"My Story Is Broken; Can You Help Me Fix It?"
Medical Ethics and the Joint Construction of Narrative*

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This essay explores some ethical implications of a narrative conception of the physician-patient relationship. I shall argue that the moral basis of the relationship is best preserved and enhanced when the physician and patient go about developing meaning within their encounter in a particular way. Ideally, the physician-patient relationship should be both ethically sound and therapeutically effective. Constructing certain sorts of narratives within that relationship attaches meaning to the patient’s illness experience in a way that enhances the healing potential of the encounter. Moreover, when narratives are jointly constructed, power is shared between physician and patient, and the sharing of power constitutes an important ethical safeguard within the relationship.

The Meaning of Illness and the Patient’s Story

Physicians have known, at least since the time of Hippocrates, that the mental, emotional, and symbolic aspects of the physician-patient encounter can ameliorate (or worsen) disease every bit as much as the specific medications and other treatments the physician employs. Modern research into the placebo response has amply documented the power of symbolic healing.1

* Two anonymous reviewers for this journal made several helpful recommendations for clarification and expansion.

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Although the concept of symbolic healing is vague, a careful review of the literature allows a more precise identification of its operating components. These may be roughly subdivided as explanatory system, care and compassion, and mastery and control. As a general rule, patients will be more inclined to get better when they are provided with satisfactory explanations for what bothers them, sense care and concern among those around them, and are helped to achieve a sense of mastery or control over their illness and its symptoms. Patients will become worse when the illness remains mysterious and frightening, when they sense social isolation and lack of support, and when the illness is accompanied by a feeling of helplessness. These components can in turn be broken down into further subdivisions for more detailed empirical study.

The physician who listens carefully to the patient’s story of the illness lays the groundwork for all the important dimensions of symbolic healing. It is the patient’s story of the illness—the way the patient has tried to organize, and hence to make sense of, the various manifestations of disease within the context of his own life—that displays the meaning the patient has attached to the illness experience before his contact with the physician. The physician can hardly offer a more satisfying explanation for the illness unless she has first heard out the patient, because the patient will not recognize the new explanation as being about his own illness unless he knows that he has been listened to initially. Being willing to listen to the patient’s story—which oftentimes family and friends have dismissed with impatience—sets a tone of care and compassion for the physician-patient relationship. Finally, in Western culture people are used to the idea of gaining mastery or control over events by being able to tell a coherent story about them. Thus, listening carefully to the patient’s story begins the process of healing at the symbolic level.

It might be argued that healing at the symbolic level is a poor substitute for the scientific application of medical therapy to a properly diagnosed disease state. But symbolic healing as just described is totally congruent with a proper scientific approach to medical diagnosis and therapy, properly understood. George L. Engel, in a highly important paper on this subject, has noted that the beginning of all science is the careful, reproducible gathering of data. In the case of illness, the patient’s history is the major source of data, since one cannot really perform an appropriate physical exam, or order the appropriate laboratory tests and x-rays, unless one has been guided by the patient’s description of his own symptoms. But taking an accurate history is far
more difficult than it might first appear. The patient must be in a particular state of alert, thoughtful candor in order to describe the course of the illness clearly and accurately and to be willing to expose all of his innermost thoughts and feelings to the physician's gaze. This state, in turn, entails a particular sort of curious, compassionate, and supportive style of interviewing on the physician's part. If care is not taken from the beginning to set the proper tone for the medical interview, the physician will never gather the scientific data necessary to make an appropriate diagnosis. (She might as well go into the laboratory and try to study slides through a dirty microscope lens.)

