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Narration in Medicine

Rishi Goyal
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1 Definition

Narration in medicine is concerned with the function and analysis of the multiple narratives produced in the context of clinical care and the healing of illness. The study of medicine and narrative can be described along three general lines: narration in the medical case history as an epistemological basis for medical cognition and clinical care; formal analysis of patient narratives of illness; research on the uses of narrative as a clinical treatment or model for medical care.

2 Explication

The medical case history (the physician's account of a patient's disease) and the illness narrative (usually a patient's first-person account of his or her illness experience) are the two forms of discourse most relevant to the study of medicine and narration. The medical case history inscribes a patient's story of illness within a framework of pathophysiologic processes, contextualizes current symptoms in a broader health history, interprets data from the physical exam and laboratory studies, and narrates a diagnostic process. This case history represents the process of clinical reasoning as a narrative of discovery and justifies a particular prognosis and treatment strategy. Specific elements of the case history suggest that narrative can be seen as central to the ways that physicians think about disease, make diagnoses and offer treatments that take into account patients' expectations and individual needs.

Illness narratives and their study have become more prominent in recent years. Illness constitutes a disruption, sometimes temporary, sometimes permanent, in an ongoing life. Illness narratives most often represent this disruption as a threat to the integrity of the self and identity. They are usually written by patients and sometimes by family members or even physicians, but unlike medical case histories, they are generally concerned with the experience of suffering as opposed to the biomedical concept of disease. Illness narratives attempt to convey an intimate knowledge of suffering, to make sense of illness in the context of a larger life history, to offer integration of an identity, especially in the case of chronic illnesses,

and to connect the sufferer with others who have the same or similar illness.

Besides the analysis of illness narratives and medical case histories, the study of medicine and narration has led to direct clinical interventions. Narrative medicine suggests that the therapeutic relationship between doctor and patient may be improved by urging a form of the encounter that is more narratively engaged and competent. Through a series of procedures or movements (attention, representation and affiliation), a physician trained in narrative competency will deliver care that is more effective and humane. And the very act of writing or telling a story can be healing in certain cases. While this has a long tradition in psychoanalysis, recent research suggests that this work may have broader applications in somatic illnesses such as ameliorating the effects of chronic pain (Brown et al. 2010) or in providing a continuous narrative of the self after brain trauma (Morris 2004).

3 Dimensions of Narration in Medicine

3.1 Narration and the medical case history

The standard medical case history, or anamnesis (chief complaint, history of present illness, past medical history, past surgical history, allergies, family history, social history, review of symptoms, physical exam, assessment and plan), has had a relatively stable form for at least a century (Klemperer [1898] 2010). The written case history typically follows a medical interview, which can take place in an outpatient clinic, a physician's office, an emergency room or a hospital bed. The patient recounts what led him or her to seek medical attention (the 'chief complaint'), narrating the sequence of events and experiences that constitute his or her illness (some histories, as in the case of a comatose or non-communicative patient, will be heteroanamnestic, i.e. narrated by a person other than the patient). The first part of this 'history' is the most overtly narrative and can be elicited through questioning, both open-ended (e.g., "What is wrong?") and close-ended (e.g., "How long has it been hurting?"). Following the history of the present illness, the physician asks a series of questions aimed at understanding the patient's global health history (past medical history, past surgical history, allergies, etc.). The medical interview ends with the physical exam, during which the physician examines the patient, laying particular emphasis on specific systems that correlate with symptoms.

