

Stories as data, data as stories: making sense of narrative inquiry in clinical education*

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BACKGROUND Narrative inquiry is a form of qualitative research that takes story as either its raw data or its product. Science and narrative can be seen as two kinds of knowing, reflected in the distinction between evidence-based medicine derived from population studies and narrative-based medicine focused upon the single case. A similar tension exists in the field of narrative inquiry between cognitive-orientated analytical methods and affective-orientated methods of synthesis.

AIMS This paper aims to make sense of narrative inquiry in clinical education through definition of 'narrative', articulation of a typology of narrative research approaches, and critical examination in particular of analytical methods, the dominant approach in the literature. The typology is illustrated by research examples, and the role of medical education in developing expertise in narrative inquiry is discussed. An argument is made that the tension between analysis of the structure of stories and empathic use of stories can be seen as productive, stimulating expertise encompassing both approaches.

DISCUSSION Analytical methods tend to lose the concrete story and its emotional impact to abstract categorisations, which may claim explanatory value but often remain descriptive. Stemming from discomfort with more integrative methods derived from the humanities, a science-orientated medical education may privilege analytical methods over approaches of synthesis. Medical education can redress this imbalance through attention to 'thinking with stories'

to gain empathy for a patient's experience of illness. Such an approach can complement understanding of story as discourse – how narratives may be used rhetorically to manage both social interactions and identity.

KEYWORDS education, medical, undergraduate/*methods; curriculum/methods; clinical competence/standards; empathy; literature; research design.

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GETTING BEYOND THE NUMBERS

Mark Haddon's¹ novel *The Curious Incident of the Dog in the Night-Time* offers an insight into the mind of a boy suffering from Asperger's syndrome, a condition on the autistic spectrum. The boy's world is numbers, not people: 'he knows a very great deal about maths and very little about human beings'. The central character, Christopher, shows a striking inability to empathise with the narrative accounts of others that carry messages about their desires. An equivalent lack of narrative acumen can be seen to have been systematically cultivated in medicine, where the telling symptom is the characteristically flat, detached account of the medical case study² serving to conceal the reality that medical practice is 'entrenched in stories'.³ Further, such stories afford rich sources for research. As a challenge emerges to medicine's self-imposed institutional autism that is a denial of the importance of story, clinical education researchers are beginning to draw on disciplines such as anthropology,⁴ psychology⁵ and sociology⁶ that have honed their narrative inquiry methodologies, to address the maxim: 'treat the patient, not the numbers'. This is not to deny the value of treating numbers. As Christopher, in Haddon's novel, says: 'Lots of things are mysteries. But that doesn't mean there isn't an

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Overview

What is already known on this subject

Narrative inquiry is a rapidly developing field but its potential has yet to be realised in medical education.

What this study adds

A clear typology of methods; a critique of current dominant approaches; an argument that empathy gained from thinking with stories could be enriched through understanding of rhetorical strategies; and a summary of the capabilities needed for effective narrative research.

Suggestions for further research

Narrative approaches in clinical education claim specific practice benefits, such as increased empathy. Such claims need to be empirically examined.

answer to them. It's just that scientists haven't found the answer yet.'

Qualitative forms of research have come to engage with health and illness in ways that were considered previously the province of the humanities, focusing upon affective, relational, ethical and imaginative aspects of experience. Some narrative researchers are interested in taking stories, such as patients' accounts of illness, and analysing them as data,^{6,7} while other researchers re-present the data of life experience in narrative form as a research product.^{8,9} Stories as data and data as stories – welcome to the world of narrative inquiry.

A 'narrative-based medicine'¹⁰ focused on the single case can complement the dominant evidence-based approach that draws from population studies, is quantitative and seeks generalisability. Huyler⁹ describes carrying out an audit research project at the morgue of the University of New Mexico. Working through a pile of legal-sized manila envelopes arranged by year of death, he would go into 'automatic' mode, typing data into a computer, 'distilling them to a residue'. Huyler found himself

anaesthetised to the tragedies that spread out before him, explicit in the photographs of crime scenes: 'the act done ... the woman in the woods'. The emotional impact of the photograph of the dead woman in the woods, a suspected suicide, contrasts starkly with the concurrent, objective medical description that chillingly correlates with his 'audit' frame of mind: 'The body received is that of a middle-aged Caucasian woman in the advanced stages of...'. Suddenly Huyler thinks of his grandmother, who also committed suicide. He shrugs this off and stiffens to the task at hand: 'Enough of that, I told myself ... This is descriptive statistics, epidemiology ...'.

