Chapter

2 Narrative Perspectives on Medicine

One of the main objectives of this book is to extend the traditional remit of narrative medicine beyond the confines of bedside manner and the individual level of medical practice, which have historically defined its role, by demonstrating its potential to enhance medical knowledge translation. In challenging the dichotomy of art versus science that narrative medicine feeds into, we aim to demonstrate that a revised and extended version of narrative medicine can serve a broader and more integrative function, opening novel avenues for understanding and applying medical knowledge. We attempt to bring together the two parts of the story (the story of science and the story of the patient embedded in a specific cultural and narrative environment) and propose productive means by which this long-standing and unhelpful dichotomy may be resolved.

We begin by offering a critique of narrative medicine based on broader conceptualisations of narrativity across various disciplines, including medicine and the medical humanities.

2.1 Defining Narratives

Definitions of narrative vary considerably across disciplines, as well as within the same discipline. At one extreme, narrative is understood as a fully articulated story with a recognisable beginning, middle, and end, and with human or human-like protagonists who are cast by a human narrator into a set of relationships among themselves and between them and the developing storyline. These fully articulated stories are realised in the form of a written or spoken text: a 'specific form of primarily linguistic expression' (Woods 2011:75). A narrative in this conceptualisation is a bounded, discrete unit of meaning expressed by verbal means.

At the other extreme, narrative is understood as 'the primary mode of being in the world', meaning that 'we instinctively and pre-reflectively embed any experience within a story or the set of stories that constitute our world in order to make sense of it' (Engebretsen and Baker 2022:10–11). In this alternative and broader conceptualisation, to which we subscribe, narrating is understood in the first instance as a sense-making mechanism, our primary interface with the world, and only secondarily as a process that often produces bounded units of meaning expressed by verbal or other means. Narrating, in this view, is a continuous and often pre-reflective process through which human beings generate meaning from the flux of lived experience. It functions as an ever-present structuring force, allowing us to connect past events, interpret present circumstances, and envision possible futures, thereby giving shape

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and meaning to our existence. It is because human beings are self-interpreting by nature that weaving narratives out of everything they experience is 'inherent to their cultural way of being' (Brockmeier and Meretoja 2014:5), leading many scholars to assert that 'the human animal's primary mode of epistemology is narrative' (Walker 2005:44). But narrative is not just an epistemology; it is also an ontology, a way of being in the world. We are born into a storied world, a world already constituted by narratives, such that 'the human self' has to be seen as 'the product of a narrative way of being' (Thiele 2005). Narrative, as Barthes argues, is 'simply there, like life itself' (1977:80).

Importantly, the narratives we entertain or tell as we grapple with interpreting ourselves and the world around us need not be coherent, consistent, or durable. They are often hesitant, contradictory, speculative, and necessarily adapted in interaction with others and with new experiences. A story need not follow the classic linear timeline or a tight plot logic to make sense. Non-linear, cyclical, associative, and fragmented patterns of organising experience are all narrative modes inasmuch as they serve to *configure* events into a (loosely) meaningful whole. This understanding of narrative allows us to engage with diverse storytelling traditions and cognitive styles well beyond modern Western expectations of strict chronology or unified plot. Narratives also need not be truthful: we often lie even to ourselves. Nor do they need to be well-meaning or charitable. Narration is an open-ended process in which we all engage continually – to make sense of ourselves; others; textual, visual, and sensory material; natural phenomena; and the activities in which we engage, including scientific activities. And to manipulate others, innocently or deliberately, to ensure they invest in and commit to our version of events. Narrative analysis must therefore be approached critically, without assuming that narratives are inherently benign or empowering. We return to this issue later in our critique of narrative medicine's treatment of narratives in the clinical encounter.

The claim, then, is not that everything we experience comes to us already constituted in narrative form, linguistic or otherwise, but rather that 'our minds construct narratives out of various types of input in order to comprehend and make sense of the world' and to be able to act in it (Baker 2018:180), and these narratives are constantly subject to revision. Applying this understanding of narrativity in the field of science, including medicine, means that scientists elaborate narratives for themselves and others continually, throughout all phases of research and practice, rather than merely exchanging them with patients during the clinical encounter. All scientific activity is shaped by what Hajek calls 'narrative reasoning', which involves cognitive processes that lead to 'story-like representations constructed in the mind/imagination of scientist–readers as they undertake some scientific activity (reading mathematical proofs, interpreting diagrams, framing their field)' (Hajek 2022:35).

Morgan (2022:4) suggests that narrative has three functions for scientists:

> Narrative-making operates as a means of making sense of their puzzling phenomena; it provides a means of representing that scientific knowledge; and it provides resources for reasoning about those phenomena. These three functions are related: it is because scientists often make sense of their world by making narratives that they then use those narratives to represent what they believe they know, and thence to reason with them.

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Narration is not merely a means by which scientists, including medical researchers, represent the knowledge they gain from various activities after the fact so to speak, but rather a continuous process of sense-making in which they engage before, during, and after they embark on a particular study or converse with a specific patient. As with all human experience, this process does not necessarily lead to clear cut or stable understandings – hence the growing calls for acknowledging uncertainty in medicine and healthcare (Han 2021) and the idea of paradigm shifts in all scientific domains (Kuhn 1962). Indeed, the increased interest in narrative in the domain of science may in part be a reflection of this growing acknowledgement of uncertainty, for as Prince (1999:45) suggests, 'One says "narrative" instead of "explanation" or "argumentation" (because it is more tentative); one prefers "narrative" to "theory," "hypothesis," or "evidence" (because it is less scientistic); one speaks of a "narrative" rather than "ideology" (because it is less judgmental); one substitutes "narrative" for "message" (because it is more indeterminate).'

To reiterate, we are drawing a distinction in this book between two ways of understanding narrative. The first is to understand it as an intuitive process in which our minds engage as we attempt to make sense of the world around us, 'a basic strategy for human understanding that links automatic, unconscious phenomena such as how we delimit experiences in the world to higher order thinking processes, such as the elusive search for personal meaning' (B. Miller 2023:7; see also Hajek 2022:53). These processes involve what Miller calls 'weak narrativity' (2023:5) – narrativity that emerges 'in the apprehension of events, prior to conscious intention to construct a narrative' (2023:33). We have no way of accessing this process in order to analyse it, but cognitive scientists often speculate about how it unfolds and what it involves. The second way of understanding narrative is as a concrete, shared product – a spoken or written text, graffiti, a photograph, or a series of photographs embedded in a textual product such as a World Health Organization (WHO) report, an opera, or a musical that combines a variety of modes of expression. In this second sense, narratives are amenable to being analysed using a range of criteria that are typically deployed by narratologists to delimit narratives (understood as genres) from other types of textual products. Rather than engaging in this exercise of defining whether a given text is or is not a narrative, or the extent to which it satisfies a set of conditions to qualify as a narrative, we draw on some of the criteria discussed in the literature later in this chapter in order to understand how specific dimensions of narrativity, such as temporal or spatial configuration, are deployed to construct a given narrative and with what implications. In other words, we focus on the process of narrativisation – 'the active process of narrative-making' (Hajek 2022:33) – and its implications, rather than the theoretical exercise of delimiting narrative from non-narrative text. For a fuzzy-set definition of narrative, or 'conditions of narrativity', see Ryan (2007).