The physician then records the encounter, transforming the patient's story of illness and physical examination into a medical case history. In formulating an assessment, diagnosis and treatment strategy, the physician ideally engages in two

complementary but distinct modes of thought, as described by Bruner (1986): the paradigmatic or logico-scientific, and the narrative. The paradigmatic is the mode of science and deals in generalities, principles, hypothesis testing, and it ultimately rests on the empirical verifiability of its concepts. Physicians clearly rely on non-narrative data like vital signs and laboratory values as well as on pathophysiologic principles to support a diagnosis and treatment plan that leads to a positive outcome in the world of the patient. But they also engage in Bruner's narrative mode, which deals in unique human intentions, contingencies and vicissitudes, constructing a *believable* as well as a *verifiable* account. The physician's diagnosis depends heavily on the story he or she hears from the patient, since it relates to a temporal structure and a change of state (usually from health to sickness). A 'good' medical story (one that makes causal connections clear, includes relevant information and interests the listener) makes diagnosis easier by eliciting the physician's empathy: recent research suggests that clinical empathy may actually be an important determinant of diagnostic accuracy (Halpern 2012). The patient's story must also captivate the physician's curiosity (curiosity, not generally considered a crucial attribute of the physician, is one of Sternberg's three 'master forces' of narrative [1978] and may be clinically relevant [Fitzgerald 1999]). An appropriate and acceptable treatment plan will often have to take account of a patient's life experiences and history, the nature of his or her individual suffering and the ways that individuals imbue their illness with meaning.

Drawing on empirical data, rhetorical argumentation and narrative elements, the physician considers biomedical principles and compares the case at hand to a store of prior cases in order to reach a diagnosis and plan, a process described by Sebeok as a "[g]estalt-yielding composite of reported (subjective) symptoms and observed (objective) signs" (1991). In order to make sense of signs and symptoms, the case history must incorporate objective material data and descriptions while relying considerably on the patient's unique narrative of illness. It is a means of communication (most often with other physicians and healthcare workers), an anamnestic reconstruction of the patient's experience of illness in terms of a biomedical model of disease, a cognitive tool for the interpretation of symptoms and signs, and a hypothesis-generating formulation of diagnosis, prognosis and therapy that suggests certain future-directed actions.

3.0.1 Perspective, voice and the medical interview

Perspective describes the narrator's position in relation to the narrative (to what he narrates, the content, etc.) as it is told; it is the way the representation is influenced by the narrator's position, assumptions and interests. Theoretical writing on perspective in narration has underscored the complexity of the term, with an

emphasis on questions of ‘voice’ (first-person versus third-person) and knowledge (omniscience versus camera mode), although more recent work has also been concerned with ideology and the narrators’ social and psychological positioning (Niederhoff → Perspective – Point of View [1]). In the medical case history, the perspective or point of view adopted is most thoroughly that of the physician or scientist while the object viewed is the patient or the disease. In addition to this spatial or topographic fact of distance, this situation also implies a figurative distance based on interpretation and evaluation.

In his analysis of the medical interview, sociolinguist Mishler (1984) offers a critique of biomedicine in terms of a limited definition of perspective, what he distinguishes as the ‘voice of medicine’ and the ‘voice of the lifeworld’. For Mishler, ‘voice’ is both a literal and a figurative term. Literally, ‘voices’ refer to the voices of patients and physicians that Mishler transcribes from recorded medical interviews. More figuratively, voices refer both to a perspective and to a normative order. Mishler does not, however, distinguish between ‘voice’ and ‘perspective’, but treats them as interchangeable, regarding perspective as ideological position.

Borrowing from Silverman and Torode (1980), Mishler defines voice as a “particular assumption about the relationship between appearance, reality and language, or more generally, a ‘voice’ represents a specific normative order” (63). In Mishler’s terms, the ‘voice of medicine’ represents the perspective of a physician as “applied bioscientist” with a technical bioscience orientation (10), while the ‘voice of the lifeworld’ is defined as “the patient’s contextually-grounded experiences of events and problems in her life [...] expressed from the perspective of a ‘natural attitude’” (104). Analyzing a corpus of medical interviews, Mishler argues that the selection, strategic placement, form and order of questions reinforce the physician’s control and the dominance of the ‘voice of medicine’ over the ‘voice of the lifeworld.’ However, these are matters more of argumentation and rhetoric than they are of voice.

