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In Search of the Good: Narrative Reasoning in Clinical Practice

Based on ethnographic work among North American occupational therapists, I compare two forms of everyday clinical talk. One, "chart talk," conforms to normative conceptions of clinical rationality. The second, storytelling, permeates clinical discussions but has no formal status as a vehicle for clinical reasoning. I argue that both modes of discourse provide avenues for reasoning about clinical problems. However, these discourses construct very different clinical objects and different phenomena to reason about. Further, the clinical problems created through storytelling point toward a more radically distinct conception of rationality than the one underlying biomedicine as it is formally conceived. Clinical storytelling is more usefully understood as a mode of Aristotle's "practical rationality" than the technical rationality of modern (enlightenment) conceptions of reasoning. [narrative, practical reasoning, clinical reasoning, ethics]

At a large university hospital in Boston it is time for lunch. The occupational therapists make a quick trip to the hospital cafeteria to pick up food and find their way upstairs to the fifth floor where they have their main treatment room. Plinths, wheelchairs, and other common accouterments of rehabilitation are scattered throughout the large room. At one end there are also two long, cafeteria-style tables. Almost all of the 15 therapists who work in the hospital come to eat lunch here. Most of them will not see each other for much of the rest of the day since they are scattered in various units throughout the hospital. As they find places to sit, they catch up with one another. Conversation weaves between work-related talk and outside-work talk. But regardless of the topic, stories get told. Some of them are about husbands, children, the traffic jam getting into the city, a friend's baby shower. Many others are about patients, especially ones where trouble has been brewing.

"Brother," declares one therapist to her lunchtime neighbor,

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> I don't know what to do about Mrs. McCarthy. You know, the one who came in with a stroke a couple of weeks ago. She doesn't want to do any of the arm exercises, which I can understand since they are pretty boring. But she tells me she loves to knit. So I think, terrific, I'll bring in some needles and we can pick out a pattern, and she can be making something. She has grandchildren she talks about a lot, a couple of really young ones, so I think maybe something for one of these babies. You know, booties or something. She can get all her upper body work, plus improve her fine motor skills. This will be great. Anyway, I take the knitting material to her room this morning, for our session, and she tells me she doesn't want to knit anymore. She used to knit, she says. Years ago. Now she doesn't have the patience for it, she tells me. So there I am, back to square one. I wonder, maybe she's just really depressed or something. And even though she talks about her grandkids, and shows me pictures and stuff, I don't think either of her daughters have been to visit. Her husband's passed away and she's been living alone.

"Oh wow," her companion sighs in sympathy, "it's so hard when they don't want to do anything. She sounds like this guy I had last week. . . . " And so the conversation goes. A bit later this therapist offers some suggestions for new tactics that might entice Mrs. McCarthy into getting involved in therapy.

What are these therapists doing when they are telling such stories? They would say that they were trading advice, offering condolences, letting off steam, gossiping, and the like. Certainly they would not say that they were practicing science. It is unlikely that they would tell these stories in formal team meetings, especially those with nonoccupational therapy colleagues present. Neither would they write up these stories in the medical charts. Formal case presentations and written documents are very different speech acts than the storytelling that permeates everyday clinical practice.

When I first began to study occupational therapists some ten years ago, I was puzzled and fascinated by the ways in which they talked about their patients. On the one hand, they described patients in familiar clinical language, a kind of "chart talk" that emphasized diagnosis and pathology. On the other hand, they were full of personal stories that they often told one another (and me). Here, they offered colorful and dramatic accounts of particular patients and what it was like to treat them. A patient described in chart talk emerged very differently when recounted as an agent in a personal story. It was not simply that the facts, descriptions, or style differed, though this was certainly true; rather, it was that storytelling transformed the clinical object and clinical problem to be solved. Clinical reasoning became narrative reasoning. I began to see that although occupational therapists relied upon a discourse and a mode of practice that conformed well with "biomedical rationality" as this term is generally deployed within the clinical community, they drew regularly upon stories as well. Sharing stories allowed them to deal in human agency, in complex social relationships, in emotion, in cultural difference, and other matters skirted by canonical medical discourse. They thus operated with a double vision of clinical work. In this article I examine this double vision and attend to the ways storytelling helps sustain their dualistic perspective. I propose that the double vision of clinical work that occupational therapists hold is expressed in the two distinct languages through which they represent clinical cases, chart talk, and personal stories.

In my analysis of clinical stories, I refer to narrative in a rather ordinary but restricted sense, as a discourse featuring human adventures and sufferings, one which connects motives, acts, and consequences in causal chains. If stories are defined in this way, not all medical talk or all medical thought is narrative. Some scholars have examined biomedical accounts themselves as narratives (e.g., Frankenberg 1986; M. J. Good 1995; Hunt 1994). Probably the most extensive argument for the underlying narrative structure of the clinical case is Hunter's (1991) *Doctor's Stories*. Although I find this line of analysis illuminating and important, my work heads in a different direction. I argue that chart talk is nonnarrative, even antinarrative. It portrays the complex experiences of suffering and healing in oddly agent-free language (Mattingly 1989, 1991a, 1991b). If everything is not narrative, if sometimes people (clinicians, patients) tell stories and sometimes they do not, clinical narrative emerges as a distinct and interesting speech act in the biomedical world.

Rationality in Biomedicine: The Anthropological Critique

The question of how Western healers reason and how they construe the nature of their reasoning has engaged anthropologists, cognitive psychologists, philosophers, sociologists, and, perhaps less frequently, clinicians themselves. At the heart of many anthropological investigations of biomedical reasoning is a fascination with (and often a strong critique of) how rationality is conceived in Western healing practices. So provocative is the question of what constitutes rationality within biomedicine that some commentators have used biomedicine as a case study for addressing the broader issue of Western rationality itself (Casper and Koenig 1996; Comaroff 1982; Foucault 1973, 1979; B. Good 1994; Lock 1988; Taussig 1980).

Medical professionals commonly assume that clinical reasoning is a form of applied natural science. "The neo-positivist philosophy of science which has played such a dominant role in our culture during this century has nourished this vision of objective, scientific medicine rising above the metaphysical speculations of the past," comments one philosopher of medicine (Jensen 1987:9). Medicine is conceived as a diagnostic science in search of the hidden causes of observable symptoms and signs. The reasoning process is described as a quest in which the successful clinician discovers an underlying disease that causes the illness symptoms. To quote from one often cited source, clinical reasoning is, quite simply, "a process of converting observed evidence into the names of diseases" (Feinstein 1973:212). Treatment, in turn, is understood as a (scientifically) tested intervention directed to attacking and overcoming the pathogen or, where this is not possible, ameliorating the consequences of the disease process on the body. The assumption that clinical reasoning is applied scientific reasoning underlies nearly all research on clinical reasoning in medical fields, and the informal perceptions of practicing health professionals, like occupational therapists.