Qualitative studies are often stereotyped as 'soft', in contrast to the 'hard' sciences¹¹ but narrative inquiry's soft data can illuminate hard realities. For example, Rich and Grey,¹² in a study subtitled 'getting beyond the numbers', consider the impact of trauma surgery on 48 young, black survivors of 'penetrating violence'. In-depth interviews stimulated narrative accounts that give dramatic insight into the lives of these socially marginalised patients, while the participants are empowered through researchers showing a genuine interest in their worlds. While objective morbidity and mortality data characteristically remain faceless, narrative inquiry often seeks not only to personalise but also to engage proactively with its research population through deliberate intervention, as research *with*, not *on*, people.

Beyond the quantitative vs. qualitative debate, we can make sense of the field of narrative inquiry in clinical education by addressing an explicit tension between two qualitative approaches. First are methods that analyse the structure of narratives and derive classifications. This approach of 'thinking *about* stories'⁶ requires a researcher to adopt an analytical mindset and involves deriving categories inductively from raw data, and/or applying such categories back to narratives for explanation or illumination. Second are methods that seek a more holistic and integrative understanding of narratives, either empathically 'entering' a given narrative, or creating a story as research product as a way of capturing elements otherwise lost to a structural analysis. This approach of 'thinking *with* stories'⁶ requires a researcher who can synthesise and has developed 'narrative competence'¹³ as applied knowledge of literary devices such as rhetoric. Where analytical approaches to stories may lead to objectifying the patient, approaches of synthesis claim to bring researchers and practitioners closer to the patient's world *through* the medium of story, acting – metaphorically – as stethoscope.

The tension between these differing approaches to narrative research echoes the familiar distinction in medicine between population and the single case as levels of analysis. Where medical education is orientated primarily to scientific method, thinking about stories may be privileged over thinking with stories. Indeed, Morris¹⁴ suggests that thinking with stories is ‘thoroughly neglected’ in narrative inquiry. For example, medical students rapidly learn to translate the patients’ stories they hear into analytical and stylised accounts² as an aural equivalent of the objectifying clinical gaze. To counter this bias, a ‘rounded’ medical education could synthesise clinical expertise and narrative acumen – the former based on science, the latter on the humanities.

WHAT IS A NARRATIVE?

Bruner¹⁵ argues that scientific and narrative ways of knowing are fundamentally different. Where science concerns itself with the establishment of truth, narrative’s concern is to endow experience with meaning. ‘Narrative’ (L. *narrare*) means ‘to know’ and storytelling involves knowledge production and shaping of experience, not simply transparent recounting of events.³ Contemporary narrative inquiry was consolidated in the 1980s, during a fertile period of rethinking the social sciences, where Sarbin¹⁶ challenged the dominant machine metaphor of science, describing narrative as a root organising principle of human activity. The orthodox view of narrative follows Murray’s¹⁷ definition: ‘an organized interpretation of a sequence of events’. Story brings temporal order to what would otherwise be experienced as a series of chaotic events.¹⁸ Plot structures narrative by putting events into a sequence, but tension is usually created through misfit between the elements of story such as agency, intention, means, goal and setting. Narratives thus often run counter to expectations, making the familiar unfamiliar, and no story has a single reading or meaning.³ Strawson¹⁹ warns against a tendency in narrative studies to treat all experience as story, where some individuals may experience life as ‘episodic’ (in space) rather than ‘diachronic’ (in time).