While we subscribe to the understanding of narrative as a pre-reflective, intuitive process of sense-making rather than as a bounded textual product, then such processes, as we have already noted, are not directly amenable to analysis. Our empirical work therefore proceeds by examining written and other material texts not as narratives in a narrow or self-contained sense but as sites where underlying processes of narrativisation become partially stabilised, negotiated, and rendered

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visible. In this perspective, texts function as traces or sedimentations of broader narrative sense-making practices that unfold across institutions, interpretive communities, and time, rather than as discrete stories with fixed boundaries. Analysing guidelines, reviews, policy documents, and related texts thus allows us to reconstruct how diffuse narrative logics shape the translation, circulation, and authority of medical knowledge, without reducing narrativity itself to the level of individual texts.

As concrete, shared products rather than elements in a cognitive process of sense-making, narratives can be diffuse and scattered across numerous texts rather than discrete and confined to one text. It is this conceptualisation of narratives as diffuse that allows us to talk about 'the master narrative of race as a biological reality' (Cusanno 2019:14) or 'sociopolitical narratives of health . . . grounded in economic interest' (Brooks and Blanchette 2021:1). The assumption that narratives are not confined to single discrete texts also allows scholars such as Engelmann (2022:280) to talk about a narrative emerging out of a series of outbreak reports on the third plague pandemic published between 1894 and 1904. Taken together, Engelmann argues, these reports elaborate an emerging narrative within medical and colonial reporting practices at the time of outbreaks as 'more than just a multiplication of individual cases, more than just a result of social and environmental conditions and more than just the workings of a pathogen' (2022:289). Similarly, narratives can be woven out of many fragments and increasingly are, as is evident in our ability to interact on social media and to make sense out of an endless flood of short, seemingly unrelated posts (Sadler 2022). This broader understanding of narrative means that we need to develop critical tools that can explain how 'interpretive communities' are able to make sense of such fragments 'in a postmodern world' (Ehrenhaus 1993:79) and how they can weave together a larger narrative from an open-ended repertoire of individual, discrete narratives, whether these narratives are elaborated in literature, film, dance, pie charts, or scientific treatises. We attempt to put together such a critical toolkit at the end of this chapter and apply it to a number of case studies in Chapters 4, 5, and 6.

This understanding of narrative as a story that can be pieced together from diverse sources or from seemingly unrelated and atomised fragments, and that involves multiple and open-ended acts of interpretation, is central to medical research and practice. It is also key to understanding the consequences of narrating a particular medical phenomenon over a long period of time, and across many textual and visual products. For example, Charters and Heitman (2021:15) explain that reporting on epidemics such as the plague in Western Europe tends to focus on its end as the point at which the number of cases return to 'normal' levels of disease in 'ordinary times'. The focus on remission encourages an optimistic view of disease as something humans can conquer, or at least control, whereas

> if narratives of an epidemic's end focused not on human agency but on the role of ecology, climate, and even chance, and if they were written from a non-European perspective – perhaps even a non-human perspective – what might emerge is a continuous cycle of disease: a world that has continuously lived with plague, adapting to its movements, rather than a linear narrative of outbreak, increase, decline, and end of epidemics. (2021:217)

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Likewise, the focus of the Human Genome Diversity Project on 'sampling and mapping the DNA sequences of diverse population groups' inevitably activated in the minds of many the narrative of race as a biological category, leading some, including Indigenous groups, to label it as 'the vampire project' (McCann-Mortimer et al. 2004:412). The 'race as biological category' narrative was widely taken for granted by scientists at least up to the middle of the twentieth century and continues to remerge, for example, in the form of genetic essentialism in at least some of the literature on precision medicine. This is again a narrative that is pieced together from many texts and interactions, rather than a single discrete text. In the typology of narratives we outline later in this chapter, it is a 'metanarrative' – a narrative that persists over very long periods of time and cuts across many social spaces and contexts, and that cannot be pinned down to a specific set of texts, although we can identify key texts and narrators who have played a major role in perpetuating or challenging it at different times in history.

Scholars of medicine and the medical humanities, including those in the field of narrative medicine, tend to focus overwhelmingly on narrative as a genre, a particular type of text, a discrete linguistic performance that provides the clinician with unique access to the subjective experience of illness. Much of the criticism directed at the use of narrative in these fields addresses the limitations of this specific concept of narrative and fails to engage with the wider understandings of narrativity discussed here. Woods (2011:2), for example, critiques what she suggests is an over-emphasis on narrative in the field on the basis that it promotes a narrative of the patient as an atomised subject: 'a specific model of the self – as an agentic, authentic, autonomous storyteller; as someone with unique insight into an essentially private and emotionally rich inner world; as someone who possesses a drive for storytelling, and whose stories reflect and (re)affirm a sense of enduring, individual identity'. This image of the self, Woods suggests, conforms to and promotes 'Western middle-class, liberal and neo-liberal modes of being' (2011:4.) – a critique we endorse but one that is limited in its reduction of narrative to a particular type of linguistic performance. A similar limitation underpins her argument (against narrative) that 'language is not the only medium for communicating matters of medicine, health and illness' (2011:4). Like McKechnie (2014:120), we would argue that 'narrative is so fundamental to meaning-making that it is not just required, it is an inherent human response to creative outputs we encounter', and hence we propose that the three forms of expression Woods defines as 'non-narrative' alternatives – metaphor, phenomenology and photography – can themselves only be processed and understood by the human mind as narratives. Even statistical charts of cases of an epidemic that have become particularly familiar during COVID-19 'provide an underlying temporal framework that mirrors . . . [a] linear narrative of origin, climax, and drift to closure' (Charters and Heitman 2021:213).

This is not to say that we cannot draw a useful distinction between the genre of narrative as a linguistic artefact and other forms of expression in terms of efficacy or emotional appeal, for example. We can do this productively without losing sight of the broader understanding of narrativity outlined previously. Hence, for example, we can endorse Ostherr's call for bridging the divide between data and narrative by supplementing forms of quantitative data visualisation such as graphs with 'raw,

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emotional and deeply personal stories' in the context of public communication about COVID-19 (2023:532, 530). At the same time, we can argue that graphs and other visualisations tell their own stories, using different means of expression. They are narratives in their own right and can be analysed in terms of established dimensions of narrativity such as temporal and spatial configuration. We see no contradiction between assessing their efficacy as a particular means of expression, their 'storytelling abilities' (Ryan 2007:26), and highlighting their status as narratives in the wider sense of narrativity we adopt in this book and in earlier work (Baker 2006/2019; Engebretsen and Baker 2022).

On the whole, we follow Brockmeier and Meretoja (2014:15) in stressing that 'narrative is woven into the fabric of life in a variety of ways. It is not found, nor is it imposed, nor is it the result of a representation; rather it is created through practices of meaning construction' that permeate every aspect of our experience of life.

