

Article ▶ A Vision in Narrative Medicine

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ABSTRACT

Background: Narrative medicine (NM) is more than just an approach to medicine; it is an approach to human contact. The field developed mostly during the 1990s and has emerged from a variety of similar concepts such as patient-centered care, literature and medicine, and relationship-centered care. The method by which NM is practiced and the fields where it is applied vary greatly across the country. Despite the inherent differences, the overall goal of the field remains the same, to use narrative skills to communicate more effectively. Currently, NM has developed extensive roots in oncology, neurology, primary care, nursing, psychology, and even the social sciences.

Methods: Survey request flyers (n=300) were distributed to three optometry offices and one ophthalmology office in the greater Cincinnati, OH area. Links to the anonymous online survey were also posted on studentdoctor.net as well as ODwire.org and emailed to the faculty of Southern College of Optometry. Twelve patients and a total of 29 optometrists and ophthalmologists responded.

Results: Approximately 70% of both doctors and patients felt they had a good relationship with each other, while 22% of patients that did feel close to their optometrist/ophthalmologist believed that better communication would improve the doctor-patient relationship. Sixty-seven percent of optometrists and ophthalmologists reported experiencing trouble communicating with patients, and 89% percent of participating doctors reported that they would be interested in learning new communication techniques.

Conclusion: There is room for improved communication between doctors and their patients in the field of optometry and ophthalmology. This improved communication may be possible through the use of NM. Narrative medicine has the potential for tangible benefits in optometry and ophthalmology such as increased patient trust, compliance to treatment, and more meaningful doctor-patient relationships. Narrative medicine in optometry and ophthalmology has the potential for tangible benefits, such as increased patient trust.

Keywords: communication, doctor-patient relationships, narrative medicine, survey

The Foundation of Narrative Medicine

In a modern world that is abundant in technology, the manner in which we speak and interact with one another has changed dramatically. As a result, the way in which health professionals and patients interact has also changed. According to Dr. Rita Charon, medical internist and director of the Narrative Medicine (NM) program at Columbia University, NM has developed as a way to address some of the issues that have arisen in the United States medical system. It is "...by no means a cure-all for a dangerously vexed healthcare system," but it certainly has a purpose to fulfill.¹

Some consider the system of healthcare in the United States to be broken.² The medical field is currently riddled with mistrust, fear of malpractice, strict time schedules, and great variance in perception between doctors and patients as to what it is like to be sick. Today, there is less focus on one of the most important components of healthcare, the patient as a person and the effect illness has on their life. Patients, especially those facing severe debilitating disease and death, are often ignored in suffering and treated as medical anomalies while being shuffled between health care providers. It is not

so much about what a patient experiences, but more about finding what appears to be wrong and fixing the problem. Solving the disease riddle may halt the symptoms, but it cannot erase the trauma of suffering. Furthermore, the proliferation of specialists and subspecialists within the healthcare system "often [leads] to fragmentation and compartmentalization of care."³ The more medical professionals a patient must see, the more impersonal the experience gets, and the predicament of illness can become more frustrating.

It is also commonplace for doctors to try to apply a singular definition of illness to all individuals, although everyone suffers from an illness uniquely.¹ Unlike the hard sciences, where environments and variables are strictly controlled, this is not possible in the field of medicine.⁴ The greater the severity of the disease to an individual patient, the more it strains her relationships. A patient will of course understand her symptoms in terms of aches, pains, nausea, and other physical manifestations of illness. More importantly, a patient will experience sickness in terms of how it affects her ability to complete everyday tasks and maintain relationships. The more isolated a person becomes in sickness, the more severely

the symptoms are felt. A doctor may judge the severity of an illness by the duration of symptoms or by the latest lab results. A patient, on the other hand, may judge the severity of disease by the way it changes everyday life.

The application of general theories to individual cases has inherent tangible problems as well. For example, medical advances have improved our knowledge and understanding of high blood pressure (hypertension) significantly. Today, the disease process of hypertension is well understood and can be effectively treated. Unfortunately, less than 10% of hypertension patients show textbook symptoms of the illness. To treat each case as if it were black or white is not effective.⁴ Luckily, patient care is becoming more individualized. Patients are given individual charts and logs, and unique data sets are created for each person. Newer technology and procedures are being developed with the more tailored patient needs in mind. Although these trends constitute an improvement, the desire to treat all cases of a particular condition in the same manner is still a problem inherent to Western medicine.

Time has become short in the medical world; medical providers are often rushed through examinations and learn little about the patients first-hand. The decline of the economy has also put money in the forefront, increasing pressure on doctors to cycle through patients rapidly. Furthermore, increases in the number of tests and procedures available have given doctors a more accurate way to gather information from the patient, limiting direct contact in search of more technological data.

