NARRATIVE POSSIBILITIES

using mindfulness in clinical practice

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ABSTRACT  Narrative is ever present in medicine and is an integral aspect of the doctor and patient relationship. Although theoretical discussions of narrative medicine and narrative ethics are important, they may serve to reify the patient's story, to make it a specific entity. In practice, the patient's story unfolds in the moment of communication depending on the individuals and the circumstances; the story is not an "object." Patients' narratives heard in clinical settings are often limited by physician behaviors, especially the tendency of physicians to control the interaction with the patient. To develop individual narratives effectively and competently, physicians must be able to help the patient tell the story that is most important, meaningful, and descriptive of the situation. If the patient's narrative is not heard fully, the possibility of diagnostic and therapeutic error increases, the likelihood of personal connections resulting from a shared experience diminishes, empathic opportunities are missed, and patients may not feel understood or cared for. The practice of mindfulness—moment-to-moment, non-judgmental awareness—opens a doorway into the patient's story as it unfolds. Such mindful practice develops the physician's focus of attention and offers the possibility for a meaningful and important narrative to arise between patient and physician.

NARRATIVE IS EVER PRESENT IN MEDICINE. Everyone—doctors, nurses, patients, staff—tell and listen to stories. The Encyclopedia of Bioethics suggests that the human species is a narrative one: basic to our human nature, the telling

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of personal stories is one way we share our existence with each other (Montgomery 1979). Since the 1980s when Howard Brody’s *Stories of Sickness* (2nd ed., 2003) and Arthur Kleinman’s *The Illness Narratives: Suffering, Healing, and the Human Condition* (1988) were published, many articles and texts have focused on narrative in medicine and patient care, and the fields of narrative medicine and ethics have developed from this work (Brady, Corbie-Smith, and Branch 2002; Branch et al. 1993; Brody 2003; Chambers 1999; Charon 2001a; Charon and Montello 2002; Greenlagh and Hurwitz 1998; Hunter 1991; Nelson 1997; Verghese 2001). These discussions have expanded our understanding of the theoretical basis of medical practice by emphasizing the importance of the patient’s story, the use of narrative concepts to understand and interpret the patient’s story, and the resultant recognition of personal meaning. The theory, however, tends to reify “the story,” such that it becomes a familiar, singular object, rather than an individual, personal, unfolding conversation about a person’s life.

In practice, the patient’s story unfolds in the moment of communication depending on the individuals and the circumstances; the patient’s story is not an “object.” This unfolding is a highly complex matter, and patient narratives are often limited by physician behaviors, especially the tendency of physicians to control the interaction with the patient. In clinical practice, the stories that patients tell—whether illness narratives or medical histories—are not often told “straight out” like chapters in a well-written book, complete, detailed, and logical. Meaningful narrative—the story most embarrassing to the patient, the story most painful to share, the story not yet consciously recognized, or the story that summarizes a life—does not in most cases just happen between the patient and physician. Occasionally patients are compelled to tell a story—usually a description of the onset of an illness or a reflection on a poignant past moment—without hesitation, and physicians listen in stunned silence. And there are some individuals who tell stories incessantly: some stories are fresh and intriguing, while others are stories retold, fabrications reinforcing the patient’s self-image. However, most patients need to be encouraged and helped in order to develop and clarify a meaningful narrative. And if this particular narrative is not heard or shared, the possibility of diagnostic and therapeutic error increases, the likelihood of personal connections resulting from a shared experience diminishes, empathic opportunities are missed, and patients may not feel understood or cared for (Ambady et al. 2002; Charon 2001b). Realizing the important implications of the theoretical aspects of narrative, this article addresses a clinically relevant concern: “How can physicians expand the possibility that such meaningful narrative will be shared during clinical interactions?”

**Barriers to Narrative in Clinical Medicine**

Howard Brody (1994) comes close to this question in his discussion of the “joint construction of narrative,” where he identifies the physician’s responsibility to
help the patient construct a narrative. He describes the physician’s role in this “co-authorship” as facilitation, or the giving of “hints, nudges, and offers of bits of narrative raw material,” but he acknowledges the difficulty of this task “for physicians who tend to be take-charge, controlling sorts of people” (Brody 2003). Other physicians and researchers who explore aspects of the patient-centered interview have offered strategies and skills to help the patient describe the depth of the illness experience (Coulehan and Block 1997; Levinson, Gorawara-Bhat, and Lamb 2000; Lipkin, Putnam, and Lazare 1995). To share the patient’s narrative remains a daunting task, because it is a reflection of a life that is continuously changing and unfolding.