2.2 Narrative Medicine

Narrative medicine has typically emphasised the humanistic and cultural dimensions of healthcare, largely focusing on the individual patient's experience within their specific cultural and narrative context (Solomon 2015). While acknowledging that 'medicine has always been saturated with narrative knowledge' (Hurwitz and Charon 2013:1886), it has overwhelmingly focused on the singular experience of the patient and clinician and on the individual act of storytelling rather than the narrative underpinnings of medical practice and research as a whole. Indeed, in her earlier work, Charon (2006:9) made a clear distinction between narrative knowledge and non-narrative knowledge, stating that 'non-narrative knowledge attempts to illuminate the universal by transcending the particular; narrative knowledge, by looking closely at individual human beings grappling with the conditions of life, attempts to illuminate the universals of the human condition by revealing the particular'. This would lead one to assume that scientific theories and lab reports, for example, are not ultimately forms of narration, and that only stories such as those exchanged between the clinician and patient count as narratives. The limitations of the distinction Charon draws here between narrative and non-narrative knowledge, however, must be understood against the backdrop of the emergence of narrative medicine as corrective to the dominance of universals in the field. By foregrounding the particular and lived experience, narrative medicine positioned itself in opposition to the abstracting tendencies of biomedical science, which often sought generalisable truths at the expense of individual experience. Yet this framing has also had the effect of reinforcing a dichotomy between narrative and non-narrative forms of knowledge, leaving less room for recognising that scientific theories, clinical protocols, and even laboratory reports are themselves shaped by narrative structures – that they embed assumptions about time, causality, agency, and meaning.

Even within this already restricted conceptualisation of narrative, narrative acts and narrative engagement are conceptualised as primarily occurring in the context of person-to-person interaction rather than potentially involving several interlocutors: 'Like narrative acts, clinical practice requires the engagement of one person with another person and realizes that authentic engagement is transformative for all

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participants' (Charon 2006:11). There is no mention here, or elsewhere, of potential mediation by another person (such as an interpreter) and the politics that brings about, nor of potential multiple, possibly conflictual, interactions in the same space – for instance when more than one consultant is present and actively involved in the diagnosis or when the patient is accompanied by family members (Charon 2006:140):

> While one person attends, the other represents, and while one person represents, the other attends. These are reciprocal and collaborative processes – no attention without representation, no representation without attention – that embroil attender and representer in situations of penetration, surrender, and mutual need and trust. And, of course, he or she who attends one moment will represent the next, making intersecting spirals within self and between self and other.

To date, the vast majority of studies that draw on narrative medicine in a diverse range of areas adopt this narrow understanding of narrative as an individual act of storytelling and story-listening involving a patient and a clinician (Camden et al. 2020; Slocum and Villano 2021; Huang et al. 2022; Chiang 2023), with practically no attention accorded to the institutional narratives of medicine and policy-making. Narrative medicine's mission, as outlined on the Division of Narrative Medicine's Columbia University web page, continues to reinforce this impression, stressing that it has developed 'to equip clinicians to better comprehend their patients' experiences and perspectives so as to deliver equitable and effective healthcare'.[1] Charon (2006:141) does treat hospital charts and private office records as narratives, claiming, for instance, that her 'drill' for reading texts (frame, form, time, plot, and desire) 'is effective whether the text is a short story, a novel, a scientific paper, a hospital chart progress note, or an entry written by a medical student in a Parallel Chart' (2006:114). But these are again narratives produced by either one individual or a small number of known individuals in the case of hospital charts. There is no attempt to engage with institutional narratives or policy documents that cannot be ascribed to a given individual or individuals, for instance. This may be a natural reaction to the epidemiological paradigm's emphasis on suppressing subjectivity and focusing on the aggregate analysis of many documents/studies undertaken by large teams of people, in which patients do not normally feature in any meaningful way in the narrative and even the narrators (those who wrote the relevant records) are effaced.

The emphasis on one-to-one clinical encounters, then, is overwhelming, despite the fact that Charon very occasionally espouses a different view of narrative in medicine that is more in line with our broader understanding of it:

> Our project recognises the narrative features of all data and the evidentiary status of all clinical text. The skilled clinician does not first collect and deploy evidence and then soften it up with narrative; rather he or she is always already embarked on grounded, rigorous, personal, particular, and perilous interpretations that, like any hypotheses, can be tested for trustworthiness and utility. (Charon and Wyer 2008:297)

Narrative medicine's restricted understanding of what counts as narrative may be partly explained by its heavy literary bias. Charon draws extensively on classical

[1] www.mhe.cuimc.columbia.edu/division-narrative-medicine (accessed 15 January 2026).

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narratology, predominantly citing sources such as Genette and Rimon-Kennan, in defining narrative. And yet it must be acknowledged that even within the restricted realm of literature, postmodern narratologists such as Mark Currie have long adopted a much broader definition of narrative within a paradigm of socio-narratology, arguing that narrative is 'as inescapable as language in general, or as cause and effect, as a mode of thinking and being' (Currie 2011:6). Thus culture, for instance, 'not only contains narratives but is contained by narrative in the sense that the idea of culture, in general or in particular, is a narrative' (Currie 2011:6). This strand of narratology seems to have had limited impact on narrative medicine's understanding of narrativity.

Even within the confines of classical narratology, narrative medicine is not consistent in its theorising of narratives, an inconsistency we welcome insofar as it leaves some room for us to adapt narrative medicine to our purposes in this book. In many places, Charon (following Genette and other classical narratologists) distinguishes between the 'story' (*histoire*) and 'discourse' (*récit*) as a representation of that story, a particular telling of it (Charon 2006, 2016b). In other instances, she seems to suggest that tellings construct rather than represent some reality or abstract story that exists independently of the telling: 'The telling does not merely expose or report that which exists prior to the narrating. It produces it' (2006:45). If tellings construct or produce rather than represent some reality as perceived by the teller at a particular point in time, it follows that no story as such can be separated from a given telling or series of tellings. As O'Neill rightly points out (1994:36), 'any attempt to isolate the story from its discourse simply results in another *telling* of the story. All we can ever do . . . other than theoretically, is *paraphrase*, *re*-tell, provide another discourse'. In line with this more constructivist understanding of narrative, to which Charon herself subscribes in various publications, we will not be adopting the distinction between *histoire* and *récit,* or story and discourse, in this book.

A further criticism levelled at narrative medicine is that it instrumentalises patient narratives and uses them to gain 'informational capital' within a power dynamic that it does not acknowledge (Neilson 2023:747). In her study of addiction and stigma, Ally Day (2021) argues that narrative medicine has been incorporated into a political economy that commodifies patient narratives. Day notes that academic programmes often ask patients to disclose intimate experiences so that practitioners can craft publications and derive cultural capital, thereby reinscribing class, race, and privilege hierarchies into the encounter. As a result, Day argues, 'deploying narrative expertise within neoliberal medical practices can harm individual patients and strengthen the very systems of oppression that programs in the medical humanities seek to destabilize' (2021:89). This unacknowledged power dynamic, including the relationship between settler medicine and Indigenous cultures in countries such as Canada and Charon's own US, is obscured by what appears to be a highly charitable, romantic construction of both patient and clinician, and by an uncritical view of narrative as inherently good, inherently empowering and therapeutic, thus failing to acknowledge that narratives are also told to obfuscate and do harm. As Woods has argued, Arthur Frank provides another emblematic example of this orientation in *The Wounded Storyteller*. His work advances the idea that narrative self-expression is '*fundamentally healthy and desirable*' (Woods 2011:75; emphasis in original), casting

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the ill person as a 'narrative wreck' (Frank 1995:54) whose healing depends upon reclaiming their story. For Woods, this framework risks valorising narrative coherence while downplaying the various ways in which stories can obscure, exclude, or even harm.

