

The art of medicine Narrative humility

“So much of a writer’s life consists of assumed suffering, rhetorical suffering”, writes Anatole Broyard in *Intoxicated by My Illness, and Other Writings on Life and Death*, a memoir published after his death from metastatic prostate cancer. Like the writer, whose work depends on entering into the imagined suffering of equally imagined characters, so too is the doctor intertwined inextricably with “assumed” or “rhetorical” suffering. This is, of course, not to suggest that pain, illness, or disfigurement are somehow not real to patients and their clinicians; rather, to suggest that entering into a suffering which necessarily resides outside the clinician’s own physical and emotional being depends upon the clinician finding an entry point into that suffering from within her own imaginative self. This entering into the suffering of another is akin to the work of the novelist, who must get to know his characters, like new acquaintances, and allow the story’s plot to unfold before him; it is like the act of the careful reader, who enters into the metaphor of the poem while allowing the metaphor of the poem to enter him, granting yet undiscovered meaning to his life’s events.

Rita Charon, my colleague at the Program in Narrative Medicine at Columbia University, has written extensively about the skills required to witness the patient’s story. Using the language of medical training, in which educational milestones are described as “competencies”, she has named this clinical skill set “narrative competence”. Over the years, in working with Charon and our other colleagues at the Program in Narrative Medicine, I have come to expand upon this notion, realising that, although clinicians should continually strive for measures of narrative competence, the stance from which we witness stories of suffering must be one of *narrative humility*.

One very literal aspect of narrative humility is the fact that the patient’s story, at least initially, belongs entirely to him. Unlike the physician of mine who, during a recent personal illness, interrupted me to say, “You don’t have to say any more. I know exactly how your story ends”, clinicians cannot, of course, ever *exactly* know how any illness story begins or ends. As careful interviewers and witnesses, we become invested in, wrapped up with, and, yes, coauthors of our patient’s illness narratives, but we cannot ever claim to comprehend the totality of another’s story, which is only ever an approximation for the totality of another’s self. In an essay on the work of philosopher Emmanuel Levinas, medical educator and philosopher Craig Irvine describes the Other as that which lies always, and necessarily, *beyond* the comprehension of the Self. Endeavours to fully capture, understand, or master the Other are, then, nothing more than totalising enterprises. Yet, the primordial ethical act, the act in which medicine is ideally engaged, lies in answering the call of the suffering Other. In this context, narrative humility is, in Irvine’s words, “the sense of humility toward that which we do not know—the face of the Other, the face we cannot know but to which we are responsible”.

Narrative humility is a response to efforts at clinical mastery, including many well intentioned ones, such as my own past work in culture and diversity training with medical trainees—what is still sometimes called “cultural competency”. Such training, which aims to enable physicians to better care for patients with socioeconomic, ethnic, or other characteristics that make them different from their care providers, can sometimes become a sort of cultural mastery of marginalised communities. Although this is fortunately no longer the usual case, cultural competency training still sometimes involves handing trainees lists of cultural characteristics: when a Dominican tells a story about “susto”, this is what she means; when a Chinese immigrant’s body reveals mysterious round markings, they are evidence of coining; and so on. This is

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not to say that familiarity with cultural beliefs and practices does not improve a physician's ease with her patient's illness narrative; rather, that the unstated assumptions of this sort of training—that trainees are necessarily from a privileged cultural group, that patients of a particular background share homogeneous beliefs, that the complex nuances of difference can be "mastered", and that ethnic similarity between clinician and patient mandates mutual understanding—believe its well intentioned goals. Most importantly, traditional cultural competency training, like traditional medical training, is externally focused, primarily concerned with mastering the Other, rather than examining the internal cultures, prejudices, fears, or identifications of the Self in relation to that Other.

In fact, my notion of narrative humility borrows from the work of Melanie Tervalon and Jann Murray-Garcia who suggested, in 1998, the term "cultural humility" as opposed to "cultural competency" or "cultural sensitivity" to guide clinicians in serving the needs of diverse populations. Bringing attention to the internal workings of the clinician, they suggest that cultural humility is a practice committed to a lifelong process of self-evaluation and self-critique.

Narrative humility acknowledges that our patients' stories are not objects that we can comprehend or master, but rather dynamic entities that we can approach and engage with, while simultaneously remaining open to their ambiguity and contradiction, and engaging in constant self-evaluation and self-critique about issues such as our own role in the story, our expectations of the story, our responsibilities to the story, and our identifications with the story—how the story attracts or repels us because it reminds us of any number of personal stories. Also by thinking about it as *narrative* humility (and not just cultural humility), we recognise that this is a perspective we take with *all* the stories with which we engage—not just something we do when those "other" people walk into our office, whatever that may mean to us—while simultaneously not losing the idea, the parallel sociopolitical narrative, that there are larger forces that enable the telling of certain sorts of stories and silence other stories. Narrative humility allows clinicians to recognise that each story we hear holds elements that are unfamiliar—be they cultural, socioeconomic, sexual, religious, or idiosyncratically personal. Assuming that our reading of any patient's story is the definitive interpretation of that story is to risk closing ourselves off to its most valuable nuances and particularities.

Like diversity training, narrative humility also addresses the hierarchical imbalance of the clinical relationship. It acknowledges that the socially more powerful player—the clinician—must willingly place herself in a position of some transparency. The clinician must not only see, but be seen, and by doing so, enable herself to see even

more clearly. Oral historian Alessandro Portelli has written extensively about mutuality in the relationship between field researcher and subject, but his comments can be easily applied to the clinical relationship. He writes, "an interview is an exchange between two subjects: literally a mutual sighting. One party cannot really see the other unless the other can see him or her in turn. The two interacting subjects cannot act together unless some kind of mutuality can be established. Thus, the [clinician] has an objective stake in equality." In other words, by entering into a stance of narrative humility, the physician is fostering a state in which, as Broyard has observed, even as the physician examines the patient, the patient is able to examine the physician. The witnessing function, so crucial to doctoring, becomes a mutual one, supporting and nourishing both individuals, while enabling a deeper, more fruitful clinical relationship.

Narrative humility is not, perhaps, a stance that traditional medicine readily takes, yet its derivatives are profound. As Broyard writes, "Not every patient can be saved, but his illness may be eased by the way the doctor responds to him—and in responding to him the doctor may save himself. But first he must become a student again; he has to dissect the cadaver of his professional persona...It may be necessary to give up some of his authority in exchange for his humanity, but as the old family doctors knew, this is not a bad bargain. In learning to talk to his patients, the doctor may talk himself back into loving his work...by letting the sick man into his heart...they can share, as few others can, the wonder, terror, and exaltation of being on the edge of being, between the natural and the supernatural."

Narrative humility suggests the possibilities of something transcendent, what Broyard calls the opportunity to become "transfigured". It approaches what has been called mindfulness in medicine. Indeed, humility is a central aspect of many spiritual traditions, whereby the stance of humility is one that enables not only personal growth, but is a hallmark of some degree of spiritual enlightenment—whereby the most learned monks are the most humble, recognising how much they have left to learn. This does not imply that physicians abandon their scientific knowledge, or their sense of "competence". Rather, narrative humility enables a physician to place herself in a position of receptivity, where she does not merely act upon others, but is in turn acted upon.

So much of a doctor's life consists of stories. Narrative humility is a point of entry into those stories, allowing us to reconfigure our own relationships to the work of doctoring, to the Other before us, and to the Self within.

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Further reading

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