Anecdote bad, story good

We may despise anecdotal evidence, but stories are still important. Not as sources of new knowledge, but to teach, to persuade and to provoke thought. Stories work in teaching because they are memorable: what medical student can forget the one about the man with a large liver and a glass eye? Then there are stories to persuade. They slip in under the guard we raise against direct attempts to persuade.¹ And the very best stories have enough ambiguity to provoke thought: consider Shakespeare!

Public health has its classic tales. There are the detective stories: Sydenstricker hunting down the cause of pellagra in the cotton villages of South Carolina,² the case of the Epping jaundice³ or Peter Pharaoh’s brilliantly told account of endemic cretinism in the jungle of Papua New Guinea. There are the tragedies, usually disastrous failures of health protection: Bhopal, Chernobyl and, less well known but in many ways a more intriguing story, Goiania.⁴

But it seems to me that, health protection apart, we are short on stories of modern public health to inspire, intrigue and provoke thought. Where are the memorable tales of the battle against smoking, alcohol or teenage pregnancy? Of the lessening of inequalities in health? Or of the efficient organization of health services?

The raw material for stories – struggle against adversity – is there, so perhaps the problem is that we do not know how to construct good stories. Academic analysis can help: for example we need to realize that narrative, epic and fable have different conventions.⁵ Failing to observe the conventions will lead to stories that irritate and mystify rather than illustrate and satisfy.

We need to be aware also of the rules for delivering the story – for example, the mechanics for writing and telling stories are different.⁶ ⁷

Simmons encourages us all to have a set of basic stories.⁸ One of these is the ‘Why I am here’ story – for us this means why we have chosen to do public health work.

For me, it was Mr Vernon. He was a man with heart failure, 80% of his heart muscle dead from repeated infarcts. He was the patient of the world-class cardiologist for whom I worked. With the best and latest treatment Mr Vernon could shuffle, gasping for breath, from his bed to the end of the ward. Sometimes he was judged fit enough to go home, but he always returned within days. Treatment was obviously futile, prevention the only answer: a career in public health beckoned.

What is your ‘Why I am here’ story – and can you tell it well?

E. G. Jessop
Editor, Journal of Public Health

References