Even if we adopt narrative medicine's restricted approach to narrative as a genre and a discrete verbal encounter in a clinical context, we cannot assume that a patient's – or indeed a clinician's – narrative is innocent, truthful, and seeks to do no harm. There is no justification for treating these stories as necessarily benign, when research has shown that both patients and clinicians lie. Patients may lie 'to avoid negative consequences, to achieve secondary gain (eg, to obtain medication or disability payments), out of embarrassment or shame, or to present themselves in a better light', while doctors have been known to lie 'to respond to intense competitive pressures' or 'to displace culpability for poor outcomes' (Palmieri and Stern 2009:165, 166; see also Sokol 2016; Alpert 2021). Indeed, we all lie in a broader sense of the word when we tell or retell narratives: we omit, embellish, or downplay aspects of the story in order to gain the sympathy or admiration of our listeners, for example, and these 'alterations and distortions are sometimes then incorporated into the teller's own memories of the events' (Misak 2008:617).

This does not make personal narratives unreliable as a source of information and a means of connecting with the patient in productive ways – any more than it makes the narratives that emerge from the laboratory report or a policy review unreliable. It simply means that we cannot uncritically treat personal narratives, including those of patients, as a source of authenticity (Atkinson 2009). Within the broader medical humanities, a number of critics have proposed alternative hermeneutic strategies that explicitly resist narrative medicine's inclination towards closure, coherence, or redemptive arcs, while foregrounding how stories are shaped, constrained, and occasionally co-opted. Garden (2015) calls for attention to the retrospective editing and imposition of recovery tropes in illness and disability narratives, arguing for *articulation* rather than representation – a practice that acknowledges the critic's own positionality and cultivates epistemic humility in the face of complex, discontinuous subjectivities. Kumagai and Wear (2014) propose a pedagogy of 'making strange', derived from Shklovsky and Brecht, in which clinicians and learners are invited to trouble their assumptions, dwell in discomfort, and resist the drive toward empathic or narrative closure. In practice, this means resisting the seductive pull of a romantic, celebratory view of illness narratives and refusing to cast the patient, clinician, or both as heroes in a story of redemption. Instead, we should approach all narratives critically, acknowledging that no narrative reflects the world or an experience as is, without alteration, whether these alterations are introduced consciously or otherwise, responsibly or irresponsibly, by the narrator. On the whole, we would agree with Atkinson (2009) that we need to free the study of illness narratives 'from the implicit assumption that there is something intrinsically "good" about [them] – that they capture experience, that they embody resistance to medical authority, or that they furnish access to an enhanced and more humane form of medicine'.

Beyond the immediate clinical encounter, Charon's claims for the power of narrative medicine to bring together and create an idealistic community of clinicians

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similarly seem somewhat romantic, somewhat impervious to the politics of medical practice and the politics of narration in general (Charon 2006:225, 232–233):

> At the same time that individual health care professionals developed insight into their practice and strengthened specific skills of attention and representation, we also found ourselves growing in honesty, altruism, collegiality, and duty, the hallmarks of health care professionalism.
>
> There is a great deal at stake in the affiliative movements of narrative medicine. Because these affiliations take place within the spheres of illness and mortality, the actions our communities take together ... imprint the communities thereby created with traces of conscience, with declarations of values, with aspects of justice.

Similarly, Charon's description of and advocacy for the various programmes she led and implemented in several sites highlights only their successes rather than analysing both their strengths and limitations realistically and critically. The picture that emerges from the discussion of these programmes and documented encounters is somewhat too good to be true, too sanitised to reflect the messy, conflictual, and contested space of narration. We recognise that the aims of narrative medicine are laudable, and its practice is likely to lead to positive outcomes much of the time. But both its theorisation and practice need to be supplemented with a more critical and realistic approach to narratives 'as contested terrains' (Harter 2009:145), as much recent critique of its assumptions and methods has pointed out.

A further, important critique of narrative medicine is that despite its original emphasis on countering the biomedicalisation of clinical practice through a more humane practice, with time it gradually became 'subject to the same scientising, hegemonic forces it tried to mitigate', insisting on repeated, quantifiable, demonstrable outcomes 'leading to the publication of paper after paper that accumulate as part of a substantiation project' (Neilson 2023:742; see also Neilson 2022). By 2013, Charon was feeling the need to justify – in explicit biomedical terms – a study by Goupy and colleagues (2013) undertaken to assess the reception by students of an elective in narrative medicine offered at Paris Descartes Medical School:

> The study is well conceived and designed to achieve the goal of initiating a purposeful tracking of an emergent phenomenon at this medical school. Although this is not a randomized control trial, although there is selection bias among study students who chose to study narrative medicine, and although it is cross-sectional and not longitudinal, it is, by necessity, where one starts in systematically and seriously studying one's pedagogic practice. (Charon 2013:4–5)

The uninterrogated, implicit assumption here is that randomised controlled trials (RCTs) are the gold standard of medicine (as well as other fields like education) and that they do not suffer from selection bias. This is a surprising position to take for a scholar who works so extensively with narrative and attempts to deploy it to question received wisdom in the field. First, it positions all studies as necessarily inferior to RCTs, and in so doing leaves itself open to a similar criticism directed at the medical humanities: it reduces itself to 'a soft, "subjective" and cultural supplement to a stable body of "objective", biomedical and scientific knowledge' (Kristeva et al. 2018:55). And second, it assumes that RCTs are totally transparent and

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objective, occluding their inescapable subjective dimension and the fact that they are conceived, designed, conducted, and reported by human beings as 'narrative animals, . . . tellers and interpreters of narrative' (Currie 1998/2011:4). But research has shown that RCTs are far from objective: even the 10 most cited RCTs worldwide examined by Krauss in 2018 were found to withhold important information, such as how the centres from which patient records were consulted to recruit a representative sample for the study were selected, their quality or diversity, and the kind of patients they typically treated, among other important dimensions (Krauss 2018:314). Understanding RCTs as forms of narration allows us to appreciate that this pattern of 'selective appropriation' is not a weakness that studies can be corrected for fully, because it is a feature of all attempts at narration (Somers and Gibson 1994; Baker 2019), as we discuss in more detail later in this chapter. Similarly, as Krauss explains, 'a correlational or causal claim about the outcome is for many trials a function of when a researcher chooses to collect baseline and endline data points and thus assesses one average outcome instead of another' (2018:317). Temporal plotting is a feature of all trials and reveals another inescapable aspect of their inherent narrativity, but Charon clearly does not conceive of RCTs as narratives, despite her claim that 'there is little in the practice of medicine that does not have narrative features; in fact, medicine is a more narratively inflected enterprise than it realizes' (Charon 2006:39).

