical professionals are accountable for the care they provide, and patients are accountable for investing in their health and wellbeing by taking seriously the relationship with their caregivers.

Like great storytelling, the hero of our narratives, the reinforcement of personal values we experience when seeking solace in our favorite stories—what Rita Charon calls the “sense of story,”—might we find the strength to craft our own narrative, featuring ourselves at the center, and refusing to settle for medical professionals who are not compelled to listen closely while we tell our stories.

Wednesday, April 12, I will tell my story again, for the nth time, but for the first time. It will be told to a room of strangers, yet, when our time together is over, the influence we have over each other will linger. This is only possible when we recognize ourselves in others, when we eliminate barriers erected in the name of responsible detachment to practice objective science and medicine, and we do this through the art of storytelling.

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