Listening to "How the Patient Presents Herself": A Case Study of a Doctor–Patient Interaction in an Emergency Room

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Abstract

This is a case-study based on a micro-ethnography analyzing a doctor-patient interaction in an emergency room (ER) in New York City. Drawing on the framework of narrative medicine (Charon, 2006), the study examines how a phenomenological approach to listening to the patient facilitated the patient's narrative orientation not only to relevant clinical information (her kidney transplant) but also to the construction of her identity as a "responsible patient." The influence of the so-called "prior context" (i.e., triage interview and the electronic medical record, EMR) is observed as constituting an institutional narrative that may shape patients' (clinical) identities. This case study illustrates how a narrative medicine approach based on attention, representation, and affiliation helps balance the heteroglossia of voices to which the doctor is exposed. It is also argued that this approach restores patients' own personal narratives while contributing to patients' agency in building their own storytelling and identities. This study may hold educational value for patients, medical students, and health care practitioners in general.

Keywords: narrative medicine, prior context, EMR, triage interview, identity, heteroglossia

1. Introduction

Interactions in medical encounters are informed not only by the pressure of time and the degree of severity in the patients' medical conditions but also by discursive, professional, and institutional constraints (e.g., see Sarangi & Roberts, 1999, and Waitzkin, 1991). Such constraints include the use of technology, such as the electronic medical record (EMR) (see Pernille & Balka, 2007). While there is consensus, at least in theory, about the need to store all patient information accumulated over time in one place (Flegel, 2008), Pernille and Balka (2007) observe that electronic medical records constitute surveillance mechanisms that take away triage nurses' discretionary intuitions. Charon's (2006) analysis is less critical, but she observes that the rhetorical style of hospital charts including the language, tone, and forms in which health professionals speak, write, and think about the patient shapes, both, the ways doctors interpret medical cases as well as the behaviors and actions they may engage in to address those cases.

This study focuses on the listening behavior of a doctor (Dr. J.) interacting with a particular patient (Carmen), whose narrative, as it unfolds, does not match the information that was written in her EMR and read by the doctor prior to the patient interview. The mismatch between the patient's narrative and the institutional narratives (e.g., the EMR and the triage interview) emerges in their interaction. This paper argues that this discrepancy becomes apparent because the doctor employs a narrative medicine approach to listening to the patient during the diagnostic interaction. With the purpose of understanding how the discrepancy between the two narratives originated, this study examines the potential discursive effect of the textual processes that all ER patients undergo (e.g., the collection of data in EMR by means of the triage interview) in order to be admitted, and how these textual processes may inform the construction of the patient's diagnosis. Here, discursive and textual processes will be referred to as *the prior context* in the sense that they preempt a diagnostic representation of the patient. The researcher observed that the diagnostic representation retrieved in the EMR by means of the triage interview may influence the patient's future treatment as well as his or her clinical identity in the ER; for instance, the patient may be characterized as the "psychiatric patient," "gallbladder patient," or "alcoholic patient"; many other labels may be assigned as well.

The methodology employed in this micro-study is qualitative (i.e., participant observation, interview with the doctor and note taking) focusing not only on a single case but also on a single moment of the interaction between the patient and her doctor. The researcher examines how the doctor listens to the patient. This aspect represents an innovative insight from this study given that there is abundant literature pointing out the failure of biomedicine to listening to the patients stories; for instance, Engel (1977) in psychiatry, Frank (1995) in sociology, Mishler (1984) in social psychology

and sociolinguistics, Kleinman (1988) in medical anthropology, and Charon (2005; 2006) in narrative medicine to mention some of the most influential.

This case study advocates for a different approach to patient care—that is, one embracing narrative medicine skills (Charon, 2005, 2006). It seeks to show how these skills can be applied by privileging the patient's narrative over prior, discursive constructions about the patient. It is speculated that if this way of listening had not been adopted by Dr. J., his perception of the patient's identity would have been different, probably resulting in less caring attention for the patient and less self-caring for the doctor (Mayeroff, 1990). Therefore, the implementation of narrative medicine skills, in listening to the patient's own diagnostic narrative, when possible, even in an ER, contributes to seeing the diagnostic interview as a co-construction (Heritage & Clayman, 2010). This approach may bring significant benefits for both the patient and the doctor.

