

article

*Narrative Medical Competence and Therapeutic Jurisprudence: Some Preliminary Thoughts**

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Introduction

This article is an attempt to link two concepts which are beginning to have a significant impact on practice theory within their respective spheres of law and medicine. Although practice within both disciplines has for many years acknowledged the importance of recognizing, interpreting and acting on the stories and experiences of patients and clients in a range of systematized encounters, this has often occurred outside of a clear theoretical framework and without the benefit of language to describe the process taking place. In law therapeutic jurisprudence now provides a lens through which to examine the humanizing potential of law, while in medicine narrative competence represents a model for humane and effective medical practice, by bridging the gap which separates physicians from patients, other professionals and society. Therapeutic jurisprudence (TJ), according to one of its originators, is a richer way of looking at the law, by teasing out the more subtle and unintended consequences of legal rules and procedures that may be anti-therapeutic (Wexler, 2002) and working to eliminate such psychologically-damaging effects. Narrative medicine (Charon, 2001B), on the other hand, is an approach to the practice of medicine that is able to give the doctor access to the lived experience of his or her patient. Through an enhanced form of history taking doctors are assisted to formulate more appropriate diagnostic and treatment options, while improving the patient-doctor relationship.

Narrative medicine bears a close affinity to narrative ethics, although it is acknowledged that there are many approaches to ethics, most of which have nothing to do with medicine per se. Both describe a process rather than a separate branch of knowledge. But whereas narrative ethics uses the study of

narrative to help doctors in making ethical decisions, narrative medicine is, arguably, a more inclusive concept and is not limited in its scope to ethical decision-making. It may include a simple written account of a physician's practices, on the hypothesis that writing about oneself and one's patients confers on medical practice a kind of understanding that is otherwise unobtainable. However, in the course of this discussion both concepts are likely to overlap to some extent, although it is principally the practice of narrative medicine which is being described here.

Because a formal linking of therapeutic jurisprudence and narrative medical competence has not been previously undertaken, what follows is expressed somewhat tentatively. The connection suggested here requires a more thorough-going development which it is not the purpose of this article to attempt. Nevertheless, such a linking is theoretically valid and offers the promise of a useful exploration of common ideas and themes. In a recently published article (Paquin and Harvey, 2002), the authors have linked therapeutic jurisprudence, transformative mediation and narrative mediation in an effort to revitalize and humanize the mediation environment which, it is argued, has become more institutionalized and settlement-oriented. The linking proposed here aims to incorporate the insights of narrative medical competence into legal settings in order to further explore the use of narrative in the lived experience of law and legal processes and to investigate how the lawyer/client relationship might be enhanced through the narrative dynamic. This is a significant challenge and has the potential to reconfigure approaches to dialogue exchanges in both law and medicine. The article aims, therefore, to posit a working thesis for a TJ/narrative medicine collaboration.

Recent writing on TJ, has emphasized its potential to transform legal processes through its focus on relationships, a conscious movement away from the 'austerity of tabulated legalism'¹ which, arguably, is a pervasive feature of modern Western legal culture. Through a TJ 'lens' it is possible to view law, like medical technology, as a tool, but one which should only rarely be permitted to subordinate human relationships as it works out its regulatory mandate.² People, and their felt needs, fears and aspirations, should always be central to any social enterprise which has the aim of changing, or at least regulating, human activity. Social structures which have become monolithic, authoritarian, and impersonal devalue individual personhood and may themselves produce levels of social alienation and dysfunction that are both undesirable and unnecessary.