Despite much focus on the importance and benefit of narrative (Frank 1995; Hawkins 1999; Pennebaker and Seagal 1999), many physicians do not fully understand what being heard or understood means to the individual person. Although narrative is addressed in many medical schools, an ongoing emphasis on narrative is often not present in the mainstream, everyday practice of medicine or medical education. There are many barriers in clinical practice and medical education that influence the patient’s telling of issues, concerns, and events important in everyday life. Undergraduate medical education and residency training may acknowledge, but do not emphasize, the importance of patient and physician communication. When medical students begin to focus on diagnosis, the scientific model tends to predominate; emphasis is placed on completeness of the interview (e.g., past history, social history, family history, and so on), rather than on the recounting of patient’s particular experience, the clues essential to a correct diagnosis and integral to a personalized therapeutic plan. As a result, most physicians know the basic ideas and strategies for communicating with patients, but explicit knowledge, the skills, and much experience are needed before consistent effort regularly results in effective communication and a deep, clear understanding of the person.

**Integration of Mindfulness into Clinical Practice**

Many physicians indicate that there is not time enough to listen as patients share issues, or time to encourage patients to explore the depth of their experiences. Many physicians feel “under the gun to produce,” distractions in the office often interfere with a crisp focus of attention on the patient, and the tendency to feel the pressure of time leads to agitation, frustration, and sometimes to a sense of being overwhelmed (Connelly 1999). Because of constant pressure, the physician may develop a tendency to react to various situations and, without fully recognizing the patient’s needs, may rely on habitual methods of interaction, assessment, and decision-making (Lantos 2002). In our habits we become automatons—at times, unaware, unfeeling, and distracted. These habits lead to the loss of presence, the loss of awareness, and the development of routine interactions and impersonal responses.
Mindfulness, a practice of nonjudgmental moment-to-moment awareness, is one way for physicians to become aware of these patterns of behavior, habits, and reactions. The practice is useful for physicians who want to “be with” patients as issues arise, to engage in relationships that attend to the various aspects of difficult and complex medical situations, and to explore the possible narratives that reveal the patient’s experience (Connelly 1999; Elliston 2001; Epstein 1999; Hopkins 2001). By developing such awareness, physicians can experience a transformation of the sense of self. Feelings of spaciousness, including ease, patience, trust, and compassion, may arise. This personal space may enable true caring for the patient, or the capacity to “be with” the patient’s situation, or even patience—the enduring of pain or trouble with calmness and composure.

Expanding one’s awareness of sensations, such as touch, emotions, and bodily tensions, may also provide room for the physician to maneuver or settle into the moment. When physicians accomplish the task of making personal space, they may be able to listen, ask questions, make interpretations, and respond to nonverbal aspects of the interaction more effectively. They are likely to be more satisfied, too, as meaningful interactions develop and as the narrative possibilities within the interaction arise.

**Using Mindfulness in Medicine:**

**A Case Narrative**

A single case narrative will be presented in three sections, each followed by brief reflections and interpretations that demonstrate how mindfulness leading to selfknowledge can expand the narrative possibilities during the care of patients. Meaningful narratives lead to clinical, personal, and professional outcomes that would not occur using standard clinical methods, and they offer opportunities to deepen medical care for all involved, as in the care of those who are suffering.

Case Narrative: Part 1

As I walked to my patient’s room, I recalled memorable moments that we had shared during the 17 years of our relationship. When I first met him, he was very short of breath: congestive heart failure due to ischemic cardiomyopathy and severe aortic insufficiency caused him to suffer even then. But he was stable and I saw him infrequently, until one day four years later he asked me, “Why does my book bounce up and down when I read in bed with it resting on my belly?” His aortic aneurysm was repaired the following day. Some years later, a presumptive diagnosis of pancreatic cancer was made as his symptoms and scans suggested the diagnosis. No biopsies or surgery were done, as he was now inoperable due to his declining cardiac status, and he refused further interventions. He went home to die. But he lived and slowly improved. For years he laughed when he said to me, “Remember the time I was dying?”

