
Article

Healing, the Patient Narrative-Story and the Medical Practitioner: A Relationship to Enhance Care for the Chronically Ill Patient

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Abstract

Patient–health care practitioner communication is riddled with complexities. In this article the authors initially describe how careful listening to another, the patient, within the context of today’s health care system has drifted from being an integral part of the “art” of medicine toward a methodological checklist of standard questions designed to support the “science” of medicine. Then they offer a way and a means for today’s biomedically trained health care practitioner to rethink or reimagine the value of authentic listening. They conclude with a critical exploration of a pedagogic speaking-listening relationship located within an understanding of dialogue as a means of gaining health-related, patient-specific evidence. By attending to a patient’s story through the health care practitioner’s attentive listening, the health care practitioner together with the patient create a place whereby a dialogue exchange actually becomes an indispensable and health-related element fostering a process of mutual learning, knowing, and being.

Keywords: interpretive phenomenology, patient-health care practitioner communication, listening, narrative and story, well-being

To know yourself, see what others are doing, to know others, look into your own heart.

—Johann Wolfgang von Goethe (cited in Zubko, 2000, p. 407)

Why this text? Why now?

We propose to show how a qualitative researcher's attentiveness, methodologically using story, provides an interpretive model for medical practitioners to assist them with broadening and enriching the diagnosis and treatment of a patient. Christine Thomas, chair of the Ottawa chapter of Osteoporosis Canada, has indicated that the time has come for patients living with a chronic illness to empower themselves:

"I was pretty much a mess for a long time," Thomas says now, "but I reached a point where I wanted to reach out. You see a doctor for twenty minutes, but then you're on your own with the disease." . . . Thomas says her experience made her realize that patients have to take ownership of their health, educate themselves about their conditions and pay attention to their treatments, even if it means asking doctors uncomfortable questions. (Kennedy, 2007, pp. D1-D2)

Furthermore, with respect to physicians, Lipton (2005) wrote,

Remember, all physicians are taught, perhaps as a side bar, that the mind can affect the body. People do get better when they believe they are getting medicine (even attentiveness or receptiveness to a chronically ill person) to help them get better or feel better—the *placebo effect*. Perhaps, this is actually a perception or belief effect. So, is it possible current modern medical practices are also based upon perceptions and beliefs? (p. 142, emphasis in original)

So, we ask; what does qualitative/interpretive inquiry, focused on narrative-story, offer to the medical practitioner-patient relationship? And, what is it about "story" itself that interpretively offers a way to reimagine the practitioner-patient relationship?

We seek, alternatively, to open up the basic differences between narrative and story in terms of what counts as relevant medical data. We make a case for a place for story within biomedical discourses and practices. If, as Ms. Thomas indicated, typically a patient has about 20 minutes with a health care practitioner, then we believe that some of the precious time should be spent respectfully attending to the patient's story.

In interpretive inquiry what is the difference that makes a difference?

Bhabha (1994) has reminded us that "identity is never an a priori, nor a finished product; it is only ever the problematic process of access to an image of totality" (p. 51). Indeed, interpretive inquiry lives as a reflexive conversation within the processes of recognizing similarity and difference as embedded in self and other, knowing and doing subjectively, intentionally, and responsibly. As such, our purpose here is not to promote qualitative dispositions or practices over quantitative dispositions or practices. Rather, we seek to describe an interpretive researcher's approach to a topic as a basic illustration of an alternative way of proceeding with medical patients.

Basically, an interpretive researcher methodologically using narrative-story begins an inquiry with an attempt to be interpretively open to a topic at hand. The researcher does this through a thoughtful wondering about how the topic had arrived or how it has become relevant inquiry, often via an interesting question. This initial reflective, question-generating, responding process brings about an awareness of a researcher's fore-understandings; that is, the researcher is already implicated in the inquiry process. As human beings and as researchers we are mediated beings. We are mediations socially constructed through patterns of experiencing, perceiving, thinking, knowing, doing, and imagining. As Gadamer (1989) reminded interpretive researchers, "The most basic of all hermeneutic preconditions remains one's own fore-understanding, which comes from being concerned with the same subject" (p. 295). As such, in turning to embrace the topic at hand, the researcher is reminded of her mediated connections to the human conditions of familiarity and strangeness as well as similarity and difference. In particular, in the tensions between familiarity and strangeness and similarity and difference, the interpretive researcher becomes suspicious of how his motives/desires/intentions are already a response in address to the topic. Gadamer wrote,

