



Bringing the doctor inside the care: the use of stories in doctor-patient communication

Andrea Smorti¹
Chiara Fioretti²

Abstract

Narrative-Based Medicine is a recent important area of research and practice which aims to provide theoretical and empirical constructs for medical practice and doctor-patient communication. In health services, medical patient-centred practices are usually built on the needs of patients while taking as much of an individualized perspective as possible, which sometimes involves a great expenditure of time and energy by the health staff and their clients. This paper aims to study the role of patient-physician communication and the current evidence on NBM in light of recent research in cognitive studies about autobiographical memory and narrative. To this end, we will stress the need for a solid and careful connection between medical patient-centred practices and theoretical constructs of narrative theories, proposing a model based on new theories on social development of the autobiographical memory.

Keywords

Narrative-based medicine, memory, patient, doctor, communication, autobiography

Communication in medicine

In 1994 in the editorial of the famous British Medical Journal, entitled “*The Inhumanity of Medicine*”, D.J. Weatherall, Regius Professor of Medicine at the University of Oxford (UK), argued that “although doctors may always have had a limited facility to treat their

¹ Department of Educational Sciences and Psychology and Laboratory META-ES (Methods and Techniques to Analyse Illness Experiences), University of Florence, Italy andrea.smorti@unifi.it

² Department of - Neurosciences, Psychology, Drug area and Child Health and Laboratory META-ES (Methods and Techniques to Analyse Illness Experiences), University of Florence, Italy, chiara.fioretti@unifi.it

patients as humans, there is no doubt that the current medical scene is highlighting our deficiencies” (Weatherall, 1994: p. 1671). In the same editorial, the author also claims that the social sciences presently show serious limitations with respect to understanding the needs of patients as people, and this suggests that most of the time human medicine is, in fact, inhuman.

It is surprising that the question of doctor-patient communication, although widely treated in healthcare and scientific literature, remains controversial: the importance of relationships and individualized care is not yet accepted by the majority of professionals in the health care area today.

The aim of this paper is to discuss some basic issues concerning doctor- patient communication, proposing a view on how recent narrative models can provide useful and convincing tools to deal with these problems. Starting from a brief review of the models and protocols concerning doctor-patient communication, we will investigate the most recurrent patient-centred care model, focusing on its strengths as well as its weaknesses and in particular on the problems of its implementation. Then we will explore this field in light of recent evidence about the Narrative-Based Medicine approach and the evidence deriving from research on autobiographical memory and narrative. In our opinion, indeed, it is essential to make a strong connection between recent theories on narrative of illness and theories in the field of narrative psychology.

In the present paper we will not present original empirical data on the practical implementation of narrative theories, focusing our analysis on the importance of psychological theories about narrative, considering them as a strong empirical base for communication in day-to-day medical practice. Our considerations are the outcome of the studies of the Laboratory META-ES (methods and techniques to analyse illness experiences) of the University of Florence, which aims to study the role of narrative in medical practice considering the point of view of a multidisciplinary team.

Recent approaches in medical practice and communication

In the last thirty years, especially in western countries, attention to communication between doctors and patients has gradually increased, as attested by the amount of publications, research, training and seminars: the theme of communication has become increasingly central in medical practice. Indeed, this is the case both for the influence that communication exerts on the process of care and the difficulties inherent in the process of communicating. The therapeutic alliance, which is essential for the success of therapy, is centred on the possibility of a relationship between doctor and patient through an open and sincere dialogue (Greenhalgh, 1999; Charon, 2011).

Looking specifically at the main areas of research emerging from the literature of the last thirty years, studies about doctor-patient communication are numerous and basically focus on the asymmetry of the relationship (Albuquerque and Roffé, 2008), the connection between efficient communication and adherence to treatments (Stewart et al., 2000), the relationship between the type of communication and degree of patient satisfaction (Sitzia and Wood, 1997) and physicians’ communicative style (Emanuel and

Emanuel, 1992). However, few studies have looked into this topic in light of the theoretical knowledge about autobiographical narrative and autobiographical memory (Williams, 2008).

Despite the considerable amount of research on the importance of communication in the therapeutic relationship and the efforts to implement effective protocols of communication, the evidence suggests that doctors and patients have such divergent views of their interactions as to appear two different realities (Stewart, 1995). Emanuel and Emanuel (1992) have outlined four possible models which describe how doctors give information to their patients. The authors identified an information model, characterized by expert and authoritative doctors who provide relevant information based on facts and by patients who, in light of what they have learned from the communication, choose the treatment they consider most suitable for their lifestyle and personal requirements; an interpretive model, in which the physicians act as counsellor and try to understand and interpret what is primarily important for the patients, informing and assisting them in the implementation of the chosen medical treatment; a deliberative model, in which the physicians deliver information, but also become mentor, helping the patients to understand the various therapeutic options, and identifying the moral aspects suited to their beliefs; and finally a paternalistic model, in which the doctors give the patients selected information and encourage them by promoting the choice they consider best for the patients.

These four models attribute a different role to the physician and patient in communication, provide for different degrees of participation and autonomy by both partners, and lead to different effects of the therapeutic relationship.

