Cancer is an uninvited life guest, disrupting daily routines, straining relationships, and shifting one’s sense of self. Instead of forming bone on her growth plates, sixteen-year-old Caitlin Shoup grew a two by two inch tumor on the end of her left distal femur, biopsied and diagnosed as osteosarcoma in June, 2004. Within ten days, she began a triple drug chemotherapy regimen. While her classmates chose between co-curricular activities, Caitlin weighed the comparative benefits and risks of limb salvage surgery versus amputation. She completed most of her junior year in the oncology ward at Akron Children’s Hospital, and though she returned to Perry High to complete her senior year, starkly visible markers of her cancer remained. She continues to bear the twelve-inch scar between her thigh and calf with dignity. “I wear my scar with pride and am honest about it most times, unless people approach me rudely, in which case the scar is from a shark attack!” In addition to hair loss and permanent hearing damage, though, Caitlin lost patience for the melodramas of teenage life. “I have a low tolerance for B.S. and immaturity,” Caitlin shared. “… It’s amazing how few people actually appreciate their life and don’t want to waste it.”

With a femur replaced with titanium and a new plastic knee, the range of motion in Caitlin’s knee remains limited, she walks slower than most people her age and with a visible limp. Her left leg is disfigured from numerous surgeries and, due to nerve damage in her foot, multiple surgeries, and staph infections, she has on occasion relied on leg braces, crutches, wheelchairs, and immobilizers to ward off infections, reduce the impact of “foot drop,” and increase mobility. A blue tag hanging from Caitlin’s rearview mirror marks her as disabled, a welcome moniker that limits the distance she must walk to her apartment, class, and restaurants. Even so, she resists the marginal position that too often accompanies living with a disability. “Although I am legally handicapped, I don’t consider myself that. I just say I am different-abled. I’m proud of everything I had to overcome and it makes me who I am today.”

Narrative Roots in Health Communication

The late Don Hewitt, legendary television news producer for CBS, said that his format for his famous show 60 Minutes was simple; namely four words that every child knows—“Tell me a story!” This anecdote is a layman’s version of rhetorician Walter Fisher’s (1987) claim that humans are inherent storytellers (and hearers). In other words, each of us, to varying degrees, makes use of our narrative tendencies in a wide array of communicative activities, including how we talk about health, illness, and medicine. Thus we begin with a brief overview of the basic elements and purposes of narratives in health-related contexts. This
is knowledge that is foundational to health communication scholarship conducted as narrative inquiry.

The story of Caitlin and her family, which we have introduced and will continue to relate throughout this essay, clearly illustrates all the classic features that constitute the communicative form widely recognized as a health narrative. It is in large part an illness narrative insofar as it was prompted by the life-threatening, life-altering personal rupture (Bruner, 1990) that is cancer. As this tale unfolds, it becomes a story of healing and hopefulness. In some ways it is a quest for the deeper meanings of this illness experience (Frank, 1995), as well as an enactment of resilience, courage, coping, family love, and community solidarity. The main protagonist and narrator, naturally, is Caitlin, but several other characters—her mom, dad, younger sister, and a hometown journalist—co-construct, narrate, and enrich this account. Each voices motives, fears, desires, and choices that work to emplot the series of events in which they find themselves; that is, to form connections among actions and ideas, to attribute agency to self and others, and to come to grips with changing circumstances and storylines (Mattingly, 1998). As with all narratives, the plotline extends

Figure 3.1 Battle ribbons: Caitlin’s hospital wristbands.
Barbara F. Sharf, Lynn M. Harter, Jill Yamasaki, and Paul Haidet

through time (Ricoeur, 1984–1988). There is a seemingly faraway past depicting a happy family prior to cancer; a series of frightening, near past episodes in which pain, diagnosis, treatments, and treatment repair predominate; an energetic, thankful, and optimistic present, tempered by ongoing challenges, lessons learned, and an altered way of living; and, thankfully, a foreseeable future, open with possibilities. The story that is eventually layered and pieced together occurs through changing scenes of home, hospital, and the public sphere. What begins as intensely personal interactions among members of Caitlin’s family evolves to include friends, health practitioners, and eventually a dialogue with a larger audience of well-wishers and interested others. We should also assume that there are deliberate silences, parts of the lived story that individual narrators have chosen not to disclose (Poirier & Ayres, 1997). As unique as the content of this particular health narrative, so is its telling through the several texts through which it unfolds, in many voices, through multiple perspectives. It is visual and verbal; oral and written; conversational, journalistic, poetic, and deliberative.

