Narrative medicine: a personal interview with expert Rita Charon

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Abstract

Narrative medicine is a simple phrase that serves as a thumbnail for a vast web of ideas that have the power to enhance manifold aspects of medicine. This is an interview with Dr. Rita Charon, Founder and Executive Director of the Narrative Medicine MSc Program at Columbia University, discussing physician burnout, medical education, and finding meaning in one's work as a doctor.

Keywords: Narrative medicine, physician burnout, physician wellness, medical education

"Narrative medicine" is the literary comparative to "a quadrillion" – a short, compact name for a giant, expansive thing – a noun whose smallness on the page belies the vastness to which it signals.

I met Rita Charon last year at the *Creating Spaces VII* conference in Winnipeg, at which she was the keynote speaker. Enchanted by the work she was doing, I immediately made plans to visit her in New York that summer to learn more. Dr. Rita Charon established the field of Narrative Medicine and is the Founder and Executive Director of the Narrative Medicine MSc program at Columbia University. Equipped with a medical degree from Harvard and a doctorate in English from Columbia, she has developed her ideas in numerous scholarly journals, such as The *New England Journal of Medicine*, *Literature and Medicine*, and *The Lancet*, and has authored several books on narrative medicine – one of which she warm-heartedly gifted to me in New York.

I had not heard much of narrative medicine before meeting Rita. But in New York that summer I was given a small project as a summer intern for the Narrative Medicine program: interview program alumni and find out how they were using their narrative medicine training. These encounters granted a real–world look into the transformative power of the concepts of narrative medicine, and only increased my interest. So in the fall of 2017 I met Rita on a video call to discuss all things narrative medicine. What follows is an interview with Dr. Charon covering physician burnout, medical education, and finding meaning in one's work as a doctor. Cheers.

How would you describe narrative medicine?

Narrative medicine is a way to fortify clinical practice with sophisticated skills of listening, understanding, writing, of receiving what patients say. My description [of narrative medicine] depends on who I am talking to. If I'm talking to a literary scholar, I will say that narrative medicine is a way to bring into healthcare what literary scholars know about form, content, and structure of text (written text and oral text). If I'm talking to a philosopher, I might say more about narrative medicine's reliance on continental philosophy and phenomenology, and how it distinguishes itself from what is called bioethics.

How would you describe narrative medicine to a doctor or a medical student?

I would say [it is a method to] help us understand deeply what it is the patient is trying to tell us. It's also a way to help us understand what we ourselves and our colleagues think about patients, about our work, and about what we do. And I do think, for clinicians, the duality of the benefit is very important. When we practice these skills, we make available to ourselves the rewards of care that don't otherwise come from clinical practice.

Do you think a lot of doctors aren't getting the rewards of care?

Yes, absolutely. I was giving a talk last week, and I realized the word *burnout* – this dysphoric, unhappy, exhausted, disillusioned, drained state that afflicts doctors, nurses, dentists, and teachers – it came to me that calling this state *burnout* was similar to calling a slave who attempted to escape from slavery a *drapetomanic*. *Drapetomania* was the name given to the mental illness that caused some slaves to attempt to escape from slavery. It was defined in 1851 by the American physician Samuel Cartwright. So, the escaping slave was thought to have a psychiatric problem that caused him to want to escape slavery.

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Oftentimes a burnt-out physician is doing what any person of ordinary good sense would do, which is to try to escape from a terrible condition, and the terrible condition in this case is the current practice of medicine. And instead of saying "We ought to fix this medical practice so that our physicians can give good care and be grateful for the chance of giving it," [and] fixing the system that causes this exhaustion, we say "Oh no, this physician has a new disease: burnout." But what else would you have him do? We caused this exhaustion. And the only effective or even humane response is to fix the conditions that led to it. We can't just say "Oh, are you burnt out? Why don't you come to our yoga session." It's not an individual problem of particular doctors, nurses, dentists, and teachers who suffer from this condition of burnout. Instead, it's like slavery, in that you have to abolish the conditions that force people into this state of burnout.