The main problem seems to be, in fact, the difference between the physician's and the patient's illness narratives: both have their own goals in telling and listening to narratives about illness, as well as different vocabulary and linguistic knowledge about it (Boyd, 2000).

Such diverging communication seems to depend, according to many studies, on contrasting perspectives of the therapeutic relationship: that of the doctor, who aims to get the right information and specifications during the interview, and that of the patient, who is interested in discussing the treatment plan and hopes to be accorded an active part in the decision-making process (Stewart, 1995; Makoul et al., 2007; Kenny et al., 2010; Moore et al., 2010).

In light of these data, the best way to underpin doctor-patient communication would appear to be by sharing information, making joint decisions not only based on the clinical implications of treatment but also on the emotional involvement of both partners. The Shared Decision Making (SDM) procedure, for instance, proposes that treatment decisions relating to the health of the patient should be taken through the health professional and the patient sharing views (Clayman, 2012). In this perspective, each therapeutic action is centred on the individual patient's wants, as he/she expresses them, and is included in co-management of the process. This patient-centred view aims to integrate the biological dimension of traditional medicine with a perspective in which the sufferer is the protagonist. Each patient's experience of illness is relevant and cannot

be reduced to mere biological components because it involves variables connected to the patient's life, including its psychological and social facets. From a clinical point of view, this medical practice focuses on the patient as a whole, actively involving and ensuring that his/her point of view, needs and concerns are pondered in the communication process with the doctor.

This model seems desirable for both the patient and the physician. Patients may find relief in resolving major decisions affecting their health through co-participation in the clinical decision making, and sharing information about the disease and its treatment options. However, all this also means bringing the emotional burden of fears, doubts and hopes about the outcome of the disease and its consequences into the therapeutic relationship. A doctor may find relief in sharing the decision about the treatment together with the patient, but this direct interaction may create anxiety too. This might push him/her, as often occurs, to use psycho-lexical stratagems such as talking *about* patients rather than *with* the patient (Mintz, 1992). Sharing patients' choices about treatment means, in some ways, accepting the idea that they may often know more than the physicians about particular aspects of their disease and, therefore, that it is necessary to collect information about the patients' state of mind and requests. This also means allowing patients to overcome the barrier separating them from the physicians (Bartoccioni et al., 2004).

Scientific literature seems to describe patient-physician communication as a microsystem in which each partner has different needs from the other. As in any other human form of communication, between doctors and patients too, information sharing is a process of understanding a meaning within a particular context (Hasson et al., 2011). Thus, when the meaning of the conversation topic is unclear to one or both interlocutors, the communication act fails. Hasson and colleagues (2011), by measuring the speakers and listeners' brain activity, found that, during communication with successful comprehension, their brains exhibited joint response patterns: in this case, the listener's brain is a sort of mirror of the speaker's.

Studies on communication between doctor and patient have shown that successful communication is not so common: neither partner is quite clear about what the other requires from their relationship or about what to do to fulfil the other's needs.

While patients affirm the need for clear and simple information about the disease and treatments, participation in treatment decisions, emotional support and participation in their illness history (Dulmen et al., 1997), the results of studies on physicians' satisfaction underline the need to feel able to practise their professional competence and perceive the success and effectiveness of the treatments they have implemented. Satisfaction correlates negatively with loss of control in communicating with their patients, lack of progress in the treatment and the perception that the patients do not trust their work and are emotionally distant from them (Ort et al., 1964).

Upon investigating patients' preferences regarding the communication styles of their doctors, Leckie and colleagues (2006) claim that physicians may create distrust in their patients and decrease their level of satisfaction in the therapeutic relationship when they are focussed only on the technical perspectives of their job and use exclusively

scientific terms, do not provide spontaneous information but only responses to their patients' questions. Some research in the field of diabetes reveals that when doctors show empathetic attitudes and are sensitive to their patients' emotional signals, it not only improves their therapeutic relationship, but also facilitates an improvement in patients' distress and perception of the symptoms of disease and therapies (Hojat, 2011).

On the contrary, for doctors it is important, especially in the first minutes of the interview, to focus on the biomedical information and symptoms of clinical relevance rather than on their patients' personal and subjective aspects (Newell et al., 1998; Haidet and Paterniti, 2003). In this way, doctors can fulfil their need to make a correct choice about the diagnosis and the cure process and be sufficiently aware and clear about their therapeutic actions. Only at a later time can practitioners afford to treat what they perceive to be the most "thorny" issues in their patients, such as their emotional experience, fears and doubts.

Particularly during subsequent meetings, doctors need to perceive their patients' trust as evidence of the fact that they are providing an appropriate act of caring. The doctors' biggest fear is of being vulnerable to their patients' illness history (Greenfield, 2012).

This evidence underlines the fact that doctors and patients often have different requests from each other in their therapeutic relationship. One way to contemplate this field while jointly considering these different points of view is to conceive of all this as a narrative process in which doctors and patients continuously tell and retell a story: "their" story of the disease. This is what the Narrative Medicine approach (Charon, 2011) proposes: if communication is always based on an act of narrative, improving it in the doctor-patient relationship could help both partners to better understand and carry out the other's requests.