This is an implicit part of the message of TJ, although it is not claimed that this is yet part of a normative framework of therapeutic jurisprudence.³ As a 'perspective', the principal focus of TJ is identifying and minimizing the psychologically damaging effects of laws and legal processes. Narrative medicine, on the other hand is a patient-centred approach to medicine, which gives physicians access to the *lived* experience of their patients. The question is whether this medical model can offer any insights that might help us better understand the character of legal relationships and law and give better expression to the dynamic of TJ principles. The importance of this linking is to suggest that narrative medicine (NM) may offer valuable insights as to how life under the law (juridical life) may be lived more healthily through the stories constructed out of people's legal experiences. The thesis advanced here is that it is possible to take a quite ordinary legal event and analyse it from both a TJ and NM perspective in order to better appreciate the human dynamics that have constructed the problem. It is possible then to show how, using established TJ practice principles, including the 'rewind' model, the problem might have been avoided.⁴

However, before further describing the role of TJ it is necessary to explain what is meant by 'narrative medicine'.

What is Narrative Medicine?

The concept of NM originated with Dr Rita Charon, currently the Director of the Narrative Medicine Program College of Physicians and Surgeons at Columbia University. Arising out of her experiences as a practitioner of internal medicine of over

twenty years standing, she came to appreciate that what patients expected of her was to listen in a committed way to complicated personal narratives. These might be told in words, gestures, silences, images and physical findings. She recognized that physicians sometimes lack the capacities to recognize the plights of their patients, to extend sympathy towards those who suffer, and to join honestly and courageously with patients in their illnesses (Charon, 2001B). This led to research which focused on communication between doctors and patients, seeking ways to improve the ability of doctors to understand what their patients tell them. The phrase 'narrative medicine' was coined by Dr Charon to connote medicine practiced with narrative *competence* and distinguished with an understanding of the highly complex narrative situations among doctors, patients, colleagues and the public.

According to Dr Charon, narrative medicine is able to offer a 'disciplined and deep set of conceptual frameworks' that give the theoretical means to understand *why* acts of doctoring are not unlike acts of reading, interpreting and writing and *how* such things as reading fiction and writing ordinary narrative prose about patients is capable of producing better doctors. According to this view NM brings sets of skills, tools and perspectives to all doctors. It proposes an *ideal* of medical care which is attentive, attuned, reflective, altruistic, loyal and able to witness others' suffering and honour their narratives, while also giving the methods which promote growth towards those ideals. She claims that any doctor or medical student is able to improve his or her capacity for empathy, reflection and professionalism through serious narrative training (Charon, 2001B).

What is significant about this approach, as regards its legal implications, is the claim that it offers promise as a means to *bridge the current divides* between doctors and patients, between doctors and doctors and between doctors *and themselves*, by describing common human experience. Equally, narrative approaches in law may ultimately prove to be instrumental in more effectively managing the communication that occurs between lawyers and their clients in a host of situations where presently adversarial debate tends to define the manner in which information is gleaned and hypotheses tested.

To the extent that NM is attuned to and able to honour the narratives of patients, it can be considered a 'bottom-up'

approach to medical practice. As such it resonates with an emerging approach to law reform implicit in TJ (Stolle, 2000). It is non-hierarchical and is dependent on multiple sources of local authority rather than monolithic 'master authorities' (Charon, 2001B). It is truly collaborative in that it emphasises the personal connections between the patient and the physician while offering doctors the means to improve the effectiveness of their work with patients. However, in the same way that TJ does not claim to 'trump' other normative legal values, NM is best viewed, not as the opposite of evidence based medicine, but rather its essential accompaniment. Its claim is to *enhance* the practice of medicine, not to *eclipse* traditional medical practice, although there appears to be a clear expectation that traditional approaches to medicine will change as recognizably clinical tasks are increasingly impacted by a narrative approach.

Importance of the Narrative Approach

Other writers have emphasized that narrative provides meaning, context and perspective for a patient's predicament, in that it defines how, why and in what way he or she is ill (or legally compromised). It offers the possibility of developing an understanding that cannot be arrived at by any other means. Thus it is said that understanding the narrative context of illness provides a framework for approaching a patient's problems *holistically*, as well as revealing diagnostic and therapeutic options (Greenhalgh and Hurwitz, 1999). Significantly, legal commentators have begun to investigate how law can be practiced more holistically through the adoption of an 'ethic of care', as lawyers functioning as counselors seek to work with clients in a holistic manner (Sprang, 2000).

