

INTERVENTIONAL NARRATOLOGY:  
FORM AND FUNCTION OF THE NARRATIVE MEDICAL WRITE-UP

By

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For my parents,  
Rodney and Becky Wood,  
who have taught me to strive for excellence  
with joy before my Maker.

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## Interventional Narratology: Form and Function of the Narrative Medical Write-up

*It is the poet who heals with his words, stanches the flow of blood, stills the rattling breath, applies poultice to the scalded skin. Did you ask me why a surgeon writes? I think it is because I wish to be a doctor.*

- Richard Selzer, *Mortal Lessons: Notes on the Art of Surgery* <sup>1</sup>

*For this was the point, surely: he would be a better doctor for having read literature.*

- *Atonement: A Novel* <sup>2</sup>

### *Introduction:*

In his essay, “The Storyteller,” Walter Benjamin identifies the hegemony of information as tantamount to the loss of story. “If the art of storytelling has become rare,” he writes, “the dissemination of information has had a decisive share in this state of affairs.”<sup>3</sup> Nowhere has there been a greater burgeoning of information than in the field of medicine, where computerized medical records and radiographic imaging put volumes of patient information at the clinician’s fingertips and every clinical decision is judged by a seemingly inexhaustible wealth of investigational data and statistical analyses.

If Benjamin is right about the role of information in the deterioration of storytelling, then we should not be surprised to note a growing suspicion in some physicians that the “the art of storytelling has become rare” among medical practitioners. Once considered the great listeners and tellers of a community’s stories of illness and recovery, physicians have ostensibly been displaced from their role and have therefore become less effective practitioners of empathetic medicine. While few would suggest that there is a dearth of physician-authors or that the quality of published medical writing has declined in recent years, patients and physicians alike have grown wary that medical education does a somewhat inadequate job of producing physicians equipped to effectively listen to and interpret the stories that daily unfold in the hospitals and clinics and operating rooms around them.

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<sup>1</sup> Richard Selzer. *Mortal Lessons: Notes on the Art of Surgery*. (New York : Simon and Schuster, 1976): 23.

<sup>2</sup> Ian McEwan. *Atonement: A Novel*. (London: Vintage, 2001): 93.

<sup>3</sup> Walter Benjamin, “The Storyteller” In *Theory of the Novel: A Historical Approach*, ed. Michael McKeon, 77-93. (Baltimore: Johns Hopkins University Press, 2000): 81.

The purpose of the emerging movement known as “narrative-based medicine” is to counteract this deterioration by attempting a vision beyond information, focusing on the narrative aspects of each medical interaction. Physician David Steensma makes the dilemma clear: “While most physicians realize that there is much more to their patients than is apparent during the typical clinical encounter, only few have had the talent to explore this further through art forms such as writing.”<sup>4</sup> Proponents hope that, by teaching students and physicians to be more insightful readers of literature and more skillful creative writers, medical schools will better equip their students to understand and respond to patients’ experiences. To that end, programs in narrative medicine include three basic components: close readings of literary texts, creative writing, and reflective discussion groups.

Literature and medicine programs are hardly a novel phenomenon within medical schools, and one may well wonder whether the emerging narrative medicine programs are simply old wine in new skins. Without attempting a full defense of the originality of the endeavor, I suggest that there is at least one aspect of narrative medicine that is unique and valuable: the narrative medical write-up, a non-traditional patient work-up in which students narrate the patient’s story, focusing on the individual experience of illness.<sup>5</sup>

While literature and medicine programs have traditionally focused on the role of the physician as a reader or listener, the narrative medical write-up casts the student as both reader *and* author. Through the narrative medical write-up, students learn that it is inadequate simply to absorb the patient’s story as it is presented. Instead, they must digest and regurgitate the transformed story, and this process presupposes effective listening, insightful interpretation, and cogent, imaginative retelling of the patient’s story.

The narrative medical write-up recasts the student-doctor as the “storyteller” of the hospital, insisting on his or her role as both reader *and* writer of the intricate dramas of daily life on the wards. It is this distinction that sets the narrative medical write-up apart from all other

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<sup>4</sup> David Steensma, “Narrative Medicine,” *Mars Hill Review*. 22 (2003): 25.