The text of the EMR is highly heteroglossic, as Charon (2006) observes. Many health care professionals of different specialties read and write in the EMR adding their voices to the patients' clinical cases. In this process, sensitive information is being reproduced and repeated; consequently, patients' clinical identities are being performed (Butler, 1990). Because the patient has little or no control over what is written about him or her in the EMR, this study suggests counteracting the "silent voices" (Swinglehurst, Roberts, & Greenhalgh, 2011) of the technology by developing narrative medicine skills in the diagnostic interview. This act would appropriately balance the representation of the institutional narrative (i.e., as constructed by the triage process and translated into the EMR) with the patient's own narrative. Here, when reference is made to listening skills, it refers not only to the physical, cognitive, and emotional task of listening to the patient's narrative but also to the listener's ability to consider, weigh, and balance the many other prior voices that inform his or her clinical condition and identity. This ability may prevent the formation of assumptions that can overshadow the patient's clinical identity.

In examining the interactive impact of the EMR usage, Swinglehurst et. al. (2011) argue that with the mediation of technology, the physician is presented with a "dilemma of attention" that "seeks to deal with the immediacy (here and now) of the interpersonal interaction and the institutional demands (there and then)" (p. 3) of the EMR. Though their study is based on primary care encounters, their findings apply to the ER, where many voices need to be considered in constructing a diagnosis and indicating treatment. Paradoxically, the increasing sophistication of the technology may make it even more challenging to listen carefully to the patient's voice. For instance, EMRs are endowed with technical devices, such as alerts and reminders, designed to ease the decision-making process involved in medical care. However, the technology introduces a powerful voice that could easily overpower the patient's voice (Evans, 1999). The doctor's narrative task becomes more complex because he or she has to interpret several texts (i.e., the heteroglossia of voices summarized in the EMR and the patient's narrative) and make sense of all of them. As this case study illustrates, this task is especially difficult when the text of the EMR and the patient's narrative do not lead to a concordant plot. To offer an alternative approach, this research echoes Greenhalgh and Hurwitz's (1998) assertion that narrative-based, rather than evidence-based medicine can become a counterbalance to the biomedical model in the clinical context. By virtue of its micro-level focus, this approach holds educational value for medical students and health care practitioners in general: it presents an illustrative case showing how the doctor proceeds in listening to these different voices while privileging the patient's voice. In this case, the physician put narrative medicine skills into practice that allowed the patient's voice to present itself rather than being "spoken" (Pêcheux, 1995) by the prior context.

2. Narrative Medicine Skills

Skills associated with narrative medicine comprise three interrelated movements (Charon, 2005; 2006) that are sequential and simultaneous: attention, representation, and affiliation. Attention is one of the core points; it emphasizes a particular way of listening that contributes to a dialogic, rather than monologic, encounter. The term *dialogic* refers not only to the conversational interdependence and the co-constructed nature of meaning between the parties (Linell, 2009) but also to the conscious and voluntary downplay of the ego to allow *the other's* voice and narrative to emerge. Charon (2006) calls this the "emptying of self so as to become an instrument for receiving the meaning of another" (p. 132). For his part, psychoanalyst Roy Schafer (2005) has called this framing, "emptying of self," into question: "A self cannot empty itself" (p. 278). Thus, the concept of *emptying oneself* used here is taken from an interactive framework according to which, the process of "emptying" refers to the way the listener (in this case, the physician) puts himself or herself in the background. In so doing, the listener momentarily downplays or silences his or her voice, allowing the voice of the other party (e.g., the patient) to come to the forefront. This "emptying" is not a passive but rather an active, communicative, process. It is communicative because it conveys emphatic attention and correspondence by signaling engagement with the other by means of visual and paralinguistic cues that assure the patient that he or she is being listened to with care.

Charon (2006) asserts that attention demands representation. Representation can be achieved clinically and

institutionally by means of the hospital charts or the EMRs. By *representation* Charon (2005; 2006) refers to the humanistic, symbolic capacity to intellectually and emotionally imagine, interpret, and articulate, especially in writing, what the patient is experiencing. Moreover, the representation invoked by narrative medicine encourages the emergence of the doctor's own voice, which has been suppressed by the institutional and professional constraints (i.e., to express what the clinician has learned, not only about the patient but also about herself or himself). An important tool for fostering representation is the use of personal narratives through what Charon (2006) calls the "parallel chart." In this paper, however, we focus not on the writing aspects of representation but rather on the doctor's capacity to imagine, interpret, and articulate the patient's experience as if it were his or her own experience. Attention and representation spiral toward affiliation, according to Charon (2006). By virtue of the work of attention and representation through which the clinician makes emotional and intellectual contact with the patient, affiliation guarantees that the patient will feel safe narrating whatever needs to be said, however difficult or bizarre.

