Problems, Mysteries, and Frustrating Cases: How Narrative Competence at the Bedside Can Improve Patient Care

Imagine cases like the following:

Worried about liability for assault, a doctor calls the ethicist after a patient refuses to allow removal of a Foley.

A patient-appointed surrogate refuses a safe discharge to SNF, while the patient's estranged daughter agrees with the care team's discharge plan.

Members of the care team experience moral distress as a patient in a long recovery from brain surgery undergoes painful multi-hour dressing changes without a prognosis of clear benefit.

Cases like these frustrate everyone involved, not because they indicate complicated ethical dilemmas, but because they center on conflicts between plans of action that are mutually unintelligible to each of the parties involved. In the first case, for example, the medical team simply cannot understand why the patient would compromise his safety by refusing the removal of a source of infection when the catheter is no longer providing medical benefit. Likewise, it seems equally obvious to the patient that removal is not worth considering. The conflict prevents both the patient and the medical team from achieving their preferred goals; and so their frustration mounts, their appraisals of the other's motives darken, and their thoughts turn to litigation. What should have been a routine interaction becomes a threat to patient care and to the professional-patient alliance.

Rita Charon's exploration of narrative competence, combined with Gabriel Marcel's distinction between problems and mysteries, offers a path out of this clinical dead end. Together, Charon's and Marcel's insights provide a fresh perspective for cases like these and demonstrate how approaching care with narrative skills can improve clinical outcomes at the bedside.

In her landmark work Narrative Medicine, Charon defines "narrative competence" as the possession of "skills of recognizing, absorbing, interpreting, and being moved by the stories of illness."[1] Narrative competence, then, is a multi-dimensional skill set and requires the development of an array of cognitive and emotional abilities. Charon's reference to interpretation is of particular importance with respect to the frustrating cases we're considering. Including that skill within

narrative competence suggests that our attention to the stories of illness our patients bring and enact is always a kind of seeing-as.

If Charon is right, how we see our patients and interpret their suffering matters. We can describe two opposed hermeneutical stances with categories provided by the French Catholic philosopher Gabriel Marcel. In several of his texts, Marcel distinguishes between problems and mysteries.[2] Understanding that distinction can help to clarify the demands of narrative competence in patient encounters.

When I interpret a situation as a problem, in Marcel's term of art, I construe it as fundamentally an object of manipulation. It doesn't directly involve me; I am not a participant but an observer, even if one with ambitions to change the situation for the better. A problem can be solved with the right resources and techniques. Anyone with the requisite skill set should be able to address it effectively. So, a problem calls for cleverness, technical know-how, or expertise. If I am confronted with a problem, I will focus my response on answering how questions; that is to say, I will concern myself with inquiring into the most effective and efficient means for manipulating the parts of the whole to obtain a given, "successful" result.

If my computer crashes, for example, I find myself confronting a problem. Though I depend on the computer in numerous ways and find my activity hindered when it fails, I have not crashed with the computer. The problem remains external to me, and I look for an effective technique to manipulate hardware and software to reverse the failure and prevent it from recurring. If I can just learn how to wield the right method, I can control the situation and remove the obstacles to my action.

But even in solving problems, method is rarely enough. Complex problems in information technology, plumbing, or car repair call for sophisticated knowledge, trained perception, and finely honed intuitions. Solving medical problems is even more demanding, and the technical skills that make it possible, correspondingly admirable. Nevertheless, the ability to solve medical problems is not enough to empower practitioners of the art of medicine to reach the ends of their practice by their means alone. In the medical context, the limitations of interpreting patient encounters solely as technical problems become readily apparent.

For example, a problem that cannot be solved becomes fertile soil for the growth of cynicism. The limits of my IT problem-solving abilities make me much more cynical about computers than my engineering-student son. This phenomenon is sadly familiar to most of us who work in health care. The patient whose problems resist our best techniques is the patient who is also most likely to become the object of cynical and exasperated comments.

For such a patient, another hermeneutical stance is necessary, and Marcel's description of mystery provides an apt alternative. When I interpret a situation as a mystery, it doesn't manifest itself as an object of technical manipulation. It cannot be held at a distance because it evokes personal attitudes such as wonder or hope. Consequently, it involves me in a way that goes beyond an acquired skill set, enlisting me as a participant rather than a mere observer. Simone Weil's reflections

on the power of attention suggest another way to characterize the hermeneutical stance that correlates with mystery: to interpret a situation as a mystery rather than a problem is to respond to it with attentive presence before attempting to solve it with technique.[3]

One's own suffering is a clear case of a phenomenon best approached as mystery. John Donne, reflecting on his life-threatening illness, wrote, "As sickness is the greatest misery, so the greatest misery of sickness is solitude."[4] But isolation is not amenable to technique or expertise; it invites one, not to cleverness, but to hope—or despair. I cannot hold it out at a distance, mastering it as an object of observation or manipulation, and it makes me long for the attentive presence of another.