Narrative competence assumes that individuals and groups *live through* their experiences of illness, which often give rise to larger existential questions touching on issues of meaning and purpose, but expressed through existential qualities like grief, despair, hopelessness and isolation. Increasingly, there is recognition that doctors who have access to such stories of personal encounter with illness, are better equipped to assist patients to find meaning and achieve an accommodation with pain and suffering, even in the face of great adversity.

Finally, it is worth observing that the narrative approach represents, at some level, a recovery of the importance of subjective accounts in the construction of persons' stories. As one writer has written, it offers us the experience of 'living

through, not simply knowledge about' the characters in the story (Anderson, 1990).

Hope

An interesting new approach in the burgeoning writing on TJ is the practice of linking inquiry in specific areas of practice through a unifying ethical theme expressing some fundamental ethical concept that is especially apposite to the particular inquiry (Brookbanks, 2001; Hall, 2002; Petrucci, 2002). In this article I suggest that the ethical concept of hope may provide a conceptual link between the two paradigms because of its focus on the idea of expecting and working towards something good, which is an important element in constructing a medical narrative and in resolving legal disputes. From this perspective both TJ and NM may be viewed as significantly optimistic practice models and, as such, they represent a refreshing change to the arid formalism of much legal and medical practice. They are dynamic concepts which evoke the promise of ideals like freedom, health, wellbeing and happiness, though not in a purely utilitarian sense. Hope is better conceived as a wellspring of human aspiration and exists as a highly subjective value, not as a mere intellectual construct. It has been characterized as 'a bubble-like safe place in which to exist for the time being' (Alexander and Rosner, 2000). Patients may take sanctuary in the narrative process, which offers the hope of interpreting the person's lived experience in a sympathetic and healing relationship. Equally, the employment of TJ principles offers the hope of challenging the ascendancy of corrosive adversarialism and reconstructing legal meaning through a greater focusing on relationships and their preservation.

In the article 'Law, Medicine and Trust' (Hall, 2002) TJ is presented as a possible unifying theme in health law and examines the psychology of *trust*, which has a pervasive influence in all other dimensions of medical relationships. Hall claims that the robust revival of trust in discussions of medical ethics and professionalism is an attempt to reconcile ethical theory and professional practice with the essential attributes of care-giving relationships. He argues that trust is essential and unavoidable in medical relationships because patients need and want to trust and without trust medical relationships never form or are entirely dysfunctional. Further, according to Hall, trust confers therapeutic benefit by activating nonspecific or self-healing mechanisms or by enhancing the effects of active therapies. It has unique instrumental value because of its strong

emotional value resulting from the ‘deep vulnerability of illness’ that gives rise to trust (Hall, 2002).

Similar claims might be made about hope which, arguably, also has an important role to play in enhancing medicine’s therapeutic value and in the resolution of legal conflicts. It has a close affinity to trust and is the dynamic factor which enables patients and clients to look forward *confidently* towards the future that is hoped for. The importance of hope is captured in a passage quoted by Hall that comes from the original version of the AMA Code of Ethics (1847). It says:

A physician should not be forward to make gloomy prognostications ... [f]or the physician should be the minister of *hope and comfort* to the sick; that ... he may smooth the bed of death, revive expiring life, and counteract the depressing influence of those maladies which often disturb the tranquility of the most resigned in their last moments. The life of a sick person can be shortened not only by the acts, but also by the words or the manner of the physician. It is, therefore, a sacred duty to guard himself carefully in this respect and to avoid all things which have a tendency to discourage the patient and depress his spirits.

With a degree of imagination, the same *hopeful* perspective could be applied to lawyers in their dealings with vulnerable clients.