3. Method

This case study is a micro-ethnography (Kleinman, 1988) focused on participant observation of a particular interaction between an ER physician (I shall call him Dr. J.) and his patient (I shall call her Carmen) in a hospital located in New York City. I attended the ER in a participant capacity for a seminar entitled "Foundations of Narrative Medicine: Giving and Receiving Accounts of Self" as part of the narrative medicine program at Columbia University. The assignment aimed to sensitize participants and help them develop their own witnessing/narrative skills, as congruent with the educational philosophy of narrative medicine. My participation in the seminar was not as a clinician but as a patient's advocate and a linguistic researcher in medical discourse.

The data were collected by means of note-taking immediately after my visit to the ER. To minimize interference, as a participant observer, I did not take notes in front of the participants, nor was the interaction recorded. The notes were taken later and were based on two hours I spent witnessing Dr. J. caring for four patients. The notes also included my observations of Dr. J.'s interactions with the computer from which he read the medical records and his interactions with other health care workers regarding their patients. Dr. J. is a volunteer with the narrative medicine program and agreed to allow a seminar participant to observe his interactions with patients in the ER. As the observer, I was assigned to witness Dr. J. that evening. However, I had not met him before this encounter, nor did I remain in contact with him after the assignment.

In particular, this study focuses on the interaction between Dr. J. and Carmen, examining the narrative medicine skills of attention put into practice. As mentioned above, the three movements of attention, representation and affiliation are interconnected.

Before giving an account of this interaction, it is necessary to explain how patients are admitted to the ER and how their narratives are processed. In other words, how does prior context work? *Prior context* refers to the discursive and textual processes used to translate the patient's narrative into an *institutional narrative* before the patient is admitted into the ER to see a doctor. These discursive processes are translated and represented in the EMR, although imperfectly, as it shall be argued. The EMR is essentially a heteroglossic document (Charon, 2006) written by various health care specialists, with information that accumulates over time. It is important to bear in mind that the patient's voice may not always be accurately represented. In addition, imperfect representations of the patient's identity, such as the "psychiatric patient," may be repeated and accumulated in the EMR over time.

4. The Prior Context

Upon a patient's arrival, a nurse assesses his or her vital signs and inquires about the patient's main complaint in a specific discursive style associated with the style of the triage interview. Overall, a triage interview consists of the sorting and allocating of treatment to patients, according to the urgency of their need for care and the availability of resources in the emergency room. FitzGerald, Jelinek, Scott, and Gerdtz (2010) observe that the triage systems are designed "to serve the value of human life and health with fairness and the efficient use of resources" (p. 86). For this reason, the triage interview follows a uniform set of criteria to assess the patient's condition and categorize the degree of urgency of the need for care. The triage interview is structured with a clear interactional and institutional purpose that is conversationally imposed upon the patient, as observed in a report by the Emergency Communicative Project (ECP, 2011). Per their communicative role, triaged narratives are informed by the set of criteria of emergency care of the ER rather than by the patient's own narrative orientations (i.e., his or her own narrative orientations to what "an emergency" means for him or her in that situation). The importance of this point is that given the discursive, professional, and institutional constraints associated with the triage system, the patient may have little or no control over what he or she is able to say and how. Moreover, in triage interviews, patients are encouraged not to talk but instead to answer very specific questions (ECP, 2001). Triage interviews are characteristically short, and despite the variations in chief complaints, they share similar conversational patterns that are guided by the triage categorization principle, as observed

by FitzGerald et al. (2010). For these institutional reasons and because of the difficulties patients may have articulating their emergency narratives under the stressful circumstances that brought them to the ER, the medical record that results from the triage interview is likely to be inaccurate or incomplete. As one nurse from the ECP observed (2011), "Often, what the patient says to triage and what they've actually got wrong with them are two totally different things" (p. 29). The patient has no control over what the nurse writes, what wording he or she uses when summarizing the narrative, or how the style may represent the patient. However, it is important to bear in mind the patient's course of treatment starts with the triage interview and the EMR that the physician receives.