As I approached his room, I assumed his wife would be with him. I can’t recall
seeing him alone in years. She was always in charge, the spokesperson, and decision maker of their partnership. He deferred to her for guidance, yet all of “their” decisions were accompanied by a dry, witty, loving display of affection.

Now 84 years of age, he was dying. During two weeks of hospitalization, he had recurrent massive gastrointestinal bleeding and disseminated intravascular coagulation, a myocardial infarction with severe congestive heart failure, and three acute episodes of pulmonary edema. He received 15 units of blood. We knew he was dying. The patient and his wife, and all of the medical staff, were frustrated by the situation: the recurrent and uncontrollable bleeding caused all of us to feel helpless. Workup failed to lead to treatable etiologies. Plans had been made on three occasions to transfer him to a nursing home, but on each day the bleeding had recurred and the plans had been canceled. We knew he would die at the nursing home if his bleeding recurred, but both he and his wife wanted to move closer to their home, and they agreed to transfer the following day despite further bleeding. Bleeding recurred on the morning of the planned transfer. The patient told the resident that he was too weak to travel and preferred to stay at the hospital to die, but his wife wanted him to be transferred anyway to be closer to their home.

The resident paged me and asked me to come help decide what should be done. As I walked toward his room, I considered the choices: should we send him to the nursing home as planned, and as his wife preferred? Or should we allow him to remain in the hospital, perhaps until he died? In my thoughts, I reviewed all of the influences on the decision. The hospital was full; other patients were in the emergency room waiting for admission. Several patients needed his monitored bed. As medical director of the nursing home to which he was to be transferred, I didn’t want to call and cancel his admission there again; this had already been a time-consuming process for the nursing staff over the last few days. Then, I noticed a conversation in my mind. I was rehearsing my advice to the patient and his wife as if directing them through the process, telling them that he needed to be transferred today as we had planned, and as we had agreed the previous day. Even though I wanted him to have a voice in this decision that would be his last, I heard my own voice and felt myself taking charge of the process, preparing to make the decision final.

Gradually I became aware of my discomfort with my own planning and predetermined aim to transfer him today. I recognized my desire to take charge of the situation and tell them what we should do. I saw one of my own behavioral patterns: I wanted to rescue them from uncertainty and chaos, and just make the situation comfortable and easy for them. And I wanted to please the residents and hospital administrators by transferring him today.

Physician self-knowledge. Self-knowledge is the understanding of one’s own capabilities, character, feelings, beliefs, and motivations. In medicine, self-knowledge has been specifically defined as “insight into how one’s life experiences and emotional make-up affect one’s interactions with patients, families, and other professionals” (Novack et al. 1997). Self-knowledge informs much of medical
practice, but many years may be required before the physician sees clearly the full meaning of the term and its effect on patient care. Self-knowledge requires self-reflection, and it evolves by being curious and open to the possibility of learning something new or recognizing something that was not previously conscious. This understanding may involve seeing personal beliefs clearly, recognizing reactions that occur repeatedly in various situations, or feeling emotional responses and knowing that they are present. Paying attention to such details of cognition, emotion, sensations of everyday life may lead to an "awareness of being aware" (Elliston 2001; Tate 1994). In other words, all of the automatic pilots are turned off—you simply pay attention to what you are doing, and you realize it.

In this case, I watched my thoughts and realized that I was making a decision in the absence of the patient. Making such decisions is the attending physician's responsibility, and many similar decisions are made as a part of daily activities. Most of these decisions are routine. However, in this setting of potential discord and at a stage so near death, the patient's perspective as well as his family's should be central to the decision-making process.

Medical ethics puts the patient in a central role here—he has the capacity to make the decision, but because he has changed his mind further understanding is needed (Connelly 2002). Is it his physical condition? Is he afraid? Has pain developed? This intellectual knowledge of medical ethics must be transferred to the clinical moment, and herein lies the challenge (Branch 2000; Connelly 2002; Miller and Schmidt 1999; Novack, Epstein, and Paulsen 1999). Physicians sort many factors and weigh much information as they come to recommendations for patients. However, I realized that I was caught up in a habit of accommodation: I wanted to make things as easy and comfortable for the patient and his wife as possible, and I wanted to please others. In this instance, my habit led to a paternalistic (perhaps paternalistic) decision that was not the person- or relationship-centered approach needed for the best outcome or plan.

