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The History of the
Present Illness as Treatment:
Who's Listening,
and Why Does It Matter?

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Placebo Response,
Sustained Partnership
and Emotional Resilience
in Practice

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The History of the Present Illness as Treatment: Who's Listening, and Why Does It Matter?

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Background: The history of the present illness (HPI) is examined as a narrative communication that has the potential to be therapeutic.

Methods: The general principles that influence the therapeutic potential of the HPI are induced from participant observation of personal experience and natural observations of conventional social interaction. These principles are corroborated by evidence from cross-cultural healing practices, clinical experience, and experimental psychology.

Results: To facilitate a therapeutic HPI, the clinician should convey a sense of safety, sensitivity, affective competence, and cognitive competence. Furthermore, the effective clinician joins the patient in coprocessing the illness experience.

Conclusions: The (HPI) is not simply a diagnostic formulation. When skillfully negotiated, it can be therapeutic because it helps patients make cognitive sense of their illness, and it serves as a vehicle for sharing the affective burden with the physician. There is therapeutic potential in each of the three overlapping operations of the HPI: (1) establishing a physician-patient relationship through the process of gathering a database, (2) transforming the database into an etiologic narrative, and (3) using the narrative to coprocess the experience of illness with the patient. The therapeutic potential can be actualized by specific clinical applications (J Am Board Fam Pract 1997;10:28-35).

People regularly process their personal experience by putting it into words and telling it to someone. When we are able to formulate the right story, and it is heard in the right way by the right listener, we are able to deal more effectively with the experience. It can be argued that the same principles of narrative communications prevail when a physician and patient formulate a history of the present illness (HPI). In fact, one might describe the clinical history-taking process as doing systematically with a stranger what people do intuitively with friends and relatives.

Clinicians take it for granted that formulating a good HPI can lead to a correct diagnosis. In addition, experienced clinicians find that taking a good HPI can also be therapeutic. It is therapeutic not only because it helps the patient to feel better but also because it helps the patient to heal better.¹ In this report I attempt to analyze the elements of the HPI that can account for its thera-

peutic potential. To this end, I will examine the HPI as three overlapping but separable processes—obtaining an accurate database, formulating an etiologic narrative, and coprocessing the illness experience. Each process can influence the therapeutic outcome.

Methods

Because we grow up giving and getting each other's histories, we also know the satisfaction that can come from transforming the chaos of experience into a coherent narrative in the course of explaining that experience to someone else. Similarly, the participant-observer inductive method couples introspection of personal experience with natural observation of social and clinical interactions to formulate a set of principles underlying a therapeutic HPI. This approach, which is in the established medical tradition of inducing hypotheses from clinical cases and confirming them with controlled studies or more wide-ranging observations, is applied to the patient's history of the illness rather than to the patient's disease. Hypotheses generated are buttressed by corroborating evidence from anthropology, experimental psychology, and clinical cases.

Using this methodology, I will examine the HPI

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as a three-stage process: (1) obtaining an accurate database, (2) formulating an etiologic narrative; and (3) coprocessing the illness experience.

Obtaining an Accurate Database

As a narrative communication, the HPI has two functions: *referential* and *transactional*. Statements are always (1) about the subject under discussion, the referential function; and (2) about us, our interpersonal transaction.

The referential function concerns the subject of the conversation. When we are inquiring about a patient's nonadherence to a medical regimen, we might authoritatively ask, "Why haven't you taken your medicine as prescribed?" or we could more collaboratively inquire, "What were the reasons that you didn't take your medicine as prescribed?" Both questions contain the same referential message, but each conveys a different transactional message.

The transactional function conveys information to the patient regarding the kind of physician-patient relationship that is being encouraged, ie, authoritarian, collaborative, detached, compassionate, perfunctory, and so forth. In eliciting an HPI, what we communicate, for better and for worse, is always a certain kind of transaction. Even as we are inquiring about the referential data in a patient's medical history, we are conveying messages that shape our relationship with each other. These messages are conveyed through all the symbolic modes of communication—the music of our vocal inflections, the responsive movements of our bodies, the visual impact of our facial expressions, and such behavior as promptness and availability. Although we necessarily describe our interaction with patients by the use of words, language is only a small part of the way we communicate with each other. In fact, a dance is in many ways a better metaphor for conversation than the sentence, because a dance is acknowledged to be a mutual, reciprocal activity. Film analysis has demonstrated that the body movements of speaker and attentive listener are synchronized as if choreographed by a common rhythmicity.² The implications for understanding the therapeutic potential of the HPI is that the process of asking personal questions is also a process of establishing an interpersonal engagement. Analogous to the courtship ritual of many social animals, the process is not just a test of

compatibility, it is a negotiation of compatibility.