Hermeneutic work is based on a polarity of familiarity and strangeness; but this polarity is not to be regarded psychologically as the range that covers the mystery of the individual, but truly hermeneutically—i.e., in regard to what has been said: the language in which the text addresses us, the story that it tells us. (p. 295)

Thus, the interpretive researcher encounters an inquiry participant, the embodiment of the topic at hand, as a familiar stranger. The participant is that knowable "self-other," yet for the researcher "the strangeness of strangers means precisely our feeling of being lost, of not knowing how to act and what to expect, and the resulting unwillingness of engagement" (Bauman, 1995, p. 149). It is within this familiar and strange tension between a participant and a researcher that an opening emerges for an exchange: a conversation. Within that opening a researcher invites the participant to tell a narrative-story of what has been or is currently experientially meaningful in her life in relation to the topic. The emergent phenomenological-quality narrative-story is a gift presented to the researcher. It is in this narrative-story, giving and receiving, where the participant and the researcher can achieve a pedagogic relationship. Simply, the participant and researcher interpretively explore and each is taught, reflexively, meaning and understanding in relation to the tensions between here and there, then and now, and the familiar and the strange and, indeed, knowingly, between the self and the other.

Within a participant's told narrative-story there are interpretive gaps. These narrative-story gaps invite the possibility of learning from or being taught by another's experiences. Why? Gaps invite interpretation. It is possible in this giving and receiving of narrative-story for a researcher and a participant to dialogically arrive together at an interpretive, indeed pedagogic, "third space." Bhabha (1994) described this third space or dimension, wherein a moment of recognition by the self cannot be wholly contained within a self/other binary. The gap between speaker and listener, or researcher and participant, is witnessed as artificial and reductionist such that the opposites of self and other, if only momentarily, move into a place/space where identity is ambivalent and mutable. Most important, within this space the two different selves find it pedagogically possible to understand what it means to be otherwise. When such an exchange occurs within the researcher-participant relationship, and if the researcher is willing to give up a positional research authority and privileging control, then in responding to the call of the other, the researcher gives up his assumed rational perspective (Komesaroff, 2001). In this act of repositioning, the researcher gives way to the

crucible of alterity¹—and this applies equally to both partners in the dialogue—the “self” has no name, no situation, no status. It has a presence afraid of presence, afraid of the insistence of the identical ego, stripped of all quality. (Lévinas, 1989, p. 31)

Simply, in this regard, as Lévinas (1969) has reminded us, otherness is irreducible and it is not reciprocal because humans are not interchangeable, or able to be substituted one for the other.

For the researcher, then, a person’s story-narrative is the invitational “data” from which she interpretively learns, is taught, to understand the other’s experiences. In accepting this gift of being otherwise present, it is the researcher who is ethically responsible, through the act of interpretation, to unconceal the person’s experiences making them available to the world and, certainly, to the teller herself. Once the experiential-phenomenological narrative-story is made representational and alive in the world, the meanings and the understandings it evokes of and for persons living with a chronic illness are, simultaneously, a conversation. In turn, this conversation is a form of action in the world.

Interpretively, what is the difference that makes a difference between narrative and story?

To this point, we have used the hyphenated term *narrative-story*. However, because the terms *narrative* and *story* are at the methodological heart of the above interruptive work, we ask, is there a telling difference that makes a difference, interpretively, between the terms *narrative* and *story*?

