Literature and Medicine

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A Practical and Pedagogical Guide

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Preface

Goals of the Book, Audience and Background, How to Use This Book

Literature and Medicine: A Practical and Pedagogical Guide is a book that grows out of more than 18 years of teaching and collaboration between the authors, Professor Ronald Schleifer, a George Lynn Cross Distinguished Research Professor of twentieth-century literature and culture, literary aesthetics, and semiotics at the University of Oklahoma, and Dr. Jerry Vannatta, a David Ross Boyd Professor of Internal Medicine (retired), former Executive Dean of the University of Oklahoma College of Medicine with a long career as a practicing physician, a researcher, and an award-winning classroom professor. The goals for this book—as they have been for authors' classes for pre-med and medical students, and for their workshops for practicing physicians and healthcare professionals—are very specific. They are:

- To help develop in physicians and healthcare professionals through the study of literature and narrative *habits of attentive listening* with the patients and others with whom they work. Among other things, these forms of attention will contribute to more precise and more efficient understandings of the medical conditions and personal concerns that brought the patient to the healthcare provider, which, in turn, will lead to more accurate diagnoses on the part of physicians and healthcare providers.
- To help develop in physicians and healthcare professionals through the study of literature and narrative *habits of responsive engagement* with their patients. Among other things, these forms of interaction will lead to a greater sense of empathy on the part of healthcare providers, a greater commitment to treatment plans on the part of patients, and a greater sense of satisfaction on the parts of *both* patients and healthcare providers.
- To help develop in physicians and healthcare professionals through the study of literature and narrative *habits of critical thinking*. Among other things, these forms of reflection will lead to everyday behaviors that will create a greater sense of professionalism and a more habitual practice of basic ethical responses such as simple decency and good will.

The goals of this text-anthology itself grow out of a generation of scholarly work by physicians, psychologists, anthropologists, and literary critics in the United States aimed at developing the ways that engagement with the humanities in general, and literature in particular, can create better and more fulfilled physicians and caretakers. As we note in our book, *The Chief Concern of Medicine: The Integration of the Medical Humanities and Narrative Knowledge into Medical Practices* (a book, like this text-anthology, greatly indebted to this generation of work),

> by "better physicians," we mean better diagnosticians in listening to and understanding the patient's story; better and more fulfilled professionals in developing powerful relationships with patients; more sensitively responsible doctors in the actions of everyday practice; and, perhaps encompassing all of these, people who will bring greater care to those who come to them ailing or in fear or faced with terrible suffering. (2013: 2)

Literature and Medicine, like our earlier work, is based upon the assumption that storytelling and narrative are centrally important in the patient-physician—and, more generally, in the patient-caretaker—relationship. In her groundbreaking book, *Narrative Medicine*, Dr. Rita Charon eloquently describes the role of narrative understanding in healthcare as "medicine practiced with the narrative competence to recognize, absorb, interpret, and be moved by the stories of illness" that patients bring to physicians. She adds that

> a medicine practiced with narrative competence will more ably recognize patients and diseases, convey knowledge and regard, join humbly with colleagues, and accompany patients and their families through the ordeals of illness. These capacities will lead to more humane, more ethical, and perhaps more effective care. (2006: vii)

In a similar fashion, in *The Chief Concern of Medicine*, we assume that "through the practice, analysis, and discussion of narrative (and particularly of literary or 'art' narratives) physicians—and, indeed, all of us—can become better at recognizing stories, comprehending their parts, rearranging them in new contexts, responding to them, and acting on the knowledge we have gained" (2013: 1). And this, of course, is what healthcare providers do every day—listen to patients' stories. It is the purpose of *Literature and Medicine* to contribute to the creation of practical pedagogical programs for this practice, analysis, and discussion in our colleges and medical schools.

The Goals of the Book

Although the work of *Literature and Medicine* falls under the wider umbrella of "medical humanities," this text is designed for a *practical* rather than a "conceptual" or "intellectual" engagement with the humanities. That is, this book, growing out of the successful team-teaching by the authors for many years—including a systematic follow-up study tracing the subsequent medical careers of our students (see Shakir et al. 2017)—aims at demonstrating the practical usefulness in medicine for

engagements with literary and everyday narratives by students who, in large numbers, have not experienced the formal study of narrative.

Our overall purpose, then, is not simply to create a collection of stories and other materials related to practicing medicine. Rather, we aim to encourage appropriate pedagogical strategies that will allow both instructors and students to develop methods of engagement that are emphasized in the humanities in general and in literary studies more specifically—what we are calling here humanistic "resources"—which are often excluded from necessarily intensely focused study in biomedical education. Such strategies emphasize interpretation, inference, and grasping the "wholeness" of meaning rather than the apprehension of demonstrable—and often isolated—"facts" of biomedical understanding. For this reason, the goals of this book are to instill, in people aspiring or pursuing careers as healthcare providers, the understanding that formal patient-caretaker encounters, such as the medical interview, call for a set of skills different from those necessary for biomedical understanding. Over the years, we have found that engagement with and classroom discussion of literary narrative allows students to think of these skills as professional resources. The basis for this assumption, as we had hoped the short survey of cognitive psychology in Chap. 1 and in Appendix 1 might suggest, is that these skills of interpersonal engagement and understanding, including the ability to grasp "narrative knowledge," are available to all as part of our human inheritances. Thus, while it might well be that, as some advocates of including humanities courses in a medical education suggest, close reading and creative writing require very intensive and personal training over years, our aim and experience has been that a basic set of "elementary" questions and focuses in relation to narrative makes students and instructors aware of the practical usefulness of existing human resources for professional use in a relatively shorter time. Many recent studies in cognitive psychology have corroborated this experience.

It has been our experience that the vast majority of pre-med and medical and healthcare students have had scant experience with the humanities in general and engagements with literary narrative in particular. One very bright second-year medical student announced in class one day that the four novels we read in our three-week class double the number of books he had read in his lifetime. (This student went on to become part of a student-team that established a literary/arts journal for the University of Oklahoma Medical College, *Blood and Thunder*.) Moreover, it has been our experience that this majority of pre-med and healthcare students consistently reads on the level of content without consideration of form. In the section of the Introduction focused on Medicine, we argue that attention to the form of patient narratives as well as their content plays an important role in clinical medicine. Moreover, we discuss, at some length, the relation of form and content in Chap. 1, and in our pedagogical appendices, a majority of questions for both discussion and daily writing asks readers to focus on *how* narrative texts create their effects. Such questions help people understand their own responses to narrative, which include, studies in cognitive psychology have found, ethical discernment, attention to metaphorical language (which necessarily focuses on motive as well as fact), and awareness of ambiguity, among other things.