The pervasiveness of malpractice lawsuits creates an environment in which doctors are increasingly hesitant to become close with patients. The fear is that by being close to a patient, a doctor will lose his ability to make an objective diagnosis and in turn will make poor decisions that result in a lawsuit. The proliferation of the idea that medical providers must distance themselves from a patient's emotions and life has created a gap between provider and individual, a gap that NM may be able to bridge.

Dr. Charon is quick to point out that the medical field did not develop these faults overnight. She suggests that, instead, "the reason that doctors' impersonality has achieved the status of crisis is not that it is any worse than it used to be, but that to fail to recognize the body is to fail to recognize the self."¹ Charon breaks down this failure as being a result of what she refers to as the "divides of health care."¹

Divisions of Doctor and Patient

A division exists not only between the doctor and patient, but between different health care providers. The way in which different specialists think and communicate can separate them. Different opinions on the value of the various specialties can also contribute to the division between medical professionals. For example, the jargon of an optometrist can be different from that of an ophthalmologist. Ophthalmologists go through a longer training process and provide patients with

a surgical correction, while optometrists treat conditions with lenses, prisms, and topical and oral medications. This creates a sense of rivalry and territoriality between the two fields. Instead of a rivalry, the two fields should work in harmony to treat their shared patients, incorporating the best of both specialties. Finding the root of this division between optometrists and ophthalmologists may help to serve both the medical professionals and the patients better.

The divides of health care form a chasm of understanding and make constructive relationships difficult to establish between all types of medical professionals and their patients. According to Charon, there are four major divisions between the healthcare professional and patient: the relations to mortality, the contexts of illness, the beliefs about disease causality, and the emotions shame, blame, and fear.¹ These divides prevent medical providers from treating patients most effectively and can prevent patients from being receptive to suggested treatment. Patients may have unrealistic expectations of the treatment they are able to receive, and doctors may become frustrated with the demand to treat incurable illnesses. Each situation is unique, but all of them share the same disconnect. Bridging these divides may ultimately leave both parties with better understanding and preparation to deal with the impact of illness.

The relation to mortality deals with the understanding of the natural life cycle of the human body. Coming to terms with death and its meaning is part of living. However, when two different people with disparate views of death must deal with mortality, conflict occurs. While doctors view death as a failing of biological systems, a patient may view it differently. The way in which each party views death can impact how they act in the face of it. While some may be fearful, others may be welcoming to the release from suffering and illness. A doctor might be reminded of her own mortality in the act of treating a terminal patient and build a barrier to protect herself from the inevitable end. Furthermore, a patient might be in denial about his eventual death and refuse to accept a terminal diagnosis. Regardless of the circumstance, a misunderstanding of what death means to another person can prevent effective communication.

The context of illness can also create a separation between a medical provider and a patient. The sick patient often views illness not only as a set of symptoms but also by how the ailment affects the normal events of his life. It is a combination of the pain of illness and the strain it causes on the individual's relationships. The perception of time changes drastically for the ill. This affects how an individual views the illness in the scope of his life. While sick, the patient may feel as if time has slowed to a crawl, and all memories of health and vigor can feel like a distant past. This perception can create a different attitude toward the illness and a unique experience of its symptoms. In order for the patient to put his illness into context, he must be allowed to tell it completely to the doctor. If the doctor begins to steer the conversation and becomes the

Table 1: Narrative Features of Medicine

	Literary Components	Patient Narrative Connection
Temporality	<ul style="list-style-type: none"> Inferred length of conversations suggests a timeline Progression of plot along a timeline uses points of reference such as dates or seasons Past, present, and future tenses give a sense of time 	<ul style="list-style-type: none"> Amount of time a patient spends on a symptom suggests the duration of that symptom Patients may refer to onset of illness by events or specific dates Patients use different tenses to express if symptoms are currently occurring or occurred in the past
Singularity	<ul style="list-style-type: none"> Each story is unique despite common themes Text is static The act of writing creates meaning and increases understanding 	<ul style="list-style-type: none"> Each case of illness is experienced differently Pain is experienced internally and only truly understood by the patient. This pain many vary over time and change from patient to patient. Patient stories hold information contained in word choice, and talking about the illness helps the patient understand what the disease means to him/her
Causality	<ul style="list-style-type: none"> Plot is a sequence of events in relation to one another Importance of events is shaped by the perspective of the narrator Importance of events and connections between them can be observed and interpreted by the reader 	<ul style="list-style-type: none"> Signs and symptoms of illness are the elements of plotline Patients may relate symptoms to the effect the illness has on elements of their lives Each part of the patient's story is shaped by the perspective of the patient based on previous experience Purpose of medicine is to find the cause of an illness, or to find a connection (plot) between individual events (symptoms). Reading for a plot in literature increases the ability of the doctor to listen for plot in a patient's story
Intersubjectivity	<ul style="list-style-type: none"> Two subjects meet, reader and narrator interact, and the novel affects the life of the reader 	<ul style="list-style-type: none"> Doctor and patient gain a greater understanding of one another by the sharing of stories
Ethicality	<ul style="list-style-type: none"> Authors write with consideration for the effects on the audience When writing, the author must be mindful of previous works of the same genre and pay respect to cited sources 	<ul style="list-style-type: none"> By listening to the patient story, the doctor is obligated to act in some way The doctor must make ethical decisions for the treatment of the patient and his/her personal information.