Hardy (1975) wrote, “Every day has its story. Whether it has been an ordinary day or an unusual one, we tell it over, to ourselves, to our journal, to other people” (p. xii). Indeed, historically and culturally our speaking-listening dispositions have been referred to as a “natural” way for human beings to communicate experiences. However, in the health care literature the terms *narrative* and *story* have taken on specific meanings. Paley and Eva (2004), in a review of the literature, revealed that the terms *story* and *narrative* are often used interchangeably. However, they went on to indicate that what really matters in relation to the two terms is the belief by, and the practices of, medical practitioners when it comes to collecting and documenting patient data. In this regard, it is evident that the medical preference is for *narrative*. Narrative is deemed as providing “data” that are more medically trustworthy. Why so?

McLeod and Makins (1993) indicated that a narrative is an account of a sequence of events in the order they happened to someone or to a group of people. This definition of a narrative suggests an objective account of someone’s experiences. Alternatively, a story provides a factual or fictional account, either recorded or perceived, of an event or series of events. Paley and Eva (2004) suggested that in medicine a narrative so defined, as above, is acted on as a reported sequence of events chronologically ordered and therefore has come to be delineated from the story because health care practitioners want controllable information/data. In a time-expedient practitioner-patient conference, the practitioner requires information/data told clearly and chronologically without what might be considered literary, indeed emotional, embellishment.

Accordingly, Paley and Eva (2004) indicated that there are degrees of narrativity in an oral or written text. There are elements of narrativity, those “things” that make a narrative a narrative that can be desegregated and arranged as a continuum. As such, Paley and Eva stated, “All stories count as narratives but not all narratives count as stories” (p. 86) and proposed a criterion-based conceptualization of narrativity and how it relates to the delineation between a story and a narrative, summarized in Table 1.

Table 1. Degrees of narrativity

Story or Narrative	Level of Narrativity	Numeric Representation of Narrativity	Elements of Narrativity
Story	High Collectively numbers 1-8 constitute a story	8	Presented in a way that is likely to elicit an emotional reaction from the audience
		7	The explanation being related to the problem they confront
		6	Characters who are confronted by some kind of difficulty or problematic issue
Narrative-story	Intermediate A plot emerges which constitutes the transition between a narrative and a story	5	A plot emerges . . . there being one or more characters centrally involved in the events described
		4	Causally related in such a way that a certain event is explained
Narrative	Narrative threshold Collectively numbers 1 to 3 constitute a narrative	3	Two or more events, some of which must be causally related
		2	The recounting of at least two events
		1	The recounting of one or more events

Source: Adapted from Paley and Eva (2004).

Note: The number 8 is an indication of an oral-written text that has high qualities of narrativity; thus, the text is a story. The number 1 indicates low narrativity and that the text is a narrative.

As such, in Table 1 we show criteria by which to determine whether a patient's text might be considered more of a narrative and to be somewhat trusted in terms of information/data provided, or a story, which takes on a fictional/emotional quality and, therefore, there are suspicions regarding the content. According to Paley and Eva (2004), if a text incorporates the features that represent narrativity to the degree in the first three steps in Table 1, then that text is considered a solid narrative. Accordingly, this text is sought after by health practitioners as information/data worthy of noting. A text that incorporates these first three features with the additional features 4 through 8 is considered a story. Obviously, at least in our interpretation of Paley and Eva's work on narrativity, the medical value of the text decreases as the emotional quality of the text increases. It follows that, for Paley and Eva, a text becomes a story when there is an interweaving of plot and character that elicits an emotional response from the reader-listener-viewer. On the other hand, a narrative text is valued because it is generally a linearly reported sequence of events and there is an underlying connection expressed: a cause and effect. This delineation of terms provided by Paley and Eva suggests that medical practitioners and quantitative researchers judge the emotional persuasiveness of a story to be less accurate in terms of data value than the objective detachment of the narrative. Because the contemporary biomedical discourses that define legitimate health care practices are overwhelmingly derived from empirical, positivistic quantitative-oriented research, then objective accuracy becomes a paradigmatic validity requirement for any data to be useful to a medical practice.