Synthesizing TJ and NM

A closer analysis of both TJ and NM reveals that both are pointing substantially in the same direction. Both are highly relational constructs and committed to improving the interaction between doctors and patients and lawyers and their clients. What needs to be further explored is their actual interrelationship and the ways in which each might be able to assist the other in addressing issues that arise at the interface of the two disciplines or otherwise equips them better to serve their practice goals. The idea of relational connectedness is an important, though not exclusive point of interface. To the extent that dysfunction in individuals may be produced, in part at least, by systemic and/or institutional concerns, both TJ and NM are also capable of offering a critique of the *impact* of institutional structures on the lived experience of individuals and to offer the means of minimizing the effects of such structures.

Increasingly, the concept of ‘affective lawyering’, which focuses on the value of emotional engagement, is being recognized by lawyers as a valid aspect of professional encounters with clients. It facilitates the recognition of intuition, experience, even passion which are endemic to narrative competence (Mills, 2000; Sprang, 2000).

Writing on narrative competence, Rita Charon provides some valuable examples of how this process might work in a dynamic encounter (Charon, 2001A). Dr Charon describes how, with guidance from a literary scholar, she began to write stories about patients who troubled or baffled her and as she did so realized that the act of narrative writing gave her access to knowledge about the patient and herself, that would otherwise have remained out of reach.

She says:

I ... realized that writing about patients changed my relationships with them. I became more invested in them, more curious, more engaged, more on their side.

I next found myself showing patients what I had written about them. If my writing constituted the hypothesis-generating step of a form of inter-subjective research, only the patient could test the hypotheses. After a particularly moving or confusing visit with a patient, I would write as accurate an account as I could summon of what I thought the patient had told me. On the next visit with that patient, I would invite her to read what I had written and would ask her whether I had gotten her story right. I would do this several times, so that each visit resulted in a ‘chapter’ about the patient’s life.

In two early efforts, the patients read what I had written and then said, in effect, ‘We left something out.’ These two patients then told me about episodes of abuse – for one, childhood sexual abuse and for the other, spousal violence in young adulthood – that, in their minds, were related to their current clinical situations. Both women then brought me texts – a childhood journal, poems about a marriage – that they had written about their experiences. In both cases, the patients’ responses to my ‘chapters’ about them were clinically significant because they brought to my attention aspects of their histories that were salient to their current emotional and physical health. It

was as if my writing about and for my patients quickened a process of disclosure that may have come much later, if at all, in the relationship.

She concludes:

In both cases, the patient and family member granted permission. More important the disclosure was therapeutic. The daughter of the elderly patient said, after reading the relevant parts of the manuscript, 'You really knew my father.' This knowledge – the fact that the patient was personally known and recognized by his doctor – became a source of comfort for the patient's whole family. When the second patient read what I had written about her (and about me) she told me that she recognized herself in what I had written and then said, at our next office visit, 'How can one person know so much about another?' In a way that I cannot yet fully explain, writing about this patient and then showing her the text remodeled our clinical relationship quite dramatically. Instead of sharing a sense of discouragement about her health, we now sit in my office as two powerful women, working hard together to solve problems and to help her get better.

There is a sense of optimism and hope that accompanies this passage. It has to do with an awareness of the emergence of a level of professional connection and communication that we might all aspire to, but in the normal course of events do not often achieve. What is significant about the passage, for the purposes of the present discussion, is its conclusion that the narrative process is itself empowering, regardless of the particular outcomes achieved. This perception aligns with the increasing recognition of the importance of procedural justice, which has significant implications for both law and medicine (Perlin, 2000). Narrative exposes the inner reality of a person's dreams and fears and may reveal concerns and desired outcomes that are far removed from the impressionistic account garnered in an initial professional encounter. If a patient's/client's true voice is allowed to speak, it may disclose a profound desire for someone to simply acknowledge their pain rather than agreeing to the formulation of plans for an adversarial conflict.

