doi:10.1093/fampra/cmh619 Family Practice Advance Access originally published online on 17 January 2005

Can 'anecdote' ever be research?

Trisha Greenhalgh[a]

Greenhalgh T. Can 'anecdote' ever be research? *Family Practice* 2005; **22:** 1.

A story has three defining features: an account of the unfolding of events over time; emplotment (i.e. the rhetorical juxtaposing of these events to convey meaning, motive and causality); and trouble (a breach from something that was expected). Trouble is the raw material from which plot is woven. Heroes are made when individuals tackle their own troubles or step in (courageously, determinedly, selflessly) to help others out of theirs. In the illness narrative, the focus of trouble is death, disability, disfigurement, intractable pain or loss of freedom. The plot conveys how well or how badly health professionals, caregivers and patients evade or face up to these adversities.

Arthur Frank divides illness narratives into four broad genres: restitution (the doctor-hero accurately diagnoses and successfully treats the illness); tragedy (the doctor-hero does his or her best but the patient nevertheless succumbs); quest (the patient-hero embarks on a journey to find meaning and purpose in his or her incurable illness); and chaos (the story is incoherent, unsatisfying and does not make sense).[1] Arguably, the various forms of 'talking therapy' offered to the ill—counselling, psychotherapy and the intermittent dialogue of long-term continuing care—constitute above all else the witnessing of tragedy or quest narratives, or, if chaos abounds, attempting to co-construct a new narrative that holds some meaning for the patient and can begin to unfold (for better or worse, but as a story should).

Jerome Bruner divides all reasoning into logico-deductive (i.e. rational, objective and scientifically verifiable) and narrative-interpretive, based on the features of a 'good story' (i.e. literary coherence, aesthetic appeal and moral order, e.g. when the hero gets his just reward or the villain her come-uppance).[2] The rigorous and conscientious application of logico-deductive truths (as in evidence-based medicine) is undeniably a critical dimension of good doctoring. Equally critical is the empathetic bearing of witness to the patient's story—especially to his or her account of personal trouble and heroic efforts to face and resolve it.[1]

In this article, a group of hospital physicians use a case report of an elderly woman with palpitations to illustrate how the opportunity to tell one's full life story can lead, they claim, to the resolution of medically unexplained symptoms. Judged by narrative criteria—does the story 'ring true'; do we (the readers) feel that things 'turned out all right'?—the case is authentic and credible. In Frank's terminology, the patient has been helped to move from a 'chaos' narrative to a 'quest' narrative, and can now get on with her life (and her journey towards death).

This report is not being sold to us as 'evidence' in the conventional sense of the word. The patient was not randomized, nor was the 'intervention' standardized or the desired outcome explicitly pre-defined. The case is not generalizable to other patients with palpitations, nor, indeed, to others who present chaos stories. The authors do not justify why they recommend a single long consultation rather than a more conventional series of counselling sessions. In many ways, therefore, this report raises more questions than it answers about what types and formats of narrative interview are likely to 'work' for what type of patient in what circumstances. Prue Chamberlayne and her team recently have published a book describing the use of biographical life narrative as a tool in social policy research.[3] They warn that it is not a panacea and can be misused by the under-trained and misguided. I strongly recommend that those interested in developing this new method for use in a clinical setting follow Chamberlayne's example and set themselves the task of evaluating its impact on patients and health professionals prospectively, systematically and reflectively.

Declaration

Funding: None.
Ethical approval: Not applicable.
Conflicts of interest: None declared.

References

[1] Frank A. Just listening: narrative and deep illness. *Fam Syst Health* 1998; **16:** 197–216.
[2] Bruner J. *Actual Minds, Possible Words*. Cambridge: Harvard University Press; 1986.
[3] Chamberlayne P, Rustin M, Wengraf T. *Biography and Social Policy in Europe: Experiences and Life Journeys*. Bristol: The Policy Press; 2002.

[a]Professor of Primary Health Care, University College London. Correspondence to Trisha Greenhalgh, Room 403, Holborn Union Building, Highgate Hill, London N19 5LW; Email: p.greenhalgh@pcps.ucl.ac.uk