The simplest way to arrive at the principles involved in obtaining an accurate history is to apply the inductive method to personal experience. Following the Golden Rule, physicians can put themselves in the patient's position and engage the patient as they would wish to be engaged. Specifically, imagine being very distressed; then consider whom would you want to tell, and not tell, and why. What type of response would we want from our listeners to feel better rather than worse after the disclosure?

Persons with whom I have examined these questions generally agree that they want the following from their listener.

Safety

Simply put, safety means the assurance that patients will not regret what they said either because it will hurt them or the listener. It is not just a matter of assured confidentiality; confidentiality is relatively easy for the physician to protect. It is the almost unavoidable embarrassment that patients feel when they disclose conventionally forbidden impulses or behaviors to a familial person, such as the family physician. In addition, the family physician faces a dilemma in some circumstances just because he or she is entrusted to treat the whole family. When a patient confides about such behavior as infidelity or substance abuse, then the physician-patient relationship for others in the family is put in jeopardy, because this behavior could affect the status of other family members. In consequence, sometimes the best way for the family physician to provide safety to the patient and protect the relationship with the family is to refer such issues to an outside consultant.

Sensitivity

A candid and comprehensive history is generally best obtained by an interviewer who has an insider's view. There is an old proverb, "Knowing is seeing, but feeling is being." If clinicians can empathically put themselves in the patient's predicament, then it will be relatively easy to ask the most productive questions and to provide the most helpful responses. For reasons that I describe below, we can discover more about ourselves with the support of a sensitive listener than we can on our own. For example, if the clinician can approach such conventionally stigmatized

subjects as sexual preference, alcohol use, and inadequate job or school performance without embarrassment, then the patient can also deal more openly with the subject.

Affective Competence

This quality is a measure of the physician's empathic ability to experience the patient's feelings steadfastly and with compassion and equanimity. Such affective stability helps the patient to achieve an optimal level of distress tolerance, somewhere between denial and overload. Patients regularly monitor the affective reaction of their physicians to what they are saying and tend to incorporate the physician's perceived reaction as their own. In consequence, patients' ability to tolerate their distress will be influenced by their clinician's ability to tolerate that distress.

Cognitive Competence

This quality is the bare minimum the family physician brings to the clinical encounter—a knowledge about how to make a correct assessment of the problem, the skill to explain it in terms that are understandable to the patient, and the ability to provide or recommend good treatment.

When the events associated with the patient's illness are properly elicited, the HPI both provides an accurate database (the referential function) and establishes a therapeutic alliance (the transactional function).

Formulating an Etiologic Narrative

Persons can process their experience in many ways, ranging from denial to expression. Personal experience can be expressed by any of the symbolic modes of communication—images, dance, music, or narrative. As a historical report, the HPI is necessarily a story. To describe the HPI as a story, however, is not to suggest that it is only a story as compared with a factual account. Rather, such a description recognizes that the clinical experience is being mediated by a narrative instead of by music, dance, or visual art, as indeed it is in other cultures.^{3,4}

The content of the etiologic narrative, the HPI, will be shaped by the clinician's theory-driven questions. A homeopathic physician would arrive at an HPI different from that of an allopathic physician, and even within allopathic medicine an infectious disease specialist might arrive

at an HPI very different from that of a family physician. Each HPI could be accurate, but each physician would select different data as relevant and emphasize different paths leading to the chief complaint. What they all have in common, however, is that the amorphous experience of being sick is transformed into a narrative. That narrative—whatever its content—makes the patient's experience more manageable by organizing it into a chronologic sequence of events connected by causal links. In addition, the HPI makes the illness experience portable, permitting the patient to relive this experience in the clinician's office, supported by the clinician's cognitive and affective competence.