So, how do qualitative researchers, also seeking to be rigorous, use story as data? Churchill and Churchill (1982) indicated that it is the actual telling of the text that not only invites topic understanding, but also "Human beings understand their experiences in and through the telling and hearing of stories. Narration is the forward movement of description of actions and events which makes possible backward action of self understanding" (p. 73). Perhaps, it is a core relationship between telling and hearing that renders the classification of labels for what defines a narrative or a story to be of less importance, interpretively, than what is said, why it is said, and by whom under what circumstances. In this regard, Hardy (1987) suggested,

We live and dream in narrative, daydream in narrative, remember, anticipate, hope, despair, believe, doubt, plan, revise, criticize, construct, gossip, learn, hate and love by narrative. In order to live we make up stories about ourselves and others, about the personal as well as the social past and future. (p. 1)

What are the qualitative lessons regarding story available to a medical practitioner?

Narrating stories of experiences offers an opportunity for a teller and a listener to catch a reflexive glimpse of what it means to become or be or imagine being something/someone otherwise. Storytelling holds the possibility for a person to review his actions or inactions, considerations or nonconsiderations, joy or pain, what has happened as well as what has or could have been. At the core of narrating storied experiences is a way to get at the meaning of that “something” that has been held as a promise of a release; that is, telling stories releases that which we have perceived we have lived with. Sometimes we have an opportunity to tell of that something that has gnawed at us or hurt us or confused us or invited us, but now, as it is revealed or unconcealed, we use a story, often outwardly and often beautifully, to ask for meaning-making assistance with what were previously internalized feelings and thinking (Churchill & Churchill, 1982). Perhaps the effect-affect of the arrival of a chronic illness and its conditions can be seen, discussed, realized, and contended with and even made peace with only if a person is invited to tell his story of experiencing a chronic illness. The power of a story is not in normalizing it but, rather, that the story is attended to by another human being who is open to the possibility of co-understanding what the story means for that specific person speaking.

Hovey (2006), in a research project focusing on what it means to live with osteoporosis, recorded this comment from a study participant who said, “I had osteoporosis, experienced fractures . . . many, many trips to doctors, hospitals and at last here at the Osteoporosis Centre, you are the first person who has asked me how it feels [to have osteoporosis]” (p. 60).

Language is the fabric that weaves individual lives in and out of the lives of others. We as human beings construct meaning through language exchanges, and when our everyday lives become threatened by a diagnosis of a chronic illness, then the stories we tell figure predominantly in the recognition, repair, and restoration of an injured self-identity (Bury, 2001; Frank, 1998; Hardy, 1975). When confronted with uncertainty, trauma, or adversity, a person’s previously held and lived story requires another chapter, but people seldom leap to a new story unassisted. Writers need readers; tellers need listeners. Usually a person who is experiencing a life-shattering pronouncement associated with a chronic illness requires assistance if she is to begin to reconstruct a sense of a different identity. In expressing a response as a story, the person is accepting an invitation to know one’s self pre and to imagine one’s self post the current health difficulty. However, the power of the story is located not in the story itself but in the thesis of telling and the antithesis of listening. Only in such a relationship might the conversational synthesis of a new and differing third space foster an emergent sense of a new identity: a person living well with a chronic illness (Bury, 2001; Charmaz, 1983; Frank, 1998; Strandmark, 2004).

When a story is brought forward and revealed, it is spoken once and heard twice (Hyden, 1997). In listening to oneself talking and in hearing what is spoken, there exists an opening for meaningful reevaluation of understanding and meaning making and the possibilities for a revised identity as a being-in-the-world living with an illness emerges (Bauman, 1995; Gullickson, 1993; Lawton, 1999; Levin, 1989). Levin, citing Heidegger (1962), wrote about the importance of a human being listening to self and the consequences if one

fails to hear its own self in listening to the they-self [i.e., the Self socialization into a condition of conformity and self—alienation, out of touch with itself]. If Dasein³ is to be able to get brought back from its lostness of failing to hear itself, and if this is to be done through itself as something which has failed to hear itself, and if this is to be done through itself, then it must first be able to find itself—to experience itself as something which has failed to hear itself, and which fails to hear in, that it listens away to the “they” [i.e. to what “others” hear, say and think] . . . This listening away must get broken off; in other words, the possibility of another kind of hearing which will disrupt it must be retrieved by Dasein itself. (p. 42; bracketed sections added by Levin)