This depiction of clinical rationality has been widely challenged by anthropologists along several interrelated dimensions. Anthropologists have argued that such a narrowly restrictive reasoning process seriously misconstrues the nature of illness. Some have also argued that this conception of reasoning is riddled with a number of questionable epistemological assumptions. A related line of anthropological attack is that this vision of reasoning is patently false: it seriously misconstrues the concrete reality of healing as conducted in the real worlds of practice. Medical

professional might *believe* they are practical scientists trafficking in neutral facts and biological universals, but their actions belie this comforting illusion (Forsythe 1996; Rapp 1993; Strathern 1995). While they may assert that they discover facts, primarily biological ones, many commentators argue that clinical transactions are necessarily hermeneutic (Good and Good 1980, 1981; Hahn and Gaines 1985; Kleinman et al. 1978) and even depend upon the creation of texts, a "clinical hermeneutics" (Charon 1989; Daniel 1986; Hunter 1986, 1991).

Anthropologists have broadened the narrow clinical picture of biomedical rationality by drawing upon discourses that were originally addressed to healing rituals in non-Western medicine, such as when Biesele and Davis-Floyd speak of the "symbolic and ritual dimensions of the cancer doctor's role" (1996:293). Here, the picture of clinician as highly trained technician is repainted; the technology of biomedicine becomes visible as a "technocratic social drama," a highly ritualized performance. The sacred dimensions of Western biomedicine are articulated and explored (Haraway 1997). Recent discussions of biomedicine also expose its aesthetic underpinnings (M.J. Good 1996; Haraway 1993; Mattingly 1998). These exposures offer a complex criticism. There is more to biomedicine than meets the eye, and more than is visible or justifiable in its own purist conceptions of its enterprise.

One pertinent, pervasive criticism of biomedicine is that it offers a language, a mode of perception, and an organization of practice that denies its moral status. Those essential moral questions that plague the sufferer of serious, disabling illness—"Why me? Why now? How can I go on with my life?" and even "Who am I now?"—are precisely the ones biomedicine sidesteps (Taussig 1980). Although suffering calls for a moral response (Kleinman and Kleinman 1996), medicalized treatment may negate it. Western biomedicine historically developed in ways that progressively distanced it from the moral, the cosmological, and the emotional (Comaroff 1982; Jensen 1987; Kirmayer 1988). This history has gone hand in hand with the development of a particular notion of rationality grounded (metaphorically as much as anything) in the vivid image of the doctor scientist. Medicine has accrued symbolic capital because of its presumptions about what constitutes knowledge and how truths are discovered. It draws its prestige and claim to truth by its relation to science. As an applied science that deals with the body, it "is interposed between formal science—our special source of 'truth' about natural processes—and the everyday experiences of such processes" (Comaroff 1982:55). The strong critique leveled here is not merely that medicine pushes the social and cultural to the margins; it is that biomedicine's very *notion* of rationality disguises the role of human relations in constructing the clinical problem and arriving at decisions about how to treat it. Distancing from the social and moral may have reinforced biomedicine's status as a purveyor of truth, but how is this denial and disengagement possible? How can life-altering illness, something that so palpably calls the moral and existential into question, be transformed into a matter for objective rational action, for science and technology stripped of its moral, social, and cultural grounding?

Anthropologists have given a number of penetrating answers to this deep cultural puzzle. In the medical world, relations are reified, acquiring a "phantom objectivity" that conceals their fundamental social nature (Taussig 1980:3). Biomedical rationality is based on an individualist notion of cause, on "idiopathic etiologies" that ignores or even denies the cultural and social (Hahn and Gaines 1985:3).

Rather than examining illness in the context of complex cultural and social worlds, or interactions between members of professional and institutional cultures and their patients, by and large medicine treats illness as though it belonged to the autonomous individual (Gordon 1988). Individualism prevails even in rehabilitation, which easily invites a more social view of clinical interventions since patients with long-term illnesses and disabilities are being prepared to reenter their social lives. Individualism is fostered because patient autonomy is generally recognized as the key goal of rehabilitation (Kaufman and Becker 1986). As Comaroff succinctly puts it, biomedicine "asserts a cogent, if implicit world-view, centered upon man as a self-determining, biologically contrived individual, who exists in a context of palpable acts and material things" (1982:57).

Biomedical professionals attempt to deploy a means-ends rationality directed to controlling the disorder created by illness. This reasoning process is justified by an empiricist and essentialist understanding of reality and the belief that the ultimate reality one is dealing with is biological (Hahn and Gaines 1985:11). The body becomes a thing apart from how it is given human significance. In Western society generally, the rational and instrumental, in which medicine is squarely placed, are separated from the symbolic and affective. As a rational and instrumental practice, medicine appears to discover natural truths that transcend the particularities of context (Comaroff 1982:49). This dissociation occurs in an everyday way as medical professionals find ways to routinize their practice and thus, metaphorically at least, bring the unruly and frightening world of illness under control. Illness, by nature, is unpredictable, and much of medicine is fraught with uncertainty (Hunter 1991). Medicine's goal to control illness, or at least give the appearance of control, is well recognized (Becker and Kaufman 1995; Rhodes 1993), and the elaboration of medical technology and its attendant rituals are prime means to do so (Browner and Press 1995; Lock 1996). The most innovative and uncertain medical technologies are quickly "tamed" and made to look ordinary; even extraordinary treatments are transformed into "assembly line" procedures that obscure the uncertainty surrounding outcomes (Koenig 1988:469). Biomedicine's tremendous focus on technology as the source of solutions to disease also reinforces a practice in which much more attention is given to "means" than "ends" (Gordon 1988). Medical practitioners are notably poor at carrying on subtle discussions about what ends ought to be pursued, leaving this thorny issue to be untangled by other specialists—medical ethicists.