Before going in to see Carmen, Dr. J. went to his computer station to electronically retrieve the information collected by the triage narrative. This electronic chart included information about previous visits at the same hospital and other hospitals associated with the same health care system. Hannan (1996) asserts that the EMR is intended to be transformed into the primary repository of information regarding patient care. However, Dr. J. mentioned to me that the electronic system used at that hospital, frequently failed to display the previously-accumulated data. Concerning the previously-accumulated data, Flegel (2008) observes that despite the increasing efforts to bring together information from different sources, these efforts not always bring more knowledge about the patient; for instance, patients' files at one health care provider may contain information that the files at another health care provider do not contain. For that reason, relationships among specific data, such as abnormal lab test results and medications prescribed to address the abnormality, may not always be apparent within a particular patient's electronic file (see also Evans, 1999). Currently, however, it needs to be mentioned that at the hospital where this observation was conducted, the doctor could not see the medical history of the patient in its entirety.

5. Interacting with the Patient

Before we went to see Carmen in her booth, Dr. J. explained to me, "We are going to see a psychiatric patient" in order to prepare me for a difficult case. Apparently, the record described Carmen as "suffering from anxiety," and a note added that she was taking care of her elderly mother with Alzheimer's disease. The reading of the medical record as a text involves an interpretation process in order to make sense of scattered information. By virtue of this interpretation process, the following questions arise: Was Carmen suffering from anxiety, temporarily, given her family situation? Or did the entry "suffering from anxiety" mean that she had a psychiatric disorder? The reading/interpretative task can be seen as similar to reading a narrative text, given that the reader (in this case, the physician) makes an assumption that is inevitably tainted by his subjective gaze. Assumptions are, however, part of the communication process. We are constantly making inferences from and assumptions about what was said in order to build our reply; interpretative assumptions may lead us into action (Linell, 2009). In reading a narrative, as Ricoeur (1984) observes, the reader has to create a plot out of the incomplete and possibly inaccurate fragments of information as they were collected and translated into the electronic record. However, the doctor's interpretive task is not completed without considering the patient's own plot. While the interaction between doctor and patient seems to be dyadic, it is in fact a triad that incorporates the heteroglossia of the prior context (that is, the triaged narrative that has been summarized and translated into the template of the EMR, as well as all previously recorded information) along with the doctor's subjective interpretation.

When we met Carmen, a woman in her fifties, she was sitting on the bed with her legs crossed. She smiled when she saw us. She had smart brown eyes and short brown hair; she looked very alert. Carmen presented herself as an experienced patient: she constructed a detailed account of herself as a credible patient who was able to articulate valid and legitimate reasons for seeking care at the emergency room (Heritage & Robinson, 2006a). Dr. J. let Carmen talk without interruption. Here, the doctor's behavior already indicated a different approach; studies such as that of Beckman and Frankel (1984) and, more recently, Heritage and Robinson (2006b) have reported that the patient's average problem presentation lasts an average of 18 or 21 seconds, respectively, before interruption. Carmen related that she had flu-like symptoms and a mild fever and that she had been in pain for several days, having missed her regular doctor's appointment—"not because of negligence or forgetfulness," she emphasized, but due to her family situation. Dr. J. did not interrupt the narrative to ask her about it, but Carmen oriented her narrative to her personal situation: her "nervousness" at leaving her mother with Alzheimer's under the care of another less skillful person in order to come to the hospital. She also introduced another theme: the recent passing of a family member.

In sum, Carmen was able to clearly articulate her symptoms and demonstrated that she was familiar with some medical jargon about medical procedures, which Dr. J. approvingly acknowledged by saying, "You even know the terms." She seemed very much aware of institutional and discursive conventions. To my surprise, neither psychiatric history nor concerns about suffering from anxiety emerged in her narrative, as I personally expected. Carmen did not orient her narrative to these types of concerns, and Dr. J. did not ask her about them either. He asked some concise questions, but only to expand on what Carmen was saying, such as her mother's age. His questions were in alignment with the thematic unfolding of Carmen's narrative orientation. In listening to Carmen's narrative, an unexpected piece of news

emerged: *the surprise factor*. What Carmen said was, "I had to come to the hospital because I thought I had the flu, but I have had a transplant, you know?"