Self-knowledge offers many potential benefits that include: an awareness of personal behaviors, stressors, beliefs, and values; more informed objective as well as creative choices, personally and professionally; deeper and clearer understanding of patients and self; the promotion of professional attitudinal and behavioral change; personal and professional growth, as well as improved physician mental health by diminishing stress and increasing satisfaction; and a possibility of developing compassion for self and within healing relationships (Novack et al. 1997).

Case Narrative: Part 2

Practicing mindfulness, I recognized my discomfort and my habitual pattern. I realized a decision point. I could assume control and make arrangements for his transfer today. But I also saw that the patient's contributions to the decision were lacking. So before I entered the room, I decided to let go of my control of the situation and be open to all the possibilities that might arise in our conversation. I promised myself to listen.
I entered the room without an agenda and felt curious about what would develop. His wife was sitting at his bedside; he raised his hand toward me, but seemed very weak. After several moments his wife said to me, “Will you kiss him on the forehead?” “Sure,” I replied with a questioning look on my face. She said, “We have a special name for you that we’ve never told you about. It is a joke between us. He calls you ‘Kissy.’” I remained bewildered. She explained that many years ago when I performed a fundoscopic examination—my face next to his—his impulse was “wanting” to kiss me. Afterwards, he jokingly told her of his desire and named me “Kissy.” The story made me laugh, and I said to him, “Well, it sounds like you are the one who wants to kiss me.” So I bent forward and he kissed my cheek. Then I teased him (as well as medical tradition) and said, “With the truth out, I guess it is OK for me to sit on your bed.” I sat down, he reached for my hand, and we remained quiet, savoring the delight of the moment.

Mindfulness as a clinical tool. Because I had been practicing mindfulness, I woke up to the various aspects of the situation. I could feel my emotions coming and going. I saw my awareness of the hospital’s triage need and my own frustration with the “on-off” situation of discharge and transfer. Without mindfulness and the associated aspects of self-knowledge, I would have taken control of the situation and simply informed the patient and his wife of my recommendations for discharge. If my intention had remained focused on making the decision, rather than allowing my attention to expand into a state of not-knowing, of being open to whatever arises, the focus of our interaction would have been limited to the question of discharge and transfer. And this would be a rather familiar, standard, professional, medical interaction. With mindfulness, I let go of my analytic mode, and a quiet presence arose as I noticed my breath and allowed myself the space to be still and calm. With this awareness, it became clear that the decision was not mine to make alone.

Mindfulness holds a place of central importance in the teachings and practice of Buddhism, but it is simply a particular way of paying attention. Joseph Goldstein (2002) describes mindfulness as “a quality of mind that notices what is present, without judgment, without interference.” Offering a method of self-inquiry or looking deeply into oneself in the spirit of self-understanding, mindfulness may be used to describe a quality to be cultivated by practice or as an innate state or quality of mind (Kabat-Zinn 1990). The practice of mindfulness is ongoing—a regular, disciplined practice of moment-to-moment awareness. In Full Catastrophe Living, Kabat-Zinn (1990) writes: “mindfulness is cultivated by purposefully paying attention to things we ordinarily never give a moment’s thought to. It is an approach to developing wisdom in our lives, based on inner capacities for paying attention, awareness, and insight.” When mindfulness is practiced by physicians during ordinary, everyday clinical tasks, it brings to consciousness personal thoughts, preferences, values, and emotional reactions within the care of patients (Bedell and Grayboys 2002; Connelly 1999; Epstein 1999; Santorelli 1999). Mindfulness moves one toward self-knowledge, and in the case of physi-
icians allows them to “hear” and “see” themselves as well as patients objectively. Practicing mindfulness in the clinical setting, physicians see from a broader personal perspective, expand opportunities to diagnose problems, and deepen personal connections.

