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Adding a narrative practitioner perspective section to case report publications

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ABSTRACT

Clinical case reports are opportunities to disseminate information on unique diagnoses and treatments through the reporting of objective and scientific data supplemented by the patient's perspective on the outcomes. The practitioner has traditionally removed their own narrative which includes perspectives and bias relating to the encounter. The absence of this practitioner narrative in published case reports reflects an incomplete picture of the therapeutic relationship and can directly impact the applicability to clinical practice. Although guidelines on publishing case reports are focused on providing complete and transparent information from which to inform research design and allow aggregation for data analysis, the physician's narrative involves the awareness of bias, distractions and recognition of shared experiences which influence the therapeutic relationship. In this paper we propose a three-phase process culminating in the inclusion of a physician narrative in published case reports to better reflect the humanity present in patient care.

1. Introduction and background

> "the greatest challenge facing contemporary medicine is for it to retain . . . or regain its humanity, its caritas — without losing its essential foundation in science . . . to find a middle way." [1]

Case reports in the medical literature often reflect little of the significant humanity present in patient care. In 2013, the International Congress on Peer Review and Scientific Publication, published the CARE guidelines to help provide rigor to case reporting in the medical literature. These guidelines were developed to bring transparency and completeness to case reporting [2]. By definition, a case report is a narrative that describes the experience of a patient [2]. In addition a focus on a concise clinical presentation of the diagnosis, treatment and outcomes through objective observation of the patient and the therapeutic encounter, these guidelines also recognize the importance of the patient perspective. However, the practitioner's narrative and bias which we argue directly impact patient outcomes and perceived quality of care [3–6] are implicitly present in the therapeutic encounter yet largely absent in case reporting.

The practitioner's beliefs and attitudes, feelings and emotions, and personal self-care all influence their interactions with the patient by adding to the context effect of the clinical encounter [7]. By ignoring the practitioner's own narrative in the patient-practitioner relationship the case report creates an incomplete picture of the shared experience. The practitioner is an equal partner in the patient-practitioner relationship and their own beliefs and attitudes necessarily impact the patient reported outcomes [8]. This paper lays out a proposal to incorporate this missing piece in order to increase completeness and transparency in case reporting.

In order to most accurately depict all aspects of the clinical encounter, the experience and engagement of the practitioner must be acknowledged, reflected upon, and shared. We propose three distinct and cumulative phases necessary for the implementation of more complete case reporting.

2. Phase 1 – acknowledgement of the significance

The initial phase begins with education of the practitioner on the significance of their interactions with the patient. This awareness expands beyond the therapeutic possibilities of rapport into areas which may be more sensitive or provocative for the practitioner, such as the awareness of bias or significant personal

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distraction. Since the practitioner attempts to model immunity from these types of influences, this acknowledgement is a profound paradigm shift. However, at this point in time, while the question of whether bias exists on a broad scale is indisputable [7] the acknowledgement of its presence on an individual basis is far less accepted and realized. The inclusion of the practitioner narrative in the case report would serve to bring greater awareness of the impact of the practitioner's biases on the patient's experience supporting this paradigm shift.

Practitioners should be prepared to acknowledge a broad array of bias, including, but not limited to those which are most commonly considered (such as expressed biases towards a patient's race, gender, sexual orientation, marital status, and age) as well as those which may be less commonly considered (such as reactions to language barriers, literacy, education level, physical fitness, body odors and hygiene, displays of wealth or politics,etc). Other factors including distractions and shared experiences may also play a role. (Fig. 1) Bias can also be something exhibited by the patient and experienced by the practitioner. In this case, the impact on the therapeutic relationship is potentially substantial.

Practitioners necessarily possess a potentially discursive internal narrative that may impact their ability to remain fully present with the patient. Examples of possible distractions which may influence the focus, and therefore the rapport, of the practitioner - patient relationship include distractions such as personal concerns, their physical pain, time and scheduling pressures, hunger, fatigue, etc. The acknowledgement of the influence of this narrative on the therapeutic relationship begins a process which set the stage for more complete case-reporting.

It is also important to discuss that practitioner perspectives are not an independent static component of the therapeutic interaction. Practitioner perspectives are dynamic. They are subject to trends of innovation in medical education and our growing scientific knowledge. Additionally, practitioners exist in the same dynamic and evolving cultural and societal mileus as patients. Soliciting the inclusion of succinct and relevant practitioner narratives, and seeing those narratives in the aggregate is a vitally important precondition to determining from a evidence based perspective what role they play, if any, in outcomes.