The suffering of others calls for interpretation as mystery as much as our own. Kenneth Gallagher, commenting on Marcel, insists, "only one who participates with me in my suffering has the right to interpret it for me."[5] Those of us caring for patients cannot avoid interpreting their suffering; so, if Charon and Marcel are right, then we must earn that right by finding a way to enter into their suffering. The questions suggested when we take a patient's illness as a problem offers no path to that goal, but rather sets the suffering at a distance and attempts to control it by asking how we can resolve it and what techniques will allow us to do so. A hermeneutical stance of mystery invites different sorts of questions. For example, when faced with resistance to our technical skills, the question why, asked with openness and a wondering curiosity, brings us into the complex of ends and purposes that constitute the intelligibility of a human life. Likewise, engaging such patients with the question what does it mean to you can manifest the forms of attention and perception in which the patients themselves become aware of their suffering. We can then join them in their vulnerability, their unwilling openness to a world of pain and solitude.

Because it concerns human suffering, then, narratively competent medicine must begin with attentive presence to mystery; and those acts of attention will often reveal problems suitable for medical skills. Mystery does not displace problems but contextualizes them. Beginning with attentive presence to a patient's story of illness can bring to the surface problems that medical skills can then appropriately address. Or perhaps we might better say that our problem-solving can, at its best, become an instrument of our attentive presence, rather than a replacement for it. Ultimately, problems are solved for the sake of entering into the mystery, which is why Our Lord insisted on a personal encounter with the woman who suffered from a hemorrhage, even after she had already experienced the resolution of her problem through the touch of his hem.[6] We need both stances of problem and mystery to serve our patients; but we must have them in the right order.

A shift from prioritizing problem to foregrounding mystery led to resolutions in each of those frustrating cases which we began with. In each case, attempts to move beyond technical problem-solving to some participation in the patient's own encounter with suffering brought to light the latent intelligibility in otherwise frustrating forms of resistance that had stymied technical problem-solving.

In the first case, pursuing those questions that

can open to mystery revealed something new. When the team finally asked why the patient was refusing the removal of the Foley catheter, they learned that what it meant to him diverged decisively from what it meant to them. Rather than focusing on the catheter as a dangerous source of infection, the patient saw its removal as a threat to his dignity and comfort, since he could not effectively use a urinal. An offer of absorbent undergarments resolved the stand-off.

Similarly, in the second case, deeper conversation surfaced the surrogate's picture of the rejected discharge option—a picture of his friend wasting away in a wheelchair in some institutional hallway, with an afghan blanket thrown over his knees. When the team acknowledged the force of that framing and provided the surrogate with another, more accurate picture, a path opened for mutually intelligible decision-making.

Finally, in the third case, the plastic surgeon continued to cheerfully predict that success was almost at hand, through surgery after painful surgery and multi-hour wound changes with heavy pain medication—for a patient whose other comorbidities were themselves significant. Empowering the patient's family to present their concerns frankly to the surgeon helped him to re-direct his attention from the technical problems of reconstructive surgery to the patient's and family's hopes and fears. The surgeon quickly saw that re-contextualizing his technically proficient surgical problem-solving as an instrument for encountering the mystery of the patient's suffering—rather than as the goal of the patient encounter—required a re-evaluation of the treatment plan and a transition for the patient to another level of care.

In all these cases, then, narrative competence at the bedside, understood as the ability and disposition to ground interventions in an attentive presence to the mystery of the patient's suffering, proved the key to achieving the clinical outcomes most appropriate for the patients. Renewed attention to developing the skills of narrative competence promises, in many situations, both to improve the care of patients and to address some of the frustrations of their caregivers. ✠

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ENDNOTES

1. Rita Charon, *Narrative Medicine: Honoring the Stories of Illness* (NY: Oxford University Press, 2006), 3.
2. For one important example, among others, see Gabriel Marcel, *Being and Having*, trans. Katharine Farrer (Glasgow: The University Press, 1949; repr. Westminster, Dacre Press), 116-121.
3. See especially Simone Weil, *Waiting for God*, trans. Emma Craufurd (NY: Harper and Row, 1973).
4. John Donne, *Devotions Upon Emergent Occasions and Death's Duel* (NY: Random House, 1999), 26.
5. Kenneth Gallagher, *The Philosophy of Gabriel Marcel* (NY: Fordham University Press, 1962; repr. Barakaldo Books, 2020), 64.
6. Luke 8:40-48.