In addition to the grammar or constituent parts, foundational narrative scholarship has spoken to the functions or applications of health narratives. Health narratives may occur as individual stories (or as in our example, a pastiche of individual stories constituting a family narrative), but there are also socially constructed stories or master narratives that arise from and exist within the larger culture; for example, exemplary depictions of what it means to live with cancer. Previous research (Sharf & Vanderford, 2003) has identified several major functions of health narratives. Stories are a way of making sense of an uncertain or chaotic set of circumstances (Bruner, 1990), which are frequently set in motion by a serious diagnosis, among other life events (Frank, 1995). The stories we create or ascribe to are both a by-product of our cultural life (Morris, 1998) and a further construction of social reality; for example, stories such as Caitlin’s enable people to understand cancer as a survivable, chronic disease rather than a death sentence. Narratives provide implicit explanations (Kleinman, 1988) that reveal ideas of causation, remedy, and future possibilities, infer warrants for decisions made, and enable a sense of control in the face of threat and disorder (Beck, 2001; Sharf, 2005). Life-altering illness or disability necessarily brings about changes in personal identity in terms of how individuals view themselves and how they are perceived by others (Frank, 1995). Narratives can help to create identification (Burke, 1950) among people experiencing similar health problems, thus building a sense of community in place of social isolation. Finally, narratives may result in beneficial health outcomes (Pennebaker, 2000).

Moving on from these fundamental understandings of what health narratives are and what purposes they serve, we now transition to the current landscape of health communication scholarship. We emphasize how the robustness of narrative theory rests in part in its focus on webs of interwoven social (and material) forces. No story is solely personal, organizational, or public; personal stories cannot escape the constraints of institutional interests, nor are they separate from cultural values, beliefs, and expectations. Meanwhile, institutional structures and scripts intertwine to form the social milieu in which performances unfold. In their seminal compilation of narrative analyses from various vantage points of health-related concerns, Harter, Japp, and Beck (2005) encapsulate the scholarly challenges of negotiating tensions between knowing and being, continuity and disruption, creativity and constraint, and the partial and the indeterminate. In what follows we account for newer directions in inquiry, and ways in which this work is enriching contemporary understandings of health, medicine, and illness.
Enlarging the Landscape of Health Narratives

Humanizing Health Care

After a routine CT scan revealed a suspicious mass on her left lung, Caitlin’s oncologist feared a worst case scenario—osteosarcoma had metastasized to her chest wall. Even after a basic explanation from the surgeon, the process and techniques of a transthoracic needle aspiration biopsy remained opaque to common sense. “I wanted to know what was going on in my own body. [The doctor] was telling me, but I couldn’t see it, I couldn’t visualize it,” stressed Caitlin. “Oftentimes they take photos for medical reasons, so I just asked him to take my camera in to my surgeries. And he did. He always had one of his medical students, that was their job for the day, to take pictures.” The transformation of Caitlin’s body was rendered seeable as well as sayable as her surgical team snapped photos, dramatizing the biopsy process, and preserving a fragment of narrative experience that might otherwise be lost. “I learned a lot about my body. Like this picture here [a photo of her chest cavity open], I thought it was cool at first, because I didn’t know what a lung looked like. I thought it looked like a tongue. But, the opening is so huge. I couldn’t believe they could do that. Unbelievable.” Images can activate patterned integrations of our remembered past, perceived present, and envisioned future, and in so doing function as anchors to transitory moments and living memories (Reismann, 2008). Three years later, the photo elicits conflicting emotions for Caitlin, a mnemonic device beckoning her to remember and reflect on a punctuated moment. “I feel angry when I look at that picture, because I told [the doctors] it had not metastasized. I knew my body, and they didn’t listen. But I also feel relief, the relief that came from the pathology report, from knowing with confidence that it had not spread.”