Thus, the goal of the book is to help instructors to create a course in which the realization of the importance and usefulness of these resources is made clear. For almost 20 years, each fall, starting in late August, the authors have taught this class to junior and senior undergraduates, mostly pre-med students; and both individually and together, we have also taught this class to second-year and fourth-year medical students and students in other healthcare programs. Every year, usually after about six weeks (in early October), students begin to internalize and habituate certain strategies of judgment and interaction, which they hadn't thought of as part of the professional work they had chosen for themselves. Needless to say, there were always some students who didn't "get it"; but significant majorities of our students came to think that interacting with patient stories *as narrative*, that pursuing rather than dismissing empathetic responses, that relating their patient encounters to stories they had "vicariously" experienced in reading literary texts, all could make their work in healthcare more successful for patients and more fulfilling for themselves as practitioners. To put it succinctly,

> The overall purpose of *Literature and Medicine* is to help structure classroom engagements which will encourage those studying to become physicians and other healthcare professionals to come to see that humanistic understanding is, in many instances in their professional lives, as important as biomedical understanding in caring for those in distress. This is achieved by encouraging and training people to be "careful" readers and listeners to narrative just as the rigorous study of biomedicine trains people to widely knowledgeable about illness and its causes.

In relation to this goal, the audience for this book includes instructors as well as students and private readers. That is, as a "text-anthology," *Literature and Medicine* aims at giving instructors in healthcare education some elementary tools with which they can more fully describe skills in attentive listening, responsive engagement, and critical thinking while at the same time giving instructors in humanities education a set of the elementary issues and questions that arise in the everyday practice of medicine. We are calling this book a "text-anthology" because it combines an anthology of literary works and medical vignettes and a textbook designed to present the basic methods and concepts that govern the study of narrative and the teaching of literature to students, instructors, and readers who might not be trained in literary studies or in the medical humanities. Our years of team-teaching and team-writing have made us acutely aware of these skills and how they can benefit both medical and humanities educators. That is, insofar as the humanistic "resources" are social and personal behaviors that most of us participate in our everyday lives, and insofar as these experiences respond to recurrent situations and problems in healthcare, *Literature and Medicine* hopes to facilitate in all its audiences useful interpersonal strategies by making these strategies explicit and explicitly experienced in relation to literary readings. For this reason, the aim of the book—and the courses it will enable—is not conceptual engagement with the humanities and literature, but *practical engagement* of storytelling on all levels for people hoping and trying to do the best for the patients they encounter.

We want to reiterate: by a "careful" reader we mean someone who might notice things that otherwise would not be seen. We believe that classroom engagements and discussions occasioned by this text-anthology can and will result in many participants discovering, and even habituating in their action, resources for care and understanding that they hadn't realized were available. In fact, it is our great hope that practicing teaching physicians might read Tolstoy with an eye toward making explicit in classroom discussion the ways in which Tolstoy's narrative can help them and their students more fully understand their successes and short-comings in their professional practice; and, equally so, that talented humanities teachers will find practical uses in the context of pre-med and medical education for the careful engagements with texts they have pursued throughout their careers. Additionally, because of the kinds of *focuses of attention* that *Literature and Medicine* promotes in (a) its aim of explicitly articulating narrative "features" and in (b) its aim of explicitly isolating particularly recurring "medical topics" and "medical issues" (including errors and mistakes, cultural awareness, strategies for listening), it is our reasonable hope that committed, if inexperienced, readers can discover important professional resources in their engagements with the strategies and content of this book. This has been our experience in co-teaching together with our complementary commitments to strengthening engagements with literary texts and developing successfully efficient clinical practices.

Finally, we want to make explicitly clear that it is not our purpose to create a text-formula for the reproduction of our courses, which in fact have greatly changed over the years. Rather the hope and goal of the book's content and organization is to make clearer to all participants an array of professional strategies and understandings that engagements with narrative repeatedly instill in students and readers over the course of a single semester or even over the shorter time span of medical-school courses. We believe—and have found in many years of undergraduate and graduate courses and professional workshops—that focusing on narrative *skills* strengthens listening, engagement, and critical thinking simply by making explicit in focused discussions attitudes and engagement-strategies of interaction that are often easily overlooked.

To these ends, this text-anthology focuses on five ways that "narrative knowledge" contributes to medical education and successful medical practices:

1. It contributes to an awareness of medical professionalism.
2. It contributes to the establishment of a strong patient-caretaker relationship.
3. It helps build a conscious awareness and a habitual sense of everyday ethics of medical practice (including, specifically, an awareness of mistakes in medicine).
4. It helps readers acquire an understanding of the ways that literary narrative provokes empathy and vicarious experience that can help negotiate differences in basic life experiences that healthcare providers and patients bring to the patient-caretaker relationship.
5. It demonstrates a systematic understanding of the logic of making a diagnosis.

Audience and Background

This text-anthology is meant for students and instructors of health sciences but also practitioners who are searching for strategies of connecting more meaningfully with their patients. It is meant to appeal to medical professionals who are interested in further developing their skills and understanding their interactions with patients by reading, reflecting on, and occasionally writing about literary narratives—stories of excellent quality that make important points in relation to the practice of medicine. To this end, the text-anthology makes studying literary art narratives more effective by providing, in Chap. 1, outlines of features of literary narrative which create an efficient (and easily habituated) understanding of how stories are structured and function. In addition, in each chapter of this text-anthology, we offer literary narratives and poems related to the chapter's focus and theme, and we offer and analyze "everyday" narratives ("vignettes") taken from actual clinical situations to help define and delimit each chapter's theme. As we note in Part II of Chap. 1, an important difference between everyday narratives and literary narratives (both of which are ubiquitous in human cultures) is that the former most often function to promote action in the world (see Boyd 2009) while the latter, as the narratologist James Phelan notes, promotes strong "focus on teller, technique, story, situation, audience, and purpose: all the elements that help determine the shape and effect of the story" (1996: 4).