Early academic work on narratives concerned itself with story content – the *what*, or internal structure, of narrative – giving rise to the term ‘narratology’.¹⁸ From analyses of patterns of stories unfolding in time, or the relations between characters and actions, narratologists reduced stories to a set of formal rules and typical structures. Labov²⁰ refined this tradition, categorising narratives functionally according to what

an element of narrative does, such as ‘scene-setting’. Other theorists, however, were less interested in abstract analysis of the structure of story, preferring to treat narrative as discourse – for example, how stories are used rhetorically in social contexts. (Rhetoric is the expressive and persuasive use of language through devices such as metaphor.) This discursive approach can be thought of as the *way*, rather than the *what*, of stories, where the meaning of a story offers the focus for research, rather than events. Where structural approaches tend to treat story as transparent and descriptive, contemporary discourse approaches see narratives as constructing social meanings.^{3,21,22} Echoing the tension, introduced earlier, between thinking about a story and thinking with a story, story as content (structure) vs. story as process (discourse) has been termed the ‘double logic of narrative’.²²

Edwards²¹ suggests that the importance of narrative’s rhetorical purpose is missed by analytically orientated research where ‘studies of narrative... have tended to pursue generalized types and categories of narrative *structure*, rather than dealing with how specific story content... may perform social actions in-the-telling’. Analytical approaches tend to idealisation, encouraging researchers to force stories into preset categories, again missing how specific narratives work for specific social occasions, such as a text rhetorically managing its own credibility by countering alternatives. For example, in a study of the rhetoric of doctors’ referral and consultation letters from differing specialties, Lingard *et al.*²³ note differences in content and style used to promote certain favoured perspectives, such as surgeons’ biases to medico-legal issues where psychiatrists favoured the cultivation of professional associations. Such letters are not neutral documents, but texts assuming positions, predicting resistance and promoting collaboration. In medical education, rhetoric has been studied for its role in 3 main areas: management of interactions,²⁴ clinical judgements employing metaphor²⁵ and identity construction.^{26,27}

NARRATIVE METHODS

This section examines critically the main methodological approaches to narrative inquiry. Polkinghorne²⁸ distinguishes between three kinds of research data: numerical, short form and narrative. Once a research question has been formulated, the researcher must then decide on the appropriate methodology to address the research question. Narrative methods are particularly appropriate for

researching experiences through time, such as chronic illness.

Data generation

Data can be generated through video or audio transcripts; field notes of naturalistic forms of communication; differing forms of interview such as stimulated recall; and examples of writing, including artefacts such as case notes. Extended interview is employed regularly in generating narrative data, but the interview itself is rarely considered critically, where researchers fail to comment on how the interview was planned and conducted, or on the qualities needed for effective interviewing.^{29,30} Interviewing is too often treated as a means to an end, and as a transparent process of information-gathering (data collection), rather than a social medium for active construction of knowledge (data generation). Mishler³⁰ notes several potential problems with interviewing, such as stemming the flow of the subject's talk so that the narrative is fractured, and bias in selection of which parts of the interview are reported.

Data analysis

Huttunen *et al.*³¹ suggest, provocatively, that 'narrative research is not a method... Rather, it is a loose frame of reference... amoeba-like'. In contrast, a number of eloquent accounts systematise narrative research.^{6,7,32,33} Despite suggesting that narrative methodology is 'more art than research' and 'can hardly be taught', Lieblich *et al.*³³ proceed to offer a clear framework for narrative analysis, invoking two dimensions – holistic vs. categorical and content vs. form – that can be combined as a grid to form four approaches (Fig. 1). Holistic approaches take a story as a whole, contextualised in a culture and history, and attempt to grasp the overall pattern or guiding metaphors, where categorical approaches dissect particular episodes. Content is *what* happens in a narrative, form is *how* something happens.

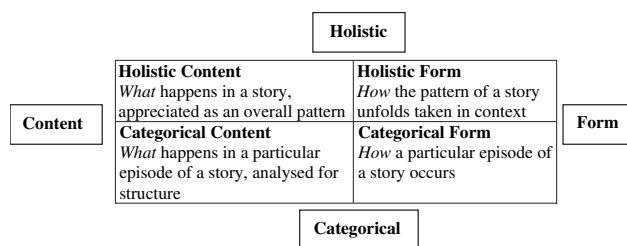


Figure 1 Four approaches to narrative.

