Conversations Inviting Change: Narrative Practice in Health Care

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Introduction: where these ideas come from.

By profession I'm both a family physician, and a family therapist. For most of my career I've worked in a busy general practice in a deprived area of London, but also worked one or two days a week in a mental health clinic, seeing children, couples and families. I've recently retired as a clinician and work as a full time educator, but these two fields – family medicine and family therapy – are both very dear to my heart. I'm particularly interested in the territory between these two fields, and how they overlap.

My main contributions as a teacher and a writer have been in the area known as narrative medicine – putting the idea of stories and story-telling at the heart of health care. I've also developed a particular interest in clinical supervision: how health care professionals help to develop each other and look after each other. I've helped to develop a particular approach to clinical supervision using narrative ideas and skills.

If you teach people narrative ideas and skills to offer supervision to each other pragmatically in their everyday work, they will apply these to every aspect of their work: in dialogue with patients and each other, and in their written reflections.

I've set up training courses in clinical supervision based on this approach, and we now have a team in London of around twenty people teaching this. We use the term 'conversations inviting change' to describe what we do and what we teach. I want to say a little about narrative, then about supervision, and then put the two together to describe narrative-based supervision, in other words 'conversations inviting change'

Why narrative?

In all our work, one of our chief aims has been to introduce sophisticated ideas about narrative to ordinary working clinicians, in a way that is immediately useful without being too simplistic.

We explain the basics as follows:

- *The 'narrative turn' has affected many fields of learning*, especially in the social sciences. It is a move away from interpreting people's behaviour (i.e. 'what is *really* going on here?') to becoming curious about how people understand and describe their experiences. People using a narrative-based approach are not

trying to dig deep, looking for the 'underlying meaning' concealed at the bottom of everything. Instead, they see reality more like a tapestry of language that is continually being woven.

- *A narrative approach is based on the idea that we are always continually making meaning,* for ourselves and for others, by putting our experiences into the form of stories. Sometimes these stories are just brief fragments (eg 'I fell over this morning') and sometimes they are far more complex ('I slept really badly last night because I was so worried about my job interview and on my into the building I was so distracted that I tripped over…'). However simple or complicated they are, they share many of the features of literature including plot, motive, character and so on.

- *These stories are never static and they never exist in isolation.* They are in a constant state of evolution: they change each time we tell them, and according to who we are talking to. We continually create our realities in conversation with people around us. Families, societies and cultures are defined through their shared stories. In other words, our understanding of the world is always 'dialogical' in its origins and can be developed further through dialogue. However, some stories can get 'stuck': they become repetitive, and stereotypical. Such stuck stories often contain elements of helplessness, or victimhood.

- *These ideas can be very useful in health care, particularly when used in combination with other more familiar ways of thinking about the world* such as evidence based medicine, clinical science, psychodynamic understanding etc. A narrative approach values all of these but not as absolute truths. Instead, it sees them as helpful *sources of possible meaning* that may or not make a difference to someone's story. It encourages us to see different discourses as sources of helpful ideas, and lets us move flexibly between these. In some cases, a straightforward medical story may be the only sensible one that is worth considering. However, in primary care it is very often helpful to encourage 'polyphony': not just looking for the single explanation, but exploring the many different stories that the patient can tell about the same experience, and the different stories that the practitioner can offer. Agreed 'truths', or solutions, are established by the process of dialogue itself.

Why supervision?

The word supervision is used a wide variety of senses. Most health care professionals use the term only in the context of management or formal training (eg in educational and clinical supervision for juniors). However, in other professions the term is used for a wider variety of conversations including case discussions between established clinicians. For example, in nursing it is understood as:

'An exchange between practising professionals to enable the development of professional skills.'(Butterworth)

In our courses, we use the word supervision in this wider sense, to mean any focussed conversation between professionals about their work. The implication is

that supervision is something that should happen throughout professional life, from student days to lifelong learning.

It is helpful to think of supervision in terms of two circles – development and performance. Sometimes supervision can be purely developmental and sometimes purely oriented towards performance. However in most supervision both are involved. Much depends on *context* ie who is asking for what to be done, who is reporting to whom and why. Although it is conventional to make a distinction between supervision, mentoring, coaching and career guidance, in practice many conversations will range between these.