What are the larger conditions that force people into a state of burnout?

We know very well what the larger conditions are. Commodification, corporatization, money controlling what happens to patients and what kind of care is given to patients. It's different in different countries based on the economics and the workforce issues, but even in Canada, there are conditions that are forced upon patients and clinicians that come about through public policy.

What it comes down to is somebody, somewhere, in some legislative body deciding that the province of Quebec, for example, is going to invest x-millions or -billions of dollars into primary healthcare. Somebody decides that. And they decide to do that instead of building a bridge, or whatever. There are decisions made all the time, and there are clear forces that make what we have now continue.

When it comes to addressing burnout, so many of us have been working around the very margins. "Maybe we can have sparkling water instead of still." Little itsy-bitsy things. I believe sometimes that when we work to bring the humanities and visual arts into medical school, it can remain at the level of itsy-bitsy. What we need to do is see the drapetomania. Whose slavery is it? Who is running from it? Who is it hurting? Who does it benefit? The humanities and the arts, when used in their full strength, can make visible these very conditions. And *then* we can do something about burnout.

All of what I'm saying pertains much, much more to the United States than other countries. I know that. But I also know that even in Canada things aren't so rosy.

I think in addition to the systemic factors contributing to physician burnout, practising medicine is itself challenging. You've spent a decade training, people are sick, you're working long hours – that seems enough to burn a person out.

Yes, but you have to think of what gives you gratitude. Where do the rewards come from? What kinds of things make you say "Boy, am I glad I'm a doctor – look at what I get to do!" Are you on the wards? Have you done a lot of clinical work? You may not know yet, and that's okay.

I'm still in the phase where it's exciting to get the medicine right – to formulate a reasonable management plan, or correctly recall the symptoms of a disease. Other than that, I haven't done much clinical work to really know for myself. But I think it's important to feel useful, like you have something to offer when patients come in and they're sick. I think that would be rewarding. And things I've heard you talk about, like making contact with patients.[1]

It's the simple things. The things of feeling that you're of use. That your being there mattered. Certainly, the contact, the intimate contact that we're able to have with patients, is very stunning. That a person, over time, will really let you into their inner world. It's stunning.

And then the very ordinary things. I was at a high-level meeting last Thursday, presenting some of the recent work in Narrative Medicine to a big committee of the university, and there was a bit of a medical crisis. In the middle of the meeting, one of the committee members seemed to faint, his head suddenly dropped to his chest. I'm there in a flash, and I said "Put him on the floor." So, we put him on the floor, put something under his head, put his legs up, and took his pulse – we did all the things. He didn't lose consciousness, but he was disoriented. He regained awareness within a minute. I didn't know what was going on, but I knew enough to put him on the floor, put something under his head, and take his pulse. It felt great to know to how do that. The other people at the table said "Rita, wow, you were there by his side so fast – how did you know?" And I said... "C'mon." How many times do I have to stay up all night on call to know what to do?

That feeling, to know what to do, that never goes away. And that's just the technical part! So, whatever type of medicine you're doing, you've got to get some real deep, deep gifts out of it. And such the shame is that many practicing physicians are not getting the gifts anymore. And it's not because they're doing a poor job, it is because they are being pushed beyond anybody's capacity to do what needs to be done, what should be done, and what patients deserve to have done. Patients in and out in eight minutes after they've waited four months for an appointment – that doesn't give you the gifts. That makes you feel like a fraud, like you're cheating somebody.

That reminds me of *reciprocity*, an idea that

[1] this is a theme in Rita's TEDx Talk.

comes up towards the end of your latest book, *Principles and Practice*.

Yes, that's a particularly useful notion for those healthcare professionals who don't often dare expect that they get some kind of reward from their practice. Now we're back to my drapetomania. The reciprocity is that they are doing something for the patient, and meanwhile, the patient is doing something for them. That's not cheating, that's part of what makes it work! And it is very important that patients know that, that their doctor is taking care of them, and they're taking care of their doctor.