Given the very short time available for most physician-patient encounters, one might well wonder how an accurate history could ever be taken and how the patient could ever be healed. It would appear that hours, if not days, of careful conversation and negotiation would be necessary to create exactly the right setting for the scientifically valid medical interview. Engel shrewdly observed that doctor and patient are aided by some deep emotional drives, which one could almost attribute to the biological makeup of human beings. On the physician's side, there is a deeply rooted "need to know"—the physician's scientific curiosity is aroused by the patient, and the mystery of the illness is there to be solved. On the patient's side is an equally deep "need to be known"—as if the patient senses that by allowing the physician to understand his disease, he will in turn be healed, by the symbolic route, as well as by whatever specific remedies the physician might apply. The complementarity of these basic drives means that the physician who genuinely appreciates the power of medical interviewing and history taking can begin to elicit scientifically valid information within a few minutes of the start of the encounter. Unfortunately, as Engel and others have noted, this is no longer the norm in modern medical practice. Much more common is the physician who interrupts the patient, who begins early on to ask closed-ended and overly technical questions, and who in a variety of ways guarantees that she will hear apparently useful bits of information but will never hear the patient's story of the illness.

Intriguing support for Engel's recommendations comes from studies conducted by family physicians at the University of Western Ontario. These physicians considered a variety of common presenting symptoms that patients bring to their family physicians; the investigators asked what characteristics of medical care would best predict the patient's report of relief of symptoms after a given interval (ranging from one month to one year). Virtually all technical aspects of care, including
adequacy of history and physical exam, types of laboratory investigations, and drugs ordered, failed to correlate with improvement of symptoms. The single most important predictor of relief of symptoms was the report of the patient that he had had a chance to discuss the problem fully with the physician at an early visit and that the physician had come to an understanding of the problem that was basically identical to the patient's own. Other studies have shown that agreement between physician and patient about the nature of the presenting problem is closely linked to a good outcome. In other words, the patient who feels *listened to* in the first encounter with the physician is far more likely to show a positive response to treatment.

It therefore appears that the physician, depending upon how well she listens to the patient and what sort of atmosphere she creates in the interview, has substantial power to alter the patient's health status for better or for worse. How the physician uses that power is an important ethical question for medicine.

### Patients, Physicians, and Power

John Ladd has commented that the central ethical problem in medicine is the responsible use of the physician's power. However, the term *power* has not been a favorite with philosophers investigating the ethical principles underlying medical practice. I have argued elsewhere that there are some special benefits to be gained from looking explicitly at power issues in medicine and putting the term *power* back into the vocabulary of medical ethics.

In most relationships marked by a power disparity between the parties, an obvious resolution is to equalize the power, either by empowering the weaker party or by taking away some of the power of the stronger. Indeed, the ethical principle of respect for the patient's autonomy might seem superficially to accomplish precisely that, thereby explaining the popularity of this principle in discussions of medical ethics in the last two decades. But on deeper analysis, any simple approach to equalizing power, particularly by removing power from the physician's side of the equation, runs into serious problems. Most important is the fact that patients, given the choice, do not seek the help of relatively powerless physicians. Patients seek out the most powerful physicians and want very much for the physician to use that power on their behalf. This behavior occurs despite the fact that patients, at some level, inevitably fear the physician's power and realize that there are a number of ways in which it can be used against them.
The same scalpel that can cut out a diseased organ or a tumor may nick a vital artery or nerve. The same medication that can heal may cause toxic side effects. As I argued above, the physician's words can promote healing or can increase the patient's suffering. There is simply no handy dividing line between the helpful and the hurtful uses of the tools the physician possesses. And, of course, the physician is seldom consciously malicious in those circumstances where the tools are misused and where the patient suffers harm as a result of the physician's exercise of power.

The critical goal of medical ethics should be to enhance the physician's use of power against the disease on the side of the patient and minimize any temptation or opportunity to use power to the patient's detriment. What this goal means in practice often requires a careful analysis of the case at hand. (I contend that a relationship based on power tends to favor casuistic and virtue-based approaches to medical ethics and to look somewhat askance at approaches that are heavily dependent on ethical principles.) Still, some general guidelines can be given. One obvious safeguard of the patient, which still avoids interfering with the physician's power to eliminate disease and promote health, is a genuine sharing of power in the physician-patient relationship. Most simplistic applications of the principle of autonomy envision a "win-lose" situation, where one party in the physician-patient relationship gains power at the other's expense, but a model of shared power is a "win-win" system. Through a variety of means, including emotional encouragement, education, and various strategies for behavioral modification, the physician seeks to empower the patient to become a more active participant in the struggle to overcome symptoms and to improve health.