Narrative medicine: narrative in medicine

The heart of communication between a doctor and a patient is the story, past, present and future, of the patient's life. Patients give an autobiographical narrative of their lives and, specifically, in relation to the disease, doctors choose the parts to use for their clinical purposes. In this sense, the communicative divergence discussed in the previous paragraphs can be explained by the fact that patients and doctors tell two different stories, which can be defined as histories of illness (the patient's, mainly centred on the personal experience of the disease) and histories of disease (the physician's, centred on an objective data report).

Rita Charon, one of the pioneers of Narrative Medicine approach (Charon 2000a; 2000b; 2006), reported the experience of her research group, who consider listening to the stories of illness not only as a human and empathetic approach to the patient, but also as a rich source of information useful for diagnosis, identification of the treatment of symptoms and therapeutic strategies.

According to her approach to medical practice, health professionals must not only consider the case history through collecting information about the disease in its pragmatic content, but also open up to illness and understand all the parts that make up the illness narrative: the people who experience it (their subjective experience), the goals that motivate them (such as how they want to deal with the care and what therapeutic goals they want to achieve with their doctor), the tools they want to use (clinical, but also practical and related to everyday life before the illness), the situation which prompted the disease (family support and relationships, problems at work, eating habits, etc. etc.).

In this domain, listening to the illness story makes for a more complete and useful medical practice for the purpose of effective communication between doctor and patient. This listening is based on the belief that narrative is the way in which patients experience their illness and that, through the storytelling, they can work together with professionals to build the significance of the illness experience. In addition, by listening to the illness rather than disease narrative, the doctor can deal with different points of view and generate new hypotheses that could enrich, in line with what we described in previous paragraphs, their "need to be clear and self-confident" in their clinical practice with patients.

Professional medical training, however, often focuses exclusively on exploring the history of the disease: the instinctive human characteristic of producing and listening to stories is lost during the university years in favour of the learned experience of building medical reports (Kleinman, 1988). These reports, which are potentially rich in information about the patient's life, appear fragmented and lacking in meaning because they are abstracted from their broader life context. Separated from narrative of the habits of daily life, the symptoms of disease provide incomplete material upon which to produce a sometimes incorrect diagnosis (Greenhalgh and Hurwitz, 1999).

From Greenhalgh's point of view (1999), this is due to the current Evidence-Based Approach according to which medicine, as a science, is based on an objective and reproducible clinical method. The lack of interest in the subjective dimensions of disease that distinguishes this approach causes interview protocols to exclude the exploration of broader contexts of the patient's life (which could illuminate the subjective meaning of the patient's account), and impoverishes doctor-patient communication so that the possibility for the patients to produce their illness narrative is precluded. In this way, the therapeutic relationship between a doctor and a patient is centred on the disease alone rather than on the illness: in the doctor-patient relationship patients are not free to develop their own experience of the illness and although the doctors have a lot of medical information, it is disconnected from the context of the patient's life.

Is it possible to retrieve the patients' subjective point of view and to give meaning to their story in order to understand their illness and not just their disease?

Some attempts to expand the information collected during patient-physician communication concern the creation of diaries to complement the patient's medical records (Di Gangi et al., 2012). In this case, the news on the psychological state of the clients and their needs and, in the case of paediatrics, the parental observations and

reports of their children, are usually harvested by nurses to be then used by the health professionals. Despite collecting some information on the illness rather than the disease, this "complementary medical record," however, is once again placed in a separate position with respect to the history of the disease: on the one hand, it incorporates the patients' and their families' perspectives during the clinical treatment, on the other, however, it leaves them in the background, namely complementary to the rest of the story. On the contrary, physicians need a method to integrate biomedical information with the patient's life history, in order to realize both clinical management of the disease and care of illness (Helman, 1981).

When a physician practices medicine with narrative competence, he/she can interpret what the patient is trying to communicate (Charon, 2006), not only understanding the patient's ability to narrate the illness, but also the disease itself. This is the reason why Narrative Medicine teaching programmes have emerged in recent years, encouraging students and health professionals to write about their patients in non-technical language, seeking the story of the illness. The basic assumption of this re-educational training is to re-apply the innate narrative structures of thought and language in work practice. The presupposition behind this method is that if one of the two partners in the dyad (doctor or patient) is not capable of focussing on the illness narrative, many of the demands both doctors and patients attribute to the therapeutic relationship may remain unfulfilled.

However, if the Narrative-Based Medicine approach is to represent an efficient theoretical model for understanding and improving doctor-patient communication, an attentive and deeper investigation of its scientific foundations is needed. The Narrative-Based Medicine approach entails psychological concepts as well as the personal story and narrative, autobiographical memory, cognitive and social process concepts entailed in narrating. What we propose in the last paragraph of the present article is to connect Narrative-Based Medicine practices with psychological evidence on narrative processes.