The domestication of treatment is particularly evident in the language of biomedicine, a language of high rhetorical power in which the disorder, uncertainty, and sheer terror that surround serious illness magically disappear. "Medical jargon," one commentator notices, "abounds with acronyms whose convenience disguises the reality of sickness. . ." (Kirmayer 1988:61). Medical discourse is often intimately tied to the production of medical knowledge (Hunter 1991) or, more darkly, to the production of ideology (Young 1993). Medicine is particularly given to naturalizing itself and to dissociating itself from the cultural roots through which it has been shaped (Hahn and Gaines 1985; Latour and Wolgar 1979; Rapp 1993; Taussig 1980). Anthropologists have largely rejected this depiction of clinical reasoning grounded in biological universals, proposing instead that biomedicine is one among many ethnomedicines and, as such, offers but one version of reality

(Hahn and Gaines 1985). In this analytic vein, medical anthropology belongs to a larger project, "the critical cultural studies of science" (B. Good 1995:393).

In the analysis of ethnographic material that follows, I join this general line of critique of biomedical rationality. I pay particular attention, however, to the way clinical practice exceeds the bounds of its own ideology and the role clinical storytelling plays in doing so. As others such as Frankenberg (1993) have pointed out, biomedicine does not have a unitary dialect. Here, I contrast two dialects that play a powerful, and often contradictory, role in shaping the ways occupational therapists conceive their clinical cases. While in this article I confine myself to a single clinical profession, recent research I have conducted with a range of other health professionals and interdisciplinary teams convinces me that the storytelling I describe is commonplace in clinical settings.

The Dualistic Reasoning of Occupational Therapists

My ethnographic data come from studying the practice of American occupational therapists in three large urban hospitals. Drawing from data collected through observations of team meetings and more casual settings, like lunch conversations, as well as interviews with therapists, I look at the discourse through which therapists present and describe their work with patients. The arguments made here are based on ethnographic work conducted over a period of ten years in three different hospital sites and in several different studies.[1] The purpose of this article is not to report the findings from a given study but to outline the way narrative thinking appears recurrently among occupational therapists.

Occupational therapists treat patients with chronic illnesses and disabilities, patients who, in some very important but very obvious sense, generally do not get well. Or, as therapists may tell you, they treat people who need health care but are not necessarily sick. They assist patients in taking up those occupations (what anthropologists would likely call "activities" or "practices") that were once important in their lives or, as in the case of children, occupations that will become important. Sometimes, and in some clinical settings, therapists attend exclusively to a standard set of self-care skills (feeding, dressing, toileting, and the like) or body strengthening exercises. But often they assume a more expansive role, and help patients discover new occupations where old ones are no longer possible or identify and develop meaningful occupations where few have existed. Although this analysis concerns only occupational therapists, I believe that narrative reasoning pervades the thinking of many health professionals.

Therapists are torn between two competing conceptions of how to reason about their task. Generally, patients are referred to therapists by doctors who have already given a diagnosis and prescribed therapy as appropriate treatment. Although therapists may do further diagnostic testing, generally their primary clinical decisions concern intervention. In deciding upon an appropriate course of treatment, therapists operate with conflicting models in mind. On the one hand, they believe that good treatment decisions must involve tailoring general treatment goals to the concerns and needs of the particular patient. They speak of this as "individualizing treatment" and they consistently regard the individualization of treatment as a highly complex clinical skill. This is not merely choosing among a standard array of options applied to patients within a diagnostic category. Rather, therapists

regard this as a matter of judging what is best for a particular patient in a particular situation. The concern to integrate therapy within the real life of patients and their families creates a need to modify treatment in accord with singular life contexts and life histories. This "individualizing" quickly moves into the social field, drawing therapists into a complex web of social relations. Their need to tell stories is related to their need to decipher these social relations.

But therapists are also driven to practice in a way that accords with the contemporary structure of health care. They strive to define standardized, measurable treatment goals that stay within clear disciplinary boundaries, are diagnostically driven, and allow progress to be visibly, physically marked. The quest for an authorized position within the health care system propels therapists to generic biomechanical delineations of the clinical task where the social and moral are ignored altogether or given only the most cursory glance.

Chart Talk

Therapists particularly rely upon chart talk when they address a patient's problems in diagnostic terms; they keep their clinical interventions closely tied to and justified by the diagnosis. Deficits, particularly those that can be described largely in biological terms, dominate the discourse. The beginning of clinical reasoning in the discourse of chart talk involves a process of labeling, first by disease and then by dysfunctional body parts. The following example illustrates this process. It is taken from field notes of a hospital staff meeting in which nurses, occupational therapists, and other rehabilitation professionals gathered for their weekly review of patients. This review primarily involves decisions about what kinds of rehabilitation services are required for various patients. The team is headed by a nurse who will pass along recommendations to doctors about appropriate referrals for rehabilitation services. The exchange recorded below occurs between an occupational therapist and two nurses. The occupational therapist, Sandra, who treats hand injuries, is trying to convince the nurses to refer some of their patients to her. Because occupational therapists provide a service that nurses may not deem essential, they are often compelled to drum up business. Their justification for recommending occupational therapy (OT) almost invariably is put in diagnostic terms.

Sandra:	Is OT needed?
Nurse:	Ah, no, just PT [physical therapist], well. . . .
Sandra:	What's the diagnosis?
Nurse:	Left CVA [cerebral vascular accident] with right residual.
Sandra:	Any problems with his speech?
Nurse:	No, none.
Sandra:	What's his right upper extension like?
Nurse:	He's functional, but can't really use his fingers.
Sandra:	Can you also request an OT consult? He needs one.
Nurse:	OK.
Sandra:	Does he have the ability to do ADLs [Activities of Daily Living]?
Nurse:	Yes. We try to put wash cloths in his hands.
Sandra:	You might try AB pads.

2nd Nurse:	We tried them, but they didn't really work.
Sandra:	Well, they should work.

[The nurse seems to drop the subject. Sandra does not pursue it. The nurse moves on to another patient.]

Nurse:	The patient is here for a nerve block.
Sandra:	She was here before?
Nurse:	Yes, she has [unclear] syndrome, terrible pain due to the constriction of blood vessels—turns hands blue.
Sandra:	Does she use her hand?
Nurse:	Yes, but she could be seen . . .
Sandra:	. . . by OT. When you see the doc, can you put a consult in for OT? I want to make sure she knows how to range her arms—make sure the uppers are okay.