narrator of the patient's story, the capacity for the patient to put her illness into context lessens.⁵

Beliefs about the cause of an illness often differ between doctor and patient. To the patient, the cause of her symptoms is not observable or meaningful. Instead, based upon background and past experiences, a patient will form her own opinion about the cause. In some cases, these opinions are wrapped around superstition, religion, or past experiences. If the patient does not believe the scientific prognosis, she may be unwilling to accept the suggested treatment. This mistrust could fracture the doctor/patient relationship and possibly impact the health of the patient. Differing opinions can also create issues between medical providers. Different doctors entertain entirely different hypotheses for an illness, and this disagreement can become problematic to the patient if a consensus cannot be reached. As different types of medical providers have varying levels of training, one party could be less respectful of the opinions of the other. Without proper respect among providers, agreement will be difficult to reach. This can create a toxic environment, not only within the team of doctors, but also between the doctor and patient.

Of all the aspects of healthcare, emotions are the most noticeable and harmful. Shame, blame, and fear present themselves in different ways. Patients often feel shame in divulging the inner details of their bodies, especially when related to diseases that have associated stigmas, like HIV or

genital herpes. Furthermore, the fear of a serious diagnosis can hang over the patient's head in the doctor's office. A doctor might blame the patient for a self-inflicted illness or worsened symptoms due to the lack of compliance to treatment. Patients, in turn, blame doctors for persistent symptoms, or lack of a miracle cure. This shared blame fractures the foundations of trust that are necessary to build a healing relationship between both parties. If all symptoms are not acknowledged, the proper diagnosis and course of action may not be taken. This could generate a cycle where the patient becomes more frustrated with a lack of results and places increasing blame on the doctor.

These divisions, accompanied by the tough economy, increased dependence on technology, surge of malpractice lawsuits, and proliferation of medical specialties, have all contributed to a need for NM. Narrative medicine can help to prevent these divisions and offer an alternative to the fragmented communication that is experienced by patients and doctors everywhere. Although the details of its practice vary depending on the context and location, the theory behind the concept is universal.

The Theory Behind Narrative Medicine

Narrative medicine is the application of narrative skills to the field of medicine. Using the analytical competencies developed through the practice of analyzing literature, doctors can dissect the patient narrative as well as articulate better

responses. According to Charon, it "... proposes that health professionals, as a matter of routine, be equipped with the skills that allow them to competently and naturally absorb, recognize, interpret, and comprehend value of all that the patients tell."¹ By learning the narrative skills, doctors can be more receptive to information and use it more effectively. To learn these skills, doctors must refer to literature and its components. Just as literature generally contains a story, so does the patient's experience of his or her illness. The patient's story of illness and literature share common characteristics: temporality, singularity, causality, inter-subjectivity, and ethicality. These common characteristics are referred to as the narrative features of medicine (Table 1).¹

Understanding how the narrative features of medicine appear in the literature helps the listener locate them in the stories of illness. By becoming better listeners, doctors can work toward the goals of NM: attention, representation, and affiliation.

Goals of Narrative Medicine

The three goals of NM are interconnected concepts that lead to better communication between doctor and patient. Attention means that the physician must concentrate fully on the needs of the patient and must not be distracted by personal thoughts, unrelated events, or prejudices. The physician acts as a healing instrument and resource. It is important that the doctor make the patient feel acknowledged as a presence, instead of a mere object.¹ Becoming an instrument for healing can be a difficult transition for the practitioner. The doctor needs to set aside personal concerns and thoughts in order to absorb all that the patient tells. Although it is rarely perfectly achieved, attention opens the lines of communication between doctor and patient.

Representation occurs as a result of attention. In representation, the doctor will make sense of the patient's narrative, analyze, and record it. This can be in the hospital chart, the parallel chart, or the form that best conveys the narrative. Representation reflects, solidifies, expands, and extracts ideas from the narrative. Charon claims that writing the patient's story helps doctors better to understand it, and therefore be more capable to act on it.¹ Although professionals will not always have the time to write a complete, deep, and comprehensive account of an experience, by hearing the story, the doctor is obligated to act in some way.