Narrative theories for Narrative-Based Medicine

A serious narrative proposal to restore effective doctor-patient communication should, in our opinion, springs from a careful consideration of the results in the field of linguistic, cognitive and social-cognitive research on autobiographical narrative. To sum up these results in a forcibly synthetic way, we can say that stories are our natural way of organizing many different types of information (McAdams, 2001): in particular, personal or autobiographical stories allow us to order the sometimes chaotic events of our lives. The desire for order and consistency can lead us to build our lives in a narrative form (Cohler, 1982). The autobiographical narrative draws on autobiographical memory, which is outsourced through the narrative in a very particular way: the use of language, the narrative format and the setting make autobiographical memory become a radically different story from what it was before being told (Smorti, 2011).

As a result, autobiographical narrative is a way through which memories are transformed. These transformations, which may be beneficial for the mental well-being

of the patient, have been demonstrated in numerous studies (Pennebaker et al., 1988; 1990; 1997; 2001), and occur because the personal story is shared and reconstructed to an interlocutor through the narrative. Therefore, one of the conditions that comes into play and affects the way in which this transformation from memory to autobiographical narrative takes place is the relational context between storyteller and listener. The narrative act always addresses someone and therefore is dependent on the type of relationship between listener and storyteller. Indeed, the partner, the one who listens to the story, contributes to its reorganization by providing insights and points of view. In doing so, he/she becomes part of the process of elaboration of the narrator's personal history. The relationship between narrator and listener, therefore, allows a "new" story to occur that is not the same as the narrator may have told others, because it is modified by new interactive situations. Theories about the social construction of autobiographical memories have argued that memory has a constructive and contextual nature. In particular, two different models can be contemplated. The first (Conway and Pleydell-Pearce, 2000) deals with the construct that autobiographical memory derives from the interplay of the self-system (individual beliefs and goals) and autobiographical knowledge (records about past experiences); in this case, goals in everyday life determine which memories are recollected and reconstructed and why. This model also gives a lot of importance to personal development (Thorne, 2000), as well as to the individual variables of the speaker that can influence the storytelling.

A second model is proposed by Pasupathi and takes into consideration the social construction of the personal past starting from the assumption that much learning and development begins with recounting past events in conversation (Pasupathi, 2001). A similar approach has been followed by Fivush and Nelson, who have devoted their studies to the parental role in the reconstruction of past events during conversations with children (Fivush 2001; Fivush and Nelson, 2004; Nelson and Fivush, 2004). In their studies, the development of autobiographical memory takes place in childhood through a process characterized by social cooperation between adults and children (Fivush and Nelson, 2004). We will now concentrate on this second approach because, according to our view, it takes greater account of the role of the narrator-listener relationship in memory and narrative processes.

Pasupathi's model (2001) is based on two principles that govern conversational recounting: consistency and co-construction. Consistency deals with the way in which speakers and listeners jointly produce memories which are retold in their conversation: retelling autobiographical memories is a way of increasing knowledge about them in terms of interpretative content (*ibidem*). The main studies in the field of autobiographical memory argue that such memories are often rehearsed, both mentally and conversationally. This procedure involves the application and construction of a schema about the event. Such schemas can improve the comprehension of many details or exclude other discrepant information in order to maintain consistency between the later and earlier recollection of events.

Co-construction is strongly dependent on three elements: the speaker, the listener and speaker-listener interaction. Although a good number of studies have

investigated the role of the narrator (McAdams et al., 1997; Fivush, 1998; Imhof, 2010), of the interlocutor (Clark, 1996; Pasupathi et al., 1998; McAdams et al., 2001), and of their interaction (Pasupathi, 2001), what has not been adequately addressed is the kind of changes that affect autobiographical memory. Pasupathi (2001), however, pointed out the importance of previous knowledge about the topic of conversation, non-verbal behaviour between the partners in the interaction, disinterest or disapproval about what is told as well as the motivation to tell. In a study on non-autobiographical memories which asked couples of individuals to recall memories about films they watched together, the author demonstrated that the collaborative production of memories implies richer and more detailed narratives than those recalled individually (Pasupathi, 2001).

Thus, co- construction assumes that that recalling a past event can produce small and progressive changes in the nature of autobiographical knowledge.

The importance of the relationship in the narrative act is based on evidence from several experiments, almost all focused on the interaction between speaker and listener. Some of them, for example, have explored the role of interaction between speakers and listeners in memories, starting from the fact that such variations can also influence long-term memories because variations in the social context of retelling a past event can affect how we narrate events to one another. Some variables, such as sense of self and quality of the narrative produced, were evaluated in young students who told personal experiences to interlocutors with varying degrees of responsiveness. Indeed, some of them had been trained to listen carefully and actively to the story of the narrator, while others had to listen in a distracted and unsympathetic way. The results show a significant difference between the consistency and length of the narratives produced in the two experimental conditions: recounting an autobiographical memory to a distracted and not involved interlocutor decreases the sense of coherence of the narrative and its length. Moreover, narratives of positive experiences were compared with those of negative ones (Pasupathi and Hoyt, 2009). The results highlighted that, like for the positive memories, even the narration of adverse events is affected by the quality of listening received from the interlocutor. These studies suggest that the meanings people give to their life events are not individually processed through the narrative alone, because they result from the joint and coordinated activity of the partners involved in the conversation. There is a strong line of research which aims to address linguistic and socio-semiotic evidences to the field of communication in medical practice (Sarangi & Coulthard, 2000; Candlin & Candlin, 2002; Roberts & Sarangi, 2005). Roberts and Sarangi (2005), for example, have considered the way in which language constructs professional practice as a form of natural interaction between two or more interlocutors. In medical environment, talking with patients is the main care activity; nevertheless, language is not just a way to express a point of view, but it is firstly a constitutive process (Roberts & Sarangi, 2005) of making sense. In the context of medical interview (as in case histories recollection), this issue is even more crucial, because the process of making sense is co-constructed (Pasupathi, 2000). In this case, the procedure to study and analyse this complex communication is deal with the consideration that every interlocutor brings to