Perspective in the medical case history is more than just a question of ideology and should be pursued in future research. While the case history, especially the history of present illness which recounts the patient’s story, is written in the third person, the ‘chief complaint’ is often written in the patient’s own words, suggesting a variable point of view. This is further complicated by the reality that the medical case history is often one document among many in a medical chart. The plurality of voices in the form of consults, case histories, social work notes, nursing assessments, and even occasionally the patient’s words represents the diversity of “social speech types” (Baxtin [1934/35] 1981: 262) and may reflect the unique concerns and competencies of distinct professional groups (Poirier & Brauner 1990).

3.0.2

Story and discourse

Most theories of narrative discriminate between ‘story’, a sequence of actions or events independent of their discursive presentation, and ‘discourse’, the particular narrative representation of these events (Genette [1972] 1980). This distinction appears crucial to an understanding of the practice of medicine in that the purpose of the case history is to reconstruct a temporal sequence of events from a patient’s narrative. However, both the patient’s narrative account elicited through the medical interview and the medical case history are narrated discourse. Both accounts already order, select, and present events in narration.

The distinction between story and discourse allows the case history to be posited as a provisional form. In the case of a young woman presenting either to a clinic or to an emergency room (the place or context will influence the kind of narratives developed) with right flank and upper abdominal pain, it can be assumed that there is a true medical condition that causes her symptoms and that should be treated. But whether or not the physician arrives at the most effective treatment will be determined by which story elements he highlights (e.g., “the pain started after I ate lunch today”) and which he intentionally chooses to under-emphasize (e.g., “I have been urinating more frequently for the last two weeks”).

While the diagnostic evaluation suggested by the medical case history is predicated on the assumption that prior events have occurred, it is also itself deterministic of those events. This may be seen as a case of what Culler calls the “double logic” of narrative: on the one hand, the priority of events determines their signification, while on the other it is structures of signification that determine events (1981: 178). The case history attempts to reconstruct an original sequence of events that will lead to a diagnosis, but that diagnosis is determined by the specific narrative case history. The case history is a teleological form that attempts to point to a particular diagnosis or diagnostic and treatment strategy. It hopes to make the particular end chosen seem inevitable. Different narratives will be constructed by dilating certain events, deleting others and suggesting specific causal chronologies. Whether the young woman with abdominal pain has cholecystitis or pyelonephritis will not be determined by the presentation of the case history, but the particular case history will determine the specific diagnostic evaluation.

3.0.4 Sequence and Causality

Hunter also distinguishes between “events and the order of their telling” in medical narration, but she uses the terms ‘story’ and ‘plot’ to refer respectively to the patient’s subjective account of symptoms and the medical case history (1991: 61–2). While she acknowledges the constructedness of the patient’s account (patients

often suggest circumstantial etiologies and offer interpretations of their symptoms), she is more interested in the ways that physicians reorder and reconstruct the patient's story of illness to plot a medical narrative of causality, discovery and treatment for a specifically medical audience. From the patient's story of illness, the physician reorders details to construct a second narrative of causality. The case history is not merely a vehicle for the truth-out-there, but a formal and generic structure that that makes clinical reasoning possible: the physician must interpret signs and symptoms and fit them into the patient's account of illness so as to form a coherent plot.

The medical case history, unlike a conventional biography, does not begin at the beginning, but with the patient's request for medical care. It then pursues a retrospective account of the illness until it is conterminous with the extended present. The life events in the patient's story and the medical case history are experienced as differing chronologies. The patient's presentation for medical care occurs in the midst of an ongoing life and is a central event in a chronological sequence beginning with the onset of an illness and preceding through diagnosis and treatment. In the medical plot, the initial presentation subordinates both past and future, while represented time is the "plotted time of medical discovery" (1991: 65). The medical case history is then a narrative both of the medical detection process and the patient's story of illness.