By “just listening,” a listener moves both herself and the teller toward the unconcealment of what is being said. Indeed, “Truth is a matter of conformity; the proposition or state of mind is true, if and only if, it conforms to the existing understanding of something as true in its fact of existence” (Levin, 1989, p. 246). Therefore, a story, even a complexly emotionally told story, has a truth-value. How so? It is in the telling-listening relationship where both listener and speaker as listener are transported toward something basic and human: meaning making. A grandmother reports that she was picking up her first grandson from his crib and she fractured her collarbone (Hovey, 2006). The grandmother has osteoporosis. However, when the grandmother is invited and she tells the story in detail, descriptively, emotively, and phenomenologically in the presence of an attentive listener, he hears and she hears a revealing of an unconcealed truth. Certainly, the grandmother still has osteoporosis. However, in the telling and the listening, both teller and listener recognize an acknowledgement that from now on the grandmother’s life with her grandson will be different than expected. Therefore, how far does the telling and listening transport this woman’s identity toward that condition of being a grandmother living (well) with osteoporosis (Hovey, 2006)?

Within the standards of good medical practices framed by the contemporary biomedical model,⁴ the physician’s language game at hand locates a person living with chronic illness within an array of controlled and procedural talk. The person who enters a physician’s examining room is asked to provide “information.” This information is most often written sound bites recorded on a chart or questionnaire. However, these data are only routinely scanned and perhaps taken into consideration if something “jumps off the page.” The information from the forms-charts-questionnaires is mediated through scientifically sanctioned taxonomic hierarchies of reductive decision-making. Simply, a patient’s information—not her story—is mediated through a biomedical lens that conditions the ear to contextually observe the eye’s search for identifiable realities and recognizable visual evidence (Hovey, 2006). The reality in medicine today is that the ear always concedes to the eye. Thus, most of the words spoken in a practitioner-patient examination are primarily those of the practitioner, who is actively engaged in the processes of diagnosis, directives, prescriptions, medications, and treatments such that there is an objectification of the person and a blurring of personhood with a disease or illness (Simmonds & Scudds, 2001). Certainly, this is not necessarily a health practitioner’s issue alone. How many of us in our personal and professional lives are able to hear, and to greet, what others tell us no matter how “threatening” to our ego, no matter how demanding on our capacity to care and be compassionate? (Bury, 2001; Frank, 1995; Levin, 1989)

Can story live within the biomedical model?

Within the history of modern medicine there is a clear message that narratives are important within the practitioner-patient relationship (Bury, 2001; Hyden, 1997). Before the modern contemporary technically-oriented biomedical model of illness was developed during the mid and

late 19th century, the ability of the medical practitioner to attend to taking an oral history from the patient was deemed crucial to a patient's diagnosis and treatment and considered a necessary practitioner skill. The patient's habits, lifestyle, moral stance, family history, and previous and current environments were taken into account (Bury, 2001). However, through the evolution of the natural science-grounded biomedical approach, the practice of medicine became relocated and redefined by technological developments as well as by the development of modern hospitals and laboratories. The importance of the patient's life experience and her story-like narrative became diminished (Risse, 1999). Today the patient's narrative has now been reduced to scripted informational responses directed toward specific charted often yes-or-no check boxes or "briefly describe" responses to questions. The patient's story is almost never asked for. If it is provided, then it is tolerated but not accepted as evidence to be calculated into the diagnosis/treatment regimens. Simply, the information/data the practitioner privileges regarding the patient are revealed by the real test results. These tests are biochemical laboratory results or photo-image results or computerized results (Hovey, 2006). A change in the person's basic physiological or anatomical structure due to disease or injury is determined from a diagnosis framed by scientific blood or fluid or sample analysis in reports that are seen, read, and understood by knowledge experts. The need to attend to a patient's narrative is reduced to the collection of pertinent information through the measurement of the difficulty or disability revealed by objective results indicating recognizable signs and symptoms (Nagi, 1991; Simmonds & Scudds, 2001). Consequently, the task of the modern practitioner becomes to clinically extract evidence from the patient that confirms a category of a definitive diagnosis that links the disease to specific biological or environmental causes and outcomes. The illness is named as an isolated entity and it is addressed within identifiable parameters defining the patient's health conditions and certainly not via evidence offered by the patient's narrative alone (Hyden, 1997). Levin (1989) wrote,