Polkinghorne²⁸ distinguishes between the 'analysis of narratives' and 'narrative analysis'. Narrative analysis is actually a process of synthesis of experience and ideas through narrative, and is reconfigured here as 'synthesis through narrative' (rather than 'narrative synthesis' – a term that has acquired a particular meaning as a way of synthesising research data produced by methods other than randomised controlled trials). The complex field of narrative cannot be reduced to a simple opposition between approaches of analysis and synthesis. However, articulating this relationship as a productive tension could help medical educators interested in narrative methods to critically consider the limitations of an adopted approach by reference to what the rejected, competing approach can also offer. Drawing on the analogy of lock and key, approaches of analysis and synthesis look different apart but constitute a unit together, suggesting the value of mixed methodologies.

The analysis of narratives: thinking about a story

Inductively producing categories from the raw narrative data

Categories may be drawn inductively from the raw narratives to provide manageable data for further investigation – often a framework or typology that can then be applied back to illuminate single cases. An example of this is Frank's⁶ three types of 'illness narratives': 'restitution', 'chaos' and 'quest'. Restitution stories rationalise illness as transitory; chaos stories describe being overwhelmed by the situation; and quest stories describe acceptance of illness as opportunity for change. Frank warns that 'messy' recounted illness stories do not fall neatly into such categories and all 3 categories may be at work in any one person's account. Frank's scheme may then offer no more than a useful heuristic, and he is the first to note that particularity of the individual story may be subsumed in the typology. However, he argues that where individuals present messy stories, it is difficult for practitioners and researchers to 'sort out the threads' without some kind of framework. Importantly, Frank claims that 'The advantage (of typologies) is to encourage close attention to the stories ill persons tell; ultimately, to aid listening to the ill.' It is, however, difficult to see how an abstract analytical frame, rather than direct immersion in a story, prepares one to listen more empathically.

Bal¹⁸ warns that 'classification, typology... is all very nice as a remedy to chaos-anxiety, but what insights does it yield?'. Categorisation methods still look to the natural sciences for inspiration in organising

otherwise 'unruly' data. Typically, narrative presents diachronically, unfolding in time. When subjected to category analysis, the diachronic narrative data is collapsed into synchronic data with no historical or developmental dimension. For example, Crossley's⁵ analysis of narrative interview data details the survival strategies used by 38 people who had been living with HIV positive diagnosis for at least 5 years. Three strategies emerged from the data as distinct categories of 'temporal orientation': 'living with a philosophy of the present' (optimistic); 'living in the future' (falsely optimistic); and 'living in the empty present' (pessimistic). These categories conveniently resemble those of Frank⁶ described above.

Applying categories to the raw narrative data

Categories inductively derived from raw data now become frameworks applied to new cases that may claim explanatory power but are often merely descriptive. Crossley's categories, above, converge with Gergen and Gergen's³⁴ temporal model of chronic illness, again describing three kinds of narratives: regressive, progressive and stable. Murray¹⁷ applies this scheme to stories of breast cancer survivors to delineate three strategies: 'stable/regressive', where stories configure cancer as yet another setback in a life of difficulties; 'progressive', where illness is seen as an opportunity and people often find faith, or a renewed focus upon the present; and 'stable', where illness is accepted stoically and integrated, in getting on with life. These stories reveal central guiding metaphors: despair, hope and acceptance. Murray claims that the same pattern can be seen in people suffering from multiple sclerosis. The recurrence of such triple classificatory systems within a small arena of research suggests that researchers may not be uncovering some archetypal pattern at work in the data, but constructing typologies through cross infection of models.

Synthesis through narrative: thinking with a story

Narrative analysis tends to lose the affective impact of the story to objective themes, where such impact may offer a powerful way of empathising with the patient's experience. There are two basic approaches to synthesis through narrative: first, the 'illness narrative'³⁵ or 'pathography';³⁶ and secondly, the social-realist memoir.^{8,9,37} The former is often interpreted, with an accompanying gloss from the researcher. The latter abandons the usual research apparatus, where the author provides a coherent, self-referencing, social-realist fiction enjoying the full use of narrative licence.