As noted earlier, a common practice for dealing with distress is to turn it into a narrative account and look for the right person to tell it to. It is precisely because the narrative structure facilitates the organization, expression, and sharing of experience that narratives are so regularly used in ordinary social interaction. A frequent exchange between friends is, "Let me tell you what happened to me." It is an exchange that has persisted with time, because personal experience narratives do the very useful therapeutic work of transforming the tumult of experience into an ordered narrative sequence, they make sense of that experience, and they provide a narrative vehicle through which to share that experience with a chosen audience. The therapeutic potential of the HPI is realized when it provides these same benefits in a medical setting—organizing a coherent illness experience,⁵ making sense of it,⁶ and engaging the clinician and the patient in a mutual processing of the experience.⁷

Mutual Acceptance Versus Validity

It is tempting to attribute the therapeutic effect of the HPI to its scientific validity rather than, as I propose, to its mutual acceptance. By separating these two attributes—scientific validity and mutual acceptance—we can see that mutual acceptance is the more important facilitator of the therapeutic potential. This is illustrated with two examples.

Scientifically Invalid HPI That Is Mutually Accepted and Provides Therapeutic Benefit

Within our culture it is difficult to uncouple the therapeutic effect that can result from a scientific-

cally valid explanation from that of a mutually accepted explanation. This difficulty stems from science being part of our mutually accepted belief system. I will present a cross-cultural example to illustrate my argument.

Let us examine an anthropologic report⁸ of a pregnant woman suffering from a life-threatening dystocia that was successfully treated by a Kuna shaman who transformed her distress into a story. Crouching beneath the suffering woman's hammock, the shaman recounted a well-established tribal story that incorporated her symptoms of distress. The story, a mutually accepted cultural myth, describes the birth process as a battle raging in the mother's birth canal between evil spirits trying to retain the fetus for themselves and the tribal elders trying to free the fetus. In concert with her uterine spasms, the opposing forces strive back and forth, giving credible meaning to her visceral sensations. Through the narrative the shaman was able to join the woman in coprocessing her psychophysiologic perturbations even though she did not grasp every detail of the narrative.⁹ As the epic chant reached its conclusion, the cervix dilated, and a healthy baby was born.

There are a number of ways to account for this outcome. They include guided imagery,¹⁰ hypnosis, trance, and the homeostatic benefits of the relaxation response.¹¹ From a purely descriptive perspective, however, we see an example of a shaman who used a mutually accepted narrative to engage the patient in an experiential journey through her distress, and at the end she recovered. His words made sense of her experience, and his physical behavior affirmed that she was in the presence of someone who cared about her welfare. This indigenous HPI provided the suffering woman both with a way to understand what was happening to her and with a fellow traveler to accompany her through the distressing experience. She was able to relax, and her self-righting homeostatic physiologic processes were able to prevail.

The shaman's explanation of what happened had nothing to do with our Western understanding of the pathophysiology of the birth process, but everything to do with the use of a mutually accepted narrative by an indigenous healer to facilitate a therapeutic engagement. Without minimizing the utility of applying biomedical understandings to treat pathophysiology, it is important

to acknowledge that as Western physicians, from a cross-cultural perspective, we ourselves are indigenous healers for patients who share our assumptive worldview. Whatever specific effects derive from our biomedical interventions, we are also recruiting the nonspecific healing powers of mutual engagement through a shared way of making sense of illness.^{12,13} The therapeutic importance of the physician and patient establishing and sharing a common health belief system has been amply documented in other settings.¹⁴

Scientifically Valid HPI Without Mutual Acceptance and With Little Therapeutic Effect

Our current understanding of somatization disorder is that it is an illness, "the subjective experience of being sick," without a disease (an objective derangement in physiologic systems), a distinction made by Eisenberg.¹⁵ Somatization disorder is considered a chronic psychiatric condition by exclusion. If a patient is willing to accept a psychologic cause and to undertake psychotherapy, the physician-patient relationship can be satisfactory, and the patient might be helped. As often happens, however, the physician and patient cannot formulate a coherent narrative (1) that can account for the symptoms, (2) that they can both believe in, and (3) that they can use to engage each other in a joint treatment effort. In other words, in this example there is no mutually accepted HPI, and in consequence, even when the physician believes that the patient's symptoms are genuine, tension persists between the physician's explanation and the patient's subjective experience.