It is immediately apparent that symbolic healing, as described in the previous section, and a shared-power model of the physician-patient relationship have many features in common. Giving the patient an adequate explanation for the illness certainly allows the patient to participate more actively in medical care. Demonstrating care and compassion may give the patient the reassurance that he needs to participate in this way. Finally, instilling a sense of mastery or control is vital if the patient is truly to feel empowered and to take specific actions that will promote health and ameliorate symptoms. When symbolic healing is construed in an appropriately broad fashion, it is seen to enhance an ethical physician-patient relationship, and vice versa.

Symbolic healing is closely tied to the meaning of the illness experience for the patient, which in turn is tied closely to the story that
the patient tells in an effort to make sense of the illness. The next question is how the shared-power model and the symbolic-healing model can be combined to suggest an optimal approach to the patient’s story.

The Joint Construction of Narrative

To summarize the argument thus far, the physician who hopes to heal and to relieve suffering ought to attend as seriously to the patient’s story of the illness experience as to the purely bodily manifestations of disease. (Put more accurately, the physician should approach a deeper inquiry into bodily processes through the vehicle of the patient’s story.) And the physician should approach the story in a way that encourages the ultimate goal of shared power: making the patient a more active participant in his medical care.

Something more must be said here about the difference between curing and healing. Eric J. Cassell has argued eloquently that today’s medicine is usually better at curing than healing and ironically may increase suffering even as it cures, or tries to cure. At the heart of suffering is a feeling that what ought to be whole is being split apart. This feeling may be experienced as a split between one’s self and one’s malfunctioning body or as an isolation of the self from the human community. Suffering cannot be relieved, however elegant a cure one performs, unless the patient’s subjective sense of split and isolation has been assuaged. Almost always, this assuagement requires a sense of reattachment to the human community from which the patient, through illness, has felt cut off. The physician is the human ambassador who most often and most directly can reach out and reestablish this sense of human connection. Her willingness to listen to the patient’s story may be the first step in this process. (Until this point, the patient may have felt, “People are unwilling to listen to my story; it either bores them or frightens them.”)

Taking the patient’s story seriously begins at the very start of the interview, with the natural question of why the patient is seeking help from the physician. Sometimes this is totally obvious, as when the patient needs a piece of paper to be signed in order to go back to work or to get married. But very often in general medical practice, it is not totally clear at the outset why the patient has sought help at that particular time. (Merely reporting a backache or a headache or a cough does not really explain the visit, as it has been well documented that
for every patient in the physician's office, there are three or four people walking around with equally severe backaches, headaches, and coughs who have not even thought of seeking medical attention.) The physician who takes stories seriously will, in any case where there is any mystery about the patient's reason for seeking help, adopt as a working hypothesis that the patient is asking a question like the following: "Something is happening to me that seems abnormal, and either I cannot think of a story that will explain it, or the only story I can think of is very frightening. Can you help me to tell a better story, one that will cause me less distress, about this experience?" If this formulation seems overly wordy, a shorter form of the patient's possible plea to the physician might be, "My story is broken; can you help me fix it?"

This question may seem at first a highly unusual way of characterizing the patient's request of the physician. It is unlikely that any patient in Western society, without a good deal of guidance, would articulate his concerns in this way. Nevertheless, this question has the virtue of clarifying an important task that the physician and patient must engage in together. This task is a major part of all good doctor-patient encounters, but it usually happens under the table, because the traditional way of looking at that encounter focuses so heavily on history taking, physical examination, diagnosis, and treatment. I have labeled this task the joint construction of narrative.

The joint construction of narrative is a complex task that consists of many elements. Its complexity may be illustrated by an example that may at first seem trivial but that is, for this very reason, a valuable glimpse of some of the important features of everyday practice. The patient consults the physician because of a cough that has been going on for several days. The physician's careful interview elicits, along with the usual description of symptoms, the fact that the patient's aunt recently nearly died of pneumonia and the patient is worried that he might have pneumonia also. The physician reassures the patient, after an appropriate examination, that he does not have pneumonia and that the cough is probably related to postnasal drip. The physician recommends a vaporizer and other simple home remedies to try to relieve the nasal congestion that is thought to be the basis for the cough.