In other instances, narrative medicine has sought to justify itself by associating its methods with those of biomedicine, emphasising clinical utility and presenting narratives as 'part of the medico-scientific toolkit' (Spencer 2023:313). By 2016, Charon was explicitly claiming that its signature method, close reading, 'has become narrative medicine's laboratory and training ground' (Charon 2016a:158). Spencer (2023:314) explains that this methodological emphasis is 'strategic and utilitarian', a necessary concession to gain access to 'the closely guarded gates of the medical school curriculum'. He further maintains that the tension between method and hermeneutics in narrative medicine is helpful because it sheds light on the workings of both epistemological paradigms – it 'evinces the contrast and exposes it to the citizens of the Fortress of Biomedicine'. Others have argued that it begs the question of whether narrative medicine can mount a genuine challenge to biomedicine's impersonal framework while operating 'from within the epistemology of biomedicine itself' (Neilson 2022:2). Ultimately, we believe, narrative medicine's growing investment in biomedicine's claim to scientific rigour, including the insistence on quantification and demonstrable outcomes (Neilson 2023:742), undercuts its ability (and willingness) to critique its methods and theoretical assumptions along the lines proposed here. The unintended outcome is 'a fortification of biomedicine, not a correction or rebalancing of medical practice' (Neilson 2022:4).

2.3 Attention, Representation, Affiliation

Narrative medicine's conceptual framework, defined by Charon (2006) as its three movements, consists of three elements: attention, representation, and affiliation. **Attention** emphasises the ethical importance of fully acknowledging and absorbing

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patients' experiences and is defined as 'the state of availability of one person to the other, a donation of one's single-minded concentration and focus to the needs of the other' (Charon 2013:4). This process is akin to close reading of a literary work, and indeed training in close reading is seen as central to developing narrative competence, the assumption being that 'good readers make good doctors' (Charon 2006:113). In the clinical encounter, attention requires 'emptying the self and ... accepting the patient's perspectives and stance' in order for the clinician 'to be filled with the patient's own particular suffering, thereby getting to glimpse the sufferer's needs and desires, as it were, from the inside' (Charon 2006:134).

Attention is something the clinician 'donates' to the patient. It is a '*donation* of one's single-minded concentration and focus to the needs of the other' (Charon 2013:4; emphasis added). Recalling an earlier experience as an intern taking care of an elderly patient, Charon reflects: 'I did not know, then, that there is no limit to what one can give as a doctor. I did not know that I was allowed, as a doctor, to *donate* my presence, my attention, my regard' (2006:34; emphasis added). A clinician in this narrative 'donates' his or her attention in much the same way as one might spare a few pounds for Save the Children or Cancer Research. It is an act of charity that is transformative for only one party: the receiver. This positioning of the clinician vis-à-vis the patient provides some support for Neilson's (2022, 2023) critique of narrative medicine as embedded in a Western, hierarchical logic that entrenches existing power imbalances in medical settings: it inadvertently casts the receiver, in this case the patient, as someone suffering from some kind of deficit, and the giver (the clinician) as the party with the knowledge and power to alleviate this suffering without being transformed by it. We return to this issue with a discussion of DasGupta's concept of narrative humility at the end of this chapter.

We do not believe that this is the intention of Charon and her colleagues, and indeed much of the literature on narrative medicine stresses the clinician's obligation to bear witness to the patient's suffering and describes, or at least aspires to, a reciprocal relation through which the clinician is as impacted by the encounter as the patient (Charon 2006:151):

> We live through victories and defeats with our patients; we are moved by these events as they happen; we incur ethical duties toward them; and we become different people ourselves because of them. By attending to them and by representing them, we incorporate ourselves into them, becoming through mimesis not only observers but participants in an infinitely complex and generative world.

Nevertheless, it is important to note that here as elsewhere narrative medicine occasionally uses language that undercuts its own aims and alerts us to the need to nurture a more critical mindset among its theorists and practitioners if it is to be applied more productively, within and beyond the clinical encounter.

The next movement requires the clinician who has 'donated' their attention to the patient's story to 'represent what he or she has witnessed' (Charon 2006:136). Charon understands **representation** as the moment when a clinician or scholar transforms the raw, unstructured flow of experience into a communicable form, whether through language, image, or data, thereby making private meanings accessible, interpretable, and actionable. Representation is thus not a neutral

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act of transcription but an interpretive gesture that entails selecting a point of view, organising events, and shaping meaning in ways that prompt recognition, evaluation, or response. We know that this interpretive gesture yields powerful results because Charon and her colleagues found that in settings such as writing seminars and primary care residency sessions, 'clinicians are able to produce complex and moving descriptions of their patients and their work with them' (Charon 2006:136).

Drawing on Ricoeur, Charon views representation as *mimesis* (the Greek term for imitation), again highlighting the constructedness of narratives by stating that mimesis 'creates something through its praxis, something that was not there before its act' (2006:138). The mimetic act contains three sequential and simultaneous movements that underpin creative understanding: $mimesis_1$ (prefiguration), $mimesis_2$ (configuration), and $mimesis_3$ (refiguration). $Mimesis_1$

> refers to the 'preunderstanding' of human action with which one beholds the world. The beholder brings to that which is beheld categories of thought – in semantics, symbols, and temporality – that endow the perceived with the potential that meaning may emerge from it, and even more fundamentally, that understandable event or action can be configured from it. . . . This complex process is the reverse, or the 'inside-out,' of emplotment, in that it is the process through which human beings recognize incipient plot when they come across it.

In other words, $mimesis_1$ is what we referred to earlier in outlining our broader understanding of narrativity as the pre-reflective, pre-rational human impulse to find meaning in everything we encounter, to make sense of the world. As evident in the provided quote, Charon (following Ricoeur) suggests that during the *prefiguration* or $mimesis_1$ stage, our understanding of what we encounter is already shaped by certain pre-existing structures (or categories) of knowledge and frameworks that come from our cultural, historical, and personal contexts – in other words, from the broader narrative world in which we are embedded. These include our language, our cultural norms, and our past experiences – all elements that prefigure our perception and interpretation, setting up expectations and a framework that guide how we understand new information or experiences. Essentially, this stage involves all the conditions that make interpretation possible.

The second stage, $mimesis_2$ or *configuration*, refers to 'the act of composition itself, the creative practice of configuring events or states of affairs into something "tellable" or "representable"' (Charon 2006:138). It involves the act of emplotment, where events of various kinds are woven into a coherent narrative that allows our 'raw experience' to become 'seeable or receivable' by others (Charon 2006:138). Within Charon's broader scheme of attention, representation, and affiliation, $mimesis_1$ corresponds to attention while $mimesis_2$ corresponds to representation.