By paying attention to their patients and representing their individual stories, medical professionals acquire a new affiliation with the patient. Patients put more trust in a doctor who they know understands them as a person and is there for them as a resource. The patient has less fear that the doctor will judge him. Finding a doctor who is focused on "... improving the health and relationships of the whole person in his or her life context rather than just managing disease," patients come to affiliate differently with these medical providers.²

Training in Narrative Medicine

The Narrative Medicine Program at Columbia University was one of the first of its kind, but similar programs are appearing all over the U.S. and parts of Europe. Many training programs begin in medical schools and are offered as creative options to first and second year students. Most of the results have been positive, with students stating that they acquired improved listening skills and have a greater capacity for empathy. Each of these programs has similar teaching techniques for narrative competencies.

At Columbia University, medical students first analyze assigned literature by looking for the narrative features of medicine. This gives students an understanding of what stories mean, and what story elements add to meaning. "Illness" as a subject can be helpful because it appeals to students and expands on issues that could be encountered in the practice of medicine. Talking or writing about the literature is important because it engages critical thinking skills and elaborates on the impact of the literary elements. While classical literature is a staple, other genres also work. In the play *W;t* by Margaret Edson, the protagonist, Vivian Bearing, is diagnosed with ovarian cancer. Vivian is shuffled between medical providers, including an emotionally distant and insensitive oncologist. By analyzing this play, students not only get a feel for narrative elements, but are also introduced to the importance of empathy and communication.

Once students reach the clinical portion of medical school, they are asked to write parallel chart entries about cases that struck them during rotations. The parallel chart is used as a training tool in NM. Medical schools spend years training students to be proficient in the textbook diagnosis and treatment of illness but do not adequately prepare students for the challenges of the clinical aspects of medicine or how to cope with life as a doctor. To expand on this type of knowledge, Charon developed the concept of the parallel chart. The goal is to help the professional understand the patient and better respond to the patient's needs. Charon states that "... becoming more comfortable with [the doctor's] own feelings [enables him/her] to focus on the problems of the patient."¹ Writing in the parallel chart helps build an understanding of the patient, while helping the professional to understand his own reaction to the encounter. Parallel charting also enhances a professional's memory of what went on during the office visit. This allows them better to serve the patient at the next visit and reduces the need to repeat questions.

Creating a parallel chart is simple: every day the health care professional writes about his or her patients. The parallel chart includes information that does not belong in a normal medical chart, including impressions about the patients, discussion about the diagnosis, and reflection on the case in general. The writing should not be so personal that it would be inappropriate to share with others, but it should be meaningful and reflective. The students in the program at Columbia University were encouraged to use everyday language and

explore personal writing styles. Thinking about the patients in a non-medical way "...helps [students] to perceive [patients], to interpret what they do, and to acknowledge [the students'] own emotional responses to their plight."¹ The reading of these parallel chart entries also formed the basis for future attentive listening that would be necessary in NM.

Students are not the only ones being taught the principles of NM. Dr. Charon also conducts seminars for doctors and other practicing professionals. As these training sessions can be brief, often a lunch seminar, the focus is more on parallel charting. Much like training students, Dr. Charon asks participants to write about patients and read these writings during the seminars. Charon claims that narrative competency is something that can be readily taught to a willing, enthusiastic audience.¹

To start a new patient meeting, Dr. Charon gives this sample dialogue: "I will be your doctor, and so I have to learn a great deal about your body and your health and your life. Please tell me what you think I should know about your situation."¹ Incorporating NM into patient care, Charon suggests that previous habits of practice will gradually change. These changes include how doctors speak, question, listen, keep records, make medical decisions, and understand and relate to others. Dr. Charon admits that she initially struggled with this process. When she started using the techniques, she needed to physically sit on her hands to avoid making notes or browsing the medical chart while the patient was speaking.¹ Her typical time frame involves 20-30 minutes of listening to the patient tell their story. After this, brief notes about the narrative and impressions of the person are made. She then either begins asking questions or starts the physical examination. Charon suggests patients receive a copy of anything the doctor writes in the parallel chart, as the patient should be the curator of her story of illness. Each person who practices NM does so differently and needs to develop their routines.

Expanding Narrative Medicine

Just as the methods of training and practicing NM change, so do the fields of optometry and ophthalmology. While these two fields prepare future health professionals to develop the skills necessary for new procedures and treatments, universities do not put as much time and effort into preparing students for the communication aspects of practice.⁶ Based on curricula listed on the websites of The Ohio State University College of Optometry⁷ and Southern College of Optometry,⁸ of the four years that optometrists spend in school, only three to five credit hours are currently designated to professional communication. Similarly, Harvard Medical School only offers two courses on ethics of treatment and patient communication skills.⁹ The use of NM would improve communication skills, and even provide other benefits such as increased patient trust and compliance to ophthalmic treatment.

What is it like to be a patient in an optometrist's or ophthalmologist's office? What is discussed? How does the discussion take place? Are there communication problems? What is the vision care provider and patient relationship like? What influences our vision? This study attempted to answer these questions.