One important element of the joint construction of narrative is that the patient is fully involved throughout the process. The physician does not hand the new narrative "postnasal drip" instead of "pneumonia" to the patient in the way that the traditional physician hands out a prescription at the end of the visit. There is an ongoing, partly nonverbal give-and-take as the physician listens carefully, throws out a few
tentative comments, and modifies her approach depending upon how the patient responds to her initial offers of advice, explanation, and reassurance. If the patient indicates acceptance and relief, the physician moves quickly to complete her account of what is bothering the patient and what should be done about it. If any of these comments produce a raised eyebrow or other evidence of questioning or resistance, the physician will stop at that point and explore much more fully what the patient might be thinking.

The involvement of the patient is critical in the next element of the joint construction of narrative, which is that the narrative must be meaningful from the patient's point of view. To explain an episode of illness, it must be the sort of story that the patient has grown to expect. If, in my example, the patient feels as if the origin of the cough must be in his chest, he is unlikely to accept the explanation that nasal congestion is the cause. Moreover, the patient has to accept that the story is truly about him. If the physician listens carefully to his account and performs an appropriate physical exam, the patient is likely to believe this story. If the physician seems rushed and does not perform an exam that the patient feels is sufficient, then the story will not seem to be a story of the patient's illness, but rather a stock story that the physician simply took off the shelf and will use for all other patients who show up with a cough that week.10

Another important element is that the story must be biomedically sound. The patient sought the physician because the physician represents the vast powers of medical science; the physician engages in a fundamental fraud if the story offered to explain the illness is not congruent with appropriate scientific thought. In my example, the patient might be greatly relieved by being told that the physician thinks an antibiotic is required and that it will surely cure any pneumonia that might be present. But if an antibiotic is not truly indicated, the physician ought not construct such a narrative simply to please the patient.

Another critical element in the joint construction of narrative is that the new story ought to promote the healing action that the physician and patient agree ought to be carried out. If the best way to get over a cough caused by postnasal drip is to use a vaporizer and to drink more fluids, an ideal story of the illness will show how these measures actually play a role in producing an improvement in the symptoms. For the patient to be as highly motivated as possible to carry out the practices in question, he must see the practices themselves as efficacious and must envision himself actually doing those things. Such
a shift in outlook involves both the explanatory system and the patient’s sense of mastery or control (empowerment) over the illness.

A final element is that the new narrative must facilitate either the patient’s getting on with his life story or his modifying it as required by the illness. In my example, the patient can go about his usual projects and routines in a day or so and need not significantly postpone or replace any of his cherished goals in life because of this cough. The new narrative account of the illness is aimed at getting the patient back into this frame of thinking as quickly as possible. This result would not have occurred, for example, if the physician had not elicited the fear about the patient’s aunt and had not offered adequate reassurance. Instead of a healthy patient going about his business in a few days, this encounter might have produced a worried patient who is continually asking himself whether the doctor missed something important and whether he can safely resume his usual activities.

In most encounters in general medicine, this sort of reassurance is the appropriate outcome, as long as the physician has taken the time to find out what really is worrying the patient. Occasionally, however, a serious disease will be diagnosed, and then the construction of narrative becomes much more difficult and taxing. The patient must then begin the task of reconstructing the story of the rest of his life to take into account this new disease and the limitations it will impose upon his activities; he must go through a grieving process for the loss of the old life plans and goals that the disease has rendered now out of reach. In that event, the joint construction of narrative obviously requires much greater skill and sensitivity on the physician’s part, and the construction occurs over an extended period, not in one encounter.

The joint construction of narrative, as just described, is not a new recommendation for physician-patient interaction. Good physicians have generally done this as a matter of course. But they have done this because it seemed instinctively like the right thing to do, not because anyone taught them to, and still less because anyone had carried out detailed research to show how each element could be performed optimally. The point of listing the various elements in the joint construction of narrative is to suggest that this task will be performed much better if more attention is paid to it explicitly. This attention, in turn, requires that one take very seriously the notion of story or narrative in medicine, which will not occur if one thinks that medicine is about biomedical abnormalities rather than about what the patient is thinking.