In this exchange two patients are discussed. A clinical shorthand is used to starkly identify patients in prose that immediately directs one's gaze to the site of physical impairment. The patients have "a left CVA with right residual" and a "nerve block." Occupational therapy problems are similarly reduced to pristine physical proportions. The "left CVA" is "functional, but can't really use his fingers." The "nerve block" has a "constriction of blood vessels" that "turns hands blue." If fingers and hands are involved, the occupational therapist can find services to offer. A simple sort of reasoning has tacitly occurred in the interchange between Sandra and the nurse in which a disease is named as cause for certain physical dysfunctions. These effects, in turn, are implicitly assumed to be treatable (taken in a broad sense) by therapy. Effective therapy, the therapist's unsaid argument goes, can ameliorate these effects or at least improve the patient's capacity to function.

The tendency to portray clinical problems atomistically is also characteristic of the way treatment interventions are described. In occupational therapy, treatment is often pictured as a serial collection of "basic actions," a linear sequence of events. For example, a therapist treating a hand injury describes a set of subproblems and a corresponding set of treatment activities. This example is taken from the therapist's chart notes that she drew from to make an oral presentation of a clinical case in a team meeting. She names three problems that are the focus of treatment: "lack of metacarpal phalangeal flexion," "lack of thumb rotation and subsequent functional opposition," and "no active motion in interphalangeal joints of the little finger." She then briefly describes her treatment approaches, which are broken down into interventions for each of the three problem categories. For instance, for the first problem, "MP flexion," she itemizes the following treatments: "(1) Wrist splint with rubber bands and finger slings for dynamic flexion; (2) Discontinued night resting extension splint since patient was in extension and active extension had improved; (3) Joint mobilization; (4) Coband wrapping in flexion and active assistive range of motion; (5) ultimately 11 months postinjury—surgical capsulotomy to MP joints and extensor tendon release; (6) Alumafoam splints to concentrate flexor power at MP joints; (7) Flexion assist wrist splint with betapile strap to flex IP joints."

In chart talk general problems are connected, one by one, to treatment interventions, and these, in turn, are matched to treatment outcomes. When a history is

given, it concerns the pathology or lesion and its course through treatment; it is not in any sense a life history of the afflicted person. Patients' and therapists' experiences are downplayed or deleted altogether. Anspach's (1988) illuminating discussion of qualities characterizing medical case presentations is highly relevant here. There is a "separation of biological processes from the person," an "omission of the agent [e.g., use of the passive voice]," and a treatment of "medical technology as the agent" (1988:363). The occupational therapist's presentation of a hand-injury case accords with an espoused model of clinical reasoning that is based on canons of scientific rationality. What logic emerges when stories are told?

Storytelling and Narrative Reasoning

Therapists are rarely content to describe their work or their patients only along the confined lines of chart talk. They are also apparently compelled to tell quite personal stories about their patients and what it is like to treat them. They are well aware of this propensity to narrate but view it as a very different sort of talk than formal case presentations (see also Coles 1989; Sacks 1987). Storytelling generally occurs at the interstices of professional life, at the end of formal presentations in relaxed team meetings, during lunch, in the elevator, and at parties with colleagues. Such stories are accorded no special status as ways of reasoning about patient cases. In fact, they are a bit embarrassing to many therapists. Therapists admit they need to tell stories about their patients but think that it is rather unprofessional for them to do so.

The power of stories to reframe clinical problems is especially evident during team meetings when clinical cases are presented. I have often noticed a distinct two-part organization. Commonly, the first portion of the presentation is rigidly standardized. It is comprised of a tightly organized account of the disease process that pays minimal attention to a person's other defining features. (The patient is introduced as a "32-year-old white male with reflex sympathetic dystrophy [RSD].") Instead, the account focuses upon treatment interventions taken. This minimal format may be accompanied by a discussion of relevant research concerning the clinical condition or the treatment approach selected. Such a presentation closely follows the canons of chart talk.

Part 2 of the presentation, which is dominated by narrative, is often initiated by the case presenter. At the close of the tightly structured account of a treatment intervention, a different form of talk emerges as presenters relate and impart anecdotes about what treating this patient has been like. Here, the 32-year-old white male with RSD emerges as Dan, the construction worker whose hand was injured on the job. He has lately taken up serious drinking as he stays home to watch the children while his wife assumes a full-time job for the first time in their marriage. Specific encounters between Dan and the occupational therapist, or Dan and his wife (in the form of a retelling of stories Dan has told), are recounted. This storytelling is likely to be frequently interrupted by colleagues who ask questions, shake their heads at the sad facts of Dan's current life, and offer stories of their own from their repertoire of experiences with patients whose physical injuries have produced similar life and marital crises. The original story about Dan is elaborated, and its meaning is coconstructed in collaboration with the audience.

Each part of the case presentation offers a way of understanding and reasoning about the "same" patient. When therapists begin telling stories about Dan, the particular 32-year-old patient with reflex sympathetic dystrophy, a different set of problems appear, ones that plunge them into such matters as marital problems, difficulties with drinking, and loss of power within the family. But it is not merely the *content* of chart talk that differs from storytelling. The *form* of presentation differs as well. Part 1 is an authoritative monologue, given by the expert. Part 2 invites audience participation. It is an oral performance in which the boundaries between speaker and spectator blur, and control over the meaning is not clearly held by any one person. As many scholars of narrative have emphasized, a story is not merely a text, it is also a performance and differences in performance contribute to differences in meaning (Atkinson 1990; Bauman 1986; Bruner and Gorfain 1984; Crapanzano 1980; Reissman 1990, 1993).

The need for narrative is most evident in clinical situations where the therapist is narratively stranded and unable to link a patient's actions to motives in an understandable way. Narratives are commonly called upon to make sense of the anomalous event (J. Bruner 1986; Hunter 1991) or to render disorderly life experiences coherent and meaningful (Becker 1994; Ewing 1990; Kaufman 1988; Kleinman 1988; Linde 1987, 1993; Monks and Frankenberg 1995; Reissman 1990, 1993). When explanatory links become difficult and the patient remains incomprehensible in some significant way, the whole direction of treatment may falter. Narrative puzzles are often triggered around questions of patient motivation. A patient may insist that he wants to return to his job, show up to all his appointments faithfully, comply with all the tasks set before him during his therapy hour, but never manage to "get around" to doing the exercises he is supposed to be carrying out at home. Without these home exercises, the therapist may explain several times, treatment will not be successful. He will not be able to use his hand. He will not be able to return to work. And yet, nothing helps. Things continue just as before. Perhaps he has been lying, or deceiving himself. Perhaps he does not want his job back after all. But if he were merely noncompliant and uninterested in returning to work, why does he show up to every appointment so faithfully, even arriving early? Why does he try so hard during therapy time? Such mysteries are common. Therapists become increasingly unclear about how to proceed in their treatment interventions, even when "the good" for a patient (say, maximal return of hand function) remains fixed in an abstract sense.