6. The Surprise Factor

This term refers to the fact that the "surprising" information was neither requested nor elicited by the physician, despite its relevance to the clinical diagnosis. Drawing on Goffman (1959), we can say that this information was not *given to* the physician by virtue of his elicitations or questions, but *given off* by the patient—that is, it *leaked* into the interaction involuntarily and unintentionally. It is suggested, however, that Dr. J.'s way of listening to the patient without interruption may have prompted the so called "leak," allowing the patient to orient herself to her real concern. Carmen's statement had not been derived from the triaged narrative. As pointed out earlier, triage interviews may present an incomplete picture of the patient. About two years earlier, Carmen had received a kidney transplant, and before that, she had been on dialysis. This new information concerning the kidney transplant provided by the patient required a reformulation or recontextualization of the patient's clinical identity, which had been constructed previously as "the psychiatric patient." Thus, Dr. J. had to revise and reframe (Goffman, 1974) the representation of Carmen as "suffering from anxiety," which he had inferred and interpreted as a "psychiatric patient," or at least put that information on hold. Given the relevance of the new information about the kidney transplant, Carmen's fever as a symptom became a more relevant piece of information because it might indicate a compromised immune system, rather than a patient with "anxiety," as described in the EMR. When Dr. J. and I returned to the computer station, I asked him directly about his initial diagnostic hypothesis, "Why did you say that we were going to see a psychiatric patient?" He humbly replied, "Anxiety may not necessarily lead to a diagnostic label of 'psychiatric patient.' *One has to see how the patient presents herself*. Now it is necessary to explore why she has a fever."

It can be argued that the information regarding the patient's transplant also could have been elicited by conducting the "review of system." However, one of the points of this study is to emphasize the construction of identity aspects that are negotiated in the clinical encounter between patients and doctors. Therefore, it is relevant to ask this question: had the emergence of this crucial information been elicited through a conventional medical interview, would the patient have had the agency to transform her identity from psychiatric (as pathological) to anxious (as normal) given her life circumstances? As further elaborated in the discussion in section 7, the patient was not only concerned with the medical diagnosis but also about demonstrating to her doctor that she was "a good patient" taking care of herself.

7. Analysis of the Encounter

While Carmen was narrating her story, Dr. J. maintained eye contact with her and back-channeled what she was saying with interjections that showed attention to, interest in, and coordination with the narrative. The clearest manifestation of attention was displayed in two subtle and interrelated ways: first, by suspending judgment, Dr. J. seemed to adopt a phenomenological approach (Heidegger, 1962; Husserl, 1931/2002) that required him to bracket his prior assumptions of a "psychiatric patient" in order to listen to the patient's own narrative *orientation* (Sacks, 1992). That is, he observed how her discursive orientations made her history relevant, what had happened to her, and what had led her to seek assistance in the ER. Dr. J.'s second manifestation of attention was demonstrated by restraining and downplaying his own voice to avoid interrupting the patient to further explore his own initial hypothesis. He allowed the patient to speak for herself and raise her own hypothesis of what might be wrong. In that manner, we see a form of "emptying oneself" that is not passive but rather active, as mentioned above. This type of listening practice allows the patient's voice to rise above the voice of the medical record. In this process, not only has the patient gained agency but also the doctor has preserved his own agency.

Representation and affiliation were also put into practice. Without the doctor's self-monitoring skill in determining whether or not his diagnostic hypothesis is in alignment with the patient's explanatory system, there is no representation or affiliation. Representation allows us to imagine that given Carmen's family situation, she had more than enough reasons to suffer "from anxiety"—without *medicalizing* her condition. And affiliation comes from the capacity to recognize that similar situations would have overwhelmed us as well.

By allowing the patient to present herself, Dr. J. momentarily downplayed the voice of medicine, represented in the impersonal form of the EMR, to instead highlight and honor the voice of the patient. This practice is, as it is argued, the result of putting into practice the narrative medicine skills that empower the clinician (and thus the patient) to listen to the patient's voice.

