

The obligation of narrative

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Did I tell you about the back pain patient who paused in our waiting room after being discharged just long enough to steal the coin change machine? He didn't get away with it though, because he stopped in the parking lot for a smoke, where security found him. He ran, but got caught and roughed up by the police, and ended up back in the ED for worsening back pain. What a world we live in!

I have another story, or maybe two or three. Listen to this one: it was my first ever patient encounter, during a physical diagnosis course in my second year of med school. I remember walking up the stairs to his room, thinking to myself that it would be a whole lot easier to get the information I needed off the chart rather than from the patient. I had to sit down and remind myself that wanting to be a doctor meant that I was really, sometime, going to have to see patients.

He had a memorable story too, of course. It started with a terrible pain in his back and led to the discovery that he had prostate cancer with spinal mets. The way he told it he collapsed in his back yard, and woke up after having an orchidectomy. "And what do you think they served for dinner that night?" he asked. "Spaghetti with meatballs!"

I had a little flight of fancy about what the menus might be for other diagnoses before beginning the "Definitive Medical Student Physical Exam" (you remember that — it takes 3 hours or so). At one point I said I would skip looking in his right ear, since the bed was up against a wall and he couldn't sit up, but by then he too had decided I had to be thorough, so he insisted I try. If you consider the logistics, the only way to look in the ear closest to the wall of someone lying supine is to cram your breasts into their face, so maybe it wasn't that silly for him to insist after all.

That was my first patient encounter ever, and I still re-

member it all, despite the thousands of patients I have seen since. His story is fixed in my brain. Somewhere, too, is the story of your first patient — or at least, the first one that profoundly impacted you; and next to that story are all the others, such as the first family you had to console, or the first patient whose cancer you diagnosed.

I was an Intern in the ED. A man had increasing dysphagia over months, and I told him, "obviously, you must be as concerned as I am about an acute oncologic process, so I've booked you an appointment tomorrow with a hematologist." When I left the room, the patient said to his nurse, "Good news — I thought this was cancer, but I guess it's not." The nurse made me go back in and say the word "cancer," and tell him "that's what you've been afraid of and that's what I'm afraid of for you, too." His is another story I'll never forget.

Tell me about the first baby you delivered, or the first patient you harmed. How about the first one you saved? We each carry a multitude of tales, because storytelling is part of what doctors do, and we in Emergency Medicine are often witness to the best tales of all. We see it all: blood, chaos and tears, the acutely ill, the acutely psychotic, death and survival, misfortune and triumph indiscriminate of age or social class.

What is the importance of storytelling, of narrative? Simply put, it is all. Narrative confers meaning to a life, in the same way that it conveys meaning to an otherwise confusing jumble of facts and figures. Just as the story of my first patient is etched on my brain, every patient and every laborious history taken are now etched on your brain. Every patient that we see is a story, and not just one that we enjoy telling, but one we have an obligation to tell, when we arrange follow-up or request consultations for the patients we see.

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We're like Maori historians, whose obligation it was to learn the lineage of their tribe, and who can recount scores of generations otherwise forgotten. We have a similar obligation to the students and residents we train to teach them how to do this right; to teach them to make sense and story out of a cloud of history and of physical exam findings. We are storytellers; a skill that's part of our job just as much as diagnosis and acute treatment. The story is not more important than the science, but it counts. It's the narrative that breathes life into laboratory and imaging results, and what we teach is as much about how to present a case as it is about the meaning of diagnostic tests.

We have an obligation to quickly synthesize a patient's presentation and findings and tell the story in a clear and convincing way, to specialists, admitting docs, and even back to the patient. Patients, after all, have been known to ask to see another doctor if they don't understand or care for the narrative that we propose. Narrative is, in fact, a large part of what we do, and perhaps the crux of our craft. Those cases when we can actually cure something in the ED are exceptions, cases like fixing the nursemaid's elbow, sewing the lac, diuresing the CHF (that's why we love CHF — it's one of the few critical care presentations where you can watch the patient improve while in the ED). The things we can fix are the easy parts of the job. There is no uncertainty with them. The hard part is to make sense of the puzzling patients, to find their true story.

Case presentations are nothing more than the latest redaction of an ongoing oral tradition. When you consider all the practice we get, emergency physicians should be the best at this of anyone. How many times per hour do we meet an undiagnosed patient, figure out what they're all about, then tell another doctor about them? It's all about the story. It gets an uncertain patient into the ICU, or convinces a specialist to leave their warm bed or tight schedule based only on an uneasy impression. Stories entertain and teach, illustrate and convince, reward and challenge.

We strive to figure out every case we see, and we tell the story at least once per patient, for at the very least, the patient needs to be convinced that we understand their case. For a complicated or sick patient, how many times is the story repeated? At my teaching hospital, there's the private attending, the hospitalist, a consultant or two, the ICU resi-

dent, and maybe an intern or student; and that's all for one patient. Pretty soon we know the story by heart — after two or three recitals, for a brief time, the patient's life story becomes part of our own.

There must have been times when you felt that you alone had true ownership of a patient, and the sole responsibility for securing the most appropriate care for them. We only know the patient 2 hours or so, but we have that responsibility because we have the story. It's up to us to figure it out, to tell it right and to do as much as we can to get the proper care for the people we see.

Effective patient care includes the ability to synthesize the data and construct a narrative — to sketch in a story on the tabula rasa. After all, the narrative that we are able to convey is what will drive a patient's care. Narrative is all, and the person who gets to the ward or goes home without our conveying a co-

gent story to those who will care for them, is someone for whom we have reneged in our medical responsibility. They are someone who may not get the care or the work-up they need. The purpose of taking a history, and the purpose of the medical record, isn't better billing, or better defence against lawsuits. It's to record the patient's story — meds, diseases, treatments, habits, anatomy, all of it. Because it all helps us make the right decisions for that individual, who, depending on his or her level of alertness or grasp of detail, may not be able to provide a cogent synopsis to each new doctor.

If we do it conscientiously, each story makes us better doctors and increases our knowledge of the range of human pathos and pathology. We add them to all the others, becoming the storehouse of fragments of lives, and the libraries of the stories of our EDs. We are privileged to work with human beings at their most stressful moments: those who are in need, in pain, seeking relief, seeking understanding, gravely ill, dying, and in mourning. What we ought to be able to do better than anyone in medicine is to hear, see and tell their story.

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