In the third and final stage of representation, Ricoeur's $mimesis_3$ or *refiguration*, the new narrative or reconfigured understanding that emerged from the configuration stage is integrated back into our life world. Specifically, *refiguration* 'refers to the consequences, for the reader, of receiving what another composes' and 'enable[es] people to do things or to change by virtue of either having produced representations of what they see or having read others' representations' (Charon 2006:138). This

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integration of *mimesis*$_2$ and *mimesis*$_3$ means that the stories we tell and the interpretations we create begin to inform and reshape both our own perception and understanding of the world, as well as that of our audience. The *mimesis* triad ultimately concludes 'in transformative contact of one with another, banishing aloneness, refusing to abandon, demonstrating love' (Charon 2006:140). Again, we return to the somewhat idealised account of human interaction discussed previously.

Affiliation, the final movement in Charon's framework, is what emerges from the previous two movements, 'the ultimate goal of the spiral put into action by attention and representation' (2006:219). It is the point at which the individual clinician bonds with the individual patient, but it also sets the stage for 'egalitarian groupings of health care professionals and sick people' (2006:219). The assumption is that narratives do not just relay facts; they also forge *affiliations* – aligning the storyteller and audience with certain communities, values, or identities. In healthcare, narrative affiliation can determine whether patients and clinicians see themselves as partners or adversaries, and whether policies are experienced as caring or alienating. This is because narratives do far more than transmit descriptive facts; they perform the rhetorical labour of *identification* – what Kenneth Burke calls the process by which speaker and listener become, however briefly, 'consubstantial' (Burke 1969). Affiliation is the ethical orientation that invites clinicians and patients into a shared community of concern, laying the emotional groundwork for collaborative action and caregiving. Mikhail Bakhtin (1981) can widen this lens with his concepts of *voicing* and *heteroglossia*. Every utterance is situated within a dialogic field of other voices; which voices a clinical report admits – or excludes – prefigures the relations of power and sympathy that ensue from it. A monologic report aligns its readers with institutional authority, whereas a polyphonic account distributes authority across experiential perspectives, signalling openness and solidarity.

The capacity for attention, representation, and affiliation can be acquired or honed by developing narrative competence through training in close reading and reflective writing: these are the key activities around which the many courses in narrative medicine are organised, at Columbia University and elsewhere. Their assumed benefits are that they lead to 'recognition of emotion, perceptual sharpness, tolerating uncertainty, decreasing burnout, improving healthcare team function, and deepening individual clinicians' knowledge of individual patients' situations' (Charon 2006:5). DasGupta, a colleague of Charon and member of the narrative medicine community, has proposed complementing this notion with the less 'skills-based', less institutionalised concept of 'narrative humility' as 'a response to efforts at clinical mastery' (2008:980). Narrative humility can better address 'the hierarchical imbalance of the clinical relationship' by acknowledging that 'the socially more powerful player – the clinician – must willingly place herself in a position of some transparency' (2008:982). Importantly, DasGupta's concept of narrative humility highlights a key element that is largely missing from Charon's narrative competence and from the narrative medicine paradigm as a whole: it acknowledges the politics of all narrative encounters, including that 'that there are larger forces that enable the telling of certain sorts of stories and silence other stories' (2008:982). This is an issue we will return to and exemplify at length in the chapters that follow.

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2.4 Analysing Narratives: A Fluid Typology and Critical Toolkit

Having outlined the broader understanding of narratives that informs this book, and used it to offer a critique of narrative medicine's approach to narrativity, we can now begin to develop a provisional toolkit for the critical analysis of the narratives of reproductive and sexual health we engage with in the chapters that follow: narratives elaborated in reports on the use of puberty blockers, in vitro fertilisation (IVF) treatment policies and guidelines on the screening and use of mosaic embryos, and guidelines on the contested issue of abortion care.

To begin with, it might be useful to distinguish loosely between different **types of narrative**. While it is often impossible in practice to mark the boundaries of any narrative and assign it a label that can distinguish it from other types of narrative, we will heuristically draw a distinction for our purposes between four types (Somers and Gibson 1994; Baker 2019). **Personal narratives** focus on the story and experience of the narrator, with the typical example in the field of health being illness narratives. **Public narratives** are elaborated by 'social and institutional formations larger than the individual' (Baker 2019:33) and include narratives elaborated and circulated by the media, the educational system, and political lobbies. Examples in the field of health include the various conflicting narratives that circulated across a variety of venues during the COVID-19 crisis, some of which are analysed in detail by Engebretsen and Baker (2022).

Conceptual narratives are scholarly and expert stories that are elaborated within a given field of knowledge such as medicine or sociology. They tend to acquire a certain level of authority both within and beyond the expert community that elaborated them but can also be contested by various groups in society, sometimes leading to change within the expert field of knowledge itself – hence the impact of counter-narratives about endometriosis, long ignored and dismissed by many clinicians (*Femtech World* 2025), which are finally beginning to influence the level of health support provided to sufferers of this debilitating condition (Endometriosis UK 2024). And, finally, **metanarratives** are highly abstract, pervasive narratives that persist over extensive periods of time and impact the lives of many communities in different parts of the world, across numerous contexts, to a greater or lesser extent. They typically acquire a transcendental status and become separated from the specifics of a time and space (Baker 2006/2019:46). Examples include enduring narratives of race that continue to have serious ramifications in the field of health; Roberts (2012) offers a detailed critique of the role this persistent metanarrative has played in shaping health research and policy historically, including some of the ways in which it continues to inform the field of precision medicine and genetic testing today.

This fluid typology allows us to engage with different types of narrative and tailor our tools of analysis to their specific features. At one extreme, for example, personal/illness narratives will typically feature a distinct, readily identifiable narrator, with a clear focus on the events and relations shaping the narrator's particular life trajectories. At the other extreme, a metanarrative cannot be reduced to a set of

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specific narrators, although – as explained earlier – we can at times identify key narrators and assign agency to those who played an important role in elaborating it historically and those who perpetuate it in the present. Roberts (2012:164) argues, for instance, that pharmaceutical companies are currently playing an important role in reviving narratives of race in the medical field and beyond. Since it is not profitable or practical to scan the genome of every patient and design 'personalised' medication for them, the alternative they are opting for is to market drugs that are tailored to specific racial minorities: people of Mexican descent, Asians, whites, blacks, and so on. Roberts (2012:162) draws our attention to an important paradox embedded in this aspect of the evolving conceptual-cum-public narrative of personalised medicine and what it is able to deliver: 'a classification system constructed centuries ago to enslave people became the portal for the most cutting-edge biomedical advance of the twenty-first century'.

In terms of **tools of analysis** that we can draw on to make sense of specific narratives and engage with their implications, we propose to focus on a set of dimensions that are particularly relevant to scientific narratives in general and medical narratives in particular: narrators, protagonists, patterns of selective appropriation, temporality, emplotment, and genericness. Our starting point is that 'the boundary between literary and scientific genres is highly porous, and that both rely on narrativity to elaborate what is ultimately an interested vision of the world' (Baker 2006/2019:16). This allows us to draw on the wealth of scholarship on the analysis of literary narratives and adapt it to the particularities of narratives elaborated in the field of medicine. The selection and definitions of the features discussed here are adapted as necessary for our current purposes and tailored to the specifics of narration in the field of medicine and science more broadly.