Methods

The study surveyed patients and vision care providers online. Researchers distributed approximately 300 survey flyers to patients exiting three optometry offices and one ophthalmology office in the greater Cincinnati, OH area over two weeks. Links to the survey were also posted on the student and professional optometry and ophthalmology sections of studentdoctor.net and ODwire.org to reach a more diverse respondent population. The flyers listed the purpose and risks of the study, contact information, and the website for survey completion. All responses were anonymous, and the survey questions were approved by the Eastern Kentucky University Internal Review Board. Questions on the patient survey were "yes/no" with an area for other comments and included:

- Do you feel you have a close relationship with your optometrist/ophthalmologist?
- If not, could it be improved with better communication?
- Have you ever told your optometrist/ophthalmologist about your personal life and/or unique circumstances?
- When you visit your optometrist/ophthalmologist does he/she ask questions, let you describe your symptoms, or both equally?
- Do you feel your optometrist/ophthalmologist listens effectively to your concerns?

The survey for optometrists and ophthalmologists shared the same first two questions as the patient survey. Requests for survey respondents were sent to five optometrists and four ophthalmologists by e-mail, and a link to the survey was distributed by e-mail to all faculty at Southern College of Optometry in Memphis, TN. A link to the provider survey was also posted on studentdoctor.net and ODwire.org. The questions on this survey were the same format as the patient survey and included:

- Have you ever felt you were not able to effectively communicate with your patients? If so, was it because they were geriatric or pediatric?
- Would you be open to learning techniques to help you communicate better with your patients?
- Do you believe environmental or psychological factors affect vision health? If yes, have you ever had a patient that had vision problems associated with psychological factors, environmental factors, or both?

Table 2: Responses to the question, “When you visit your optometrist/ophthalmologist does he/she most often...?”

Response	#	%
Let you explain your symptoms on your own	0	0%
Ask specific questions to determine your symptoms	2	17%
Both equally	8	67%
Other please specify	2	17%

Results

Twelve patients and 29 optometrists and ophthalmologists responded to the survey. The exact number of ophthalmologists versus optometrists participating could not be quantified as the survey link was anonymous.

Patient Survey Results:

Seventy-five percent of patients responded that they had a close relationship with their optometrist/ophthalmologist. Of the 25% that did not have a close relationship, 22% thought that the relationship could be improved by better communication. Furthermore, 67% of patients reported telling their optometrist/ophthalmologist about their personal lives, and 100% of patients felt that their vision providers listened adequately to their concerns. Responses to question four (When you visit your optometrist/ophthalmologist does he/she most often____?) are listed in Table 2. Other replies included one response that the individual did not need any explanation or questions because she only needed a refraction. Another respondent reported that she was never asked questions by her optometrist or ophthalmologist.

Sixty-seven percent of patients reported that psychological or environmental factors impacted their vision health. Lastly, only one respondent had accompanied a young child to an eye appointment. This respondent felt that the child was treated effectively.

Optometrist/Ophthalmologist survey results:

Seventy-one percent of vision providers surveyed said that they had close relationships with their patients. The remaining 29% answered the following question: Do you think the quality of these relationships could be improved with better communication? Two (12%) answered yes and four (25%) answered no, while two made additional comments. One respondent reported she did not have the time to improve communication while another participant stated he did not want to get too close to patients.

When asked if they ever found themselves unable to communicate with a patient, 61% of vision providers responded yes. The results for the patient miscommunication category are found in Table 3.

Eighty-nine percent of optometrists and ophthalmologists responded that they would be open to learning new

Table 3: Results for the Patient Miscommunication Category

Response	#	%
Pediatric	1	4%
Geriatric	4	15%
Both pediatric and geriatric	7	27%
Neither pediatric nor geriatric	10	38%

techniques to improve communication with patients. One respondent said that improved Spanish speaking skills would benefit doctor-patient relationships. Two respondents went on to elaborate that there is always room for growth in communication. Additionally, 100% agreed that environmental and psychological factors affect vision health to some degree. Some stated that environmental factors were more influential than psychological.

Discussion

Approximately 70% of both doctors and patients felt that they had close relationships with one another. It is unclear whether the remaining 30% of patients felt that they had a helpful and resourceful relationship with their vision specialists. Of the 30%, however, only about 15% thought that better communication could improve the relationship. This study indicates that an opportunity remains to improve communication skills between the doctor and patient.

Surprisingly, all of the patients surveyed felt that their vision specialists adequately addressed their concerns. If patients feel that doctors listen to and understand them, then why do they lack a close and meaningful doctor-patient relationship? This question is difficult to address, and the answer may lie in the individual personality types of the patients. One responder wrote that she felt she had a good relationship with her doctor, but not necessarily a close one. This may be the case with other patients as well. If an individual has generally good eye health, he may not feel it necessary to become close to his vision specialist. It can be difficult to establish strong relationships with the patient seen only every 1-2 years. However, this does not describe every patient.