Storytelling often creeps into accounts of practice when diagnoses are uncertain. In such cases, diagnostic uncertainty may become confounded with uncertainty about the *meaning* of the illness to patients or kin. This is evident in the following instance, which is described in more detail below, when a therapist realizes her patient evinces symptoms that defy her expectations, do not fit her initial diagnosis, and call her treatment approach into question. A pediatric therapist who initially diagnosed a three-year-old child as having "sensory integration dysfunction" began working with the child with that in mind. Later she became increasingly unsure about the child's problems, wondering if she was seeing a patient with a head injury instead. When I interviewed the therapist, she first discussed her uncertainty in terms of her difficulty in making an accurate diagnosis. Was she seeing a patient with sensory integration dysfunction or a child with a head injury? The evidence for the former was that the child was "opposed to any

kind of movement and tactilely defensive." But "physically," she said, "his diagnostics are not clear. He now looks more like a head injured child than anything" because "he also has a lot of things . . . that sensory integration dysfunction doesn't have."

This diagnostic muddle quickly led her in search of a story that could make sense of her difficulties and guide her treatment intervention. As she put it, "I was trying to decide, should I treat him more like a physically disabled child or try to integrate the information from the environment?" A key element in the therapist's puzzle concerned the family's response to the possibility of a head injury, which she euphemistically referred to as "information from the environment." She reported that "the family was making light of [the head injury]." This puzzling fact propelled her into a narrative mode of reasoning. A diagnostic mystery was transformed into a narrative mystery. What was going on with this family? She investigated by trying to talk to them, a task made difficult because they spoke only Spanish, and she had to converse through a translator. The mother told the therapist that the child had been dropped on his head by an uncle. Because this mother did not appear especially upset when she delivered this information, the therapist was confronted with a new question. Was she dealing with abuse or, at the very least, serious neglect?

The answer to this question lay in the therapist's interpretive reading of multiple narratives as she tried to piece together a story of her own. First, in order to explore the head injury question, the therapist elicited a story from a parent. Second, the therapist's interpretation of the mother's story—that is, the story she constructed from the mother's story—depended upon her interpretation of the mother's response to the narrated events. A head injury may have resulted from the uncle's action but this in itself would not constitute an abuse or neglect case. Potential neglect or abuse comes into question when families (and particularly therapists look to mothers here) do not seem sufficiently disturbed by such an event. It was pivotal in the therapist's account that the mother "didn't seem especially upset about this or appear to take it very seriously."

But as the therapist continued her investigation of the events surrounding the initial injury (now two years past), new possibilities arose, this time centering on possible negligence on the part of the hospital. She discovered that no one in the hospital, including the child's pediatrician, had pursued the possibility of head injury when the accident had originally occurred. When the therapist began treating the child, the pediatrician's referral simply said "developmental delay"—a catch-all category physicians often use to refer children to rehabilitation therapies. As the therapist uncovered the events surrounding the head injury, she discovered that the parents had originally brought the child to the emergency room. He had spent four hours in the hospital and yet was released without any follow-up. The therapist explained with some anger that the child should have been followed right at the time of injury, but this did not happen. She was led, as a consequence of this new information, to construct a very different kind of story in which her young patient had "gotten lost." She said, "people get lost in the system all the time. That is a very big frustration of mine."

The family was poor, non-English speaking, and "private pay." Children from such families are very likely to slip through the cracks. The therapist herself became culpable in this narrative reading. She believed she contributed to inadequate

care of this child, for he was not coming in frequently enough to therapy. What he really needed, she said, was to be in a school program because therapy through schools was a free service. But, as a new therapist herself, she did not know how to negotiate this with the local school system. "When I first saw him I should have gotten him right into the school system. . . . He really needed more therapy and that is what I feel bad about. They [the family] are private pay. They don't want to come in a lot to see me." Since visits were infrequent, the therapist could not "get a handle on him. I can't get a good feeling of what he can or can't do." Therefore, she could not devise an appropriate treatment plan. The therapist found that she was lost in the story; she could not find a place in which she could be effective. The patient was lost as well. He was never properly diagnosed or treated. The family, too, was lost. They were paying for services they could not afford, and no one was helping them locate good resources for their child.

While it is obvious that this therapist was struggling to make sense of a confusing and distressing clinical situation, and that she told stories to express her way of making sense, it may not be so clear just how her storytelling was part of a *reasoning* process. In the remainder of this article, I examine three characteristic features of narrative reasoning in clinical work: (1) an emphasis on motives as *causes* for clinical consequences, (2) a connection between individual motives and social and cultural worlds, and (3) an exploration (or assertion) of what constitutes morally and practically appropriate action ("the good") given the exigencies of a particular situation.

Motives Serve as Key Causes for Therapeutic Outcomes

When therapists tell stories, clinical problems and treatment activities are organized as an unfolding drama. A cast of characters emerges. Motives are inferred or examined. Feelings often dominate the drama, as narrators intersperse descriptions of what happened with interpretations of how they and their patients felt about the events they recount. There are unexpected difficulties, or great successes that could not have been predicted. Usually there is some suspense surrounding the telling, except in the briefest tales.

Therapists draw upon narrative when they want to understand concrete events that cannot be comprehended without relating an inner world of desire and motive to an outer world of observable actions and states of affairs. In narrative reasoning, an "inner world" of motives and desires is seen as the significant underlying cause of events. Narratives concern the relation among motives, actions, and consequences as these play out in some specific situation; narratives ascend to the concrete (J. Bruner 1986; Ricoeur 1981, 1984). Chart talk, of course, is also grounded in specificities characterized by the precise delineation of physiological particulars and by the logic of the concrete case. "The individual case is the touchstone of knowledge in medicine," as Hunter (1991:28) notes. Narrative reasoning, however, utilizes specifics of a very special sort: it involves a search for the precise motives that led to certain key actions and for how those critical actions produced some further set of consequences. In the previous case, for example, the mother's morally puzzling affect concerning her child's injury was partly responsible for triggering the therapist's reframing of a diagnostic mystery into a narrative one. The therapist's narrative reconstruction of an event two years earlier led her to ask

questions about the motives and actions of an increasingly broad array of actors, including the family pediatrician, the emergency room personnel, and, more diffusely, "the system" that neglects those who cannot pay. This therapist's shifting and expanding narrative illuminates a second feature of narrative reasoning, which is described below.

