

IN THE LITERATURE

From *Doctors' Stories* to Doctors' Stories, and Back Again

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Montgomery K. *Doctors' Stories: The Narrative Structure of Medical Knowledge*. Princeton, NJ: Princeton University Press; 1991.

Abstract

Stories have always been central to medicine, but during the twentieth century bioscience all but eclipsed narrative's presence in medical practice. In *Doctors' Stories*, published in 1991, Kathryn Montgomery excavated medicine's narrative foundations and functions to reveal new possibilities for how to conceive and characterize medicine. Physicians' engagement with stories has since flourished, especially through the narrative medicine movement, although in the twenty-first century this has been challenged by the health care industry's business-minded and data-driven clinical systems. But doctors' stories—and Montgomery's text—remain crucial, schooling clinicians in reflection, ethical awareness, and resilience. Physicians who write even short, 55-word reflective stories can hold to humanistic and ethical understandings of patient care and of themselves as healers even as they practice in systematized settings and employ evidence-based expertise.

Introduction

Stories have always been central to medicine, but the meteoric rise of bioscience during the twentieth century all but eclipsed narrative's enduring presence in medical practice. The 1910 Flexner report put US medical education on a scientific footing [1], and the biomedical innovations that followed—from antibiotics to transplant surgeries—enabled doctors to treat many conditions. Science was key to medical progress, arguably to the neglect of medicine's art. Clinical encounters trended ever more scientific: diagnosis depended on objective testing; treatment, on research-based clinical protocols; and wellness, on patients achieving or maintaining certain "numbers."

From mid-century on, doctoring tended to overlook, even screen off, medicine's core uncertainty: medical practice is a *human* endeavor, each patient an *n* of one. With science supreme, the clinical encounter's narrative elements had but shadowy status. "Anecdote" was a derisive term. The patient's story shrank to a single sentence in the chart, the subjective chief complaint cordoned off by quotes. Doctors' stories—

chronicles of careful observation and judgment starting with “What’s the matter?” or “Where does it hurt?”—often seemed just the gate- or record-keeping mechanisms that ushered patients into medical care and then documented their management from hospital admission to discharge.

Doctors’ Stories and the Case for Narrative in Medicine

In 1991, Kathryn Montgomery published *Doctors’ Stories*, a meticulous excavation of medicine’s narrative foundations and functions [2]. A literary scholar teaching in a medical school, Montgomery was an outsider, a self-described “licensed trespasser in clinical territory” [3], who cast a keen yet compassionate eye on medical learning and practice. Her inquiry discovers medicine’s narrative epistemology and acknowledges the generic narrative form—the individual medical case—at the heart of clinical practice. Her study also exposes medicine’s aversion to its own fundamental uncertainty: if only biomedical science could override each patient’s human particularity, each illness’s idiosyncratic expression in an individual life!

Montgomery makes a compelling case for narrative ways of conceiving and characterizing medical practice. In both *Doctors’ Stories* and her later volume, *How Doctors Think*, she clarifies that medicine is not itself a science but rather “a rational, *science-using* . . . interpretive activity” (my emphasis) that depends on the physician cultivating clinical judgment through practical reasoning and experienced knowing. Such an interpretive practice, she suggests, “takes the patient as its text and seeks to understand his or her malady in the light of current biological, epidemiological, and psychological knowledge” [4].

Montgomery’s explanatory model borrows from literary study—close reading (a form of close observation directed at texts), analysis, and interpretation—and turns these methods to the myriad “texts” of clinical medicine, including, especially, patients’ stories, patient-physician encounters, and doctors’ “translations” of those interactions into histories, diagnoses, [chart notes](#), and treatment plans. Montgomery gives us license and a lexicon with which to parse medicine’s narrative principles and practices. She reminds us that patients and clinical situations are made meaningful and memorable in story form as individual narratives replete with descriptive particularity, plot twists, idiosyncratic turns of phrase, and points of emotional connection.

She focuses not only on clinical judgment as acquired and used by doctors but also on the exchange between patient and physician, a crucial human dynamic at once rationally governed (by patterned clinical reasoning and protocols for interviews and physical exams) and emotionally felt (as empathy, compassion, and trust), for doctor and patient alike. She finds both clinical judgment and the patient-physician encounter to be narratively based, founded in the exchange of stories, attentive listening, interpreting and meaning-making, and active response. To illustrate her claims, Montgomery invokes

literature's iconic detective, Sherlock Holmes. This master of close observation, dispassionate analysis, and inductive reasoning—born of Scottish physician Sir Arthur Conan Doyle's imagination and medical experience—is, she says, something of a model clinician [2].

