Making Sense of Patterns in Narratives: Theoretical and Conceptual Frameworks

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‘It is the theory that decides what we can observe.’ Einstein (Heisenberg, 1971)

INTRODUCTION

The disease framework predominates in medical/health care. Health, illness and quality of life have been viewed through objective lenses, similar to disease approaches. Yet, the situation, meaning and process of construction of the individual experience is highly personal and contextual. Constructivist approaches are thereby identified as having the potential to account for the subjective and contextual nature of illness. Turner and Samson (1996) argue for the study of chronic illness construction at three levels: the individual (phenomenology), the social (sociology of disease, knowledge, health care, etc.) and societal (political economy of health and illness). ‘In essence, reality evolves through continued socialization, yielding outcomes that result from social interactions, negotiations, and power’ (Huber & Gillaspy, 1998).

Sensemaking (Kurtz & Snowden, 2003; Weick, Sutcliffe et al., 2005) or Sense Making (Dervin, 2010) is a field of study that has emerged in order to develop mechanisms to assist decision making in complex systems. Sensemaking or Sense-Making is essentially the process of people giving meaning to their experience. Distinct but related research areas related to health involve a wide range of disciplines, including mathematics, biological modelling, philosophy, sociology and cognitive science, communication studies, complexity science, informatics and knowledge engineering. The field centres around key areas and leaders: Communications (Dervin, 2010); Organizational studies (Weick, Sutcliffe, et al., 2005); Intelligence and multi-ontology sense-making (Snowden & Boone, et al., 2005); and Mathematical modelling (Guastello, 2009; Katerndahl, 2005).

Engaging with these sense making dialogues and knowledge development to aid decision making in complex adaptive clinical practice and health systems management is a pressing challenge as health care continue to struggle to adapt to changing internal and external constraints (Martin, 2010). Narrative evidence-based medicine

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(NEBM) is a field that has emerged to address the tensions and contradictions, and polarities and uncertainties of clinical practice.

“Medical practice is poised astride insoluble tensions between the known and the unknown (or at least the knowable and the unknowable), the universal and the particular, and the body and the self. Nested, these tensions beget and amplify one another. The unwary physician, caught in the headlights of one of them, usually succumbs to the paralysing effects of all three, often without knowing what waylaid him or her on the country road to begin with” (Charon, Wyer, et al., 2008)

Charon and her group identify the key polarities to be that of evidence-based medicine which is ‘objective’ and explicit and narrative-based medicine which is ‘subjective’ and tacit. This perspective accepts the tenets of evidence-based medicine that knowledge is reducible to statistics and probabilities derived from randomized controlled trials and meta-analysis predominantly. The knowledge base for narrative-based medicine is founded upon studies in the humanities and literature. The narrative singularity of both patients’ and clinicians’ lived experience contextualize illness and healing unfold in stories.

NEBM proposes that clinical decisions be made on the basis of trustworthy evidence deployed by clinicians who use their clinical judgment and take into account the patient’s values and circumstances. The stories or narratives provide the accounts by which these values and circumstances are made known to clinicians.

According to Charon and Dwyer et al, there are 3 fundamental tensions upon which medicine finds itself (when coming from a medical evidence paradigm):

1. The management of health when there are known and unknown of lack of evidence
2. How to particularize the universal or average case from statistical analyses to the individual journey and
3. How to personalize or embody the evidence about the body for an individual experience and patient journey.

They make the case that narrative based medicine complements EBM in that

‘Clinical evidence examines the known and unknown.
Clinical circumstances integrate the universal and particular.
Patients’ values speak to both body and self.

By virtue of its capacity to recognize the tensions fully, narrative medicine can lend to evidence-based medicine the methods of respecting its three circles of attention (Charon, Wyer, et al., 2008)

Evidentiary texts—contemporary novels, grounded theory, papers from the EBM literature, patient-written illness narratives, aesthetic theories of illness, and phenomenological theories of embodiment.’ (Charon, Wyer et al., 2008)

However, postmodern thinking would probably have preferred integrating a variety of different stakeholder perspectives and values much earlier in the EBM process, before unilaterally establishing what’s best (Simone, 2006). Reducing the known to reductionist paradigm of science as ‘evidence’ curtails a broader understanding of what is known and unknown in scientific terms. For example outcomes of diabetes interventions demonstrate that better outcomes of care – significant improvement in HbA1c, significant decrease in hospitalizations, and significant decrease in emergency department visits – were associated with programmes that had complex adaptive system characteristics – agents who learn, interconnections
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