Figure 3.2 Caitlin’s chest cavity during surgery.
The provision of health care would be impossible if not for our human capacity to organize and embody lived experience in narrative form (Hunter, 1991). Diagnosis and treatment are narratively inflected enterprises consumed with emplotment processes (Charon, 2006). A central difficulty arises, though, when the singularities of a patient’s case are juxtaposed with the generalities of a science–using practice. Caitlin’s providers followed warning signs to detect potential problems, search for patterns of causality, and chart courses of action. They were trained and legitimated to do so by the language and practices of technology, complex and esoteric terminology and techniques. The Shoup family had not heard of a solitary pulmonary nodule (SPN). Caitlin’s doctors were faced with a narrative challenge: to help the family comprehend and contemplate “the shadow” on the CT scan of Caitlin’s lungs, and the potential consequences of a malignant mass. Extraordinary health care providers are endowed with the gift of plot—those who understand how clinical practice relies on narrative activity to not only facilitate treatment but also build relationships with patients and probe what it means to be sick and well.

Narrative sense-making is not new in medical practice. Even so, the fact that information from patients often arrives in narrative form usually goes unrecognized. Until recently, the explicit acknowledgment of narrative activity in clinical work was whispered on the fringes of mainstream medicine. The growing interest in narrative activity in health contexts is evident in scholarship on the narrative nature of clinical judgment and health care (e.g., Ellingson, 2005; Hunter, 1991; Montgomery, 2006), and the emergence of the narrative medicine movement (e.g., Charon, 2006, 2009; Greenhalgh & Hurwitz, 1998). Loosely coupled, these research and praxis trajectories emphasize the role of narrative practices in humanizing health care.

**Cultural Stories: Moving between Public and Private**

Of course, you have to be careful. You hear a lot of stories on ACOR [online cancer list-serv]. We have buried a lot of kids. Sometimes you have to filter what you read, ’cause it can create a lot of “what ifs,” and it can take a toll on you. But, we’ve made life-long friends through ACOR.—Tricia, Caitlin’s mom

Narratives rarely, if ever, have a solitary existence. They operate concurrently in relation to other stories, and may reinforce, indirectly compete with, or actively confront or resist one another (Lindemann-Nelson, 2001) in ways that shape our understandings of disease, illness, healthiness, care, healing, survival, and mortality, among other issues. This is the case even with master narratives, stories that underlie, reflect, and perpetuate predominant cultural values and assumptions about how the world is constituted and how society functions. For example, at present the master narrative that the U.S. health care system is the best in the world, albeit that it has grown too expensive, is being challenged by other versions of what is at stake and how reform should occur: stories that illustrate a health care system whose outcomes lag far behind those of other national systems that are less costly and technologically dependent, is inaccessible to large groups of working people, and unfair in terms of who benefits and who is omitted. The saliency, vividness, clarity, and resonance of these competing, sometimes colliding, narrative accounts now circulating in the public sphere is likely to determine how U.S. health care will be reshaped for generations to come. Making sense out of the multiplicity of overlapping but frequently contradictory stories told about specific health concerns is a challenging aspect of health literacy. Some issues that come into
Narrative Turns Epic

play in considering how health narratives are communicated, shared, and understood in the public sphere include intertextuality, narrative transformations, and instrumental, as well as expressive, functions. We’ll discuss each of these factors in turn.