Narratives Construct and Investigate Social Worlds

Narratives make sense of an act not only by connecting it to a single actor's motives and desires but also by situating that act in a social domain where others are also acting. An action is explained (becomes comprehensible and meaningful) when it is viewed as part of a larger temporal context (a history) and within a particular social world. "Narrative history of a certain kind," the philosopher Alisdair MacIntyre writes, "turns out to be the basic and essential genre for the characterization of human actions" (1981:194). Narrative provides a powerful vehicle for making sense of actions because it seeks to make actions comprehensible by showing how they are *reasonable* from the agent's perspective. This point has been discussed at length in the philosophy of history (Carr 1986; Collingwood 1946; Dray 1954, 1980; Olafson 1979). The agent's actions are deemed reasonable in light of immediate surrounding events as well as the agent's cultural beliefs, assumptions, and practices, the "local moral worlds" (Kleinman and Kleinman 1991) to which the agent belongs. In medical anthropology, the potent connection between narrative and belief system may explain why so often an analysis of illness models is based upon an analysis of illness stories.

In some clinical narratives, actions acquire reasonability (to narrator and audience) from a well understood and broadly shared cultural context. Often, however, therapists struggle to understand the motives of patients by constructing a picture of the context that makes certain actions and motives intelligible. Telling clinical stories allows them to simultaneously investigate possible motives and interpret social contexts. These investigations may render particular reported actions sensible, even if they are undesirable. For instance, a mother may not show emotion when describing her child's accident because she is abusive and it is reasonable (in American folk psychology) for a neglectful or cruel person to ignore another's pain.

The narrative rendering of an action as reasonable can happen subtly, merely in the way that an action is labeled or described. Take the mother's calm recitation of her child's accident in the example above. This "calm recitation" is a kind of observable behavior, something the therapist witnessed. But what sort of action is it? How should it be named and interpreted? Is the mother calm because she does not care about her child—is neglectful or abusive? Or is she calm because she trusts her pediatrician and hospital professionals who released her child and declared him uninjured? Or does the mother merely *appear* calm—is this a controlled presentation offered to a medical professional that disguises some quite different internal state? These are all narrative questions that impel therapists to embed observable behaviors within various possible social contexts. Such embedding is required simply to decipher what sort of *action* is being carried out. Is this "callous calm," "naive calm," or "the illusion of calm"? The interplay between the naming of acts, the construction of social contexts, and the interpretation of "hidden" motives is a

hermeneutic task, a tacking between part and whole and between inner and outer. It is fundamental to the construction of clinical stories.

Furthermore, telling stories allows a narrator to understand personal experiences in light of broader social and political contexts, and even to use such experiences to understand and critique such contexts (Farmer 1994; Layne 1996; Monks and Frankenberg 1995). Returning to the case given above, as the pediatric therapist gradually constructed a story about the child's prior accident, institutional contexts (the hospital emergency room, the private pay health care system) emerged as crucial "actors" who helped ensure that the injured child did not receive adequate or timely treatment. The therapist also held herself and the patient's pediatrician culpable for contributing to delays in providing good care, though she excused herself because she was a "new therapist" at the time.

Narratives Offer Moral Arguments about "The Good"

Telling stories also allows therapists to reason about how to act in particular clinical situations, taking into consideration the motives and desires of themselves, their clients, and other relevant actors. As Carrithers remarks, "Narrative thinking allows people to comprehend a complex flow of action and to act appropriately within it . . . narrative thinking is the very process we use to understand the social life around us" (1992:77–78). A good storyteller is persuasive and seduces the audience into seeing the world in a particular way (Bauman 1986; E. Bruner 1986).

Stories guide future actions. They provide historical contexts in which certain actions emerge as the inevitable next steps leading to the most promising future. Although the question of what "the good" future is for any particular patient may never be explicitly asked by therapists, the process of telling stories about a patient's past history or ongoing involvement in treatment is very often a process of exploring and negotiating a vision of the future good. When telling clinical stories, therapists assess how they can reshape a patient's situation for the better through actions of their own. They contemplate just how to situate their therapeutic interventions (a kind of "therapeutic present") in light of a patient's past and their hopes about what will follow in the future when the patient is discharged. Telling a story is integral to the reasoning process in which therapists consider the sort of therapeutic story they want to come to pass.

A story also affixes blame and assigns responsibility, though this may happen in a very indirect way. A powerful story may also persuade actors to understand a situation as, in an important sense, caused by certain significant actors and what they have done or have failed to do. Very often, stories point toward the morally appropriate by recounting instances of moral violations or, at the least, moral ambiguity (Good and Good 1994). One learns what is right to do by hearing accounts of transgressions, as Price (1987) nicely shows in her study of Ecuadorian illness stories that convey cultural knowledge about how to care for an ill family member. So effective are stories at encoding moral beliefs that learning how to tell a proper illness story may be considered integral to the healing process, as in Cain's (1991) study of storytelling in Alcoholics Anonymous.

The capacity of narrative to direct action is explored in the following example. It is taken from field notes of a staff meeting of psychiatric occupational therapists reviewing their units' current case load. Their interchange illustrates how a well-

developed narrative is constructed that allows them to ponder alternative views about what is good for a patient, and to collectively determine future actions of the treating therapist. Their storytelling is triggered by a puzzle about why the patient (Joe) has been readmitted to the unit.