Hunter compares the work of the physician with that of Sherlock Holmes who also begins at the end, with a crime or a puzzle, and must work backwards to construct a parsimonious narrative embodiment of causality. Like a detective story, the plot is at once a revelation and a narrative of that revelation in a causal sequence. One of the tasks of the physician is to differentiate between what Barthes called the confusion between consecutiveness and consequence or the logical fallacy of *post hoc, ergo propter hoc* (Barthes [1966] 1975: 248; cf. Pier 2008: 109–40). The physician distinguishes between 'kernels' and 'satellites' (Chatman 1978: 53–6), i.e. between elements that are critical to a particular plot and those that are not, and rearranges the patient's story to provide a narrative logic of causality that fits other such stories and pathophysiologic principles. Unlike fictional plots, however, the physician's plot of a particular illness story must result in diagnosis, therapy and resolution of suffering—processes facilitated and enabled by the presentation of illness in narrative.

3.0.5 Schemata and scripts

Schemata, and the related terms, frames, scripts and scenarios, offer another way to approach medical case histories (Emmott & Alexander → Schemata [2]; Herman → Cognitive Narratology [3]). Although schemata are commonly employed in

medicine, they are rarely explicitly taken into account. A schema is a mental structure appropriate for representing generic concepts as opposed to facts (Stein & Trabasso 1982). Schemata allow a vast amount of information to be stored in memory, organized and made easily retrievable. Most experienced physicians have multiple patient schemata at their disposal such as ‘a young woman who presents in a coma’ or ‘an old man with shortness of breath’. Schemata provide a template that allows for rapid evaluation and diagnosis, a consideration of exceptions, causes and prognoses. For the ‘old man with shortness of breath’, specific questions like smoking history or heart disease, the presence or absence of a fever, and the particular appearance of a chest x-ray would allow a rapid diagnosis that dispenses with a complete consideration of all pathophysiologic principles. These generic templates are built up from a store of experience and the reading or hearing of similar cases. They are usually stable over time and shared among a group.

When a schema offers a specific time-sequence, it is referred to as a script. Feltovich and Barrows (1984) describe illness script theory in terms of a general or abstract ‘illness script’ made up of an enabling condition, a fault and a consequence. Enabling conditions are contextual and patient-dependent factors, while the fault is a pathophysiologic process which results in the consequences or complaints, signs and symptoms that bring the patient to medical attention. The difference between case history and illness script is that while case histories are specific and individualized instances, illness scripts are general and abstract. Case histories can be compared against scripts, allowing for missing or omitted information to be filled in and re-ordered.

In addition to their use in clinical care, scripts and schemata play a potent pedagogical role, serving as mnemonic devices and potential educational constructs that allow the typical course or plot of an illness to be remembered and compared to the particular instance at hand.

3.1 Illness Narratives

Efforts to recontextualize the meaning of health and sickness in patient-specific terms are the basis for what Greenhalgh and Hurwitz (1998) call Narrative Based Medicine. The contextualization of medical discourse has generated an interest in patients’ accounts of illness that has often been framed in narrative terms. The increasing visibility of patient narratives (Broyard 1992; Mairs 1993; Brookes 1994), what Frank calls the “self-stories that proliferate in post-modern times” (1995: 68), noting their use as teaching vehicles in medical schools (Kumagi 2008), seems to parallel recent interests in memoir, autobiography and life-writing (Bamberg → Identity and Narration [4]).

Hawkins has resurrected Freud's term "pathography" to define the genre of narrative descriptions of illness, most often now used to designate patients' first-person accounts (1984: 232). For Hawkins, the construction of a pathography is an interpretive and narrative act that gives coherence, unity and form to an event or experience that never had it to begin with. Authors of illness narratives use a kind of fictional technique to select and arrange material from the life world or from lived experience to give meaning and value to their illness. They use established forms, genres and narrative strategies to make their illnesses narratively visible. Tracing the sociocultural metaphors that invade and consecrate medical narrative, Hawkins argues that these personal and public metaphors enable patients to achieve 'transcendence' over their illness. Hawkins explicitly compares illness narratives to spiritual autobiographies, although the 'transcendence' envisioned by the latter is hardly achievable in the context of embodied illness.