**Intertextuality.** This term refers to the processes through which discrete narrative meanings influence one another (Harter et al., 2005), and even give rise to newly derived significance not intended or implied in preexisting stories. Perhaps the most important interface is between private and public versions of illness narratives. Upon diagnosis of a life-changing or life-threatening condition, one struggles to revise one’s autobiography to make sense of an altered identity and why this has happened, and to accommodate ensuing changes in body, lifestyle, and social relations, amongst others. In Caitlin’s case, her revision is, by necessity, sudden, radical, and unavoidable: “I was worried about school because I was on the fast track to being valedictorian…. Life just seemed to change in an instant.” The difficulty of this transition was in part lessened by exchanging stories with Michelle, another girl undergoing similar experiences: “Cancer brought me a new best friend. She understood in ways that my other friends from school couldn’t.” Caitlin’s mother Tricia found a similar enhanced meaning through participation on a cancer web site in which stories are shared.

However, Tricia also points out a more problematic side of intertextuality in this venue, in which hopeful, positive meanings are superseded by tragic ones. Another intertextual difficulty is what happens when there is a breach or outright contradiction between one’s personal narrative and a more public version. Caitlin’s father, Doug, commented on the pros and cons of making their personal story public: “It was nice that people thought to donate to us. But a lot of the time, I didn’t feel like I needed it, there were probably people who needed it worse. I donated a lot to churches, soup kitchens, ’cause we didn’t have a need for it.” Japp and Japp (2005), examining experiences with Chronic Fatigue Syndrome, describe the additional suffering brought about when one’s private illness narrative is at odds with the dominant public version; in this case the biomedical master narrative of what constitutes a legitimate disease, necessitates the evolution of the “legitimacy narrative” in which an individual’s account of illness must attempt to establish moral, medical, and public legitimation for the suffering s/he experiences (p. 109). A more optimistic trajectory may occur when going public with one’s private account is voluntary and provides positive functions for both the storyteller and her audience. Beck (2005) emphasizes how readers or listeners became collaborators in the co-construction of an illness story, thus broadening a support community.

**Narrative Transformations.** When Caitlin’s experiences with cancer were communicated to the people of Massilon, Ohio through a series of articles in the local newspaper, she and her family received many responses, though how exactly the readers were affected is difficult to know. A question of great interest that has been investigated through several theoretical vantage points is how the narrative process works. Some of this work is distinctly psychological in nature, theorizing how comprehension of stories impacts individuals and mass audiences, including narrative transportation or how respondents are psychologically transported out of the here-and-now through story (Green & Brock, 2000), authenticity as a necessary quality of effective narrative content in public health (Petraglia, 2009), and education-entertainment in which mass-mediated stories are used purposively to instill ideas, values, and ideologies (Singhal & Rogers, 1999; Slater, 2002). Alternative conceptualizations posit mediated characters and plots as role models (Sharf,
Freimuth, Greenspon, & Plotnick, 1996) and representative anecdotes (Workman, 2005) that enable viewers to work through problematic health scenarios encountered in real time. In sum, current research looks to cultural health narratives as conduits for transforming viewers/listeners, shaping their understandings, feelings, attitudes, and perhaps behaviors in particular ways.

The connection between the personal and public runs both ways. A different perspective on transformation focuses on how personal health narratives are changed through media and other forms of cultural exposure. One of the likely outcomes of the publication of Caitlin’s story was public education about the illness experience, cancer diagnosis, and treatment. Since she has been in remission, Caitlin is active in writing and speaking publicly about cancer: “My experience with cancer has been life altering and now it is my duty as a survivor to help good come from this bad chapter in the book of life.” However, making personal accounts public may have much more complicated consequences.

The sad, extremely difficult story of Terri Schiavo, a young woman in a persistent vegetative state, is a case in point. The private family disagreement between Terri’s parents and her husband over whether life-sustaining treatment should be withdrawn became a national narrative and counternarrative that was portrayed repeatedly on television, through the Internet, and other journalistic outlets. Members of Congress weighed in with contrasting opinions, religious beliefs about the nature of life were invoked, and conversations about advance directives were sparked among ordinary people. How did the popularization of the Schiavo case affect the personal relations among Terri’s various advocates? Could the argument have been negotiated with less rancor had the story remained private? What purposes were served by the public debate that ensued from opening this conflict to public scrutiny? What costs were engendered? Was the human dignity of Terri in her compromised state honored or degraded by the public retelling and interpretation of her story?