Such a problem does not occur in alternative or complementary health care systems. One therapeutic advantage that these systems enjoy is that they lack the exclusionary (there is no biomedical explanation for your symptoms) category of somatization disorder, and thus can keep the patient's illness experience within the healer-patient explanatory model. All symptoms are therefore legitimated in terms of both an acceptable cause and treatment. Interestingly, many patients treated by indigenous healers report that they feel better even when their symptoms remain the same or become worse.^{14,16,17}

I am not suggesting that physicians accept a patient's scientifically invalid theory of cause if doing so would result in poor treatment. I am, however, stressing the importance of finding, or

creating, common ground by taking the time and effort to establish a mutually accepted explanation of the patient's symptoms. Sometimes a common ground occurs incidentally in the course of treatment. I have seen somatizing patients who were the bane of a medical practice because they were chronically angry, clinging, and complaining. The physicians and their patients were caught in a negative feedback loop in which they mutually frustrated each other's needs. The physicians could not get the satisfaction of feeling competent as a healer, and the patients could not get the satisfaction of feeling that their symptoms were validated. Then a clinically recognizable biomedical disease—even one as severe as a malignancy—is diagnosed. Very quickly the physician-patient relationship changes for the better, because now they can genuinely unite on an agreed cause, a set of authenticated symptoms, and an agreed treatment program. The patient and physician confirm each other's roles and responsibilities, a sense of camaraderie develops, the repetitive complaining calls stop, and the therapeutic potential of the HPI is actualized.

Coprocessing the Illness Experience

Thus far I have described the HPI as a process for accessing the patient's experience of illness and organizing it into a mutually accepted narrative form. Now I describe how the very process of the patient relating a personal experience narrative to the clinician can actually change the patient's personal experience of the illness.

Previously I invoked the participatory-observer approach to describe the ideal listener for personal disclosure. As we reflect on the principles underlying the choice of an ideal listener, it becomes clear that we make personal disclosures not only to our listener but also with and through them, because as we speak, we simultaneously monitor their response to us for safety, sensitivity, and affect. When we tell someone about our personal experience, we vicariously reexperience it in a way that we believe is being experienced by our listener. This coprocessing and individual reprocessing component of history taking describes how the affective experience of the teller is reconfigured by the perceived reaction of the listener.

The candid, comprehensive HPI incorporates the original illness experience, transports it from the time and place of its occurrence, and makes it

accessible to coprocessing in the clinical setting. The patient and the physician then become fellow travelers on a journey undertaken through the patient's illness narrative. This process has both psychotherapeutic and psychotoxic potentials. When clinicians can convey messages of empathy and positive regard and also have the affective strength to bear their patients' distress with compassionate equanimity, then the patients can adopt these attitudes as their own. On the other hand, if a clinician is distant, defensive, or rejecting, this attitude could worsen the patient's experience of the illness. Validation by a respected authority raises self-esteem and eases suffering, whereas its opposite jeopardizes the patient's physical and psychological status.

Corroborating Evidence

The power of a caring person to mitigate distress by sharing it is widely supported by anthropologic evidence, experimental psychology, and conventional experience. For example, the *couvade* syndrome is a process whereby some of the pain of childbirth is diminished for the woman through her husband's empathic response.¹⁸ In conventional social interaction, we count as close friends those to whom we can unburden our distress. When those persons we care about tell us of their distress, they often feel a little bit better, and we often feel a little bit worse. For this reason, it should be part of the professional training of clinicians to learn how to engage the patient with compassionate equanimity in such a way that the patient adopts the clinician's therapeutic attitude without the clinician acquiring the patient's distressed attitude. This process can be illustrated by a clinical vignette.

I had been caring for a married, middle-aged woman who suffered from intermittent episodes of dysphoria for about 4 years, and she had reached the stage in her psychotherapy where we no longer made regular appointments but met as necessary. Appointments occurred once or twice a year. I had not heard from her for more than a year when I got a call requesting an urgent appointment because she was preoccupied with a distressing episode that she could not stop talking about. When she came in, she told me with tears and anguish about an argument she had with an in-law in another country during a visit 3 weeks previously. After she returned home, she talked

about it incessantly to her friends and family and got no relief. In fact, every time she talked about it, she felt worse. The precipitating event occurred while she was shopping early one morning and ran into a woman whom she had not seen since high school, some 30 years past. After exchanging identifying greetings, she found herself blurting out this personal story to her old classmate and then feeling humiliated at the realization of the social impropriety of her disclosure. When she went home and told her husband of her embarrassing indiscretion, particularly how talking about the problem made it worse, he insisted that she call me.