For clinicians steeped in medicine-as-science, Montgomery's work legitimizes "storying" language in and about medicine. Indeed, her conclusions inform and are consistent with the "narrative medicine" movement more recently championed by physician and literary scholar Rita Charon [5]. As defined by Charon [6], narrative medicine is clinical practice grounded in the physician's "narrative competence"—that is, "the competence that human beings use to absorb, interpret, and respond to stories" [7]. Charon contrasts what she calls medicine's "narrative knowledge" with its more widely known "logicoscientific knowledge" [8] but insists that both are necessary—and necessarily in balance—if doctors are to practice "with empathy, reflection, professionalism, and trustworthiness" [7]. As a theoretical construct advanced by Montgomery and Charon (and as a systematic practice taught by Charon and others in narrative-medicine curricula), narrative medicine in recent years has given physicians, patients, scholars, and medical educators alike new approaches to practicing, experiencing, and reflecting on medicine [9].

Do Doctors' Stories Matter Now?

Fast forward to 2017, a quarter-century after *Doctors' Stories* appeared. Health care is among the US's largest industries, with health-related spending reaching \$3.2 trillion in 2015 and projected to surpass one-fifth of the nation's total economy by 2025 [10]. Organized medicine remains bioscientifically based but now also invokes business models, methods, and metaphors as it seeks to grow—in services provided, patients served, profits realized—and to manage costs. Within clinical systems, evidence-based protocols and treatment algorithms are the rule, with laudable objectives to affirm best practices, achieve efficiencies, reduce error, and standardize good care, all to improve patient outcomes. Clinicians are expected to follow practice guidelines, their compliance charted quantitatively in terms of practice patterns and clinical outcomes [11]. Now-ubiquitous electronic health records best capture numbers, not narratives.

Amid the clinical data deluge, the checklist-rich electronic charts, and the buzzwords of bioscience and business, where now is "story"? Is the narrative medicine movement just a rearguard cry of resistance? Or do the stories of medicine—including doctors' stories—still thrive, still count? And is Montgomery's landmark text still helpful as we try to understand better what transpires between patient and physician, what ethical doctoring is all about, and how doctors reflect and take care of themselves?

Teaching Twenty-First-Century Doctors to Write Stories

As a longtime teacher of physicians-in-training, I unequivocally affirm that doctors' stories remain at the heart—indeed, may be the beating heart—of clinical medicine. Like Montgomery, I am a literary scholar and another “licensed trespasser” in the medical domain. Like her, I appreciate—because I observe this almost daily—that physicians know, remember, and learn from patients and practice situations *as stories*. They process clinical experience as Charon's narrative knowledge—as “pearls” or lessons, epiphanies, or cautionary tales. The doctors' stories I know best are those I ask clinically active medical students and residents to write.

Reflective story writing differs from oral tale-telling among peers, as when doctors swap stories from the clinical trenches, each narrator one-upping the other. Rather, story *writing* is work that calls for a different, perhaps more authentic kind of ego investment. It requires discriminating attention to lived experience and a slew of deliberate compositional choices—about genre and form, point of view, plot, chronology, character, voice, tone, a way of beginning, and a sense of an ending. Writing orders experience and in doing so mines it for meaning and practical wisdom. And writing out a signal memory can actually make a new memory.

What medical students learn from narrative writing. My students' stories capture memorable moments in their learning and make them available for scrutiny. Their stories represent opportunities to exercise compassion and humanity toward patients and peers, cultivate moral awareness and a vocabulary for moral discourse, interrogate ambiguity and uncertainty, and engage in self-care, including reflecting on their own and others' attitudes and actions and realigning their professional and personal lives—all practices that novice practitioners will need in order to sustain themselves against the pressures of twenty-first-century clinical work. As internist Kate Scannell observes in “Writing for Our Lives: Physician Narratives and Medical Practice” [12], clinicians' storying can sometimes be life-saving. Writing about their work can preserve practitioners' morale, reconnect them with their sense of purpose, and “so fully expand and engage the personal and professional dimensions of doctoring [as to] expressly remind us of the vast range of human and transcendental experiences available to us” [13].

Richly detailed stories about patients anchor physicians ethically as well as existentially. Patients, after all, really make a doctor a doctor. As Montgomery notes, “Only with the examined and reflective care of patients do well educated students of human biology become physicians” [14]. To know patients as whole persons, to apprehend their worlds and advocate for them, and then to tailor care to their circumstances—these ethical actions are fundamental to good doctoring and well addressed through storytelling.

Provided learners have time, space, and careful mentoring, my experience has been that writing about their clinical lives significantly affects young physicians' formation as reflective practitioners. Young physicians have a nascent moral awareness about their work, derived as much from observing how medicine is practiced as by actually performing it. Learning to story about what they have noticed shapes their clinical style: it is good practice for how to practice. In storying, apprentices refine their sense of [practical ethics](#). They find words for moral hazards and quandaries they witness and any moral queasiness they feel. Their narratives are repositories for humanistic observations, actions, and attitudes that receive scant attention on rounds or in patients' records.