For this reason, as we argue in Part I of Chap. 1, engagements with literary narrative make us more sensitive to narratives in general, and throughout *Literature and Medicine*, we emphasize this by juxtaposing literary and everyday narratives in every chapter. This is also apparent in the two-part "Introduction" below, which creates frameworks in both literature and medicine for people engaged with this book. In addition, the appendices in Part II of this book provide supplementary materials for the topics of this text-anthology: particular guides for writing assignments (if desired); and a particular guide for discussing diagnosis and diagnosis errors for instructors; discussion questions for instructors in working with these narratives in medical school; a detailed program of the use of literature in inculcating professionalism in medical students and physicians, which includes, in its bibliography, a number of empirical studies in cognitive psychology validating the effectiveness of literary reading; and finally, a guide to the "unsaid" that is encountered both in literature and in the clinic.

How to Use This Book

Literature and Medicine is designed to provide clear examples of strategies of reading and analysis of texts that are focuses of literature courses in ways that will be *practically useful* for students and instructors of medicine and other healthcare fields. A notable feature of the text-anthology is the fact that each chapter begins by analyzing a vignette from medical practice which helps define a field of concern that engagement with a literary text can help illuminate. That is, built into the structure of the

book itself is the practical relationship between the situations and practices of healthcare and strategies of understanding and behavior that literature helps foster. We have organized this text-anthology so that it can be the basis of both long and short courses on literature and medicine in undergraduate and postgraduate courses. Its double Introduction plus 14 chapters can organize a full semester of study—especially if instructors incorporate discussions of poetry as well as fiction and if *Literature and Medicine* is supplemented by the full-length novels, Roddy Doyle's *The Woman Who Walked into Doors* and Toni Morrison's *Beloved*, discussed in two chapters, and perhaps also supplemented by a full-length "vignette" such as Anne Fadiman's *The Spirit Catches You and You Fall Down*. (In addition, we discuss five texts, which are readily available (see Bibliography), that might supplement the work of this volume: Ernest Hemingway's short story, "Indian Camp," discussed in Chap. 5 and Appendix 6; Anatole Broyard's narrative of being a patient in "Doctor Talk to Me," discussed in Chap. 6; Dr. David Cassel's "The Nature of Suffering and the Goals of Medicine," discussed in Chap. 11; Dr. David Hilfiker's "Facing Our Mistakes," discussed in Chap. 13; and Dr. William Carlos Williams' "The Use of Force," also discussed in Chap. 13.) At the same time, however, this text-anthology also lends itself to shorter, four- or eight-session courses following its section topics represented by the roman numerals in the Contents. Thus, the texts and topics of the book—after the short introductions and opening chapter focused on the ways literary narrative works in relation to clinical medicine—present a wide range of global issues facing physicians that we have already listed: systematic diagnosis, professionalism, the patient-physician relationship, ethics in medicine, the diversity of patients for most healthcare providers, mistakes in medicine, and death and dying. And we end with a short Postscript, which returns readers to the fulfillments of a career in healthcare, something that can be lost in the welter of "problems" that arise in the professional caring for others.

The book is structured to allow great flexibility for instructors and readers. Thus, while the two-part Introduction and Chap. 1 create a framework for the examination of the relationship between literature and medicine, instructors and readers can focus on subsequent chapters in any order that serves their purposes. Moreover, the choices of sub-topics focused on the patient-caretaker relationship and the vicarious experience of literature also allow for great flexibility. And the addition of poems in each chapter—along with the appendices—again offers instructors and readers the ability to organize the use of *Literature and Medicine* with their own goals in mind.

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Vignettes and Vignette-Discussions

Introduction to *Literature and Medicine*

Part I

Literature Introduction: Structure and Focus of the Chapters

In the Medicine Introduction, Part II of the book's Introduction, we set forth the complexity of clinical medicine—namely the combination of cognitive and affective skills and responses necessary for facilitating the most efficient, informative, and medically effective narrative from a patient—and also set forth the more general goals of clinical medicine. By training and, most usually, by temperament, healthcare students—especially medical students—and practicing healthcare professionals focus most fully on the valorization of one order of understanding in the patient-physician encounter, that of apprehending the patient's story primarily in biomedical terms. We argue in this book that soliciting and understanding the patient's concern about her condition or ailment and acknowledging the emotions that accompany that concern lead to a fuller understanding of the patient's plight, clearer and more efficient insight into the nature of his condition, and development of strategies to respond to that situation which more fully involves the patient. Among other things, this last phenomenon also reduces the pressure and stress physicians sometimes feel. The structure of this book pursues these goals by focusing on a small number of "topics" or themes outlined in the Preface and spelled out in the Table of Contents:

I. Narrative and Medicine (the overarching framework for the book, so not technically a focused topic)
II. The Logic of Making a Diagnosis
III. Professionalism
IV. Building the Patient-Provider Relationship
V. Everyday Ethics of Medical Practices
VI. Vicarious Experiences
VII. Mistakes in Medicine
VIII. Death and Dying
IX. Postscript: The Fulfillments of Healthcare

While this is not an exhaustive list of topics with which to explore the ways that narrative competence in healthcare practices can contribute to an education in healthcare and greater success in practicing, we have found that students are particularly responsive to the items on this list and that these areas of concern engender particularly acute discussions in class and in writing assignments, and—we have found in a long-term study (see Shakir et al. 2017)—particularly richer engagements in the clinic. Before introducing these topic-sections, the Medicine Introduction offers a short argument for the parallels between skills useful in clinical practice and skills useful in critical reading; in the general topic of "Narrative and Medicine" in Chap. 1, we examine a number of "features" of literary narrative that help habituate the related skills of clinical practice and critical reading. The topic of Chap. 1, then, offers a broad overview of the "textbook" aspect of *Literature and Medicine*, which the individual chapters explore more specifically.

The Chapters: Vignettes, Stories, Poems

Here, though, in the Literature Introduction, let us set forth a chart of the organization of topics and narrative texts in this book.