Identifying **narrators** is key to engaging with any narrative. The narrator(s) may be named individuals or institutions or a combination of both; an example might be a research article written by a particular group of researchers and published in a journal such as *The Lancet* or the *New England Journal of Medicine*, or a report commissioned and published by the WHO. We intuitively assess the veracity of a story on the basis of the immediate context in which we encounter it, which includes who is narrating it and where it is published, in the case of medical literature, because the venue endows the narrator with authority and recognition. Andersen (2022:399) suggests that how readers of mathematical proofs perceive the narrator/author of the proof influences the way they check unusual moves: they 'may be more thorough if the author is a PhD student than if the author is an experienced mathematician', for instance. Very occasionally, and with considerable effort and persistence, some narratives manage to break through these rigid structures of recognising authority and introduce changes in research practices in mainstream medicine: Epstein (1995) documents some of the ways in which activists in the AIDS movement managed to constitute themselves as credible narrators in the eyes of the medical establishment and exercise considerable influence on biomedical research. He concludes that 'activist movements, through amassing different forms of credibility, can in certain circumstances become genuine participants in the construction of scientific knowledge – that they can (within definite limits) effect changes both in the epistemic practices of biomedical research and in the therapeutic techniques of

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medical care' (Epstein 1995:409). In other words, there is always room for 'unauthorised' or marginalised narrators to break through the walls of dominant narration practices and be accepted as credible, but only with considerable determination and after much effort.

Who narrates and who is being narrated, explicitly or implicitly, is also central to understanding how a given narrative fits into a larger context, what might motivate the narrator to configure it in the way it is presented, whose voices and interests are woven into the narrative, and with what consequences. The narratives elaborated by AIDS activists and introduced into the conceptual narrative space of mainstream medicine, for example, resulted in 'the mass conversion of disease "victims" into activist-experts' (Epstein 1995:414) and introduced major changes in the conduct of RCTs because it promoted *their* interests rather than those of the mainstream medical establishment at the time.

Scientific narratives are typically elaborated by institutions or a large group of scientists associated with specific institutions and abiding by institutional norms in constructing their stories. In both cases, narrators/authors do not just tell a story but also 'craft the character of the researcher . . . for instance, as an able, attentive and accurate experimenter' (Meunier 2022:253). Patterns of referencing in scientific publications, and scholarly publications in general, reflect the narrator's investment in constructing their persona as knowledgeable and situating themselves within a specific intellectual tradition, and hence contribute to the way we assess the narrative as we process it. Even the 1980s AIDS activists discussed by Epstein (1995) had to engage with mainstream medical literature, specifically pre-existing debates about the purpose of clinical trials, and reference it in elaborating their case for relaxing the strict requirements of RCTs and accepting pragmatic trials as necessary and credible. They had to construct themselves as knowledgeable narrators in order to be heard and taken seriously.

Scientific narratives typically revolve around 'nonhuman, even generic, protagonists' (Hajek 2022:53) rather than human subjects and their actions. In medicine the **protagonist** may be a specific disease, condition, or treatment. Where humans feature at all as protagonists, they are typically unnamed and often deliberately unidentifiable for ethical and legal reasons. Biomedical and patient narratives may also feature the same protagonists but configure them in quite different ways. For example, biomedical narratives configure hormonal contraceptives as 'tools enabling women to take control of their bodies and fertility, but also as tools for managing health more generally'. In the narratives of women who use them, 'hormonal contraceptives . . . emerge as central protagonists that act on the body and provoke not only physical, but also affective effects' (Erikainen et al. 2025:7, 9).

Beyond what is actually spelled out in the narrative, we might also consider whose voices or experiences are given primacy as opposed to being excluded or downplayed in the story being constructed about a given condition or treatment. For example, clinical trials often fail to recruit non-native speakers of the national language, including migrant populations, with a prevalence of trials in the United States that even require fluency in English as a precondition for enrolling in a trial (Egleston et al. 2015). The exclusion of the particulars and experiences of these groups – their individual stories of pain and treatment – impacts the configuration and outcome of

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the larger narrative constructed in the reported trial. This inclusion or exclusion – as well as foregrounding or downplaying – of particular protagonists is part of a larger pattern of selective appropriation that is inherent to all narration.

Selective appropriation is an inherent feature of narration because no narrative can include every detail of a given experience and remain processable and coherent. All narratives are 'constructed according to evaluative criteria that guide selective appropriation of a set of events or elements from the vast array of open-ended and overlapping events that constitute experience' (Baker 2006/2019:71). Evidence-based medicine has developed explicit guidelines for what should or should not be included in reports of RCTs, and these guidelines are subject to regular revision; the latest such guidelines at the time of writing appeared in *BMJ* in April 2025 (Hopewell et al. 2025). This rigid system determines what aspects of a given narrative are worth bringing to the attention of the research community, and hence where the value of the narrative lies and how it should be interpreted. RCTs never feature personal information about participants, for example: the narrated are treated as abstract groups with identical profiles, although researchers know that each individual participating in a trial will have a unique medical, social, and psychological profile that will distinguish them from others and that these differences have implications for the effectiveness of the treatment being tested.

Beyond guidelines for individual RCTs, much has been written about the process of selective appropriation in systematic reviews and its implications, though without engaging with these reviews as narratives. The medical literature typically names this feature of narrativity 'bias' and expends considerable energy in trying to find ways to reduce it, if not eliminate it altogether. Indeed, as Shyam (2015) confirms, 'evidence-based Medicine . . . has been built on the cornerstone of eliminating bias'. We would argue that bias, whether intentional or otherwise, is built into the process of narration and can never be avoided altogether. Since no coherent narrative can be elaborated by including every detail of a given experience, the narrator must select certain aspects to weave into the narrative and exclude others on the basis of conscious or subconscious evaluative criteria that are relevant to the purpose in hand. We can question the criteria used to select or deselect what is woven into the narrative, but we cannot eliminate the process of selection altogether. When Roberts and colleagues (2015) critique a systematic review of starch solutions in critically ill patients, arguing that its conclusions 'changed substantially after excluding seven trials that were retracted owing to misconduct by an investigator', what they are questioning is the integrity of the researchers and their questionable criteria of selection, rather than the fact that a systematic review, like any narrative, inevitably includes some information relevant to its topic and excludes others.