There is an apparent problem in communication, according to optometrists and ophthalmologists. Over 61% reported having problems communicating with patients. Several participants suggested that a foreign language barrier was a large issue. However, practitioners reported that 46% of communication issues were related to pediatric and geriatric patients. These patient populations provide unique challenges and may be better approached using NM.

One of the most intriguing elements of this survey dealt with what is actually discussed during typical visits. Sixty-seven percent of patients and 100% of optometrists and ophthalmologists felt that environmental and psychological factors influence vision. One practitioner even stated that

those factors came into play every day, while another responded, “Absolutely, and I teach this!” Both parties seem to agree that these factors impact vision, and yet only 67% of patients discuss personal information with their optometrist or ophthalmologist. This type of information could include work place setting, stress levels, pollution exposure, other illnesses, or even traumatic sightings. Some of the patients who withhold this information may be those who do not feel that they are close enough with their practitioner to discuss these details, or they may be from the group of patients who are not encouraged to speak freely and are therefore not given the opportunity to divulge this information. Regardless of the reasoning, the disconnect can result in the issues not being addressed.

Possible Applications in Optometry and Ophthalmology

Narrative medicine may help address some of the communication problems in medicine. Eighty-nine percent of optometrists and ophthalmologists responding to this survey reported that they are open to learning new communication techniques. Given that high number, it seems that NM has the potential to flourish in these two fields.

Some oncologists have embraced NM. Cancer in any part of the body poses the threat of spreading, and treatment can be devastating. Patients may be forced to come to terms with mortality and may harbor a great deal of anxiety. Each individual patient, however, deals with the disease in his or her own way. Cooper states, “The outward show of emotion can vary immensely and may be embroiled within the whole turn of events, including the support provided at the time of the diagnosis.”¹⁰ The impact of ocular cancer on the patients’ lives is immense, and proper communication with patients during and after treatment is important to maintain an understanding of their coping skills. Narrative medicine has the potential to help optometrists and ophthalmologists build therapeutic relationships with patients, and create an environment where they will feel comfortable enough to discuss with them the seriousness of the condition. Patients suffering from ocular cancer are usually treated by a number of different doctors, so communicating with this medical team is the best way to provide care.

Adherence to a prescribed treatment regimen is important in controlling glaucoma. However, reported rates for non-adherence among patients with glaucoma generally range from 24% to 59%, although rates as high as 80% have been reported.¹¹ Reasons for not following suggested treatments vary among individuals but include a lack of information about the disorder, unpleasant side effects, misunderstanding of dosing, and the cost of medicine. Although a significant number of patients do not adhere to treatments, they do not share this information with their optometrist or ophthalmologist. In interviews, more than 90% of patients state that they are following treatment guidelines closely.¹¹ Patients go to great lengths to convince their vision specialist

that they are following treatment, and may increase frequency of medication use immediately before an appointment to maintain the illusion of adherence. The fear of judgment by the vision specialist is considered the primary factor for misrepresentation of these facts. When the vision specialist is misinformed about the use of medication, she may change the dosage or add additional medications which may be harmful. Recent studies indicate “...that even modest changes in doctor-patient communication can significantly improve patients’ understanding of their illness [and] motivation to adhere.”¹¹

Narrative competencies improve the eye care provider’s ability to explain glaucoma in common terms so the patient can understand the impact it has on ocular health as well as more clearly understand dosage instructions. Familiarity with the risks of non-adherence may increase the likelihood that patients would follow their prescribed treatment regimen. Improved listening skills that develop as a result of practicing NM can also increase the physician’s ability to identify the issue of non-adherence.

While ocular disease seems to have the clearest need for NM, the improvements to overall doctor-patient relationships would be beneficial in pediatrics, geriatrics, psychological and environmental related vision problems, low vision, and vision therapy. Many of these patient populations fit into the model for NM. Many of the conditions encountered require multidisciplinary teams, strict treatment regimens, and frequent monitoring and have an emotional impact on the patient and their family. The benefit of building a stronger, more meaningful doctor-patient relationship, however, is a common thread amongst them all.

Both pediatric and geriatric patient care are considered subspecialties. These two patient categories comprise a wide range of different diagnoses and procedures. Pediatric patients are unique because there are actually two parties that need to be satisfied, the child and the parent. Often, children can be very elaborate storytellers, and narrative competencies can help the history taker to grasp better what it is the child is trying to say. Furthermore, some children do not respond well to a long series of questions and may have the tendency to become shy or reclusive. By allowing the child to speak openly, the doctor can avoid creating this barrier. According to Jane D. Kivlin, a pediatric and strabismus ophthalmology specialist, the overall satisfaction of the child is primarily centered on whether the child feels listened to. Kivlin suggests stooping down to the child’s level, and encouraging or rewarding good behavior and willingness to answer questions.¹²

While being able to communicate with the child is important for proper diagnosis and overall patient satisfaction, being able to discuss treatment and diagnoses with the parent is another concern. Some vision problems such as amblyopia or convergence insufficiency in children show few symptoms, and treatments for these problems might not demonstrate noticeable improvements immediately, so explanations of the

types of results to be expected are very important. Kivlin also asserts that “parents are more satisfied and tend to adhere to treatment programs if physicians talk more extensively with the child.”¹² Because some pediatric vision problems may require extensive treatment, a parent’s willingness to follow the treatment regimen is crucial to the overall health of the child. Narrative medicine provides medical professionals the opportunity to improve communication skills and their ability to speak about illness in everyday language. This skill is useful in order to help explain the course of treatment to the parents of pediatric patients.