Narrative Functionality Continued. The aforementioned functions of sense-making, exerting control, warranting decisions, and coping with changing identity are especially pertinent to the communication of personal health narratives (even if this occurs in a public setting). Building community, to which we have now added increasing public awareness and education, are necessarily narrative functions that must transpire in the public sphere. There are two more potential functions connected to public communication we would like to mention. Counternarratives that challenge widely ascribed master narratives are primary and necessary aspects of health advocacy and social activism (Sharf, 2001; Zoller, 2005); for example, poet Audre Lorde’s (1980) prescient and memorable image of one-breasted women descending upon Congress to change what was a climate of secrecy and invisibility surrounding breast cancer. Thus, closely related, is the use of narrative to propel changes in social and governmental health care policies (Sharf, 2001). As our scholarship moves more in the direction of these newer functions, we envision a parallel continuum of stories of illness to stories of prevention, healing, and mobilization of resources.

The Narrative Nature of Clinical Judgment and Health Care

What knowledge is necessary to practice medicine, mused Kathryn Montgomery Hunter (1991), an English professor then on the faculty of Morehouse Medical School. Scientific
and instrumental logics remain central to the practice of Western medicine, reasoning skills powerfully equipped to address certain dilemmas even as they obscure other ways of knowing. The almost unquestioned assumption that medicine is a science is misleading to the extent that it fails to acknowledge how clinical success also depends on a provider’s interpretive capacities to make clinical judgments in inescapably uncertain and contingent moments (Montgomery, 2006). Montgomery enlarged dominant notions of rationality by positioning narrative sense-making as vital for the provision of health care (see also Greenhalgh & Hurwitz, 1998; Mattingly, 1998).

Medicine is far from an unmediated representation of reality. Health care participants construct understandings of experience and use those interpretive frames to guide future actions. Providers and patients alike read physical symptoms narratively and contextually, urged by the impulse to emplot events befalling a character, search for causality, and develop actionable interventions. Individuals offer storied accounts of symptoms, side-effects, and, if invited or supported, their experience of illness in the diverse scenes that compose their lives. But in health care contexts, narratives also take the form of cultural scripts and even performances which create as well as comment upon prior experiences. Norms characterizing the biomedical model (e.g., detached concern) represent institutionalized scripts about how people, labor, and health care delivery should be arranged and performed. The biomedical model itself can be understood as a grand narrative, an ongoing structure of values and beliefs including a hierarchy of characters, archetypal plots, and sacred spaces (Morris, 1998). For example, drawing on ethnographic fieldwork, Morgan-Witte (2005) positioned nurses’ stations as backstage storytelling hubs, webs of narrative activity endorsing (and dismissing) value structures, and Ellingson (2005) emphasized the interconnectedness between backstage and frontstage role performances among providers interacting with patients being served by an interdisciplinary oncology team. Of course, personal narratives and cultural scripts are told and lived in material circumstances that shape performances. In reporting on fieldwork with a mobile health clinic serving families in rural Appalachia, Harter, Deardorff, Kenniston, Carmack, and Rattine-Flaherty (2008) illustrated the difficulty of sustaining the taken-for-granted script of patient–provider confidentiality amidst shifting material and social circumstances that call it into question (e.g., paper-thin doors separating exam rooms from waiting areas).

From a performance perspective, clinical action itself is an ever-emerging story, what Mattingly (1994, 1998) termed therapeutic emplotment. “Therapists and patients not only tell stories, sometimes they create story-like structures through their interactions,” argued Mattingly (1998, p. 19), story-making that is integral to healing. To envision clinical action as an unfolding story reaches beyond looking at narrative as raw material offered by patients and family members. Mattingly’s performative stance assumes narratives are lived before they are told (see also, Langellier, 2009). In recounting her immersion with occupational therapists, Mattingly described how they are motivated to locate themselves and patients in an intelligible plot in the midst of interaction. The success of occupational therapy rests with what the therapist and patient accomplish together; “One could say that a therapist’s clinical task is to create a therapeutic plot which compels a patient to see therapy as integral to healing” (Mattingly, 1994, p. 813).