Topic I. Narrative and Medicine	**1. Cognitive Psychology and Reading Literature** **2. 13 Features of Narrative** Literary text: Grace Paley, "Conversation with My Father"
Topic II. The Logic of Making a Diagnosis	**Systematic Hypothesis Formation** Literary Text: Dr. Arthur Conan Doyle, "The Resident Patient"
Topic III. Professionalism	**The Nature of Professionalism** Literary Text: Dr. Richard Selzer, "Imelda"
Topic IV. Building the Patient-Provider Relationship 1. Rapport and Empathy 2. Listening to Patients 3. The Patient 4. The Doctor	Literary texts: 1. Dr. Anton Chekhov, "The Doctor's Visit" 2. James Joyce, "Araby" 3. Charlotte Gilman, "The Yellow Wallpaper" 4. Paul Laurence Dunbar, "The Lynching of Jube Benson"
Topic V. Everyday Ethics of Medical Practices	**Virtue Ethics and Narrative** Literary text: Dr. Anton Chekhov, "Enemies"
Topic VI. Vicarious Experiences 1. Culture 2. Sexual Abuse 3. Pain 4. Ageing	Literary texts: 1. Demetria Martinez, "The Annunciation: Lupe" 2. Edgar Allan Poe, "Berenice" 3. Herman Melville, "The Operation" 4. Nathaniel Hawthorne, excerpt from *House of Seven Gables*
Topic VII. Mistakes in Medicine	**Systematically Understanding Mistakes** Literary text: Gustav Flaubert, excerpt from *Madame Bovary*
Topic VIII. Death and Dying	**Facing Mortality in Healthcare** Literary text: Leo Tolstoy, *The Death of Ivan Ilych*
Topic IX. Postscript: The Fulfillments of Healthcare	**Good news in Healthcare** Literary text: Derek Mahon, "Everything is Going to be All Right"

Topic I After the consideration of "The Complexity of Clinical Medicine" later in this Introduction, which examines parallels between clinical practice and critical reading, in Chap. 1 we offer an exploration of the working relationship between narrative and medicine by first presenting and analyzing recent work in cognitive psychology; and second, we offer a thorough analysis of a medical vignette describing the first encounter of patient and physician and Grace Paley's short story, "A Conversation with My Father" (Paley's father was a physician). In analyzing the story, we set forth 13 primary "features" involved in literary narrative that are useful in developing narrative competence; these features create the basic, "elementary" focus for all the readings—short stories, vignettes, poems—of *Literature and Medicine*. Chap. 1 also offers strong suggestions that narrative organization of experience is an evolutionary adaptation of human beings, and to this end, it reviews extensive studies in cognitive psychology that demonstrate the measurable effectiveness of engagements with literary narrative in fostering ordinary human interactions. Specifically, cognitive psychology has demonstrated that engagement with literary texts (1) creates empathy, (2) refines Theory of Mind (psychologists' description of the powerful skill of human beings—and to a lesser extent, other primates—that enable us to apprehend that other creatures have cognitive and affective responses to the world that may be different from our own), and (3) "transports" readers into the world of a narrative that, among other things, produces vicarious experience. Each chapter presents an actual "vignette" from medical practice, and in each chapter, the vignette and its analysis come first to create a real-world context for the engagement with the literary texts.

Topic II After the first, longest chapter, the next two chapters offer a general sense of narrative reasoning. The first of these topics examines diagnosis in relation to the popular literary form of the detective story. Chap. 2 presents the engaged fun of reading in the form of a Sherlock Holmes story. In so doing, it also offers an exploration of the "logic" used in making a medical diagnosis that is rooted in a strong sense of narrative. This chapter—along with Chaps. 3 and 8—presents a "strategy" of comprehension and action that supplements the features of literary narrative presented in Chap. 1 with a focus on narrative concerns that are generally important to medicine: diagnosis (Chap. 2), professionalism (Chap. 3), and interpersonal ethics (Chap. 8). The logic of diagnosis was first described by the nineteenth-century American polymath, Charles Sanders Pierce. He described it as "abduction," a word he coined that is sometimes defined as "hypothesis formation" or "inference to the best explanation." Students are commonly surprised to know that this logic has been described not only philosophically but narratively in detective stories, such as the Sherlock Holmes stories created by the physician-writer Arthur Conan Doyle at the same time Peirce was writing.

This chapter presents one of Dr. Arthur Conan Doyle's Holmes stories, "The Resident Patient," and develops in a short analysis the analogy of medical detective work in making a diagnosis and criminal detective work in solving a crime to demonstrate, even to beginning students, that the cognitive and affective information obtained in a patient interview can, and should, lead to the systematic examination

of possible diagnoses and actions in relation to the patient's condition. The vignette associated with this chapter, "The Woman with Hyponatremia," examines the ways that an attending physician displays many of the qualities of a classical detective. The related poem in this chapter, Shakespeare's sonnet, "That Time of Year," allows, early in the course—if this chapter is taken up by instructors early in the semester—for an instructor to turn students into literary "detectives" by asking them to recompose the sonnet, printed in the anthology with its lines out of order. In order to do this, students have to develop (hypothetical) order out of disordered phenomenal evidence, a problem that often faces physicians in the clinic. The strategies of assuming the systematic order of the poem and its various levels of meaning and structure offer a fine parallel to the systematic confrontation with symptoms to the end of figuring out what's going on. We include in Appendix 4 pedagogical strategies we have found useful in creating the link between literary narrative and practical diagnostic strategies.

Topic III Chapter 3 focuses on a specific general topic for medical education and medical practice, "professionalization" in healthcare practices. More specifically, it focuses on the ACGME (Accreditation Council for Graduate Medical Education) program of developing specialty criteria for professionalization in medicine. It describes the ways that an analysis of Dr. Richard Selzer's "Imelda"—particularly focusing upon the features of "patterned repetition," "the unsaid," "narrative agents and concern," and "narrative as moral education" outlined in Chap. 1—can materially help students comprehend what is at stake in medical professionalization. The vignette analyzed in this chapter, a short excerpt from "Playing God" by Dr. Michael LaCombe, allows students to examine a particular patient-physician encounter in light of the understanding of both professionalization and narrative that can result from careful reading of Selzer's short story. In this chapter, we present and discuss Dr. Audrey Shafer's poem, "Monday Morning," to examine the relation of family life to professional life in relation to this topic. We include in Appendix 5 a study of the programmatic use of this story in a Professionalization Workshop run by our colleague, Dr. Casey Hester.