Illness narratives

Illness narrative data are usually collected through collaborative interviewing, supplemented by autobiographical writing, attempting to capture the voice of the person to invoke empathy in the reader. Such narratives characteristically avoid reduction to a medical case, situating the person in a wider psychosocial context. For example, Couser³⁸ suggests that 'cancer is more than a medical story, it's a feeling story', and notes characteristic 'plotmarks' to narratives of breast cancer survivors, such as the moments of discovery of a lump and diagnosis; difficulties of choice about treatments including mastectomy and reconstruction; the side effects of chemotherapy such as loss of hair, night sweats and early menopause; confusion over sexuality; and resolutions about the future.

Such narratives are not limited to confessional accounts, that can be self-indulgent³⁹ but give insight into the intellectual, spiritual and practical, as well as the emotional and relational, aspects of living with illness. Contemporary research through illness narratives shows explicit interest in rhetorical management of interaction and identity formation. Riessman⁴⁰ offers an account of a recently divorced white working class male with advanced multiple sclerosis. The man reconfigures his identity, despite his setbacks, by selectively and rhetorically recounting key incidents in a narrative retelling of his life that centres on maintaining a strong masculine identity. The way he addresses the listener guides the impressions we form of him.

Social-realist literary accounts

A stronger version of thinking with a story is to write a piece of social-realist 'fiction', as memoir.^{8,9,37} These accounts do not count as 'research' by conventional definitions, because they do not collect and analyse data in a systematic and rigorous way; reach conclusions or recommendations; uphold or falsify hypotheses; inductively generate models to be tested; or invite validity and reliability checks. While they may explicitly flaunt such rigour through employment of literary licence, such narratives offer important 'witness' documents explicitly addressing the moral imagination.

Attributes needed by narrative researchers

The attributes of researchers are central to the quality of narrative inquiry. Narrative research demands high levels of ethical and critical engagement and the

cultivation of a narrative sensibility, in which both people and artefacts are witnessed and 'read' closely, as text.¹³ Reflexivity and tolerance of ambiguity are critical to such intensive reading.³⁹ Gherardi and Turner¹¹ remind us, tongues firmly in cheeks, that 'Real men don't collect soft data'. Are stories not for children (or women)? Perhaps the most important virtue of a narrative researcher is the stereotypically feminine attribute of sensitivity – not simply to research participants, but also to data. As research subjects can be turned into numbers and objects, so 'soft' qualitative data can be readily squashed or treated in a ham-fisted way through a blunt imagination.

CONCLUSION

In making sense of narrative inquiry, this article has critically addressed the apparent split between approaches of analysis and synthesis, reframing this as a productive tension and calling for greater parity between the two approaches. A typology of approaches to narrative research is offered, acknowledging that such a framework helps to make sense of a complex field of inquiry. A further tension is addressed – between approaches that emphasise the structure of a story (content) and those emphasising the meaning of a story (discourse). This can be illustrated by two examples. Ginsburg *et al.*⁴¹ describe medical students resolving professional conflicts. As they report professional lapses, students 're-story' the lapse through certain reasoning strategies, one of which is 'narrative attitude'. Some students characteristically *deflect* responsibility through re-storying critical incidents, where others *reflect*. Good⁴² describes how, through learning the genre of case presentations, medical students come to transform patients' idiosyncratic stories into medicalised accounts, where phenomenological description is translated into specific pathophysiological analysis. While this process encourages necessary focus upon scientific consideration of diagnosis and treatment, and also serves to protect the doctor from unnecessary intimacy, it results in a practice where 'persons are formulated as... medical problems'.

In the first example, the challenge to medical educators is how to promote reflective, rather than deflective, strategies of telling. In the second example, where doctors, in the role of medical educators, traditionally socialise students and juniors into the structure and content of the standard case presentation, to what extent are they aware of

such case presentation as discourse and rhetorical practice that, in transforming the patient's story, may compromise empathy? Further, will medical educators tend to privilege convergent and analytical approaches to story over divergent approaches of synthesis that may educate sensitive listening through story as a medium, again leading to empathy? Rather than being seen as an accidental by-product of practice, narratives can offer a potent medium for structured clinical learning. A further challenge for medical education is to evaluate such a claim.

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