the conversation a personal type of language and knowledge (Roberts & Sarangi, 2005). The conversation analysis approach, for example, is a way to examine doctor-patient communication as an arena of naturally occurring interactions (Maynard & Heritage, 2005): the nature of this type of conversation, indeed, is different from other kinds of narrative in medical practice as anecdote or case histories. This particular analysis procedure implies to collect data of conversation in real time, capturing the interview on audio or videotape. Thus, it is possible to focus attention on the way in which utterances, behaviour and language style of one participant affect another (Maynard & Heritage, 2005). In this sense, conversation analysis approach is not just focused on speaker's and listener's contribution in conversation, but on their mutual influence.

The listener's role, indeed, is not just to receive information, but to give it a meaning (Imhof, 2010): the speaker's intonation, pauses and emphasis are used by the listener to identify the relevant words and meaning. In doing so, the speaker's interlocutors can take part in the co-construction of the contents of the narrative and their negotiation in the conversation, producing the meaning of the event narrated within the story (Pearce and Cronen, 1980; Gergen, 1999; McNamee, 2004).

The evidence underlined in the previous paragraphs shows the patient's request for an attentive and empathic doctor; similarly, these studies highlighted the important role the doctor plays in listening to their patients' stories of illness. To develop effective doctor communication skills it is not just important to improve the way in which bad news is given to a patient, but also the way of listening to the patient.

Scientific literature about the impact of social interaction in the development of autobiographical memory, however, has also suggested that the listener's familiarity and similarity play a role. Familiarity refers to how the speaker knows the listener: individuals who recall past events together with a friend tend to remember more information than when they have a recall task with a stranger (Alea and Bluck, 2010). Similarity deals with the idea that some personal characteristics of the listener compared to those of speaker, such as gender, age or personality, can (or cannot) improve autobiographical memory: subjects who retell a story to a similar listener (a peer, for example) tend to provide a more emotional evaluation than with a dissimilar partner (Alea and Bluck, 2010).

The relationship between narrator and listener influences not only the kind of story that is told, but also the act of listening itself. Bluck et al. (2013) experimented this topic with the Autobiographical Memory Sharing (AMS) method. They studied the social function of autobiographical memory by stimulating empathy between the narrator and the interlocutor, focusing on the variables that may affect this ability. The participants, selected on the basis of having or not having experienced traumatic events in the past, were requested to read autobiographical narratives about traumatic memories. The level of empathy was measured before and after reading the stories. The results show that in the group of readers who had had traumatic experiences the level of empathy increased after reading the story (compared to those who had not experienced trauma). According to the authors, when it means sharing similar experiences, listening to autobiographical stories facilitates the development of an empathic attitude. According to Pillemer (1992) and Bluck et al. (2013), sharing autobiographical memories (such as those related to the

disease that arise in patient-physician communication), greatly increases the listener's empathy towards the narrator of traumatic events. Indeed, although the doctors may not have experienced a traumatic event in their personal lives, dealing with disease and death on a daily basis is nevertheless a traumatic memory to share.

The Autobiographical Memory Sharing (AMS) approach assumes that the listener (the physician) can search for his/her own autobiographical memories, choosing those episodes that are similar to what has been recounted by the narrator (the patient) and extracting those elements useful for understanding (Lockhart, 1989). Empathic understanding, in fact, can improve if the listener is interested and close to the experiences told to him/her. Every day physicians collect a large number of stories of illness, in a job that involves a substantial burden of suffering. Especially if they deal with deadly diseases, they could experience high levels of stress from managing the emotional burden of their job (Sandrin, 2004).

Considering what we have written so far, it would seem that doctors are the ideal partner for the practice of AMS: by listening to the patient's stories and comparing them with the experience accumulated in their working lives, they can increase the intimacy of the communication, develop empathy for their client and then give the correct information necessary for the creation of a therapeutic alliance. In this process of joint reconstruction of disease, the doctor may incorporate the patient's history in a medical lexicon (Donnelly, 1997), at the same time learning to master the subjective and emotional experience. In a single story, built by "four hands", this type of bio-psycho-social approach, not new to research in this field (Engel, 1977), embraces the various aspects of illness and disease and may allow both the doctor and patient to meet the needs of their partner in the therapeutic relationship.

Conclusions

In this paper we have tried to focus on two key points within the debate on doctor-patient communication.