3. Phase 2 – self-reflection of the clinician

Once a practitioner has acknowledged the presence of these influencing factors, the second phase is to undergo a self-reflection as part of their case report composition. The practitioner can examine their internal dialogue and interactions with the patient, beginning at their first impressions and continuing through the length of their therapeutic relationship. A practitioner may internally acknowledge their impressions, exchanges, feelings, and internal distractions to the consultation which may have had an impact.

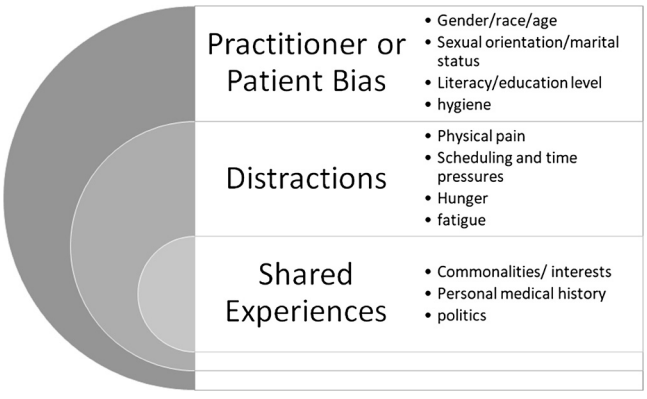

Fig. 1. Examples of Practitioner Influences on the Therapeutic Encounter.

The self-reflection process is especially helpful in the story of the practitioner's rapport with the patient as they note the ease with which this developed and their overall perception of the relationship. This internal narrative should begin as a private process of exploration and acknowledgement *entirely independent* from the reporting aspect in the third phase, encouraging the practitioner to have an honest internal dialogue.

Validated self assessment of Cultural Competency using tools like the Cultural Self-Efficacy scale (CSES) [10], the Trans-cultural Self-Efficacy tool (TSET) [10], or the Campinha-Bacote's Inventory for Assessing the Process of Cultural Competence among Healthcare Professionals Revised (IAPCC-R) to name a few [11], can be valuable in helping the practitioner to understand their own cultural biases which might play a role in the therapeutic encounter. The value of this self assessment has not yet been applied to Case Report preparation but opens up interesting possibilities for future research.

4. Phase 3 – manifestation of this reflection within case reports

The final phase is the determination and manifestation of the process presented as a practitioner narrative in the case report composition. Many case-reporting guidelines incorporate a patient perspective or narrative and the proposal layed out in this paper builds upon this humanizing framework by proposing a section which depicts the practitioner perspective or narrative.

The practitioner perspective is the product of a self-reflective process followed by a more didactic approach to the factors the practitioner has observed. The framing of this perspective as part of the case report should take into account the public nature of the published work, calling for a demonstration of respect for the patient while maintaining the spirit of the experience. Table 1 provides three examples illustrating the product of the above process.

5. Discussion

Rita Charon [12] distinguishes between the "Logicoscientific" knowledge we see in Case Reports from the Narrative Knowledge our proposal is recommending. She defines "Logicoscientific" knowledge as when "a detached and replaceable observer generates or comprehends replicable and generalizable notices" [12]. In comparison, a narrative knowledge is "what one uses to understand the meaning and significance of stories through cognitive, symbolic and affective means." We propose that by adding a practitioner narrative to the primarily logicoscientific presentation of current Case Reports, we will gain insight into how the practitioner's narrative may influence the patient's health outcomes through a context effect. The "meaning" of the narrative emerges from the space between the patient and the practitioner. Without insight into the practitioner's side of the narrative knowledge we lack the ability to contextualize the logicoscientific perspective within a larger narrative that more accurately reflects the full therapeutic interaction.

In practice, the dyad between the patient and the practitioner includes not only the practitioner's skills and clinical experience but is also the primary substrate for the cultivation and practice of medical humility. Medical humility has been defined as "unflinching self-awareness; empathetic openness to others; and a keen appreciation of and gratitude for the privilege of caring for sick persons." [13] This modern humanized approach has a direct impact on the relationship between the patient and the practitioner, including trust building and greater adherence

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