Therapist 1:	Why did Joe come back in?
Therapist 2:	Well since he left he's been trying to control his mom and *didn't want* his mom to leave his side and I guess his family's like uptight and real frustrated with him [pause] and his dad was going on a date, no, his mom is going on a date with a new boyfriend and she started [pause] no, and he started clinging to her saying "Don't go" and screaming. [pause] The boyfriend beat him up.
Therapist 3:	He threw a brick at the boyfriend's car.
Therapist 4:	Yeah, he threw a brick at the boyfriend's car.
Therapist 1:	Ohh.
Therapist 4:	And did his tires.
Therapist 3:	Yeah, did his tires.
Therapist 4:	So that's not the worst of it, then his older brother came home and beat him up.
Therapist 1:	Why did he beat him up again?
Therapist 4:	Because he...
Therapist 3:	He heard about it.
Therapist 4:	He heard about that he wouldn't let his mom go out on a date.
Therapist 3:	So his back was loaded with contusions, pretty bad and [pause] his whole back [pause] has strap marks on his arms.
Therapist 2:	The big issue with him is his mom wants him in foster care, 'cos she can't deal with him at home and he doesn't want to go into foster care so that's I guess the main focus of his treatment here.
Therapist 1:	How old is Joe?
Therapist 3:	14.
Therapist 4:	13 [pause] 14.
Therapist 3:	The problem is that he's real tied to her too in some senses so if that's what the doctors are worried about is that he's got this real separation.
Therapist 4:	But I guess since he's been gone which is what two [months?] or so.
Therapist 5:	From the hospital?
Therapist 4:	From the hospital. He hasn't had a panic attack so that's a good sign.
Therapist 3:	mmm.
Therapist 5:	Well, I mean he does well on the unit, despite the fact that he can't stand being away from his mother, he does well on the unit. And I think a foster home might be the same type of thing once he settles in. And it doesn't sound like he has a good relationship with the boyfriend—obviously so.
Therapist 4:	Or his brother.
Therapist 3:	Brother?

Therapist 5: Or his brother.
Therapist 2: So he's back and that's the focus of his treatment.

This story explains Joe's situation in quite a special way, not by reference to a general set of pathological conditions (which lurk in the background but are not explicitly explored) but to a particular traumatic event. Highly particular, event-centered discourse is a hallmark of narrative. The "that" that therapist 2 declares as the focus of this treatment is a powerful collective telling of a fight. Telling the story allows the therapists to contemplate an array of motives that prompt not only Joe's behavior, but those of critical family members as well, particularly the mother who has played the key role in his appearance on the unit. The therapists construct a story in order to explain the puzzle of Joe's return. It is not unreasonable that Joe has been readmitted (in a general sense) because of his diagnostic label, but any specific readmittance calls for a particular explanation.

This explanation does practical work. The explanatory story created guides the therapists in deciding what they ought to do. By constructing the story, they identify those therapeutic interventions most appropriate in steering the unfolding narrative to its most desirable conclusion. Their storytelling begins with an ongoing problematic situation between Joe and his mother that spans the time since his prior discharge from the hospital. "Well since he left he's been trying to control his mom and *didn't want* his mom to leave his side and I guess his family's like uptight and real frustrated with him." A background scene is thus cursorily painted (control struggles, tensions, frustrations) that, in turn, renders this particular family blowup reasonable. Last night's drama is thus intelligible as a culmination; things finally came to a head.

The therapists' storytelling efforts reveal how easily explanatory links between behavior and intention are buried in narrative description. As the therapists tell it, Joe clings to his mother, screams, throws bricks, and punctures tires because he does not want her to leave. As construed in psychiatry, he has "separation anxiety," a diagnostic label that adds subconscious reason to conscious intent. Joe attempts to physically prevent his mother from leaving him by chasing her boyfriend away. The mother's (and to a lesser extent the boyfriend's and the brother's actions) are explained as responses to Joe's extreme behavior and to the general climate of tension and frustration created by Joe's presence at home. His pathology is important, but it is by no means the sole cause for the "moral" of the story, which is that Joe should be removed from his family. In explaining, stories implicitly assign blame. As this story is told, blame shifts from one actor to the next. At first Joe appears to be the instigator—trying unreasonably to control his mom. Then a boyfriend appears on the scene, who beats the boy. But simply blaming the boyfriend is made more difficult as we discover that Joe not only clung to his mother, but he also threw a brick at the boyfriend's car and "did his tires." But Joe's moral position in the narrative shifts again when an older brother "came home and beat him up." As the storytelling ends, Joe is conclusively the victim, a boy of 13 or 14 whose "back was loaded with contusions" and who had "strap marks on his arms."

Interestingly, the conclusion of this narrative supports the mother's desires and sets the therapists against the boy. They, too, feel he should go to a foster home, not because they think the boy is too much trouble, but because the family does not take care of him. The therapists cite further evidence to support their

conclusion. One therapist remarks, "He does well on the unit despite the fact that he can't stand being away from home. And I think a foster home might be the same type of thing once he settles in." This narrative contemplation is seamlessly woven into a discussion of best treatment interventions. The story they have told leads quite naturally to the view that Joe's key issue is separation from his mother. The story has such power, seems to convey so vividly Joe's problematic situation (underscored by the fact that his mother wants him placed in foster care), that the therapists do not feel any need to explore other possible ways of framing Joe's problem. Rather, they move without pause to a problem-solving mode, generating a variety of ideas about how to help him deal with separation. The graphic, negative images of home life conveyed by the story affirm the therapists' understanding that Joe needs foster care. Hence all therapists on the team contribute suggestions about how to best navigate through this difficult process.

In sum, moral arguments are buried within clinical stories. In the case of Joe and his mother, the therapists' interpretive process of telling the story is inextricably intertwined with identifying the morally good treatment for this patient. But this good is never explicitly discussed. Rather, it is naturalized in the very process of the telling itself, the "obvious" result of a recital of apparently relevant facts. But however invisible the reasoning process here, disguised as simply getting the facts straight, the therapists's discussion belongs much more to an Aristotelian notion of practical judgment than to clinical reasoning as applied science.

While biomedical rationality purports to involve the practical and objective task of finding the best means to serve pregiven ends (e.g., treating cancer), narrative rationality is very likely to raise the question of which ends are worth pursuing (Burrell and Hauerwas 1977; Murdoch 1972). Philosophers reviving an Aristotelian conception of practical reasoning (as against Kantian or utilitarian paradigms) argue that narrative is fundamental to practical thinking, especially in regard to that deepest practical question: how should one live? In narrative, questions about the good are asked in the context of a contingent and chancy world. Narrative reasoning is not grounded on the logic of the necessary or probable, but on the logic of suspense, the logic of the plausible after all (Barthes 1977). Narrative is needed to contemplate the world in its complexities and to decipher how one should navigate ones way in it, for narrative is built on surprise, chance, contingency, the anomalous event. Its very form offers a vision of life that is constituted by "significant surprises" (Nussbaum 1990:3).