It is easier for us to shut our eyes than close our ears. It is easier for us to remain untouched and unmoved by what we see than by what we hear; what we see is kept at a distance, but what we hear penetrates our entire body. (p. 32)

The modern biomedical model deals with illness/disease through mediations of rapidly advancing diagnostic technologies that privilege the eye. This model itself becomes engrossed within this capacity to envision or to see an illness and seeing convincingly becomes self-fulfilling believing. Seeing the patient disconnected from her body and system parts means that the narrative of the patient becomes less important to the medical treatment process, and her story is rendered even more useless. Thus, this contemporary visually driven data evidence medical process actually reinforces the tendency to position the patient as passive in the face of the practitioner's active code-reading diagnostic activity (Bury, 2001). These procedures that bring the "problem" into full view render the subjective, nonmedical utterances of the patient virtually irrelevant. Under the impact of the technology-assisted physical and pharmacological responses to showing illness, the biomedical model becomes the expected, effective, and efficient mode of practice. However, despite the normalizing for patient-physician relationships as determined by technology-dominated medical practices, the current modern-postmodern condition has served to disrupt and raise questions regarding current standards of medical practices. According to Hyden (1997), the success of the biomedical model in reducing infectious diseases and cancer in middle- to high-income countries has brought about a new medical phenomenon. There is an ever-growing prevalence of degenerative and chronic illnesses emergent within an aging population. People populating these countries are living longer and thus becoming more susceptible to chronic health conditions. Many chronic health conditions, such as type 2 diabetes, some forms of cardiovascular disease, and osteoporosis, are now considered "manageable" chronic conditions (Hovey, 2006). These conditions are examples of chronic health conditions that, when managed appropriately, might not be immediately life threatening.

The efficiency of the biomedical model means that a person can live longer with a chronic health condition and even live well. Indeed, sound biomedical practices have increased the numbers of persons living with the complexities of a chronic illness. However, these persons have also lived to this point with high expectations of living everyday life well. When faced with an announcement, illustrated on an image screen or as a bottom-line test result read out, that they have a chronic illness, “boomer”-aged persons are increasingly voicing concern regarding how they are treated. Some are telling their stories about experiences with the health system to call attention to the situation (Bury, 2001). Thus, a state of increasing tension seems to be emergent between the biomedically trained physician, armed with objectifying evidence technologies, and the aging person discovering and wondering how he will live with a chronic illness (Bury, 2001). In this regard, Broyard (1992) wrote,

My initial experience of illness was a series of disconnected shocks, and my first was to try to bring it under control by turning it into a narrative. Always in emergencies we invent narratives. We describe what is happening, as if to confine the catastrophe. When people heard I was ill, they inundated me with stories of their own illnesses, as well as the cases of friends. Storytelling seems to be a natural reaction to illness. (p. 19)

Broyard (1992) was writing about his experience of living with an illness, prostate cancer and how he brought his illness experience “disconnected shocks” under control through narrating his story. The (re)construction of his illness experiences into a story about living with an illness helped him to understand the unexpected discovery. In telling his story, Broyard realized that telling his story was personally beneficial, but his storytelling also became an invitation for others who were living with illness to tell their stories. Churchill and Churchill (1982) wrote,

Unlike the careful factual description of history, narrative asserts the human meaning of events, creating, often metaphorically, the categories for interpreting those events. So, one may review past events through narration and say, “Oh now I see,” as if it were the first time. (p. 73)

Listening to the story of a person experiencing a chronic illness serves to help self and others understand the meaning of how the illness lives in that person’s life. Storytelling is a natural human mode of expression and communication that has the power to inform, heal, and reveal important personal and health considerations that could be helpful in terms of emotional, social, and psychological wellness. As well, the receiving of personal stories of chronic illness is a means to articulate the links between body, self, and society (Bury, 2001). Bury indicated that this relationship between the physical body, the perception of self, one’s identity, and how a person living with illness lives within her world beats at the heart of interpretive understanding. The story becomes a means for a person living with a chronic illness to reflect on the biographical geography of a life lived, yet this is a life now to be lived differently, within a new context of an emergent illness. In essence, health care practitioners need to hear what each patient has to say about what it now means to discover and imagine living well with a chronic illness. Story attending repositions the ear and invites the mind’s eye to imagine what it means to become, often in a moment, otherwise.