Topic IV The next of the book's topic-sections, "Building the Patient-Provider Relationship," suggests how literature can help students develop or understand four different aspects of that relationship, namely the ability to cultivate a powerful sense of empathy and rapport by experiencing what Dr. Vannatta describes as a "flood" of emotion in relation to a patient in the clinic (Chap. 4), the ability to carefully listen to what we describe in Chap. 1 as the "unsaid" in patient narratives (Chap. 5), the ability to engage with the experience of being a patient in a world of cultural stereotypes (Chap. 6), and finally, the ability to engage with the experience of being a doctor in a world of cultural stereotypes (Chap. 7).

Chapter 4, "Rapport and Empathy in Medicine," examines how reading Toni Morrison's novel *Beloved* affected Dr. Vannatta's encounter with a patient and, indeed, convinced him of the value of a literary education in the practice of

medicine. The chapter goes on to present a powerful story by Dr. Anton Chekhov, which narrates and provokes empathy simultaneously. The poem associated with the chapter, "He Makes a House Call" by Dr. John Stone, reinforces the way that two time-frames of narrative (features discussed in Chap. 1) provoke the kind of rapport and empathy Chekhov enacts in his story and Dr. Vannatta describes in his practice.

The next chapter under this heading (Chap. 5), "Listening to Patients," presents James Joyce's short story of a young boy experiencing "puppy love" for the first time, "Araby." The discussion of this story asks readers to "fill in" what is unsaid by the young boy in the story. (Appendix 6, related to this chapter, offers an analysis of Ernest Hemingway's well-known short story, "Indian Camp." Appendix 6 offers a systematic analysis of the narrative unsaid in relation to clinical medicine that could supplement discussion of Joyce's story with that of Hemingway.) The vignette analyzed in this chapter, "Young Mother with Abdominal Pain," allows students and readers to see how attending to the "unsaid" works in clinical medicine. The poem associated with this chapter is Dr. William Carlos Williams' famous poem, "The Red Wheelbarrow," which strongly connects the narrative form of literature to acts of discernment in a poem that requires its readers to "fill in" its implicit narrative and thematic purport.

The third chapter of this section, "The Patient," presents Charlotte Perkins Gilman's harrowing representation of a patient suffering from postpartum psychosis descending into irrationality. The vignette associated with this story, an excerpt from Audre Lorde's powerful memoir, *The Cancer Journals*, offers a highly detailed first-person account of a patient's encounter with life-transforming and life threatening illness. In the course of this discussion, we also touch upon Anatole Broyard's detailed examination of the patient-physician encounter from the vantage of the patient entitled "Doctor Talk to Me" (a text that is widely available: see Bibliography). The poem related to this chapter, Dr. Rafael Campo's "The Couple," expands the role of "patient" to include the family of the ill person.

The final chapter in this section, "The Doctor," examines stereotyping—in this case, racist stereotyping in both the vignette and the short story and sexist stereotyping analyzed in a second vignette—in the practice of medicine. Its literary selection, Paul Laurence Dunbar's short story "The Lynching of Jube Benson" is a classic and powerful examination of deadly racist stereotyping narrated by a physician. This chapter takes the unusual strategy of including two vignettes (Chap. 14 does so as well): one from Dr. Damon Tweedy's memoir *Black Man in a White Coat*, which presents the unrelenting ordinariness and banality of prejudice, and a second a single paragraph from Dr. Michael LaCombe's first-person narrative of a woman physician's work that is hardly part of the overall trajectory of his narrative description of diagnosis, but an off-hand description of ordinary everyday sexist encounters of a female physician with colleagues. The offhand nature of this paragraph describes ordinary "everyday" prejudice, what Dr. Tweedy calls "unconscious (implicit) bias" (2015: 270). Such "implicit" bias does not seem to be intentional prejudice, but habitual, unreflected-upon behavior, and the fact that LaCombe mentions it seemingly outside the significant trajectory of his narrative underlines—as a "formal" rather than "content" feature of his narrative—how it is unconscious and implicit.

Topic V Chapter 8, "Everyday Ethics in Medicine," could also fall under the category of "Building the Patient-Provider Relationship," but we feel it is necessary to offer it as a topic section on its own because the examination of the way that narrative knowledge can inform ethical behavior is an important part of what the study of literature in a medical education has to offer. Rather than principle-based (or "normative") ethics of proper behavior that is usually part of medical education or utilitarian (or "cost-benefit") ethics that governs much discussion in epidemiology, a discussion of the ethics of everyday practice of medicine, organized around "virtue ethics" as introduced by Aristotle, underlines the relationship of narrative events to habitual ethical behavior. That is, Aristotle's virtues are organized around the *actions* of agents—people acting in actual situations, described in Chap. 1 as the feature of "narrative agents and concerns"—rather than more or less abstract propositions about right and wrong found in the principle-based ethics often associated with medicine or cost-benefit analyses associated with public health concerns. This chapter presents Dr. Anton Chekhov's short story "Enemies," which examines the behavior of a physician weighing the plight of a patient against his own personal tragedy. This chapter examines the story in relation to a schema of six virtues particularly appropriate to the patient-physician relationship that physicians and caregivers can easily remember in order to reflect upon and judge their own actions as they go about their everyday practice. (Chekhov's story is also a powerful example of the feature of "twice told stories" discussed in Chap. 1.) The vignette analyzed in this chapter, "The Patient with Diabetic Ketoacidosis," demonstrates what occurs in the absence of these everyday virtues. The related poem in this chapter is William Blake's "A Poison Tree," a poem that examines ethical behavior in relation to emotion and agency. (As mentioned earlier, this chapter, like Chap. 2, "The Logic of Making a Diagnosis," and Chap. 3, "Professionalism," focuses upon a "strategy" of comprehension and action that supplements the features presented in Chap. 1. All three of these chapters are a little longer than other chapters: Chap. 8 presents an acronym related to virtue ethics, and the earlier two stories have related appendices in Part II.)

Topic VI The next topic-section of the text-anthology, consisting of four chapters, examines particular examples of "vicarious experience" that can contribute to an education in medicine, namely experiences of cultural differences (Chap. 9), sexual abuse (Chap. 10), pain (Chap. 11), and ageing (Chap. 12). This section encompasses many of the qualities of engaging with literature discussed in Chap. 1, which analyze the ability of literature to provoke vicarious experiences in readers/listeners by means of the various features of literary texts discussed in the earlier chapter.