<sup>5</sup> Students are instructed to interview one of their patients in order to elicit a “narrative history.” The narrative history differs from the traditional history and physical in that it focuses on the patient’s experience, and students simply ask patients to tell them their story. The students then write a short narrative that they present to their medical team (residents and attendings). At Vanderbilt University, where the narrative medicine program was started in the surgery department, students present their narrative to the tumor board in lieu of a traditional patient presentation.

aspects of narrative medicine and which sets narrative medicine apart from its long line of “literature and medicine” predecessors.

The narrative medical write-up is valuable to the medical community because it offers an alternate “way of telling”<sup>6</sup>—an alternate genre—that is better than the traditional patient narrative, the “history and physical.” These forms diverge, in the first instance, in their intentions, and, as Robert Scholes has suggested, “generic investigation is in fact the most precise and legitimate way into the vexed question of the intentionality of a work.”<sup>7</sup> Let us begin, then, with consideration of the genre of the narrative medical write-up.

### *Fact and Fiction in the Narrative Medical Write-up*

The genre of the narrative medical write-up, if it is ever named, is usually called “creative non-fiction.” In truth, a term such as “non-fictive creation” might better capture the mix of fact and creativity involved in the narrative write-up. But terms are relatively unimportant so long as one understands both the bounds and the latitude of the narrative write-up, in which the student assumes a creative, literary voice while remaining true to the facts of the patient’s life. The narrative medical write-up, then, is considered to fall somewhere between the poles of fact and fiction, between reality and imagination.

A completely factual rendering is impossible even in the most objective account, even in the history and physical, and this is true for both the physician and the patient. In my own clinical experience, I have often encountered patients who bring in long lists of appointments, medications, operations, etc. But even these lists include only those things the patient felt were important. While those lists are helpful for comprehensiveness, they are often equally a hindrance. I have found myself staring at a catalogue of events from a person's medical history, only to lay it aside and ask them to *tell me* the events as they remember them. To understand the events, as they really happened, patients need to be able to tell a story and physicians need to hear a story-- to emphasize some points, leave others out, arrange them in a logical order, etc. Physicians are not bound to interpret things the way the patient does, but they are bound to interpret the same things. That is, they create a new interpretation of the events by listening to the patient's interpretation of the events.

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<sup>6</sup> Jerome Bruner, "The Narrative Construction of Reality." *Critical Inquiry* 18 (1991): 1-21.

<sup>7</sup> Robert Scholes, "An Approach through Genre," *Towards a Poetics of Fiction*. Ed. Mark Spilka. (Bloomington, Indiana UP, 1977): 51

To use the Russian Formalists language, the students are bound to what they perceive to be the *fabula* of their patient's life, but they are not bound to the *suzjet* of the patient's narrative. Or in another terminology, they must be faithful to the story but not necessarily the plot.<sup>8</sup> The story or *fabula* is the actual sequence of events as they occurred in time. The plot or *suzjet* is the logico-temporal arrangement of events by the narrator based on causality.<sup>9</sup> This constraint of the student (to the *fabula* and not the *suzjet*) is clearest in pediatrics or psychology where physicians necessarily discount parts of the patient's story and often even disagree with the narrative construction the patient offers. Of course, the only access to the *fabula* offered the student is the *suzjet* and its context. So the student creates a new *suzjet* from the patient's *suzjet*.

The two supposed poles of fact and fiction are impossible and ultimately undesirable. Impossible because the student, like the patient, necessarily interprets and arranges the patient's story according to his or her own narrative judgment. Undesirable because restricting the student to a recitation of the patient's story hinders the student from achieving the ultimate end of the narrative medical write-up: to discover (or create) meaning.

Take, for example, one student's narrative write-up which begins in a manner remarkably similar to the standard history and physical: "Mr. JM is a 39-year-old man who underwent a living related renal transplantation last week." She then moves through a brief account of the course and etiology of the patient's disease. Anyone familiar with the format of the history and physical would quickly recognize the pattern: patient identifier, history of present illness, past medical history, etc. Although I think it would be unfair to suggest that the student has only given a recapitulation of the history and physical (she gives much attention to the spiritual aspects of the patient's illness and relates his religiosity to his social condition), there is a marked lack of interpretive narration in the write-up. In fact, the write-up seems in some ways to be simply a longer social history than usually given in the history and physical.

The deficiency of this approach to the narrative write-up becomes clear when the student (like a number of other students who followed this same pattern) has to editorialize at the end of their narrative. Instead of conveying meaning *in* the narrative through the causality and

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<sup>8</sup> E.M. Forster, "Story and Plot" In *Narrative Dynamics*. Ed. Brian Richardson. (Columbus: Ohio State University Press, 2002): 71.