Unlike her caring but reluctant previous listeners, I not only let her disclose every detail she remembered, but the safety of our relationship permitted her to recover details that she had kept half-hidden from herself. I helped her to understand it in terms of ongoing issues in her life, but I did not tell her anything that she did not already know. Mainly, by really hearing her out, I steadfastly accompanied her through the affective anguish of her narrative journey. She left, feeling sad but composed. When I saw her a week later, she said that after telling the episode to me, she had no need to tell it to anyone else, nor, indeed, to me, again.

Samuel Taylor Coleridge's ancient mariner is doomed to travel the world reliving his posttraumatic stress disorder through endless retellings of his story because no one is willing to hear him out. Isak Dinesen, the author of *Out of Africa*, writes in her autobiography, "All sorrows can be borne if you put them into a story or tell a story about them."¹⁹ That is most likely to be the case if there is a receptive listener—real or fantasized. From this perspective, for those who believe, God is the listener of last resort.

Experimental psychology also offers compelling evidence that telling one's story, even to a projected audience, can be therapeutic. In his book, Pennebaker²⁰ described studies he did together with Shortt in which they conducted videotaped interviews of holocaust survivors. While the survivors described their experiences in concentration camps, the researchers measured their physiologic indicators of stress. Later these videos were shown to college students while recording the same stress indicators. A comparison of the physiologic stress measurements of the

holocaust survivors with those of the student listeners on a minute-by-minute basis revealed that as the survivors talked about their distress, their stress indicators decreased. By contrast, the more that the college students listened to the distressing accounts, the more their stress indicators increased. Even though the speakers and listeners were present to each other only in imagination, there was a displacement of distress from speakers to listeners.

Our ordinary personal experience confirms that when the speaker and listener are in face-to-face contact, they establish an empathic feedback loop that transfers distress even more readily. Whereas affects can be contagious between closely involved people,²¹ the skillful clinician can control the direction taken by the affect. A mark of the competent clinician is the ability to engage the patient in such a way that the patient is left with the clinician's therapeutic attitude rather than the clinician being left with the patient's despairing attitude.

Summary and Clinical Applications

The therapeutic potential in each of the three components of the HPI can be actualized by specific clinical applications.

Gathering a Database

As clinicians are gathering data, they are also negotiating a particular kind of relationship. That relationship should always respect the patient's autonomy, but it can lean in the direction of the traditional authoritative role or the more currently favored mutual collaborative effort. Clinicians, therefore, should make a thoughtful decision regarding the type of physician-patient relationship that works best for them so that it can be purposeful instead of accidental. Generally, communicating safety, sensitivity, and caring improves rapport and permits a fuller disclosure of information.

The HPI should be taken by the physician who will be treating the patient. Even if all the facts are already contained in a questionnaire or have been taken by an assistant, clinicians should nevertheless ask patients to tell it again in their own words. Furthermore, clinicians should listen attentively rather than, for example, browsing through the chart. This attentive listening is regularly accompanied by synchronous body move-

ments that engage the physician and patient at a deep level and facilitate rapport. One place to look for the beneficial effects of homeopathy might not be in the minuscule dose of medicine physicians dispense, but in the large dose of time and effort that goes into the typical homeopathic HPI. For some patients, a large dose of HPI might be a better treatment tradeoff than a small dose of HPI and a large dose of medication.

If there is a problem with a long-time or recently enrolled patient, do another HPI. Doing so will probably widen the database and strengthen the therapeutic alliance.

Transforming the Database Into a Narrative

Because the HPI is a story, it should be a good story. That is, it should encompass all the relevant facts, make sense of the experience, be nonstigmatizing, permit the maximum allowable hope, and be credible to both the clinician and the patient. Even while convinced that they have organic diseases, patients with somatoform disorder can still accept the causative role of stress or autonomic hypersensitivity if the story is presented as an arena of engagement and exploration rather than as dismissive of their experience.