In summary, scientific rationality is a limited conception of reason. Isolating a physiological problem and situating it in a realm of its own disconnects illness from the scenes of everyday experience.
Continuing the Conversation

Broadening Narrative Scholarship

I’ve been scrapbooking a long time. So, anything of significance in our family deserves its own book, be it a prom or birth of a baby or wedding. Each of my kids have scrapbooks from birth to present day. In terms of scrapbooking our cancer experience, initially, I just had to preserve everything. I had to preserve every second and every nuance in case she wasn’t here anymore. I had to. I had to. And, as it went on and she fought harder and got stronger, then it became a book of her victory. When I wrote the letter on the back, I said I was just proud of her and I thanked her for letting me go on the journey with her because I learned so much from her, from humility to humor. Normally, you don’t learn those things from your children. And she taught me all those things. So it came from preserving her life into her victory.—Tricia, Caitlin’s mom

Figure 3.3 Another surgery: Treating staph infection.
Communication scholars naturally gravitate toward linguistic narrative in oral or written form, but individuals use many ways to express their stories of health and illness in everyday life. Scrapbookers like Tricia, for example, serve as memory curators, storytellers who function as what Langellier and Peterson (2006) term *keepers of the kin*. By highlighting special occasions and everyday rituals, individuals make meaning and extend family culture to future generations. The events memorialized in Caitlin’s scrapbook mirror moments of importance to most teens—prom, birthday parties, and graduation. In Caitlin’s case, however, movie tickets are placed alongside photos of her left lung and leg during surgical procedures, hardware used during reconstructive surgery, and Caitlin’s “battle ribbons”: plastic ID bracelets from every hospital stay. Obituaries of friends who succumbed to cancer rest beside photos of benefits and blood drives in Caitlin’s honor. All told, the scrapbook offers an aesthetic, imaginative representation of Caitlin’s storied experiences as a teenager living with cancer.

Narrative frameworks that reflect the multisensorial sense-making of individuals in health and illness (Ellingson, 2009; Harter, 2009; Sharf, 2009) provide voice to individuals who are disenfranchised or otherwise unable to verbally articulate their points of view, and offer opportunities for “representing participants in ways that challenge social conventions” (Cole, Quinlan, & Hayward, 2009, p. 81). Narrative scholars have turned to documentary (Cole et al., 2009), poetic transcription (Carr, 2003), choreographed movement (Joseph, 2008), quilting (Jones & Dawson, 2000), and performance (Gray & Sinding, 2002), in their work with individuals living with AIDS, cancer, or other physical and mental disabilities. These narrative forms offer different ways of understanding the lived experiences of others while also challenging conventional representations and prevailing assumptions. For example, the director and producers of *Plan F* documented the ways in which an auto mechanic’s work influences and is influenced by his blindness through particular aesthetic choices (Cole et al., 2009). The short film is shot in the garage with a camera lens that causes only a fraction of the image to be in focus at any given time and resists standard plots of disability by instead depicting the 71-year-old mechanic’s life as “thoroughly ordinary, save for his living with a disability” (Cole et al., 2009, p. 85). Such sensibilities ultimately enlarge traditional research rationalities to include “knowledge derived from storied, emotive, and embodied experience” (Harter, Ellingson, Dutta, & Norander, 2009, p. 35).

Aesthetic sensibilities extend to creative and collaborative analytic practices, as well. Ellingson (2009) advocates crystallization methodology as a framework for blending social scientific analyses with creative representations of data into a coherent text or series of related texts. Crystallization manifests in qualitative projects that (a) represent multiple, contrasting ways of knowing on a continuum anchored by art and science; (b) offer complexly rendered interpretations of meanings; (c) utilize more than one genre of writing or other medium; (d) include a significant degree of reflexive consideration on the researcher’s role; and (e) embrace knowledge as partial, embodied, constructed, and situated (Ellingson, 2009, p. 10). Given the interactive nature of qualitative research, much of narrative inquiry has expanded to include the researcher’s actions for co-constructing meaning with participants, as well. Narrative scholars endorse dialogic ways of knowing that emphasize “how researcher and participant came together in some shared time and space and had diverse effects on each other” (Frank, 2005, p. 968).