Taking narrative seriously will require increased attention to spoken as well as unspoken communication between physician and patient.
The metaphors employed by each will require much more careful scrutiny. The rituals of the encounter will require explicit study. To the committed advocate of a purely biomedical model, it will seem as if scientific physicians are being asked to embrace precisely those aspects of "good bedside manner" that have usually been associated with quacks—people who were forced to employ as pleasing a manner as possible because they lacked any scientific tools for healing—rather than with legitimate physicians.

Is this conscious employment of ritual, metaphor, and storytelling not insincere, fraudulent, or manipulative? The answer will lie both in the physician's assessment of the scientific evidence that supports the efficacy of symbolic modes of healing and in the physician's attitude toward this behavior. It might well be that the narrative approach will degenerate into a shallow pose if it is employed merely as a tool in the interview, in the way that one might use, for example, an alcoholism-screening questionnaire. Or the approach might represent a sincere attempt on the physician's part to develop over time into a certain sort of person—a healing sort of person—for whom the primary focus of attention is outward, toward the experience and suffering of the patient, and not inward, toward the physician's own preconceived agenda. As Warren Thomas Reich has argued, the litmus test of the sincerity of this approach will be the extent to which the physician becomes vulnerable to a compassionate and empathic experience of the patient's suffering. That is, when "narrative interviewing" is used as an impersonal tool, the patient's experience of suffering (and the patient) are kept at a safe distance, and the patient is likely to feel this. When a narrative approach is used in the way advocated in this essay, both physician and patient feel that the physician is open and vulnerable to the patient's experience of suffering.

The notion that one is trying over time to develop into a special sort of person and that one is willing to open oneself to being changed by experiencing the suffering of others proves finally that the physician has accepted a suitably humble status in the power hierarchy of the physician-patient relationship. The physician has not abandoned the very powerful scientific armamentarium for which the patient initially sought her assistance. But neither has the physician used that armamentarium as a prop to protect herself from any possible feelings of powerlessness as she confronts the patient's experience. To the biomedically oriented physician, any such sense of powerlessness is threatening and unseemly, so that physician emphasizes the importance of objective detachment. The "narrative physician" knows that some-
times objective detachment is both necessary and comforting to the patient but sometimes a compassionate vulnerability is required. The choice between them is dictated by what is necessary to empower the patient in the face of the illness, rather than what will make the physician feel powerful. Mastering this approach to patient care requires an understanding that sometimes what seems to be an admission of powerlessness actually makes the physician more powerful in terms of being able genuinely to help the patient.

My treatment of the joint construction of narrative is a brief overview of a new way of looking at the everyday behavior of physicians, and it has necessarily glossed over some substantial questions. Can a truly tragic narrative perform a healing function? Might not the wise patient want to keep the physician—and her meanings—out of his life narrative? In what ways can the physician’s narrative become abusive to patients? Doesn’t this treatment still retain a degree of physician-centeredness that undermines the purported goals of joint construction and shared power? The value of the approach sketched here will depend on how well it suggests a line of inquiry to address these and similar questions.

Conclusion: The Convergence of Good Medical Practice

A widely accepted view holds that medicine is fundamentally an applied science. Scientific knowledge is used to determine the presence or absence of various diseases from the signs and symptoms presented by the patient, and this diagnostic evaluation in turn leads to therapeutic interventions of a physical and chemical nature. Because these actions occur in a social and cultural setting, they will have a special meaning for the participants and onlookers. Therefore, an analysis of the language used in these encounters, as well as an analysis of the stories people might tell about them, allows scholars to gain additional insight into those social and cultural meanings.

I have been arguing instead for a rather different conception of medical practice. Without denigrating the value of accurate diagnosis and appropriate biomedical therapy, I have tried to show that language, narrative, and meaning are inherent in the physician-patient encounter and the act of healing itself. The construction of narrative is not something added by an outside observer; it is a critical portion of the healing encounter.

