

Editor's Introduction

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In seeing this issue come together, I am reminded of narrative scholar's Amy Shuman¹ examination of available narratives and counter-narratives. Available narratives are the preferred and prevailing accounts of a society, accepted cultural discourses from which narrators can readily draw to tell their own stories. As is the case with the canonical hospice narrative of hopelessness in what Tullis, Roscoe and Dillon² characterize as the *death avoidant* United States, or the psychiatric narrative of anorexia nervosa as something in the individual's mind taken up by Ciabattoni,³ once available narratives become institutionalized they become dominant by appearing to represent a collective ethos.

I say appearing because narratives can be deconstructed and reconstructed. Writing about how personal narratives of disability have not only countered dominant narratives of disability but actually reimagined the field of Disability Studies, Shuman notes that by revealing disruption and disjuncture in dominant accounts, counter narratives resist the restrictions and impositions of available narratives from being placed on the lived experiences of narrators – and that is not just how they tell their story, but how they live it.

The article by Tullis, Roscoe and Dillon² beautifully demonstrates how hospice patients are able to do just that by telling second stories of hope in hospice. These stories

resist the traditional definition of hope as beating illness or death, for in them patients reject the fight metaphor that casts them as losers, but rather see hope and hospice as a way of still valuing life and reclaiming their authority on (and authoring of) it. Vivid and compelling, Ciabattoni's personal narrative³ of her multi-voiced relationship with anorexia as a presence in her life not only counters the nosological narrative of psychiatry, but opens up ways to resist the isolation that sustains the dominant story of anorexia, and to choose other ways of telling the self.

Though the authors of the three articles that follow do not write about narrative per se, I see the studies by Munteanu & Jordan,⁴ Baldwin *et al.*,⁵ and Spataro *et al.*,⁶ are also very much engaged in countering available narratives, and opening up the space for novel ways of accounting for healthcare experiences and situated (re)tellings.

By endeavoring to elicit and listen to stories as yet institutionally unavailable, Munteanu and Jordan's interviews with physicians allow the researchers to acknowledge that though Clinical Practice Guidelines may make good sense for institutional praxis, those who must practice them find themselves at odds with them. The authors' work in this piece serves an important reminder that guidelines should fit people, rather than the other way around.

The examination of how patients with Hepatitis C experience fatigue by Spataro, Afdhal, Weinstein, Escheik, Austin, Brodie, Gerber, and Younossi similarly engages with the dominant medical narrative of fatigue in order to problematize it from the bottom up, by interrupting the diagnostic account a complex condition with the actual bodies and voices of those for whom the term signifies multiple life changes. I see the authors' effort as a step in allowing life stories of living with fatigue to in-form, or give shape to assessment measures that purportedly classify the experiences of those with what medical discourse understands as fatigue, so that the exigencies of the institutional narrative not result in rendering the term meaningless to patient lives or, for that matter, in invalid measures and assessments.

The article by Baldwin, Pope and Marks offers an occasion for readers to reflect on the case study as an analytical and theory-building occasion in qualitative research in medicine. In *Doctor's Stories*,⁷ English profes-

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sor Kathryn Hunter remarks that medicine is narrative practice, recoverable by careful reconstruction of how the many voices that comprise medical care speak as one to codify their stories for institutional purposes. Hunter notes that the case studies published in medical journals follow the structure of detective stories, where the omniscient voice of medical science balances the tension between the unique nature of the singular case and that of the requirements of generalizability by following a known and well-documented protocol of investigation, uncovering the solution, and solving the mystery of the illness. The patient's body, in these stories, is merely the setting for the story; a stage for the illness and the medical dénouement alike.

Quite a different matter is the case study as presented by Baldwin and her co-authors. By narrating Ravi's culturally situated and gendered case of an Asian Indian son taking over the role of caregiver of his parents as a first generation citizen of the United States, Ravi's case speaks to the interpersonal complexities of caregiving, and how health care professionals must adapt their own available accounts to address these. As with the other research articles that make up this issue, I invite readers to appreciate how qualitative research is itself a narrative endeavor, a way to take dominant narratives to task, and encourage, if not push for versions that counter the way things are, by proposing viable ways for healthcare practices to take up ways things should and could be.

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