These are issues that deserve a more thorough-going analysis. However, it is not my purpose to develop these ideas further in this context, but simply to 'flag' them for future debate.

The following is a summary of features of a narrative approach, adapted from a discussion on narrative medicine (Charon, 2001A) which might also be useful in re-imagining the lawyer's task by giving it a more deliberately narrative flavour:

- (1) The processes of encountering a legal problem, resolving it and learning to live with the consequences of a legal dispute, can be thought of as enacted narratives within the wider stories of people's lives.
- (2) Narratives of law provide a framework for approaching a client's problems holistically, and may uncover problem-solving options.
- (3) Taking a history is an interpretative act; interpretation (the discernment of meaning) is central to the analysis of narratives.
- (4) Narratives offer a method for addressing existential qualities such as inner hurt, despair, hope(lessness), grief and moral pain which often accompany legal disputes.
- (5) The lost tradition of narrative should be revived in the teaching and practice of law.

It is possible to identify a number of areas of current legal practice where these principles might have direct relevance to the way in which a particular problem is approached and ultimately resolved. Family law, mental health law, healthcare law, domestic violence law, elder law, employment law, juvenile law and criminal justice are obvious examples. Further reflection would readily reveal other areas where a narrative approach could be beneficially employed.

Conclusion

The core of the narrative medicine approach resonates with the core concerns of TJ. Both ideas, although relatively new, have already captured the imagination of scholars and practicing professionals worldwide and are having a significant impact on the ways in which both law and medicine are practiced. Having suggested a working connection between the two models, it is anticipated that others will also work to develop this significant collaboration, to the enrichment of both disciplines. Too often in law, form has been allowed to eclipse substance and we have often been left with arid rules and prescriptions that are harbingers of legalism and despair. Similar criticisms may be made of medicine. An obsession with formalistic rules and procedures, especially where accompanied by relentless specialization and 'technologization', may actually undermine the therapeutic

importance of recognizing patients in the context of their lives and acknowledging their suffering (Charon, 2001A). These effects are antithetical to the healthy vitality of whole relationships to which all professionals should aspire, both in their personal lives and in their professional dealings. It is contended that the collaboration of therapeutic jurisprudence and narrative competence could be instrumental in the recovery of that elusive wholeness in the enterprises of both law and medicine in their very diverse forms.

Notes

*The article is based on a paper presented at a symposium with Professor David Wexler held at La Trobe University City Campus, 215 Franklin Street, Melbourne, 23 November 2002.

1. The expression is attributed to Lord Wilberforce in *Minister of Home Affairs v Fisher* [1980] AC 319, 328–329. However, its true derivation is S. De Smith (1964, p.194). I am indebted to my colleague Paul Rishworth for pointing me to this source.
 2. The law's police power obligation to protect citizens from the antisocial behaviour of dangerous individuals and its *parens patriae* duty to protect the interests of mentally impaired persons, are examples of situations in which human relationships may be impaired as a direct result of the operation of law. However, in these cases the impact of the law on relationships is a *collateral effect* of achieving the societal benefit of public safety and is not the *purpose* of legal regulation. Ideally, the law should aim to intrude on human relationships to the least extent consistent with preserving peace and good government.
 3. Recent writing on therapeutic jurisprudence has begun to investigate the desirability of establishing a normative framework for TJ, in order to guide its transformation from a 'perspective' to a 'movement' and to be able to pursue its legal reform agenda.
 4. By 'rewinding' the case to an earlier point in time it is possible to describe how a particular situation might have been prevented or diminished in severity by other legal actors at earlier points in time. See discussion in Stolle *et al* (2000, p.73).
 5. Dennis Stolle notes that by the mid 1990s TJ thinking was focusing not only on how laws could be *changed* to be more therapeutic, but also how *existing* laws could be made more therapeutic *in application*. See Stolle *et al* (2000, xv-xvi).
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