The first is the opportunity to move from a "patient-centred model" to a "patient-physician-centred model" that places at the heart of medical practice both actors of the therapeutic relationship and the result of their interaction: the history of the disease. Starting from the current studies on doctor-patient communication, we have explored the role of narrative of illness as a tool in the creation of personalized care. The goal of the Narrative-Based Medicine approach, in this sense, is not only to incorporate the patient's perspective into the work of the physician, but, through narrative, to shape a common perspective created by both in equal measure in observance of the roles played in the therapeutic relationship. The role of social and cognitive theories about narrative and autobiographical memory is essential in this field and can contribute to the doctor's correct overtone to the patients' stories. We know that this approach to the stories of illness needs to develop a great deal before it becomes part of daily medical practice. Although doctor-patient communication has been central in the health-care debate for several decades, the beliefs and expectations of health staff, as well as those

of their clients, are still different and have different goals. However, in an evidence-based world, it is now certain that medical practice should take advantage of the evidence derived from the narratives of disease (Greenhalgh, 1999).

According to the studies on autobiographical narrative and its influence on life event memories, we think that basing medical practice on the joint construction of the history of illness could be the correct approach in order to redefine what illness means in a patient's life and what it means in the work experience of the physician. From the above considerations, it comes out that one of the skills a doctor should learn during his/her training years (master, PhD) would be that of learning how to communicate and how to interact with a person who is suffering for at least some physical preoccupations. Individual or group trainings based on development of practical and theoretical communication skills, the use of diaries as a tool to narrate own experiences in caring patients, the sharing of autobiographical memories on professional and personal events, the review of videotaped interviews with patients, are some of the possible means to develop doctors' capacity of managing their relationship with the patient.

The second point we have emphasized concerns our model of doctor-patient communication. It is based on three concepts: relationship, narrative and memory. Methods like the Autobiographical Memory Sharing (AMS) procedure can be considered a deeper form of relationship where the knowledge of the life history and its joint doctor-patient development can lead to a therapeutic approach that addresses important variables useful for clinical practice that are not considered in more traditional approaches. In fact, a suffering person is striving to implement coping strategies aimed to deal with pain while trying to make sense of his/her life experiences and then to remember and to narrate them.

In our perspective, therefore, and in agreement with what Davenport (2011) concluded, patients' experiences (memory) assume a new meaning when communicated (narratively) to a careful physician (attentive relationship) who, by using his/her autobiographical memory, can find points of similarity and analogy that will lead to sharing these experiences and develop not only attentive but also empathetic listening, favouring additional narratives from the patient. This means that the history of illness, which is co-constructed, is also an important tool for placing illness in a trajectory with a past, which is the patient's life story, and a future, on which the two partners in the therapeutic relationship will work together.

REFERENCES

- Alea, N. & Bluck, S. (2003) Why are you telling me that? A conceptual model of the social function of autobiographical memory. *Memory*, 11, 165-178.
- Albuquerque, M.C. & Roffé, R. (2008) The asymmetrical relationship between the health care professional and the patient in public hospitals. *International Journal of Bioethics*, 19, 165-79.

- Bartoccioni, S., Bonadonna, G. & Sartori, F. (2006) *Dall'altra parte [On the other side]*. Milan, Rizzoli.
- Bluck, S., Baron, J.M., Ainsworth, S.A., Gesselman, A.N. & Gold, K.L. (2013) Eliciting empathy for adults in chronic pain through autobiographical memory sharing. *Applied Cognitive Psychology*, 27, 81–90.
- Boyd, K.M. (2000) Disease, illness, sickness, health, healing and wholeness: exploring some elusive concepts. *Journal of Medical Ethics: Medical Humanities*, 26, 9-17.
- Candlin, C.N. & Candlin, S. (2002) Expert Talk and Risk in Health Care. [Special issue of:] *Research on Language and Social Interaction*, 35 (2).
- Charon R. (2000a) Literature and medicine: origins and destinies. *Academic Medicine*, 75, 23-7.
- Charon R. (2000b) Reading, writing, and doctoring: literature and medicine. *American Journal of Medical Science*, 319, 285-91.
- Charon, R. (2006) *Narrative Medicine: Honoring the stories of illness*. New York, Oxford University Press.
- Charon, R. (2011) The lives of stories, or the body of words. *The Lancet*, 377 (9784), 2170.
- Clayman, M.L., Makoul, G., Harper, M., Koby, D. & Williams, A.R. (2012) Development of a shared decision making coding system for analysis of patient–healthcare provider encounters. *Patient Education and Counseling*, 88, 367–372.
- Cohler, B.J. (1982) Personal narrative and life course. *Life-Span Development and Behaviour*, 4, 205-241.
- Conway, M.A. & Pleydell Pearce, C.W. (2000) The construction of autobiographical memories in the self-memory system. *Psychological review*, 107, 261-288.
- Davenport, N.H.M. (2011) Medical residents' use of narrative templates in storytelling and diagnosis. *Social Science and Medicine*, 73, 873-881.
- Di Gangi, S., Naretto, G., Cravero, N. & Livigni, S. (2012) A narrative-based study on communication by family members in intensive care unit. *Journal of Critical Care*, Article in press.
- Donnelly, W.J. (1997) The language of medical case history. *Annals of Internal Medicine*, 127, 1045-1048.
- Dulmen, A.M., Verhaak, P.F.M. & Bilo, H.J.G. (1997) Shifts in doctor-patient communication during a series of outpatient consultations in non-insulin-dependent diabetes mellitus. *Patient Education and Counseling*, 30, 227-237.
- Elwyn, G. & Gwyn, R. (1999) Narrative Based Medicine: Stories we hear and stories we tell: Analysing Talk in Clinical Practice. *British Medical Journal*, 318, 186-188.
- Emanuel, E.J. & Emanuel, L.L. (1992) Four models of the physician-patient relationship. *Journal of American Medical Association*, 267, 2221-6.
- Engel, G.L. (1977) The need for a new medical model: A challenge in medicine. *Science*, 196, 129-136.
- Fivush, R. (1998) Interest, Gender and personal narrative: how children construct self-understanding. In Karp, A., Renninger, A., Baumestier, J. and Hoffman, L. (Eds) *Interest and gender in education*. Kiel, Germany, Institute for Science Education, pp. 58-73.