8. Discussion

This simple case indicates that the practice of narrative skills may transform the physician-patient encounter from a monologic to a dialogic one, emphasizing the patient's self-knowledge and wisdom about her condition. A dialogic encounter between doctor and patient is understood as a conversational transaction or negotiation that has taken place between the doctor's initial hypothesis and the patient's opportunity to unfold the narrative according to her own

explanatory system. The result of this dialogic process is the discursive space for the patient to construct her identity and to represent herself. While it may not be possible to implement the narrative medicine approach of attention, representation, and affiliation in all medical encounters, it is worthwhile to raise awareness regarding the influence that the prior context may have in constructing a patient's identity. This paper observes how accumulated information in the EMR may not always represent the patient's (clinical) identity. In fact, one of the most subtle aspects of the medical records (either electronic or on paper) is the repetition of entries about the symptoms and conditions. Charon (2006) observes that medical records are characterized not only by their common structures shared across hospitals but also by the repetition of data that appear over and over in the first few lines (e.g., the age, admitting diagnosis, and patient situation). Thus, it is safe to say that the statement "suffering from anxiety" originally read by Dr. J. was probably not new information but instead the result of systematic repetition. As Butler (1990) theorizes, identities are constructed through repetition in discourse. This repetition has a performative effect (Butler, 1990) that may contribute to fossilizing a patient's identity, such as a "psychiatric patient" but without the agency of the patient. This paper does not intend to suggest that EMRs are not a valuable technological tool in improving the delivery of health care, but it does intend to raise awareness about how subtly the information collected about the patient—without her agency—may be manipulated, and how the prior discourse may shape the patient's identity in a way that obscures her medical and emotional needs. Motivated by similar concerns about patients' lack of access to their EMRs and the implications for possible errors and treatment, Dr. Leana Wen (2014) started sharing her charts with her patients, promoting patients' access to their doctors' notes about them. This practice led to the establishment of the Open Notes project (see www.myopennotes.org) in 2010. Delbanco et. al. (2012) and Walker et. al. (2011) report that increasing patients' access to their medical records empowers them to detect errors and rectify information in their histories while also improving patients' understanding of their conditions and their adherence to medical treatment. This dynamic creates a more fluid working partnership with doctors.

To let the patient present herself is not an easy task in the current medical system in the United States. Dr. J.'s willingness and skills to listen to the patient's narrative included listening for information (or subplots) that might not seem initially relevant (although it opened the door for clinically relevant information), as well as listening for the patient's explanatory systems as the conversation unfolded. The benefit of this way of listening is twofold: clinical and story-building. It allowed Carmen to construct a self-respectful identity in the ER that gave her dignity: "I don't want you to think that I came to the ER because I did not take care of myself before," she emphasized to Dr. J. As a transplant patient, she is aware of the amount of medical effort put into giving her a better quality of life, and her statement is an acknowledgment of that effort. Carmen's concern about constructing an image of a responsible patient aligns with the findings of Goetzmann et. al. (2008) regarding patients' psychological responses after transplantation. The authors, who collected responses from 370 patients, found that 72% developed a strong sense of responsibility toward family, friends, and the treatment team and the donor with respect to maintaining their health and the proper functioning of their transplanted organ, especially in the case of kidney transplants.

It is then, suggested, that a narrative medicine approach to listening contributes not only to the patient's care but also to the doctor's self-care (Mayeroff, 1990). As Mayeroff asserts, "To care for myself, I must be able to experience myself as other" (1990, p. 59), which can be achieved by means of representation of the patient's narrative and affiliation with the patient.

9. Conclusions and Future Directions

As a case study, the observations in this study cannot be generalized. A drawback of this case study is that it was not complemented by a follow-up interview with Dr. J. to learn more about his assumptions and narrative interpretations in order to triangulate this information with that of the observer. Similarly, the patient was not interviewed. A strength of this study is found in the micro-ethnography and the micro-analysis focusing on a particular moment in the encounter between doctor and patient (i.e., the surprise factor in the patient's narrative). This paper has argued that the surprising information about the patient's kidney transplant, which was not included in the EMR, emerged as a result of the phenomenological approach to listening. The microanalysis permitted insights into how the prior context influenced the doctor's diagnostic hypothesis and, consequently, what listening and narrative skills he used to balance the information provided by the institutional narrative with that of the patient's. This listening approach offered clinical and story-building benefits that resulted in the patient's agency to construct her own (clinical) identity. More studies are needed to raise ethical awareness about the construction of patients' identities as the technology of EMRs progressively expands and matures. With approval from the respective institutional internal review boards, a deeper study including a comparative ethnography of at least six months could be conducted in different ERs to observe triage interviews, medical records, and doctors' management of the prior context in their encounters with their patients. Such research could compare the discursive practices between those who use a narrative medicine approach in listening to their patients with those who do not.

Acknowledgements

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