Kivlin also mentions that “interpersonal sensitivity” was rated as the single most important characteristic that a family doctor should possess.¹² Understanding the life of the patient and parent is important to overall satisfaction and may be best achieved through NM. The parent may also feel a great deal of guilt for symptoms the child is experiencing and often just wants to be acknowledged by the doctor as being a good parent.¹² The divides of shame, blame, and fear play a large role in such a situation. By acknowledging the parent’s fears, the optometrist/ophthalmologist is practicing representation and is more likely to provide a satisfactory visit for both the child and parent.

Geriatric patients have large lists of visual health problems, many of which can result in a loss of vision. As the body ages, the eyes may begin to develop cataracts, glaucoma, macular degeneration, or other issues. The fear of vision loss and the impact on quality of life these vision problems create make effective treatment a priority. The fear of losing one’s vision is a difficult experience, and “...when old age, infirmity, and confusion are added to the mix—coupled with cultural diversity—the level of anxiety is further enhanced.”¹³ Geriatric patients also grew up during a different time, and their cultures can vary immensely from that of some eye care providers. This becomes important when discussing treatment options that the patient must thoroughly understand. Cultural perspective may be easier to discern if the vision specialist understands the entire person, and not just her symptoms.

Aside from language and culture issues, communication itself can be a challenge. Hearing, enunciation problems, and dementia can make conversations difficult for the geriatric patient. Rather than asking brief questions or discussing information with family members, NM suggests taking the time to let the patient speak. A great deal of patience must be employed by the vision specialist to overcome these difficulties and allow the patient to feel talked to and not talked about. Especially in cases where family members accompany the patient, making the individual feel as if he is respected and recognized is important. Geriatric patients must be addressed not as children, but as respected adults. These patients know a great deal about their bodies, and while “health professionals are experts on specific illnesses, patients are experts on their own lives.”¹³

These individuals may be suffering from numerous illnesses and seeing several different health care professionals. Opening the lines of communication via NM will ultimately provide the geriatric patient with a greater sense of presence in front of the eye care provider, as well as a clearer understanding of diagnoses and treatment options. Communication with the family members involved may also be improved.

Psychological factors have the ability to influence vision as well. Seymour and Martson provide two examples of traumatic events and stress that were linked to visual health problems. In one example, after a shocking death of a family member, a woman began to have problems with distance vision. The second case involved a woman who, as a child, developed myopia after witnessing a traumatic event. Both patients suffered vision problems for a considerable length of time as a result of not dealing emotionally with these traumatic events. In both cases, addressing the psychological influences improved visual health.¹⁴

In our survey of optometrists and ophthalmologists, one participant wrote that stress is one of the most important psychological factors that impacts the health of the eye. Autism and schizophrenia also have ocular components, according to the National Eye Institute and The University of Illinois Center for Cognitive Medicine.^{15,16} Each of these disorders has unique eye movement patterns associated with them related to the circuitry of the brain. There is a possibility that the movement patterns could be used to diagnose these disorders objectively.¹⁶ While these disorders affect the eye, they primarily impact the everyday life of the patient. Awareness of these conditions helps eye care providers better to understand the context of the vision problems these patients face and ultimately create tailored treatment regimens. As our patient survey indicated, many patients are not discussing this information, especially if they have not been formally diagnosed. In the cases of the two women discussed by Seymour and Marston, ignoring psychological factors impacted vision health. Even if acknowledging the impact of these disorders does not directly impact the health of the visual system, it will give the vision specialist a greater understanding of the patient as a whole.

The environment in which one lives impacts the overall health of the entire body, including the eyes. From exposure to pollution to work environment, there are a number of environmental factors that cause issues in visual health. For example, pollution can increase the risk for ocular surface disorders including redness, irritation, and lacrimation.¹⁷ Climate has also been linked to dry eye. Work environment can greatly impact visual health. Computer vision syndrome is increasing in prevalence as computers, smart phones, and E-readers (e.g., Kindle) become more commonplace. Computer vision syndrome impacts 75-90% of workers who use computers on a daily basis. The symptoms include eye strain, asthenopia, irritation, blurred vision, and headaches.¹⁸ Lighting and posture are causative to the symptom levels, but these issues can be minimized. By using NM, optometrists

and ophthalmologists are more likely to discern this type of information and may be able to provide suggestions to decrease symptoms.