Case Narrative: Part 3

I could see that the patient was very weak and tired. He had been in pain for so long that I assumed he must be now, although he did not mention it. I began to wonder about his present state: “He must be suffering, in this condition who wouldn’t be?” I wanted to know the deeper aspects of his experience, the personal meaning that would help me understand him more completely, and might influence our decision. So I said to him, “I can see you are suffering.” He nodded and I encouraged him, “Tell me about your experience.” He said, “I’m not a person anymore. I can’t walk outside; I can’t play the piano. I’m just not a person. My time is up.” He talked about his three children who would arrive at noon the following day. He confirmed that his priority was to live long enough to have this final visit with his children. We discussed his wife’s concerns. He was pale and short of breath; slowly, I realized that he would probably die during the two-hour trip to the nursing facility. So he needed to stay in the hospital through the following day for the visit. Two more days in the hospital; I cringed. I told them of my concern about his fragile condition, and they realized that his transfer needed to be delayed. Initially when I informed the medical team of our decision, they were dismayed because his bed was needed by other patients. After some discussion, all of the staff agreed that a final visit with his children was as important as other concerns. The next day he enjoyed a wonderful visit with his children. The following day, two hours after his arrival at the nursing facility, he died.

Diagnosing suffering: The patient’s perspective. Suffering is an individual issue, a unique experience that involves the person. Eric Cassell (1999) refers to suffering as “some symptom or process that threatens the patient because of fear, the meaning of the symptom, and concerns about the future.” To realize that a person may be suffering and to know how to inquire into the meaning of the situation or the nature of the suffering may in fact relieve much of the suffering. This relief of suffering occurs as patients give voice to the unique features of their pain that is then acknowledged and understood by others. Suffering and pain are apparent in many situations, and this obvious nature of suffering can actually discourage physicians or keep them from inquiring into the nature of the experience and coming to understand suffering from the patient’s perspective (Cassell 1982). For instance, when the patient has tubes in every orifice, the physician may realize that suffering is present and not respond in a personal way. To ask, “Are you suffering?” may seem ridiculous, but to say, “I can see you are suffering” invites the patient to respond and give voice to the experience from a personal perspective that may not be about the tubes at all. In this case, the patient’s words were profound. He no longer understood or recognized himself
as a person. He had defined his being by his body and its functional status, and both were failing him—and quickly.

**Discussion**

Many stories are possible during a single clinical interaction. For instance, if a patient has several symptoms—chest pain, left hip pain, and is grieving for the spouse of 47 years who died six months ago—which story will the patient tell? What story will the physician hear? Which of the narrative possibilities becomes the focus of attention? Many factors influence the construction of narratives. The intention here is simply to point out the obvious: there are many narrative possibilities for each interaction between the patient and the physician, and the narrative that is told by the patient may not be the most meaningful or personally important one.

How then can physicians find and attend to the most important, real, and meaningful stories that also are held by individual patients at a particular moment? If this is to happen, physicians need to be aware of these narrative possibilities, and they must have the skills needed to encourage stories to emerge out of the present moment. The physician may need to proceed with an attitude of “not knowing” or simply an open mind—still, not distracted or predetermined. Living with the aim to be mindful offers the physician the opportunity to see and hear what arises in the space that is created for the evaluation and care of the patient. Mindfulness is a practice that may take many forms, both formal and informal. Meditation is an example of a formal practice that encourages awareness, stillness, and openness, while specific meditation practices may encourage, for example, insight or compassion. Informal practices move mindfulness into the world as sensing, looking, and listening exercises, an awareness of being aware, and a focus on the tendency of our minds to think, react, and judge.

Without the physician’s ongoing mindfulness practice, the case narrative presented in this paper would not have occurred. My intention in this paper is not to claim there is a theoretical relationship between narrative and mindfulness, but rather to demonstrate that the practice of mindfulness is a doorway that opens to an awareness of the patient’s story unfolding in the present moment. Mindfulness then influences the narrative. As happened in the case, the story the patient’s wife told—their secret story—would not likely have been expressed if my focus had been on the decision regarding transfer, rather than on being open to unfolding of the interaction. Other aspects probably would not have been shared either, including the details and importance of the family relationship, the degree of the patient’s suffering, or the recognition of the likelihood of his death during transfer.

The practice of mindfulness is suggested as a method to encourage awareness on many levels (e.g., emotions, physical sensations, judgments, reactions, thoughts), to make space for the unexpected or real “story” or interaction to
evolve, and to focus specific attention on the individual patient with the intention of diminishing suffering. Awakening to our habits and beginning practices of mindfulness will open the door to the sharing of personal narratives or “patients’ stories” that are not reified as in the theoretical work, but real and dynamic, as well as meaningful and important to both the patient and the physician.

References