- Fivush, R. (2001) Owing experiences: the development of subjective perspective in autobiographical memory. In Moore, C. and Lemmon, K. (Eds) *The self in time: developmental perspectives*. Mahwah NJ, Erlbaum, pp. 35-52.
- Fivush, R. and Nelson, K. (2004) Culture and language in the emergence of autobiographical memory. *Psychological Science*, 15, 573-577.
- Gergen, K.J. (1999) *An invitation to social construction*. London, Sage Publications.
- Greenfield, G., Pliskin, J.S., Feder-Bubis, P., Wientroub, S. & Davidovitch, N. (2012) Patient–physician relationships in second opinion encounters – The physicians’ perspective. *Social Science and Medicine*, 75(7), 1202-1212.
- Greenhalgh, T. (1999) Narrative based medicine: narrative based medicine in an evidence based world. *British Medical Journal*, 318, 323-325.
- Greenhalgh T. & Hurwitz B. (1999) Narrative based medicine: why study narrative? *British Medical Journal*, 318(2), 48-50.
- Haidet, P. & Paterniti, D.A. (2003) “Building” a story rather than “taking” one. *Archives of Internal Medicine*, 163, 1134-1140.
- Hasson, U., Ghazanfar, A.A., Galantucci, B., Garrod, S. & Keysers, C. (2011). Brain to brain coupling: a mechanism for creating and sharing a social world. *Trends in Cognitive Science*, xx, 1-8.
- Helman, N.G. (1981) Disease versus illness in general practice. *Journal of the Royal College of General Practitioners*, 31, 548-552.
- Hojat, M., Louis, D.Z., Markham, F.W., Wender, R., Rabinowitz, C. & Gonnella, J.S. (2011) Physician's empathy and clinical outcomes for diabetic patients. *Academic Medicine*, 86(3), 359-364.
- Imhof, M. (2010). What is going on in the mind of a listener? The cognitive Psychology of listening. In Wolvin, A. (Ed.), *Listening and human communication in the 21st century* (pp. 97-126). Chichester (UK): Wiley- Blackwell.
- Kleinman, A. (1988) *The illness narratives*. New York: Basic Book.
- Kenny, D.A., Veldhuijzen, W., Van der Weijden, T., LeBlanc, A., Lockyer, J., Le’ Gare, F. & Campbell, C. (2010) Interpersonal perception in the context of doctor–patient relationships: A dyadic analysis of doctor–patient communication. *Social Science and Medicine*, 70, 763-768,
- Leckie, J., Bull, R. & Vrij, A. (2006) The development of a scale to discover outpatients’ perceptions of the relative desirability of different elements of doctors’ communication behaviours. *Patient Education and Counseling*, 64, 69-77.
- Lockhart, R. (1989) *Consciousness and the function of remembered episodes: Comments on the fourth section. Varieties of memory and consciousness: Essays in honour of Endel Tulving*. NJ England, Hillsdale Lawrence Erlbaum Associates.
- Maynard, D.W. & Heritage, J. (2005). Conversation analysis, doctor-patient interaction and medical communication. *Medical Education*, 39, 428-435.
- Makoul, G., Krupat, E. & Chang, C. H. (2007) Measuring patient views of physician communication skills: development and testing of the communication assessment tool. *Patient Education and Counseling*, 67(3), 333–342.