For scholars preoccupied with defining what qualifies a given text as a narrative, temporal configuration is a key requirement: it disqualifies chronicles, for example, from being considered narratives because the sequence of events and spatial details they enumerate are not emplotted, meaning that they do not specify the relationship between these events and details (see the discussion about **emplotment** later in this chapter). For our current purposes, however, we focus on the situatedness of narrative in space and time – its **temporality** – not in order to determine a given text's degree of narrativity but as part of a toolkit that allows us to understand how

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a particular narrative or type of narrative develops and acquires meaning for narrators and receivers. In this terminology, space is an aspect of temporal ordering, of temporality. Bruner discusses both time and space under the heading 'narrative diachronicity' and argues that the spatial ordering and layout of elements in cartoon strips and cathedral windows represent the unfolding of events over time. Without drawing on the concept of narrative, Kress and van Leewuen (1996) go further in demonstrating the importance of spatial organisation (layout) in assigning significance to different elements of a visual in genres as varied as advertising and flow charts, and how the layout contributes to the way the visual is 'read' or understood by its receivers, including how receivers interpret the temporal relations between its components. The difference between the standard map of the world and the Peters Projection map demonstrates the fact that even maps do not reflect the world but rather construct it for us, and that spatial dimensions such as the size of different countries in relation to each other is meaningful and is connected to how larger public and metanarratives are constructed. The standard, Mercator map, which the Peters map attempts to correct, inflates the size of Europe and North America at the expense of other countries and land masses.

Hajek (2022:39) suggests that 'many scientific narratives . . . have what we might call a "fundamental linearity" – a straightforward, and highly significant, temporal structure – particularly those of the so-called historical sciences (geology, evolutionary biology)'. We would argue that all scientific narratives – indeed, all conceptual narratives – exhibit features of temporality, though they may do so in different ways and at different times in history. Research articles published in major medical journals today follow a specific linear order that endows the narrative with meaning and allows its receivers to interpret the relationships between the various stages of the research in specific ways. While personal and public narratives often have highly flexible temporal structures, conceptual narratives are typically constrained in their mode of progression because they have to be readily interpretable by a community socialised into particular ways of processing information. The IMRaD format for research articles (providing an Introduction, Methods, Results, and Discussion) is an extreme example. It packages the narrative of the study being reported within a highly linear structure that facilitates the reconstruction of the story in the mind of the reader. The Introduction, for instance, introduces the protagonists of the study, whether these are proteins or patients or both, and sets the story within a specific temporal and spatial location. These details are important for justifying the study – why it is needed and what gaps the narrator sets out to fulfil. This must be followed by the Methods and Results sections, both normally written in the past tense as a report on how the researchers designed and conducted the study and what it revealed to them. The Discussion section, on the other hand, is where the narrators explicitly interpret and assess the findings and is normally written in the present tense to engage the reader in the unfolding story. The switches in tense are not accidental: they are part of the fabric of this type of narrative and constitute a code that is shared among members of that particular community.

Temporality and selective appropriation are intricately woven into another feature of narrativity, namely **emplotment**. Emplotment allows us to turn a set of carefully selected propositions into an intelligible sequence about which we can

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form an opinion and charges the events depicted with moral significance. As Hurwitz explains (2000:2086), 'Temporal succession alone cannot make a story'; what makes a story is that aspect of it that addresses questions such as '"and then" coupled with a notion of causality which gives meaning to phrases such as "that's why" and "therefore"'. Its interdependence with temporality means that emplotment 'can be signalled merely through sequence and the ordering of events' (Baker 2019:67) – the relationship between whatever is represented in temporal or spatial sequence does not have to be spelled out for the 'and then', 'that's why', and 'therefore' connections to be worked out by the receiver.

Narrative elements take on narrative meaning only when they are emplotted, when the narrator has engaged in the crucial process of weighting them and signalling what links obtain between them, rather than simply listing them randomly, without indicating relationships such as cause and effect, praise and blame, and who or what is responsible for certain events unfolding (Baker 2014). Importantly, as we will demonstrate in Chapter 5, in particular, this means that different people and institutions may agree on the 'facts', taken individually, but 'disagree strongly on how to interpret them in relation to each other' (Baker 2019:67). Because it is the particular sequencing and weighting of individual facts or events in a given version of the narrative that give that narrative meaning, that allow us to make practical and moral sense of it.

The particular pattern of emplotment elaborated by the narrator(s) has consequences, often very serious, for how the characters depicted are assessed and how they – or characters in the same or similar category as them (in terms of gender, race, religion, nationality, etc.) – are treated in a particular narrative environment. Unsubstantiated but widely circulated narratives of the COVID-19 virus having been developed in a laboratory in Wuhan and those that attributed the pandemic to unsanitary practices in wet markets in Asia, for instance, led to a surge in anti-Asian racism in many parts of the world. These narratives, as Perng and Dhaliwal (2022) point out, tapped into a history of racialisation of disease (the Spanish flu, the Mexican flu, the Ebola virus, the Middle East Respiratory Syndrome), which in turn activated larger metanarratives of race in Western societies.

Similarly, in a British Medical Association (BMA) blog that questions the stigma engendered by cultural and clinical narratives of obesity, David Strain (Chair of the BMA Board of Science) argues:

> Many of us have been trained to see obesity through a clinical lens, focusing on metrics like BMI, waist:hip ratio, diet and exercise. Yet there is growing recognition that this approach can inadvertently perpetuate stigma. Is it enough to view obesity as a clinical problem? Or should we also interrogate the social context?
>
> Some argue that medical discourse has long been complicit in reinforcing stereotypes – emphasising personal responsibility and neglecting the structural factors that contribute to obesity. Over 100 acts of parliament to try and tackle obesity have focused on personal responsibility.[2]

[2] www.bma.org.uk/news-and-opinion/challenging-the-stigma-of-obesity.

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What Strain and others are questioning about the dominant societal and clinical narratives of obesity is their allocation of responsibility, which is a key element of emplotment: what is the cause of a particular phenomenon or event, who is responsible, and hence how can the issue be resolved? Alternative narratives of obesity emplot it as the result of 'a complex interplay of genetic and environment factors most of which are outside an individual's control' (Westbury et al. 2023:10), with very different implications for public policy and the way society views and treats individuals living with obesity.

Genericness is a narrative feature discussed briefly in Bruner (1991) and at length in Baker (2019). It means that individual narratives have to be elaborated within established frameworks of narration in order to be intelligible and effective: a guideline, a systematic review, an article in a scientific journal, a case report, a news editorial, a press release. These established frameworks are associated with a variety of meanings that contribute to developing the narrative and impact its reception in subtle ways. Every genre comes imbued with a set of implicit assumptions and values that influence the way individual narratives presented in its format are interpreted and assessed. Guidelines, for instance, are associated with a particular paradigm of medicine, with their history being 'coextensive with the emergence and ongoing development of evidence-based medicine' (Wickman 2023:140), and they have to follow specific patterns of narration. They reinforce RCTs as the golden standard, are part of a broader network of regulatory narratives that police the boundaries of biomedicine, and define what counts as evidence in this domain. They are associated with rigour and transparency, and their narrators are endowed with authority as trusted members of the medical community. The WHO guideline discussed in Chapter 6 is a good example of this genre.

Narrative analysis of the type elaborated in this book draws on the previously mentioned and other features of narrativity to lay bare the often hidden and taken-for-granted values and assumptions that are embedded in the structure of all narratives. In the chapters that follow, we draw on these features to offer a close narrative analysis of the conceptualisation of 'knowledge' and 'translation' in existing models of knowledge translation (Chapter 3), followed by analyses of debates relating to three central controversies in the field of reproductive health: puberty blockers (Chapter 4), mosaic embryos in IVF treatments (Chapter 5), and abortion care (Chapter 6).

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