Chapter 9 presents the experience of living within the Mexican American subculture in the United States in the presentation of Demetria Martinez's story "The Annunciation: Lupe." Given this story, one could particularly focus upon the features of literature—"patterned repetition," "the unsaid," "narrative genres"—that condition the vicarious experience of Mexican American culture the story provokes. But we have chosen this story for other reasons as well: the manner in which it presents biomedicine as a belief-system (the belief in cholesterol as parallel to

religious belief) and the way it brings up birthing in relation to medicine. The vignette analyzed in this chapter, "The Patient's Chief Concern," portrays two doctors engaging with a patient with a very different cultural sense of illness than the physicians possess. The related poem is Alicia Gaspar de Alba's poem "Making Tortillas." Besides describing everyday actions that constitute what we describe as the "hum" of culture, the story undramatically presents the naturalness of nonheterosexual relationships.

The analysis of the vignette of Chap. 10—Dr. Vannatta's narrative of his encounter with a long-term patient who presents symptoms of spousal abuse—analyzes this sadly not unusual aspect of healthcare in relation to Roddy Doyle's *The Woman Who Walked into Doors*, a novel about long-term spousal abuse written by a man in the first-person voice of a woman. The novel uses many of the features of literature described in Chap. 1 to provoke *vicarious experience* of a woman's terrible ordeal, not only at home but in the clinic, particularly "the dynamic of form and content," "defamiliarization and style," and "patterned repetition,"which create the voice of the main character, Paula Spencer. The vignette analyzed in this chapter, *You Don't Deserve This*, presents a physician who—having read Doyle's novel—is confronted with a patient whose bruises do not fit with the narrative she presents. The fictional text of this chapter is one of Edgar Allan Poe's horror stories, "Berenice," that presents domestic abuse from the vantage of an obsessed narrator who, as in much abuse, reduces a person to body parts. The related poem in this chapter is Yeats's great poem, "Leda and the Swan," which confronts, philosophically and poetically, violence in the world with the example of the terrible crime of rape.

Chapter 11 presents Herman Melville's "The Operation" from *White Jacket*, which describes the wide difference between a patient's terrible apprehension of an operation and its pompous description by the surgeon. Here, again, in reading Melville's narrative—and especially the satirical use of proper names—one could pursue a particular focus on the "patterned repetition in language" of literary texts. The vignette analyzed in this chapter is an excerpt from Lous Heshusius's memoir *Inside Chronic Pain: An Intimate and Critical Account*. The poem associated with this chapter is Emily Dickinson's "Pain has an Element of Blank."

Finally, the last chapter of this section, "Ageing," presents an early chapter of Nathaniel Hawthorne's *House of Seven Gables* that examines a day in the life of an ageing woman. In reading this chapter, one could focus on how implicit "patterned repetition of events" allows the main character, Hepzibah Pyncheon, to internalize governing prejudices about ageing in a manner that allows young readers to reflect on their own assumptions and prejudices. The vignette analyzed in this chapter examines a physician's encounter with a very old man. The related poem in this chapter is Thomas Hardy's "I Look into My Glass," a poem that presents the lack of any sense of future in its "endless rest" that is foreign to most young students, and indeed, to mid-career professionals.

Topic VII Chapter 13 presents another topic that could fit under the category of "Building the Patient-Provider Relationship" or the category "Everyday Ethics of Medicine," but it does so here by describing the "destruction," rather than the build-

ing, of that relationship by means of "Mistakes in Medicine." The vignette of this chapter, presenting a systematic and horrifying mistake encountered in Dr. Vannatta's medical practice, allows him to reflect the important chapter of Dr. David Hilfiker's *Healing the Wounds*, entitled "Facing Our Mistakes," that many years ago (1984) offered a powerful catalogue of kinds of mistakes in medicine, which were then—and often still remain—unreflected upon in the profession. The literary text of this chapter, an excerpt from Gustav Flaubert's *Madame Bovary*, describes professional and social pressures that lead to mistakes, another area (besides the "systematic" mistakes Dr. Vannatta describes) supplementing Dr. Hilfiker's catalog. The related poem in this chapter is Dr. Dannie Abse's poem about the terrible consequences of badly executed brain surgery.

Topic VIII The final topic in Part I, "Death and Dying," presents another matter that could fit under the category of "Vicarious Experience." This chapter presents Leo Tolstoy's novella, *The Death of Ivan Ilych*, which, in fact, gathers up together all the topics of Part I and offers as well a fine sense of the working of literary narrative by offering a strong example of the "defamiliarization" that literature creates, discussed in Chap. 1. The vignettes analyzed in this chapter describe physicians encountering both a "good" dying—where a patient and her family has come to terms with end of life—and the panic and frenzy associated with a patient and his family who haven't been able to do so. The poem related to this chapter is John Donne's "Death Be Not Proud," that engages death and dying from the vantage of religious contemplation.

Postscript Still, the topics of Part I do not, adequately enough in our opinion, emphasize the great motive of caretaking for those who pursue careers as healthcare providers, so we end Part I with a short Postscript that focuses on the good news medical care often brings to those suffering and in distress. Here, the literary text is a short poem by Derek Mahon, "Everthing is Going to be All Right." Although there is not a vignette as such to the postscript, we do quote Dr. John Stone's wonderful description of the usefulness of this literary text in his work in healthcare. In the Postscript we are trying not to lose sight of the goodness in caretaking, a powerful motivating energy for those pursuing healthcare and, indeed, for this book.

Each chapter of Part I ends with a short section entitled "Lessons for Providers." Needless to say, these are not the only lessons our readings might provoke, but they touch upon each chapter's readings with a gesture toward the clinical and medical benefits that might arise in engaging with them. In fact, readers might want to look at them before going through the chapter as a whole. And in group discussion, readers might want to supplement the "lessons" with their own. In many cases, these lessons at the end of each chapter offer questions and observations specific to healthcare providers.

The appendices of *Literature and Medicine* offer readers'/teachers' guides (Appendix 2) for discussion questions, (Appendix 3) for daily writing questions, and (Appendix 4) for a specific class handout associated with the chapter/class

focused on diagnosis. Appendix 5 reproduces the systematic presentation of a professionalization workshop written by the authors and their colleague Dr. Casey Hester, which describes the practical usefulness of literature in physician training and also offers an outline for the "elements" or "structure" of narrative and narrative genres. Finally, Appendix 6 offers a strictly clinical analysis of Ernest Hemingway's story, "Indian Camp," that complements the literary analysis of Joyce in Chap. 5 in a manner, we hope, that offers a good sense of how literary and clinical education work together. Appendix 1 supplements Part I of Chap. 1 with further considerations of "The Cognitive Science of Literary Reading."