Whether doctors write to remember cherished patients, revisit challenging ones, try to decipher clinical puzzles, rail against uncertainty, forgive themselves, or record flashes of insight, they are exercising moral imagination and elucidating moral lessons. They reinhabit crucial experiences and hunt for the right words to represent and interpret themselves and their own and others' actions, all against a backdrop of professional ethics and [personal values](#). In the process, they may ruminate on what it is and what it means to be a doctor.

The 55-word story. Time being short for medical students, and shorter for residents, the 55-word story is a powerful tool for busy clinicians' reflective writing. This tiny narrative template seems to have been first described in 1995 [15]. Now well used in medicine [16-18], it has been championed in *JAMA*, three "A Piece of My Mind" essays offering guidance and examples [19-21]. As a literary form, it is simple. As an assignment, it may or may not be written to a prompt. As a task, it is blessedly brief—also game-like, distractingly, even addictively, so. Here is the trick: the story must be *55 words exactly*, no more and no fewer (not counting an optional title). There are no other rules. The exercise involves words and numbers, composing and counting—a lively combination of mental functions. The story may be written fast (in under ten minutes) or slow (take a week); it need not use complete sentences; it may be arranged on the page any which way; its word count may be edited down or built up to the magic 55; in topic and tone it may be dark or droll, silly, sweet, or stunning. Perhaps most importantly, anyone can write a 55-word story. Also, in my experience, more doctors than not love this exercise and many make it a permanent addition to their medical toolkit.

The 55-word story has long had a place in my literature and medicine course, where senior medical students write to remember significant moments from their clerkships and then share their narratives with classmates. More recently, students in our Gold Humanism Honor Society chapter collected peers' 55-word tales about clinical life and bound them into a pocket-sized booklet for presentation to the new clinical clerks titled *Don't Forget—Stories from the Clerkship Year*. Here are two, by two of the story project's leaders.

Don't Forget

The resident you (almost) followed into the bathroom.

All the times you felt completely clueless about where you were supposed to go or what to do.

The physics equation you couldn't remember.

The residents who made you feel like part of the team.

All the incredible patients you had the opportunity to take care of.

(© 2017 Claire Montaigne, class of 2016)

Written at the close of the clerkships, this story looks back on a momentous year with a potent mix of disbelief (did I really do that?) and relief (I made it!). In choosing moments to remember, the writer charts her growing competence and balances naïve embarrassment against newfound clinical confidence. Tellingly, the narrative arc trends positive, the young clinician's last lines focusing on the patients she served and the house staff who welcomed her rather than on the times her ineptitude made her cringe.

An Avocado Tree in Monterrey

In his CCU bed with a failing heart, he told me about when that now sickly organ had driven a farm boy from Virginia to Monterrey, where he sat beneath an avocado tree with Elena. I plied him for more each day, treating his heart as he treated mine, unsure who was the greater beneficiary.

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This story draws deftly on the manifold meanings we attach to the human heart. While centered on an older man in cardiac failure, it quickly reveals the apprentice doctor's heart-felt, transformative engagement with his patient, who had shared a vivid tale of an intrepid journey and romantic encounter many miles and years ago. Patients matter to their doctors: they teach and even help to take care of their doctors; in turn, physicians honor and remember patients by holding their rich, idiosyncratic stories. The student supplemented his 55 words with a small sketch depicting his patient (as a young man) in faraway Mexico, sitting under the avocado tree alongside Elena. Imaginatively, compassionately, my student was there too, and this changed him, as well as the care he gave in the coronary care unit.

In my experience, apprentice doctors are schooled and soothed by what they write. If we instill in them a habit of regular narrative practice, trainees may learn to manage stressful careers more adroitly, better tolerate medicine's uncertainties, maintain healthy self-regard, and find greater satisfaction and meaning in their life and work. And

writing stories about being a clinician also makes explicit, and discussable, what Montgomery affirms: the narrative nature of medical knowledge, learning, and practice.

Conclusion

With concerns about practitioner burnout and associated patient-safety risks [22], medical schools now give priority to reflection and self-care, which can help doctors-to-be cultivate emotional resilience for a lifetime's practice. Reflection is increasingly considered a core clinical competency [23-26]. Reflective physicians are likely more self-aware, more open to self-improvement—even, potentially, more wise. But reflection and self-care are disciplined practices, ones that we in medical education are challenged to inculcate in trainees via traditional methods of medical learning and assessment. Storying, though, is a time-honored mode of reflection and self-examination, and, increasingly, medical schools are turning to narrative-writing strategies to help learners cultivate self-awareness and become reflective practitioners [27]. Storying early, storying often, in 55 words or more, physicians can hold to humanistic and ethical understandings of patient care and of themselves as healers even as they work in high-pressure, systematized settings and employ evidence-based expertise. Montgomery still matters: *Doctors' Stories* licenses twenty-first century practitioners to affirm the value of their narrative knowledge and practice and to confidently, compassionately care for patients and for themselves.

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ISSN 2376-6980**