- McAdams, D.P., Diamond, A., De St Aubin, E. & Mansfield, E. (1997) Stories of commitment: The psychosocial construction of generative lives. *Journal of Personality and Social Psychology*, 72, 678-694.
- McAdams, D. P., Reynolds, J., Lewis, M., Patten, A. H. & Bowman, P. J. (2001) When bad things turn good and good things turn bad: Sequences of redemption and contamination in life narrative and their relation to psychosocial adaptation in midlife adults and in students. *Personality and Social Psychology Bulletin*, 27, 474-485.
- McNamee, S. (2004) Social construction as practical theory: lessons for practice and reflection in psychotherapy. In Parè, D.A., Lerner, G. (Eds) *Collaborative practice in psychology and therapy*, New York, The Hawthorn Clinical Practice Press.
- Mintz, D. (1992) What's in a word: the distancing function of language in medicine. *Journal of Medical Humanities*, 13, 223-233.
- Moore, R.J. & Hallenbeck, J. (2010) Narrative Empathy and How Dealing with Stories Helps: Creating a Space for Empathy in Culturally Diverse Care Settings. *Journal of Pain and Symptom Management*, 40, 471-476.
- Nelson, K. & Fivush, R. (2004) The emergence of autobiographical memory: a social cultural developmental theory. *Psychological Review*, 111, 486-511.
- Newell, S., Sanson-Fisher, R.W., Girgis, A. & Bonaventura, A. (1998) How well do medical oncologists' perceptions reflect their patients' reported physical and psychosocial problems? Data from a survey of five oncologists. *Cancer*, 83, 1640-1651.
- Ort, R.S., Ford, A.B. & Liske, R.E. (1964) The doctor-patient relationship as described by physicians and medical students. *Journal of Health and Human Behavior*, 5, 25-34.
- Pasupathi, M. (2001) The social construction of the personal past and its implications for adult development. *Psychological Bulletin*, 127, 651-672.
- Pasupathi, M. & Hoyt, T. (2009) The Development of Narrative Identity in Late Adolescence and Emergent Adulthood: The Continued Importance of Listeners. *Developmental Psychology*, 45, 558-574.
- Pasupathi, M., Stallworth, L.M. & Murdoch, K. (1998) How what we tell becomes what we know: listeners effects on speakers' long-term memory for events. *Discours processes*, 26, 1-25.
- Pearce, B.W. & Cronen, V.E. (1980) *Communication, action and meaning. The creation of social reality*. New York, Praeger Publisher.
- Pennebaker, J.W., Colder, M., & Sharp, L.K. (1990) Accelerating the coping process. *Journal of Personality and Social Psychology*, 58, 528-537.
- Pennebaker J.W., Francis M.E. & Booth R.J. (2001) *Linguistic Inquiry and Word Count (LIWC): A Computerized Text Analysis Program*. Mahwah NJ, Erlbaum Publishers.
- Pennebaker J.W., Kiecolt-Glaser J. E. & Glaser R. (1988) Disclosure of traumas and immune function: Health implications for psychotherapy. *Journal of Consulting and Clinical Psychology*, 56, 239-245.
- Pennebaker, J. W. (1997) *Opening Up: The Healing Power of Expressing Emotion*. New York, Guilford Press.

- Pillemer, D. B. (1992) Remembering personal circumstances: A functional analysis, In E. Winograd, and U. Neisser (Eds), *Affect and accuracy in recall: Studies of "flashbulb" memories*. New York, Cambridge University Press, pp. 236–264.
- Roberts, C. & Sarangi, S. (2005) Theme-oriented discourse analysis of medical encounters. *Medical Education*, 39, 632-640.
- Sandrin, L. (2004) *Aiutare senza bruciarsi. Come superare il burnout nelle professioni di aiuto [Helping without burning: how to overcome burnout in health-care professions]*. Milan, Paoline Editoriale Libri.
- Sarangi, S. & Coulthard, M. (2000) *Discourse and Social Life*. London, Longman.
- Sitzia, J. & Wood, N. (1997) Patient Satisfaction: a review of issues and concepts. *Social Science and Medicine*, 45, 1829-1843.
- Smorti, A. (2011) Autobiographical memory and autobiographical narrative. Which is the relationship? *Narrative Inquiry*??, 21, 303-310.
- Stewart, M. (1995) Effective Physician-patient communication and health outcomes: a review. *Canadian Medical Association Journal*, 152(9), 1423-1433.
- Stewart, M., Belle Brown, J., Donner, A., McWinnhey, I.R., Oates, J., Wayne Weston, W. & Jordan J. (2000) The impact of patient-centered care on outcomes. *Journal of family practice*, 49, 796-804.
- Thorne, A. (2000) Personal memory telling and personality development. *Personality and Social Psychology Review*, 4, 45-46.
- Weatherall, D.J. (1994) The Inhumanity of Medicine. *British Medical Journal*, 309, 1671-1672.
- Williams, G. (2008) The genesis of chronic illness: narrative re-construction. *Sociology of Health and Illness*, 6, 175-200.

Andrea Smorti is full University Professor in the Department of Education Sciences and Psychology in the University of Florence. He currently teaches Developmental Psychology in the School of Psychology in the same University where also coordinates the Jointed Laboratory META-ES (methods and techniques to analyse illness experiences). In the last three decades he has been working on Narrative thought and on the use of autobiographical narrative in sickness situations.

Chiara Fioretti is currently PhD student in Neurosciences and Psychology at the University of Florence in Biomedical Doctorate School. She is member of the Jointed Laboratory META-ES (methods and techniques to analyse illness experiences) and she is also teaching assistant in the field of developmental psychology in the School of Psychology of the University of Florence. She works in the development of research and intervention projects in illness experiences following the Narrative Based Medicine Approach.