Looking back on your career in narrative medicine, is it fair to say that it started with your PhD in English at Columbia?

That's what gave me the intellectual background to know something beyond "Oh isn't that interesting, patients have stories." It was working very hard for ten years, (while also working fulltime as a doctor) to get through a really rigorous graduate program and get a grip on some complex literary and philosophical ideas. What happens in an autobiography? What happens when a person writes about themselves or tells about themselves? How does a person, a writer, or a teller convey anything to anybody? It gets to be very basic – learning and thinking about language, about emotion, about exposure. I could talk to you for hours and never expose a thing about myself! And at the very same time, I know that every sentence I speak or write is stamped by who I am. It could only be written by me. And I keep having, more and more, and with more and more intensity, the experience of writing something and then saying "Oh, that's what I think!" only after I've written it. That happens every day now.

Did you have a sense at the time that your PhD was laying the groundwork for something much larger? Did you have a master plan?

It was pure pleasure! I was a reader but I didn't know very much about reading. I knew a number of people who were literary scholars doing work in medicine – something that was just beginning, in the 70s and 80s. And so, I started to say "Well gee, the university's right there! Why don't I just go to the English department and take a course? That would be so fun." That's all I was trying to do, was go take a course. So, I talked to some people and they said "Oh, don't take a course, take a Master's." And I said "Okay." That's how it started; it was very incidental. I took two seminars per semester, and some in the summer as well. I would run from my clinic over to the campus. It was thrilling! It wasn't because I had some grand plan of what I was going to do at the end. It was just "Wow, this is great!" And then when they said "Well, do you want to stay for the PhD?" I said "Sure." I didn't have a plan, I just loved the process.

What do you think should be the role of narrative medicine in the medical school curriculum? I think there's probably a minimum amount of anatomy that every doctor should know. Likewise, do you think there is a minimum amount of narrative competence a doctor should maintain?

If you had to pick the parts of anatomy that were essential, you would pick the parts that, if the doctor didn't know, they could really do damage. So, you need to know where the aorta is so that if you're doing abdominal surgery you won't cut into it. If you think about it in that way, what everybody really needs to know is that, in taking care of patients, someone is trying to tell you something about themselves. The very central event of healthcare is one person telling another person that something's the matter. And that's a very complex thing. And there are a lot of ways to get it wrong. There's a lot of risk involved in really receiving what it is that that person's trying to tell you. I think that's where I'd start. I wouldn't start with reading fiction or poetry. Those are some of the methods that can help us. But I think the curriculum has to begin with "How can I train myself to comprehend what this person is trying to convey to me?"

So, I think the cardinal contribution that everybody ought to get from narrative medicine is how to radically listen. We've been calling it "radical listening" these days, which helps make the point that it's not just "every now and then your head bobs up and you ask another question and you listen to the answer and you write it down." It isn't that! It's deep. It's risky. You're making yourself available to somebody who's going to tell you something that they're not going to tell everybody! They've chosen you to tell, and if you're not the right person when they come into the office, you won't get to hear it. Maybe there are some routine things, where if you go have your teeth cleaned, or go get your flu shot, this isn't going to happen. But other than that? You're in the doctor's office because you're mortal. That's why you're there. So I guess one thing this suggests is that there needs to be a great attention to words, to language. That's why we make the students write and read.

End

Thank you to Rita Charon for being so generous with her time and energy; and thank you to Tayla Curran, Program Director of the Narrative Medicine MSc at Columbia, for allowing me to work with her and the rest of the team last summer. Dr. Charon is working on a new book exploring the topic of creativity and doubt as the foundations of science, art, and medicine. You can learn more about narrative medicine by visiting the following sites:

Narrative Medicine MSc website
Rita Charon TEDx Talk
Charon R, NEJM, 2004