Aristotelian practical reasoning understands action as a *judgment* rather than an application of general rules to a particular case. If every act is a judgment, discovering how to act is more than the application of the general to the specific, more than applied theory or science, and more than calculation about means. It involves deliberation about what an appropriate action would be with a particular patient, and at a particular time and place. This is no mere technical question because every context of action is always, in some way, unique. As a consequence, judging how to act requires capacities to "read" intentions of actors, to imagine outcomes based on a variety of possible actions, to discern what actions will be considered appropriate by others, and to understand the important historical contexts of which any given moment or any single act is just one part. Narratively speaking, practical judgment requires the actor to answer such questions as: What story or stories am I

a part of here? How will these stories change if I take this act in this way rather than that one?

In the case of Joe, the psychiatric therapists use a staff meeting to develop a shared narrative about how Joe's situation should be handled. The shared narrative is simultaneously a history of relevant prior events and a judgment about what ought to happen in the future. Various therapists contribute bits of the story until a satisfactory one is constructed. The story they create is not only about Joe and his family, but it also concerns their own roles as actors. They need to get their own parts straight so that each therapist will act to further the plot. The future of their actions, however, holds no guarantee; there are threats on many sides. Their plotline could be undercut not only by Joe (who has a very different sense of "the good" for his life) but, more significantly, by the treating psychiatrist, who in the past has tended to see things Joe's way. As occupational therapists with less power than physicians, they recognize that they do not have the same authority to enforce an intervention as the psychiatrist. But if they consensually devise a plan, perhaps they will be able to persuade the psychiatrist and other members of the interdisciplinary team to accede to their judgment.

What is so compelling about this narrative strategy is that, for the therapists, the process of story construction feels more like "getting the facts straight" than like plotting an argument (White 1980, 1987). "The good" that they narratively shape is rhetorically powerful because it is patently obvious. Thus the Aristotelian problem of ascertaining the good is handled tacitly. The therapists do not explicitly acknowledge that in reconstructing the history of Joe's relationship with his mother and the dramatic incident that precipitated his readmission, they are also developing a moral judgment about what ought to be done.

Conclusion

Drawing from my studies of occupational therapists, I have argued that reasoning is mediated by representations that are socially constructed. Such representations guide the clinical gaze of therapists, what they foreground and background, how they ascribe causality, who they blame or praise, and how they experience their patients. When therapists tell stories about (and to) their patients, the patient's illness experiences and therapist's experience of treating the patient are likely to take center stage. Through their narratives, they create clinical objects that are different than those constructed by authorized biomedical discourse; that is, they offer different things to reason about. These narratively constructed objects suggest a radically different conception of rationality than the canonical depiction of clinical reasoning. They suggest the practical rationality of Aristotle rather than the technical rationality of modern (enlightenment) conceptions of reasoning.

The most central narrative questions are those that address the deepest, most difficult questions for practical actions. What ought I desire here? What story ought I wish to make come true? These are at the heart of Aristotle's picture of practical reasoning. Practical action is an answer to the question: What is the good here? What telos ought I desire to bring about? Aristotle (1985) associated the expert practical actor with a virtuous actor, one who is able to correctly see how to act in a given situation. Even apparently simple actions require an expertise that is more like acquired wisdom (what Aristotle called "intelligence") than mere

competence, because they require the actor to ascertain what the right action should be in a given case. For Aristotle, as Rabinow points out, "there are no rules . . . it is a question of experience and practical activity" (1996:20).

In the cultural world of medicine, when a moral good is in question (should a dying patient be kept on life support systems?), it is viewed as a problem of ethics, which is distinguished from a problem of clinical reasoning. Aristotle made no such distinction. He linked expertise in rational calculation (i.e., assessing the best means to achieve the good) with intelligence to discern the "best good" for a given situation. He connected the need to assess the particular situation, the ability to calculate, the need to discover the best good in a particular context, and the critical role of experience as well as general knowledge in doing so. "The unconditionally good deliberator," he stated, "is the one whose aim expresses rational calculation in pursuit of the best good for a human being that is achievable in action" (1985:158). This unconditionally good deliberator was expected to have an understanding both of general truths, "universals," and also the capacity to discern particulars. "Nor is intelligence about universals only. It must also come to know particulars, since it is concerned with action and action is about particulars" (1985:158).

Contrary to what therapists would ordinarily say about themselves, I have proposed that they engage in clinical reasoning in their storytelling about patients. But it is clinical reasoning of a particular kind, one that is compatible with Aristotle's notion.[2] Telling stories offers therapists a way to express emotion, offer experience-near accounts of their encounters with patients, physicians, and other key actors, and infuse their work with moral language. It also allows them to engage in a reasoning process that connects decisions about treatment to complex social histories and subtle readings of motives and intentions. A final argument made here, rather an obvious one, is that while storytelling introduces the actions and experiences of therapist, patient, and other key actors, this introduction may not benefit the patient. While some, myself included, have argued that stories offer a way for practitioners to think more complexly about their clients and can serve to improve decisions about patient care, there is no necessity that stories do so.

When therapists tell stories, "the good" becomes situated within very human dramas that involve a number of actors whose motives and acts are often not easily deciphered. In storytelling, clinical reasoning is no longer simply a matter of matching symptoms and signs to diagnostic categories and choosing among a number of treatment alternatives. It enters a far more shadowy and conflicted practical domain. In this shadowy territory, an Aristotelian version of practical reasoning has more to offer than the enlightened concepts of rationality that constitute biomedicine's inheritance from the Age of Reason.

NOTES

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1. Each of the 3 sites was a large urban hospital connected to a major university. These hospitals covered a wide variety of acute and rehabilitation wards, as well as a multitude of out-patient clinics. The sites supported occupational therapy departments of between ten and twenty staff. In the Boston site, where I did by far the most extensive work, I spent two years conducting an ethnographic study. I observed practice, interviewed therapists, and videotaped clinical interactions of 13 of the 15 staff members. I also reviewed written charts. (For more detailed discussion of the research design itself, see Mattingly and Fleming 1994; Mattingly and Gillette 1991.) In the two subsequent sites, I observed and interviewed therapists and, on occasion, patients and family members as well. I also supervised the videotaping of some treatment sessions and chart reviews.

2. The connection between narrative reasoning and Aristotle has been explored by a number of philosophers, including MacIntyre (1981), Nussbaum (1990), Murdoch (1972), and Ricoeur (1981, 1984, 1992).

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