If patients believe in an alternative or complementary explanation that does not conflict operationally with good medical treatment, clinicians should not push too hard to make the patients give up their story for the clinicians'. Clinicians should be sufficiently open-minded to accommodate both, recognizing that as long as patients continue in appropriate medical treatment, their faith in another causative explanation could have an additive effect on the outcome.

Coprocessing the Patient's Illness Experience

Therapeutic listening can be thought of as analogous to dialysis, in which the patient's illness experience is passed through the compassionate equanimity of the clinician for affective detoxification and cognitive clarification. From this perspective, the clinician should pursue two tasks: (1) getting as much of the patient's illness experience as possible into the dialogue so that it will be available to be treated, and (2) coprocessing that experience with a salutary attitude such as compassionate equanimity.

A corollary to the dialysis model is that the clinician can subsequently feel overburdened by the

patient's distress and then might have to "detoxify" to prevent burnout.²⁰ Clinicians should minimize their burden through narrative communication by presenting at grand rounds, writing case reports, and discussing their difficult patients with colleagues either informally or in the more structured setting of Balint groups.⁵ Among the most effective antidotes for the clinician, however, is a recognition that the pain of hearing the patient out has a redeeming therapeutic value. If physicians realize that they are helping the patient to dialyze their distress, they are less likely to be angry at patients for dumping on them or to be angry at themselves because they cannot cure them.

A final suggestion is to share the good news of favorable laboratory reports with patients instead of delegating the task. Sharing good news amplifies its effect and acts as a positive counterweight to the inevitable deliveries of bad news.

The therapeutic potential of obtaining a good history is as old as the religious healing tradition of bearing witness and as recent as one's last conversation with a friend. When the HPI is properly conducted, the patient feels the maximum relief possible under the circumstances and the clinician feels the maximum personal and professional satisfaction. Who it is that is listening influences the history of the illness as well as the experience of the illness for both the patient and the clinician.

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Placebo Response, Sustained Partnership, and Emotional Resilience in Practice

In 1973 Herbert M. Adler coauthored a paper that marked a watershed in the literature on the placebo response.¹ Since 1945 others had commented upon the placebo effect as it was revealed in research settings through the use of double-blind studies. Adler and Hammett tied this new line of research to lessons taught in a few classic articles from an earlier era.² They showed, first, that cross-cultural studies could shed considerable light upon placebo phenomena; and second, that understood this way, the placebo response was a part of every healing encounter and thus required careful study by all clinicians, not only by investigators concerned about research design. Their work triggered an expanded appreciation of the placebo response, allowing others, for instance, to discern that the distinction between diagnosis and therapy in the typical encounter is artificial—that diagnostic investigation is an important part of the actual work of healing.^{3,4}

Dr. Adler now returns with a detailed analysis of the history of the present illness as a form of therapeutics.⁵ His work demands commentary on what he claims for the therapeutic nature of the medical interview, the implications for the structure of the clinical practice of primary care, and the emotional demands his model makes upon the practitioner.

Adler suggests that the right sort of narrative account of the patient's illness does more than lead to correct diagnosis; it also begins the process of healing. Moreover, the construction of this narrative need not be left to the patient alone; ideally, it is the product of coprocessing involving both patient and physician. A few years ago this suggestion might have seemed wildly improbable. Work within the past decade, however, has high-

lighted the importance of narrative for medicine and has demonstrated the manner in which narrative accounts can relieve suffering and promote healing actions.⁶ For instance, the rate of functional recovery of elderly hip fracture patients can be correlated with the narratives they tell about their injuries and the extent to which the narratives suggest reintegration into daily life.⁷

The importance of narrative for healing can extend beyond the sick individual or the dyadic patient-physician relationship. Frank⁸ has recently argued, especially in connection with chronic illness, that giving testimony of one's suffering is a critical part of the process of healing, and that the communal practice of listening empathically to such testimony is ultimately a healing practice for the community as a whole. If, as Frank suggests, there is an ethical obligation at the community level to give and to attend to such testimony, then the caring physician would seem to have a special obligation to study patient narratives of illness and to aid patients in finding words for their suffering when they feel overwhelmed.⁹

In today's practice environment, comments about the patient's story of illness might appear to be laughably naive. Even those physicians who have been successfully converted to a biopsychosocial model of medical science and practice might still object that the era when the physician had the time and resources to attend to the psychological and social aspects of illness has now receded into the distance. Instead, the growing emphasis on cost-containment through managed care has so shortened the typical primary care encounter, and so distorted the traditional physician-patient relationship into an assembly-line process, that it is a counsel of perfection to prescribe narrative sensitivity as part of the physician's daily work.