Cases: Most supervision takes place in order to address cases. These may be addressed in terms of technical management but often they raise broader issues, for example:

- when there is no one easy answer
- ethical issues
- complex co-morbidity
- when it is unclear when to stop investigations or treatment
- 'grey area' cases: eg somatisation, frequent attenders, chronic fatigue, irritable bowel
- complaints, distressed families, angry patients, unlikeable patients

Contexts. Cases never occur in a vacuum. Case management often depends on trying to achieve coherence among the professionals. Supervision may need to address:

- professional or interprofessional rivalries
- problems concerning communication
- teamwork issues
- roles and boundaries
- the differing expectations of patients and clinicians
- money, politics, gender, sexuality and power

Careers. Case conversations quite often bring up issues about careers, for example:

- the need for further training
- work place conditions and job prospects
- longer term career aspirations

The seven C's

We have found seven core concepts useful in communicating the essentials of the narrative approach in relation to both consultations and supervision. We call these the seven C's. (NB the seven Cs do not map exactly onto the technique: they are more like a mantra to get you into the right frame of mind.)

Conversations. Effective conversations don't just describe reality, they create new understanding of it. In supervision, just as in counselling (or indeed ordinary GP consultations) conversations can be seen as interventions in their own right: the end as well as the means. Simply by taking place, they create opportunities for people to rethink and redefine their realities.

Curiosity. This is the common factor that turns conversations with colleagues from chatter into something more substantial. It should be friendly but not nosy. Curiosity invites colleagues to reframe their stories. An essential aspect of curiosity is neutrality (to people, to blame, to interpretations, to facts.) Curiosity should also extend to yourself. How can you stop being bored, critical, impatient?

Contexts. This is what it is most effective to be curious about. Important contexts in professional conversations are people's practices and professional networks, history, geography, community, faith, belief systems, values. They also include the patient's contexts. These are what people want to talk about and make conversations come alive.

Complexity. Life seen as an endless and infinite dance of interactions, three dimensions and over time, and with people and conversations. A sense of complexity gets away from fixed ideas of cause and effect, unchangeable problems, over-concrete solutions.

Challenge. What you are looking for in supervision is a better account of reality than the present one, which means a story (a narrative) that makes better sense for people of what they are going through. However you may need to ask some surprising and challenging questions to bring out the creative potential of the conversation.

Caution. If people want straightforward advice, be prepared to give it (while being aware of its limitations). Also, remember you're not doing therapy – on colleagues or on patients! You need to balance challenge with confirmation.

Care. None of the other ideas will work unless you are respectful, affectionate and attentive. Supervision, like consulting with patients, needs to be grounded in moral commitment.

Bibliography

These short articles are open access on the web and provide an introduction to some of the ideas I use:

The art of questioning (The value of questions, and Karl Tomm's approach):
http://qjmed.oxfordjournals.org/content/95/7/489.full

It takes two (The reflective aspect of supervision):
http://qjmed.oxfordjournals.org/content/96/6/461.full

Uniqueness and conformity (How to combine narrative and normative questioning):
http://qjmed.oxfordjournals.org/content/96/8/615.full

How not to be a doctor (Following conversational cues):
http://qjmed.oxfordjournals.org/content/99/2/125.full

Conversations inviting change (Description of supervision courses):

http://pmj.bmj.com/content/84/987/4.full

Why narrative? (Introduction to narrative medicine):
http://pmj.bmj.com/content/85/1001/167.full

Odyssey:
http://pmj.bmj.com/content/88/1045/675.full

In addition, here are some more scholarly items:

Launer J (2002) *Narrative-based Primary Care: a practical guide.* Oxford, Radcliffe.

Launer J (2006) New Stories For Old: Narrative-based primary care in Great Britain. *Families, Systems and Health* **24**: 379-389

Launer J. (2013) Supervision, Mentoring and Coaching. Chapter 8 (Pages 111-122) in : T. Swanwick (ed.), *Understanding Medical Education: Evidence, Theory and Practice, 2nd Edition.* London, Wiley-Blackwell.

Launer J (2013) Narrative Based supervision. Chapter 7 (Pages 147-161) in : L.S. Sommers and J. Launer (eds.), *Clinical Uncertainty in Primary Care: The Challenge of Collaborative Engagement.* New York, Springer.

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