Why is honoring the story relevant to contemporary patient health care?

In this text we sought to show health care practitioners directly and patients living with chronic illness indirectly that when interpretive researchers embrace the complexity of the human experience manifested in a person’s narrating her story, there are understandings and healing

possibilities evident for both the teller and the listener. A person's story of illness reveals lived meaning. However, the telling of the story must be received within a receptive communicative interactive relationship. This is why the practitioner must be aware of the power of the story, and this awareness cannot be sidetracked by the time or knowledge demand restrictions of the formal practitioner-patient conference. A story-exchange engagement between teller and listener can occur even in a short-term, time-specific relationship like that typically evident between the patient and the practitioner. The power of story is that it is phenomenological. A story evokes lived time; that is, we have agreed, as a society, that 5 minutes is 5 timed minutes, and we have defined that time span as technologically 300 seconds (and a second can be further dissected in 10ths and 100ths, etc.). However, a phenomenological experienced 5 minutes with your dentist or accountant or mother-in-law or lover does not feel like the same 5 minutes. For health care practitioners the essential argument to be gleaned from interpretive work that accepts story as a source of meaning making is this: if it can be shown that at the very least listening well, carefully and interpretively, even in a contested time-space setting and even with weighty, absolute-certain scientific-technology evidence declaring an illness, it does no harm to the patient and, in fact, could aid the patient's sense of wellness and identity recovery, then where is the harm in such an attentive act? Where is the harm in opening up the possibility for a pedagogic moment when the teller tells and the listener listens? Where is the harm in active roles for both the health practitioner and the patient in constructing and understanding meaning making? Epstein (1999) noted that when such a relationship exists, the patient is not only healing, but the physician is recognizing and refining technical and pedagogic skills, revisiting evidence-based decisions and clarifying values so that she can act within a compassion presence, a technical competence, and, perhaps, even practical wisdom.

So, why now? Why change practice now if I were a health care practitioner? Simply, in terms of our current cultural and societal conditions, we find ourselves living within a topsy-turvy modern-postmodern world. Therein we are increasingly recognizing that our constructed ways of being in the world—via the mediations of language, gender, ethicality, race, socioeconomic circumstances, politics, education, heritages, and so on—both hinders and advances our knowing and doing practices. Heidegger (1968) reminded us, as forgetful beings, that our personal, cultural, and societal narrative-story orientation is the means by which we as human beings make sense of our temporal and finite lives. Responsively, in changing times, today's health care patient experiencing chronic illness is, consciously or not, a walking and talking riddle of yesterdays, today, and tomorrows. If persons are now different and our society is in a state of rapid change and flux, then it is now necessary to reenvision practices of patient health care.

Lipton (2005) wrote,

While many in the medical profession are aware of the placebo effect, few have considered its implications for self-healing. If positive thinking can pull you out of depression and heal a damaged knee, consider what negative thinking can do in life. When the mind, through positive suggestion improves health, it is referred to as the placebo effect. Conversely, when the mind is engaged in negative suggestions that can damage health, the negative effects are referred to as the *nocebo effect*. In medicine, the *nocebo effect* can be as powerful as the placebo effect, a fact you should keep in mind every time you step into a doctor's office. By their words and their demeanor, physicians can convey hope-deflating messages to their patients, messages that are, I believe completely unwarranted. (p. 142)

Within the reality of a new world order there is a need for an alternative way of practicing patient care. Within that practice there must be a conscious recognition, by practitioners and patients, that beliefs and perceptions are always evident and at work, first and foremost, in a person's life. Furthermore, this awareness applies to both the practitioner and patient. A lesson learned from doing interpretive work is that by telling one's story to a receptive listener, there is a space opened up for a conversation regarding one's perceptions and beliefs in relation to another's beliefs and perceptions. Imagine: a healthy way to begin to understand a person living with a chronic illness is to begin with her storied perceptions and beliefs.