But this cynical view assumes that all managed care environments are equally detrimental to the physician-patient relationship, and that today's version of managed care represents its most mature developmental stage. It assumes further that primary care physicians, including academic physicians in primary care, have no influence upon the future of managed care systems. If there is hope for change, and if readers of this journal are among the possible agents of change, then we need to study especially where the interests of patients, of primary care providers dedicated to

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high-quality practice, and of fiscal managers might most overlap. There are already some data to support the proposition that the well-managed and solvent plan would promote continuity in the primary care relationship, as continuity of care with the primary provider is most likely to control costs while simultaneously enhancing patient satisfaction.¹⁰

Thus the notion of sustained partnership in primary care has become the focus of both clinical research and policy proposals.¹¹ Read in this light, Adler's analysis suggests some further dimensions of the primary care relationship that could be predicted to be cost-effective. Attending carefully to the history of the present illness, in the manner Adler describes, might extend the length of visits and drive up costs in the short run—as do most highly effective preventive interventions. If this approach reduces the number of patients who return for multiple visits for varied somatic complaints, because their underlying psychological distress was never recognized and treated,^{12,13} then it will ultimately reduce costs at the same time that it increases both patient and physician morale.

A final objection to Adler's proposal might be the emotional demands it places upon the physician and its apparent violation of the accepted wisdom of detached concern as the ideal relationship with patients.¹⁴ Adler points out that the physician who attends carefully to the patient's narrative will vicariously reexperience the illness and suffering to some degree. Ironically, the more fully and empathically the physician can experience the patient's distress, the better the patient will feel—for the patient is carefully monitoring the physician for signs of empathic receptiveness and feels most safe in telling the story and most relieved of the worst aspects of personal anguish, the more the physician appears to be in tune with the narrative. It seems highly doubtful the physician can fake this level of empathy or reduce it to a mechanical technique of interviewing that allows for maintaining a large emotional distance. But allowing that degree of empathic experience of the patient's suffering can be highly threatening to the physician's emotional equilibrium and, therefore, perhaps to the physician's objectivity and ability to treat effectively.

Some would submit that the flaw in this reasoning is not in Adler's advice, but rather in our having adopted detached concern as our ideal model of

the relationship. That model presumes that the real danger to the physician's effectiveness lies in emotional overengagement, that emotional distance is, by contrast, by far the safer course. If we listen to the complaints of today's patients, however, they do not allege that they get poor care because the physician is reduced to a blubbing imbecile upon hearing of their distress. Instead they complain, virtually with one voice, that physicians don't seem to care and don't listen to them.¹⁵

In medicine, especially a male-dominated world of medicine, close relationships seem scary and potentially overwhelming, whereas isolation seems safe.¹⁶ Our own sense of safety in emotional distance has probably led us to be overeager to hear the message of detached concern, with the emphasis on the detached rather than the concern. It might be time to explode the myth of getting too close to the patient as a serious danger of attending carefully to the patient's story and affect. I would propose that physicians who mistreat and exploit patients, because they get too close, are not attending empathically to the patient's narrative at all, nor are they coprocessing the patient's experience as Adler recommends. Instead, they are attending to their internally driven needs and fantasies and projecting those upon the patient.¹⁷ Physicians who engage in sexual relationships with patients are probably the clearest example of this sort of abuse.¹⁸

The empathic physician who attends most carefully to the patient's narrative still runs a danger of emotional vulnerability, as Adler admits; indeed, it can be said that the virtue of compassion, which most would view as a desideratum of good practice, requires this degree of vulnerability.¹⁷ As Adler suggests, this places a special demand upon medical educators to prepare future physicians to be suitably empathic and involved listeners without burning out as a result. Coulehan¹⁹ has recently described emotional resilience as the quality we should aim to instill in our trainees and has suggested various ways in which this quality could be promoted.

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