<sup>9</sup> Peter Brooks, *Reading for the Plot: Designs and Intention in Narrative* (Cambridge: Harvard University Press, 1984).

temporality of the sequence of events, the student has catalogued the events and finds herself in a position of needing to explain what the events mean after the narrative has come to a conclusion.

One might think that this approach helps to maintain the fidelity of the student's story to the patient's by separating the facts of the story from student's interpretation. But this is precisely what we are working against in narrative based medicine. It is our objective to create such a complicity of event and experience, of fact and meaning, that students and physicians cannot encounter one without the other.

### *Authorship of the Narrative Medical Write-up*

Let me begin with a simplified explanation of the process of the write-up. The patient tells his or her own story (the narrative history), the student listens to that story and then retells it in the narrative medical write-up.

We might suggest that the patient is the true author and that the write-up is autobiography since students are instructed to allow the patients "tell their own story." This would suggest that the student simply recorded the events of the patient's life. However, James Olney suggests a more complicated and illuminating understanding of autobiography in which reader and writer enter into a triangular relationship with the life-story as mediator in a mutual pursuit of meaning.<sup>10</sup>

"In a collaborative gesture," Olney suggests, the reader and writer create a new text, a third entity formed from the memory of both. Olney uses a passage from Vladimir Nabokov's autobiography, *Speak, Memory*, in which the novelist remembers his time at Cambridge, to illustrate this idea :

The three arches of an Italian bridge, spanning the narrow stream, combined to form, with the help of their almost perfect, almost unrippled replicas in the water, three lovely ovals. . . . Now and then, shed by a blossoming tree, a petal would come down, down, down, and with the odd feeling of seeing something neither worshiper nor casual spectator ought to see, one would manage to glimpse its reflection which swiftly-- more swiftly than the petal fell-- rose to meet it; and, for the fraction of a second, one feared that the trick would not work, that the blessed oil would not catch fire, that the reflection might miss and the petal float away alone, but every time the delicate union did take place, with the magic

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<sup>10</sup> James Olney, "Life and the Memory of It," (Paper read at Narrative Medicine Conference, Columbia University, NY, 2-3 May 2003), 4.

precision of a poet's work meeting halfway his, or a reader's, recollection.<sup>11</sup>

Even as Nabokov performs the task of recollection, his memory rises to meet the real halfway. And as he narrates that moment in his life, the reader's memory meets his in much the same way, creating ovals from arcs.

Students walking into a patient's room to elicit a narrative history bring with them all of their own memories. It is through the lens of their own experience that they are able to encounter the patient's story, and if the trick will work, as Nabokov suggests, their memory must rise to meet that of the patient. The student and patient enter what might be called an inter-authority, what Olney describes as "a complete partnership in empathetic recollection and correlative creation."<sup>12</sup>

In the write-up, the student tells a life story back to the patient in a reversal of this autobiographical process. But this cannot be considered pure biography. When the student changes from listener to storyteller, shaping and molding the facts of the patient's life into narrative, like all storytellers, the student is bound to leave handprints all over the story.<sup>13</sup> In fact, what he tells is, in some sense, an entirely new story. And because it is constructed according to his own narrative judgments, it tells as much about him as it does about the patient. From one perspective (Olney's and Nabokov's), there can be no true biography—all biography is at least partly autobiography.

Rita Charon has suggested that patients offer themselves to physicians as texts.<sup>14</sup> In the write-up the physician offers a new text (a version of the "correlative creation") back to the patient. Although students may never actually read a write-up to a patient, they bring that construction of the patient with them to their next encounter to be "read" nonetheless. The student is in a constant process of revision in which the *suzjet* of the patient is critiqued or read against each new experience of the patient.

If we include a third, implied reader of the student's narrative, we might suggest that the patient, the student, and the reader are in a sort of triangular relationship in which each leg of the triangle is a story which is the meeting of the memories of the persons at the vertices.

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<sup>11</sup> Quoted in Olney, 9.

<sup>12</sup> Olney, 9.

<sup>13</sup> Benjamin, 81.

<sup>14</sup> Charon, "Literature and Medicine," 24.

Although it is most explicit with the biography (narrative write-up), this triangular relationship can be found in the autobiography (narrative history) as well. Like the biographer (student or physician), the autobiographers (patients) are continually revising their own narrative constructions according to experience so that they (as writers) enter into a triangular relationship with themselves (as readers) and what they perceive as reality.