Why? A lesson learned from those using story in interpretive work is this: A story shared in an interpretive relationship between an active teller and an active listener has the power to reveal complexity and invite understanding. Again, why? The story is actually an archetypal meaning-making mechanism shepherding our human evolution. Technically a story has remarkable qualities. Every story, riddled with simplicity or complexity, is told through changing perspectives. Herein is embodied its magic. There is a then-perspective and a now-perspective. The now-perspective changes with each (re)telling and new information and new circumstances influence the teller and reshape the story. The storytelling event is not reality itself replicated but a communicative living representation from a particular vantage point: the teller's current now-perspective. As the vantage point changes and mutates through time and space, distancing, so does the story itself change and the reality we are able to perceive as listener and, indeed, as the teller listening. This is why the act of telling in and of itself must be what is attended to interpretively. What matters here is what the teller tells now about what happened then. Each telling of the story organizes and reorganizes that "then" experience for the teller; that is, we are constantly engaged as tellers and as listeners in interpretive meaning making. Where we as listeners and speakers begin with a conversational exchange is where the story ends. However, what is taken up is the story itself. We do not fixate on the story's degrees of falsification or qualities of verification or its relevance in relation to "truth"; rather, we attend to its meanings to the teller (Hovey, 2006).

In conclusion, de Zengotita (2005) reminded us, even if we are not entirely conscious of this fact, that as thoroughly modern-postmodern citizens we are awash in an alchemy that exists and lives throughout the fabric of each contemporary person's life. de Zengotita indicated that this alchemy shows itself to be an unprecedented fusion whereby the "real" has become the "represented." The scope, width, breadth, and depth dimensions of our culture, of our being contemporary citizens, previously guided by proximity to the empirical/scientific real, has paradigmatically mutated into a hyper present conglomerate of mediated representational performances. Furthermore, his point is that there is no turning back time. de Zengotita wrote,

The issue is no longer representation versus reality, phony versus authentic, artificial versus natural . . . there is no going back to reality. . . . We have been consigned to a new plane of being engendered by mediating representations of fabulous quality and inescapable ubiquity, a place where everything is addressed to us, everything is for us, and nothing is beyond us anymore. (p. 11)

Early in the 21st century citizens should expect reliable, high-quality, and affordable health care that will be there when needed. Citizens should expect a health care system structured and functioning that is affordable, transparent, portable, and efficient. Currently there is much commonplace talk across individuals, groups, and institutions about how to reform and improve and achieve the health care expectations stated above. As interpretive researchers we are not offering a large-order solution to move the health care system from here to there. What we are offering is a way for people, practitioners and patients, to connect with each other through the use

of story with the intent of understanding our own and another's beliefs and perceptions about our health and well-being. Without this storied connectedness between persons, meanings, and understandings, a healthy and healing relationship is not possible.

Notes

1. Alterity is the state or quality of being other, being otherwise. (Word Web Online, 2007).
2. A discourse is a verbal expression in speech or writing, or a verbal exchange, conversation, or a formal, lengthy discussion of a subject, either written or spoken. A discourse may also be understood as an institutional (inclusive-exclusive), often dominant, language game (Mills, 2005).
3. Dasein, as Heidegger (Dreyfus, 1991) noted, is the primal nature of "being," and Dasein is always a being engaged with the world. The fundamental mode of being is not that of a subject or of the objective but of a coherence of being-in-the-world.
4. The biomedical model is a model of perceiving and organizing illness and disease in Western medical education and research and practice. The model has two assumptions: (a) reductionism, that all conditions can be linearly reduced to a single cause; and (b) dualism, whereby illness and disease are divided either to an organic disorder having an objectively defined cause, or a functional disorder, with no specific cause or pathophysiology (International Foundation for Functional Gastrointestinal Disorders, 2006).

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