Hawkins' pathographies can be described in Frank's terms as quest narratives in which the hero gains a special insight as a result of the trials of his or her illness (1995: 115–36); however, they are not the only kinds of illness narratives told. In addition to the quest narrative, Frank describes two other kinds: the restitution narrative (75–96) and the chaos narrative (97–114). The restitution narrative focuses on the restoration of health while the chaos narrative describes an experience of illness that is incomprehensible, unpredictable and almost untellable. The differing storylines also suggest an important aspect of the self in relation to illness. In the restitution narrative, the illness is a temporary alteration or impairment, and the self remains intact and unchanged. By contrast, the self in the chaos storyline is fragmented as identity is threatened and disrupted by illness. Finally, the quest narrative depicts an identity that has been altered, usually positively, by the experience of illness.

Illness narratives can also have other purposes and motivations. In some cases, they serve to express anger, either at the illness or at society or at the medical establishment for its perceived failures. Some illness narratives are pedagogical, motivated by an attempt to help others in a similar situation. Finally, illness narratives are most often testimonial, attempts to bear witness to an experience and to come to terms with change and suffering (McLellan 1997: 618)

3.2 Narrative as a clinical and therapeutic mode

Starting from prior analytical work, internist and literary scholar Charon defined narrative medicine as the "competence to recognize, absorb, interpret and be moved by stories" (2006: vii). Charon shifts the focus from the narrative analysis of medicine to a practice of medicine that is narratively engaged and competent. By

understanding how narratives are built, transmitted, received and function in the world, Charon argues that we will be able to deliver healthcare which is more humane, empathetic, respectful and sensitive.

Narrative medicine derives its mandate from an ethical and imaginative impulse to inhabit and be with the other through the movements of attention, representation and affiliation (Charon 2005: 263). Specifically, Charon suggests that in listening to patients' narratives of illness, physicians should attend to questions of temporality, singularity, plot and perspective. Listening is then followed by representation, usually in the case of writing the medial case history. The fact of bearing witness implicit in the attention paid to medical stories of illness combined with its representational reconstruction in medical narratives results in the final movement: affiliation. Affiliation registers the ethical impulse to act on the patient's behalf generated by the narrative competencies expected of attention and representation.

The narrative work of recounting stories of illness might itself result in healing in certain cases (Brody 1988). That telling one's story of his or her sickness to a trained witness can result in the resolution of symptoms is the cornerstone of Freud's 'talking cure' (*Redekur*; Breuer & Freud [1895] 1955). The "storying" of illness provides a truth claim about its reality that purges the psychological fears of uncertainty and ambiguity; and knowing that the story is told to someone who will undertake actions to remedy one's condition and relieve pain can alleviate distress. Mattingly (1998) contends that narratives can be especially helpful in occupational therapy as a way for patients with disabilities to understand their experience and for therapists to connect their interventions with what outcome patients most desire. Finally, Hunter (1991) argues that for the narrative act to be truly therapeutic, the medical reconstruction or story must be returned to the patient, not just in terms of diagnosis and therapy, but as a mixed narrative that accounts for both the patient's and the physician's understanding of illness and recontexualizes it in the whole of the patient's life, which is never just the story of disease (1991: 13).

4 Topics for Further Investigation

Future research in the field of narration and medicine may want to take up the relation between narrative accounts and non-narrative data in the arena of the clinical case history. How are the two distinguished and how are they combined in the formulation of a treatment plan and strategy? What are their respective contributions to the actual diagnosis? Are certain medical specialties more narrative-friendly than others? Future research should investigate the typology of medical narratives with respect to narrativity, i.e. some medical narratives such as 'case

histories' have low degrees of narrativity while others such as 'illness narratives' may have a high degree of narrativity (Abbott → Narrativity [5]).

Population-based research, which has often eschewed local and anecdotal experience, has been a dominant framework for medical diagnostics and therapeutics, but advances in genome-based medicine suggest that medical care may be beginning to target the particular and individual biological realities and destinies of unique patients. As the risk of contracting an illness becomes almost synonymous with having an illness, research into narratives that precede the specific medical event of becoming or feeling ill (Wexler 1996) may provide valuable insights.

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