The turn toward a relational and coconstructive approach to narrative sense-making recognizes narrativity as an inherently social and dialogic communicative process (Harter et al., 2005). Tricia’s unconventional representation of Caitlin’s lived experiences, for
example, ends with a letter included in the back cover of the scrapbook. “May this book be a reminder to you of your strength, determination, and quest for life,” writes Tricia to Caitlin. “Thank you for letting me take this journey with you.” In similar fashion, participatory research methods such as photovoice (Wang & Burris, 1997; Yamasaki, 2009) and readers’ theater (Schneider et al., 2004) can empower and situate ordinary community members as coresearchers in the design, participation, and implementation of scholarly projects. For example, Yamasaki’s (2009) narrative analysis of late life in community settings incorporates the photographs of 34 elderly participants who live in the small town and the assisted living facility at the center of the project. The participants chose which pictures to take; titled and described them in in-depth interviews; and selected their favorites for display in local community and online exhibits. In another project (Schneider et al., 2004), individuals with schizophrenia chose a topic (experiences with clinicians), conducted in-depth interviews with each other, and then developed and performed a readers’ theater presentation of their results and recommendations for medical professionals.

**Practicing Narrative Medicine**

Institutional and cultural narratives articulate possibilities and preferences that social actors invoke, orientations that lead to trained incapacities and fossilized institutions (Burke, 1935/1984). In the dominant culture of medicine, patients’ experiences deemed notable (and chartable) typically appear as depersonalized abstractions imprinted by the omnipresent voice of the medical enterprise (Poirier et al., 1992). Even so, professional cultures are contested terrains—dynamic, situated, and indeterminate webs of sense-making (Gubrium & Holstein, 2009). The rise of narrative medicine signifies growing acknowledgment that clinical judgment is an interpretive act drawing on narrative skills to integrate overlapping stories told by patients, clinicians, and diagnostic taxonomies.

Dr. Rita Charon, Professor of Clinical Medicine at Columbia University, is a widely recognized, pioneering authority in the practice of narrative medicine. She is Founding Director of the Program in Narrative Medicine at Columbia, and has written extensively on possibilities and difficulties of practicing medicine with narrative sensibilities (e.g., Charon, 2006, 2009). Charon characterizes narrative medicine as practiced with the competence to recognize, absorb, interpret, and be moved by stories of illness. Practicing narrative medicine does not require providers to reject scientific logics, or to privilege personal anecdotes over randomized control trials. Instead, it presupposes that patients experience illness in unique ways that must be juxtaposed with the generalities of a science-using practice (Haidet & Paterniti, 2003). Narrative activity provides meaning, context, and perspective for a patient’s predicament, sense-making that clinicians can draw on to understand the plight of the patient and recast it into a medical story coupled with appropriate treatment (Greenhalgh & Hurwitz, 1998).

How is narrative medicine practiced? In the realities of clinical interactions, patients’ stories frequently fail to be fully articulated, let alone understood. Why? The achievement of what we refer to as an “aligning moment,” an experience of genuine shared understanding, must overcome formidable obstacles. First, doctors must be open to hearing a personal narrative that runs parallel to their own biomedical narratives. Second, patients must be willing and empowered to tell their own stories. In an ideal situation, the inclusion of patients’ storied concerns can provide a “narrative jolt,” creating a pause in the scripts of biomedical practice and focusing both the doctor and patient on the fully contextualized health issue. There is still much work to be done to realize such an ideal, however, as patients’ role
Narrative Turns Epic

expectations often present barriers to telling their own stories, and physicians who have the capacity to hear and understand such stories may still not have the training to know how to respond to and incorporate into decision making what they have heard (Waitzkin, 1991).