Part II

Medicine Introduction: The Complexity of Clinical Medicine

In Part I, the Literature Introduction, we have offered a narrative of the trajectory of *Literature and Medicine*, its local tactics and its overall strategy in pursuing the goals and purposes of this book we described in the Preface. In Part II, the second "Medicine" Introduction, we articulate those tactics and strategies in relation to the complex nature of clinical medicine. Thus, before we turn to the specific examination of the "features" of literary narrative that can contribute to training for a career in medicine and healthcare, it is important to situate this program in the context of clinical medicine more generally. This is certainly the aim of such recent works as Dr. Rita Charon's *Narrative Medicine*, Dr. John Biro's *Listening to Pain: Finding Words, Compassion, and Relief*, or our own *The Chief Concern of Medicine*.

The Complexity of Clinical Medicine

One of the notable features of clinical medicine that the study of narrative and literature helps make clear is its complexity. The patient-physician interaction—both the initial interview with new patients that results in the History and Physical Exam and ongoing patient-physician encounters in general – involves three different orders of cognition and interpersonal relationship at the same time: that of *biomedical understanding*, that of *the patient's understanding*, and finally that of *the affective engagement*—an emotional rather than cognitive order—of both patient and physician. The first order of cognitive understanding—that which is most readily perceivable by people whose training has prepared them for work as physicians and other healthcare providers—is that of the simple biomedical "facts" that patients present, the patient's *chief complaint*. The work of clinical medicine, and especially the History of Present Illness (HPI), is to solicit the *narrative* of facts that led the patient to consult the physician on this particular occasion with these particular problems or symptoms. It is then the job of the physician to "translate" the narrative patients bring into another narrative, that of biomedical knowledge and understanding. Such a translation needs also to be retranslated back to the patient in a vocabulary that she can comprehend and understand.

A second order of cognitive understanding in clinical medicine that is often given less emphasis than the recognition of biomedical facts discerned in the patient's narrative is the *patient's agenda*. That is, patients bring particular concerns and desires to the patient-physician encounter, which are not always fully congruent with the *physician's biomedical agenda* (even though quite often the two agendas are fully congruent). Thus, along with biomedical facts, the patient-physician interview entails a different order of cognitive understanding by the physician. In this text-anthology—and also more fully in *The Chief Concern of Medicine*—we describe this as the patient's *chief concern*. The chief concern is the patient's understanding of the consequences of his chief complaint: death or suffering, the loss of friends or job, the destruction of personal relations or goals, and so on. If the chief complaint exists within the physician's sphere of expertise—after all, she is trained in a vast amount of biomedical facts, histories, and procedures—then the chief concern exists within the patient's sphere of expertise: after all, the patient knows what the physician can only guess, what his particular condition or ailment *means* to him. It is the task of the initial medical interview not only to define or delineate the patient's chief complaint, but also to solicit and engage the patient's chief concern. Such solicitation demonstrates that the physician knows the difference between the patient's symptoms and the patient's understanding and concern *as a patient*, and it also can serve as the basis of the deliberation and negotiation between patient and physician concerning what is to be done in relation to the ailment or condition that brings the patient to her doctor.

It is our contention in this book that the systematic study of literature can aid the physician in accomplishing these goals. As we more completely explain in Chap. 1, reading literature helps the reader improve empathy. An empathic caregiver is more likely to habituate wondering about the patient's concern, and more specifically, about their affective response to that concern. Second, the study of literature focuses on the characters' actions and motives in order to define literary genres, which conditions the apprehension of the *whole* meaning of a narrative. Thus, training and practice in grasping the local and global meanings in a literary narrative is excellent practice for listening to and comprehending patients' histories of present illness. It is also excellent practice at listening for the unsaid—often important in uncovering subconscious motivations in a patient's telling of the story or motivations in the patient's life journey. There are other ways—revealed throughout the chapters of the book—that careful study and reflection on literary narrative can help a physician in her care of patients. Third, the study of literary narratives helps students of medicine develop critical thinking skills. The curriculum of a medical education—at least in the early years—requires rote memorization of huge amounts of necessary biomedical facts. This process does not call for critical thinking skills. However, the most important diagnostic information the physician will have access to is *narrative* in nature, namely the patient's story, which calls for critical thinking skills along with empirical knowledge. It is, therefore, our claim that understanding how literary narratives do their work—their structure, their genre, the motives and actions of their characters—will aid the physician in facilitating and understanding this knowledge, which can be called *narrative knowledge*, in the service of making a correct diagnosis.

For the past several years, at the University of Oklahoma College of Medicine, students have been trained to formally elicit the patient's "chief concern" as well as her "chief complaint," and our students and instructors have found that this addition to the protocols of the history and physical has *habituated* both the attentive listening and the responsive engagement we mentioned at the beginning of the Preface. An emphasis on these two orders of cognitive engagement—the physician's agenda and the patient's agenda—grows out of the engagements with literature and narrative we pursue in this text-anthology, and in large part, the purpose of fostering a relationship between literature and medicine is to encourage attention to these two orders of understanding by demonstrating—in practice as well as theory—how engagements with literature can create a broader sense of the relationship between a patient's ailment and his wider life. Specifically, this is clear in the first of the features of literature we examine in Chap. 1, the dynamic relationship between content and form that is emphasized in literary narrative. "Content" corresponds to the biomedical facts discernable in the patient's narrative, and "form" corresponds to the "style" of a patient's story and more generally to the present encounter of storyteller and listener, patient and caretaker.