Blindness, or low levels of vision, impacts every aspect of life. In *Touching the Rock*, John Hull details his loss of vision over 36 years and the impact it had on his life.¹⁹ The book was written as a way for Hull to come to terms with his blindness. During the early years of his vision loss, he visited many different general practitioners, optometrists, and ophthalmologists, and underwent numerous surgeries in an attempt to remove his cataracts and repair his detached retina. At one point, Hull was forced to write a letter explaining his frustration with his circumstances in order to convince a vision specialist to see him.¹⁹ The specialist initially could not find a reason for the black discs that appeared in his vision and refused to see him for further examinations. As a result, his condition progressed to the point that he needed immediate surgery, which was only partially successful. The inability of the specialist to determine what was wrong may have instilled a sense of guilt, and out of fear, the vision specialist may have refrained from seeing Hull. If the team of medical providers practiced NM, they would have worked together more cooperatively to improve his care. This could have possibly postponed his vision loss, although according to Hull, blindness was inevitable.

If Hull's eye care providers had been practicing NM, they might also have been more aware of the emotional struggles he encountered. From appetite, to sexual desire, to playing with his children, everything was affected by his vision loss. Hull wrote many times about his feelings of loneliness and sense of being talked about instead of talked to. A vision specialist practicing NM would have made Hull feel acknowledged, and perhaps acted as a resource for him to discuss the challenges he faced in his loss of vision.

Vision therapy may also benefit from the use of NM. Some children who undergo vision therapy are diagnosed with learning related vision problems. Helping the children cope with the social stigmas attached to learning problems is important to build self-esteem and confidence in academics. The divides of shame, blame, and fear can be prevalent when children are ashamed of their academic struggles, and patients may blame the vision specialists if the results are not immediate or as efficacious as hoped. Narrative competencies would also help the optometrist or ophthalmologist better understand the child and communicate more effectively with the parent and child.

Vision therapy may be used for adults suffering from acquired brain injury. In brain injury rehabilitation, a wide variety of medical providers may treat the totality of patient symptoms. Communication within this team is important to ensure that the patient receives the best treatment possible. Brain damage due to injury or stroke can cause not only emotional problems, but also problems with speech and motor skills, which impact quality of life. Vision specialists

practicing NM are more attuned to the emotional struggle patients might face, and may serve to comfort them. Understanding the impact on activities of daily living also helps in developing strategies to increase functionality while the patient regains his faculties.

Conclusion

Narrative medicine has the potential to impact the quality of care offered by optometrists and ophthalmologists. By paying greater attention to patients and better understanding the uniqueness of the patients' lives, doctors can improve communication with their patients. Humans are social creatures by nature; communication serves as a foundation to our existence. Regardless of other possible benefits of NM, the ability to improve communication skills is worth the effort and time involved in teaching and practicing it.

Even if vision specialists do not regularly integrate the techniques into daily practice, the opportunity to use narrative competencies to develop communication skills should be offered as an option in optometry and ophthalmology curricula. Sending optometry and ophthalmology students into clinical rotations and residencies without proper training in listening and verbal communication may be deemed as irresponsible. It is the job of these post-secondary institutions to produce caring, compassionate, and competent eye care providers. An elective or extracurricular club in NM should be offered to students as a way to improve patient care.

Nearly 90% of vision specialists surveyed in this study are open to trying new techniques for increasing communication skills. As NM has been applied differently across the healthcare system, it will have a unique format for optometry and ophthalmology. Narrative medicine is adaptable to many scenarios. It allows for different types of clinicians, as well as doctors and patients, to be brought together, planting the seeds for stronger, more meaningful relationships.

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ANNOUNCING: 2013 COVD AWARD RECIPIENTS

The COVD Board of Directors is honored to announce this year's award recipients. Awards will be presented at the Awards Luncheon during the COVD 43rd Annual Meeting in Orlando, Florida, this October. Please join us in congratulating the following individuals:

A.M. Skeffington Award: Kelly Frantz, OD, FCOVD

G.N. Getman Award: Ron Bateman, OD, FCOVD

COVT of the Year Award: Robert Nurisio, COVT

President's Award: To Be Announced

OVD Journal 2012 Article of the Year: *Considerations of Informed Consent by Proxy in Pediatric Optometry*. *Optom Vis Dev* 2012;43(2):60-66.

Paul Abplanalp, PhD, OD; Richard T. Hull, PhD

Announcing the awards in advance, allows awardees the opportunity to invite their family and friends to attend the luncheon and also allows us to issue a press release prior to the annual meeting.

2014 Call for Courses

COVD is soliciting proposals for general education presentations for the 44th Annual Meeting. Any person wishing to make a presentation is invited to submit a proposal. More information is available at www.covd.org or contact Jackie Cencer at jcencer@covd.org.

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