At the 2007 National Communication Association convention, Dr. Charon, delivering the Vice-Presidential Plenary Lecture, emphasized that, at a minimal level, all clinical interactions possess a narrative structure; that said, some clinical moments are more narrative than others. Serious illness is a breach of the commonplace, moving individuals through disorienting terrain. In such cases, attending to human suffering involves witnessing transitions and transformations. Charon (2006) draws on her literary background to develop future physicians’ capacities to join with another who suffers and act on that person’s behalf. As students learn to closely read literature (i.e., form, genre, frame, plot, time), one may hope that they become better equipped to listen to patients, read symptoms contextually, and represent what is heard in a form that honors the patients’ meanings. Charon also coaches students to write parallel charts and reflect on what they themselves undergo in the care of individuals. As suggested by their name, parallel charts remain separate from official medical records, and articulate socio-emotional aspects of care that may otherwise remain unspoken. Although a literary background has oriented Charon to narrative practices that contextualize and personalize care, other aesthetic experiences provide similar inspiration. Notable examples include Dr. Paul Haidet’s translation of jazz improvisation in clinical contexts (Haidet, 2007) and Dr. Pete Anderson’s use of photography in coconstructing medical records with patients and family members (see Harter, 2009).

Responses to Charon spawned an intellectual exchange that continued in a special issue of the Journal of Applied Communication Research (Harter & Bochner, 2009). In that issue, several narrative scholars explored the vulnerability (Bochner, 2009), moral dilemmas (Thompson, 2009; Zaner, 2009), and ethos of friendship (Rawlins, 2009) that can accompany narrative medicine. Authors encouraged scholars and practitioners to enlarge narrative frameworks to reflect aesthetic and performative concerns (Harter, 2009; Langellier, 2009; Sharf, 2009). Collectively, authors remind us that narratives represent equipment for living—symbolic resources that allow individuals to size up circumstances and chart future actions (Burke, 1935/1984). Storytelling in health care reflects the narrative impulse and is a powerful form of experiencing and expressing suffering, loss, and healing. Several first tier medical journals (see Journal of the American Medical Association, Annals of Internal Medicine, Health Affairs) over the past several years have instituted sections for narrative writing. Joining them, Health Communication, starting with Volume 24, Issue 7, will publish a regular narrative feature titled “Defining Moments.” For the first time within the communication discipline, members of our academic community will be invited to submit essays illustrating the power of narrative to foster health-related commentary and social action.

Reaching Out and Carrying On

For all Dr. Charon’s successes—in addition to her extensive scholarship and teaching, her work has been featured on National Public Radio and in the New York Times—she still struggles to be understood and influential within her own profession. Likewise, it is incumbent upon narrative scholars engaged in health communication scholarship and practice to develop ways of extending their work beyond academic journals into actionable outcomes. Consider the range of stakeholders who may benefit from our work—general publics, patients and families, practitioners, medical schools, activist organizations, policy makers. Whatever inroads we have made in this regard are slight and open to improvement.
The concept of “translational research,” a mandate to make theoretical and esoteric studies accessible to practitioners and publics that can put such knowledge to everyday use, has been emphasized in medicine and public health, but not in health communication. For narrative scholars, a move in this direction sets the stage for learning from storied cultural and socio-economic diversification (e.g., Dutta, 2004), working toward broader systemic changes, and striving to enrich individuals’ lives.

Throughout this whole process, strangers have contacted me, friends have prided me, my parents have stood by me, and my whole community has helped me. They all say that I am an inspiration to everyone due to my strength and perseverance. I enjoy the praise knowing that people believe in my ability to get better, but I do not feel that I am an inspiration at all. I just look at it as if I did what I had to do.—Caitlin Shoup, 2005

Figure 3.4 Caitlin’s commentary.
Acknowledgment: The authors are indebted to Caitlin Shoup and her family for permitting their story to become a significant part of this essay.

References


Harter, L. M., Ellingson, L. L., Dutta, M. J., & Norander, S. (2009). The poetic is political … and other notes on engaged scholarship. In L. M. Harter, M. J. Dutta, & C. E. Cole (Eds.), *Commu-


Narrative Turns Epic