The third order of the patient-caretaker relationship in the complexity of clinical medicine entails the task of creating a foundation of trust, honesty, and goodwill. The acknowledgment of the complementary nature of the cognitive orders we have described—that is, the active solicitation of the patient's agenda in connection with the physician's agenda—goes a long way toward establishing this foundation. But this order of interpersonal relationship is less a cognitive aspect of interactions between patients and physicians and more an *affective* aspect of what goes on between a patient and his caretaker. Part of the solicitation of the chief concern involves the physician's *conscious awareness* of the patient's emotional state that always accompanies the patient's cognitive understanding of her ailment, and much recent work in cognitive psychology (examined in Chap. 1 and Appendix 1 of this text) demonstrates that engagements with literary texts make people more sensitive to the affective states of others. As we discuss in more detail in Chap. 1, research teams associated with Raymond Mar, David Miall, and Melanie Green, among others, have demonstrated, using empirical research methods, that reading literary narrative both enhances the ability to acknowledge that other people can understand the world differently from the way one does and enhances a greater awareness of the emotional states of others, both necessary to increase empathy. This enhanced empathy as well as the expanded understanding of lives different from one's own (accomplished in literature through the provocation of vicarious experience) enhances the education of the student and also of the practicing healthcare provider.

Thus, it is our contention in this text-anthology that explicit training in narrative understanding and narrative knowledge, with particular attention to the manner in which authors and patients articulate their histories, can help healthcare students and physicians develop the combination of skills and comprehension that the complexity of clinical medicine requires. As we have suggested, traditionally courses in clinical medicine have focused upon the first cognitive order of understanding,

while not attending as fully as possible to the second cognitive order and the third affective order that are also involved in narrative. In fact, studies continue to demonstrate that patients consistently complain that their physicians do not seem to care enough—they do not *listen* to their patients—and that they almost never complain that the physicians do not know enough. The overall purpose of serious engagements with literature, as we note in Chap. 1, is the apprehension of a text's overall meaning or purport, what we describe as the author's or the text's "overall meaning"—which is not necessarily conscious or fully intentional, but which is, nevertheless, apprehensible. Moreover, it is our contention—based upon years of teaching students committed to healthcare—that the systematic engagement with literary texts can develop habits of attention to this *overall* sense of concern, meaning, and purpose in the patient-caretaker encounter.

It is our further contention that familiarity with even a small number of literary narratives such as presented in this book (as well as "everyday" narratives that patients bring to their physicians, which are also presented in the various analyses of "vignettes" in this book) can allow students and instructors to integrate the complex levels of cognition and affect into habitual practices in their engagements with patients. Grace Paley's story "A Conversation with My Father" examined in Chap. 1, demonstrates the complexity of narrative corresponding to the complexity of the medical interview. Specifically, the story presents explicitly the dynamic of form and content we have already mentioned. In *Narrative Medicine*, Dr. Charon describes this as focusing on both the "what" of a story and "how" it is told (2006: 109). As we note in Chap. 1, one of the features of literary narrative—that gives rise to the proven effects of Theory of Mind, empathy, and the "transportation" of readers into the world of narrative (i.e., a version of vicarious experience) that recent experiments in cognitive psychology have demonstrated—is that literary texts are almost always "twice-told tales," and learning to attend to how stories are told and retold allow physicians and other caretakers to more fully engage with their patients. After all, the stories patients bring to their physicians are usually "re-told" by their caretakers, and awareness of the *features* of literary narrative we describe in Chap. 1 lends to this process greater attention, precision, and efficiency. As we mention in Chap. 1, these two tellings often reflect the general fact of *two time-frames* in narrative, the time of the events that are recounted (usually in the past) and the time of the telling in the engagement of storyteller and listener (in the present). The first order of cognition of the patient's HPI emphasizes and focuses upon the first of these time-frames; but the patient's present concern and present emotional state—the second and third orders of cognition and interaction—emphasize the second (the time that the patient is in the office telling the tale). We believe the achievement of the *simultaneous* cognitive and affective comprehension of all three orders in the patient narratives that constitute in good part the patient-caretaker relationship will be aided by the systematic understanding of literary and everyday narrative. Such achievement will allow physicians and healthcare providers more effectively and efficiently to

1. obtain the necessary biomedical information from the patient that will allow a more accurate diagnosis;
2. obtain the necessary personal information ("concern") from the patient that will allow the physician and patient together to determine the best "goals" to be achieved in this particular situation; and
3. create a better and more fulfilling interpersonal relationship between patient and physician that will forge trust, honesty, and goodwill that will, again, allow a more efficient, more effective, and satisfying response to the situation at hand *by both the patient and the caretaker*.

The Goals of Clinical Medicine

As we have suggested, the aim of this text-anthology is to create practical engagements with literary and "everyday" narratives, which help *habituate* practical forms of attention and action that more readily instill in medical students the goals of medicine of defining and promoting good health. There are four major goals of narrative medicine implicit in the patient-provider relationship that further specify the goals of *Literature and Medicine* we described in the Preface. In Chap. 1, the features of literary narrative we describe further specify objects of attention that can practically promote these goals in reading literary texts:

1. The facilitation of detailed information concerning the patient's **chief complaint**. The physician facilitates the narration of events and circumstances surrounding the particular ailment or condition that occasioned the patient's seeking out medical help.
2. The facilitation of detailed information concerning the patient's **chief concern**. The physician solicits the patient's worry or concern that accompanies the chief complaint. Implicit here is the goal of developing through joint deliberation and negotiation between patient and physician what would constitute "health" or some other practical goal or end toward which the medical consultation strives.
3. The development of a relationship of **trust and honesty** between patient and physician. Such a relationship is based upon mutual respect, the physician's recognition of the dignity of the patient, and the explicit acknowledgment on the part of the physician or healthcare provider that the patient's story—both the complaint and the concern—is "honored" (see Charon 2006). Active engagement with literature and the vicarious experience it provokes substantially promotes all three of these goals.
4. The development, on the basis of the information that grows out of the patient-physician interview, of a **differential diagnosis**. Clinical medicine, as it is conceived here and, in fact, as it is conceived, at least implicitly, in courses focused on clinical medicine, strives to develop *usable information* toward the end of addressing, and, when possible, alleviating the patient's condition or ailment that has concerned the patient sufficiently to seek out medical aid. Needless to say,

clinical medicine courses in the first years of medical education cannot call upon a large database of biomedical information that students have yet to master, but even so the overall purpose of clinical medicine is precisely to demonstrate even to novices that diagnosis lends itself to *systematic practices* of hypothesis formation that can be efficiently habituated.

These goals are always implicit and sometimes explicit aspects of clinical medicine, and one overriding purpose of *Literature and Medicine* is to clearly define these goals in the education and practice of physicians and other healthcare providers.

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