In summary, this model of the physician-patient encounter argues
for the convergence of a number of important characteristics of good medical care: scientific medicine, ethical medicine, humane medicine, effective medicine, and cost-conscious medicine. All too frequently, one or more of these descriptors is portrayed as being in fundamental opposition to some of the others. Many have argued that scientific medicine has become overly technological and impersonal, and hence inhumane. Scientific and technological progress in medicine is seen as directly in conflict with cost containment. Often humane medicine is contrasted with effective medicine: the former is seen as an issue of handholding or good bedside manner; the latter is seen as growing out of scientifically applied diagnosis and therapy. And it is often argued that the ethical physician must be a patient advocate and cannot, therefore, be expected to control costs by trading the well-being of one patient against the well-being of others.

By contrast, a focus on the narrative elements in good doctor-patient encounters suggests that there is at least a significant portion of medical practice where real convergence among the values just mentioned is possible. The physician who attends carefully to the patient’s story of the illness is, as Engel noted, a scientific investigator in the truest sense. Attending carefully to the patient’s story provides important emotional support for the patient, which in turn allows the patient to become more actively involved in his own care. Thus, a narrative focus achieves in an important way the sharing of power, which is a critical aspect of the ethical physician-patient relationship. Because suffering results when an illness experience is perceived as meaningless or as threatening the integrity of the patient’s life and relationships, and healing occurs when a more comforting meaning is assigned to the illness and the patient sees himself reconnected to his social network, a focus on narrative promotes the most humane version of medical practice. The available research suggests that such an approach can be extremely effective in relieving symptoms and ameliorating the effects of disease. The model can be further tested in rigorous fashion and the results of that research used to refine further the techniques of the physician-patient encounter and the joint construction of narrative. Finally, an approach that focuses on narrative and the symbolic dimensions of the physician-patient encounter provides relief of symptoms, appropriate emotional support, and perhaps preventive lifestyle changes for the majority of patients, with a minimal need to use expensive diagnostic and therapeutic interventions. Such an approach is likely to be cheaper than much of contemporary medical practice, because it
reserves the more expensive interventions for the smaller group of patients who truly stand to benefit to the maximal degree.

Patients have always emerged from an encounter with a physician bearing a new story about the nature and significance of their illnesses. Sensitive physicians have generally seen to it that the new story bears the stamp of a particular patient’s unique individuality and that the patient himself has been involved in constructing the story. Scientific medicine has made great strides by ignoring this level of storytelling and by focusing instead on quite different stories, at the organic, cellular, and molecular levels, to explain how medicine works. For a complete understanding of medical activity, the question of how physicians and patients can best construct stories about illness must be returned to the center stage of medical inquiry. This is an inquiry to which both scientific investigators and humanities scholars can contribute significantly, with the outcome being an enhanced healing ability for modern medical practice.

NOTES

1. The most comprehensive overview of placebo research and theory is Leonard White, Bernard Tursky, and Gary E. Schwartz, eds., Placebo: Theory, Research, and Mechanisms (New York: Guilford, 1985). See also Howard Brody, Placebos and the Philosophy of Medicine: Clinical, Conceptual, and Ethical Issues (Chicago: University of Chicago Press, 1980). This research documents at great length that the bodily changes produced by placebo responses and related mechanisms are real and measurable. Thus, the term symbolic healing, as used in this paper, refers to those aspects of the physician-patient encounter that bring about measurable bodily responses; the term is not intended to suggest that the responses themselves are imaginary or fleeting.


10. This discussion makes it appear as if a few simple moves on the physician's part will assure that the patient accepts the meaning that the physician feels is the best explanation of the symptom. Of course, the real world is not so simple: sometimes a protracted process of negotiation is required for physician and patient to arrive together at a satisfactory meaning (assuming that the patient doesn’t simply go out shopping for a more agreeable physician). One case of my own comes to mind in which the negotiation as to whether a recurring problem with eye pain and double vision meant "undiagnosed brain tumor, like my mother had" or "emotional stress triggered by unresolved grief over your mother’s death" lasted for several years and had not finally been resolved when the patient moved to another state.