To conclude, let us ask of the narrative medical write-up two of the questions Ian Watt asked of the novel: “Is the novel a new literary form?” “How does it differ from the prose fiction of the past?”<sup>15</sup> If the narrative medical write-up is a new literary form it is because it *explicitly* transcends the categories of biography and autobiography. The narrative medical write-up is neither fact nor fiction, neither biography nor autobiography. Rather, it is an amalgam of all these that tells as much about the student as the patient and is as much fact as it is fiction. It is in this complexity of truth and this complicity of authorship that the power of the medical narrative write-up resides.

#### *A/P: Assessing a Patient / Planning a Narrative*

Second-year medical students are taught in their physical diagnosis course the art of constructing a history and physical. Third-year students, in their clinical clerkships, are often admonished, “sell your diagnosis.” That is, they are instructed to organize the history and physical in such a way that the conclusion or diagnosis seems inevitable. Students learn to gather and interpret large volumes of data-- laboratory results, physical findings, patient histories, family histories of heritable diseases, social histories, radiographic findings, etc.-- in order to formulate the final section of the history and physical, the assessment and plan (often abbreviated “A/P”). But once the assessment has been made, the student retrospectively constructs a coherent outline which is presented as the patient history. In other words, the patient history, which produces the assessment and informs the plan, is ultimately the product of that conclusion.

It is this ability to construct a reasonable story from the bare facts of the patient history that marks the skilled clinician. Take for example a forty year-old woman who presents to the emergency room with severe abdominal pain that is worst after meals and which radiates to her

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<sup>15</sup> Ian Watt, from *The Rise of the Novel: Studies in Defoe, Richardson, and Fielding*, in *Theory of the Novel: A Historical Approach*, ed. Michael McKeon, (Baltimore: Johns Hopkins University Press, 2000): 363

right shoulder blade. After a thorough history, physical exam, and a few laboratory tests, the physician might conclude that the patient has acute cholecystitis or inflammation of the gallbladder. Once the physician has come to this diagnosis, a history will be constructed (including onset, duration, alleviating and exacerbating factors, associated symptoms, etc.) that ignores some things deemed irrelevant and highlights those which support the conclusion. That is, the physician will tell the story that supports his diagnosis.

The competent clinician is always willing to change the assessment of a patient when new data come to light, but until then, the clinician will "sell" the diagnosis as though it were established fact. The perfect history and physical, then, is a perfectly plausible narrative. And whether it is fiction or fact, in the absence of a diagnostic error, one would not doubt its truth.

One function of narrative medicine is the displacement of diagnosis with experience. It asks not "what is it?" but "what does it mean?" The plot of the narrative medical write-up functions much in the same way as the format of the history and physical, but its conclusion is a sense of experience or meaning. Like the history and physical, instead of *only* rendering a final meaning from the events, the act of narration imbues the events with coherence and significance by showing their relation to the end. "Common opinion has it," writes Hayden White, "that the plot of a narrative imposes a meaning in the events that comprise its story level by revealing at the end a structure that was immanent in the events *all along*."<sup>16</sup> The narrative medical write-up, then, can be understood as an interpretive act that interprets *by telling the story*.

Let me emphasize that the student's role is first as a reader (listening to an order which he or she supposes masks chaos) and then as a writer (restructuring the events of the patient's life in a way that not only is logically more coherent but that leads to a more appropriate conclusion.) As I have noted above, the student's task is the creation of *suzjet* from another *suzjet*. This is particularly true with the narrative medical write-up, in which students are instructed to let patients tell their own stories and only to interpret. However, student's only recourse for interpretation is storytelling. Their chief act of reading is writing.

Students, like any other authors, construct a plot in this manner—fashioning the events of the patient's life into a coherent structure that moves temporally and causally toward a conclusion or interpretation. Just as with the history and physical, students gather information from the patient, the patient's friends and family, the medical record, and the other members of

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<sup>16</sup> Hayden White, "The Value of Narrativity in the Representation of Reality," *Critical Inquiry* 7(1980): 23

the medical team in order to gain an understanding of the events of the patient's life. In constructing the write-up, the student might be understood as something of an editor: splicing, highlighting, deleting and arranging events.

In this function, students are mimicking their patients who have offered a plot to the student. One lesson that students learn early on, though not explicitly labeled thus, is that the patient, in recounting the history of an illness, is constructing a plot. No patient has ever simply regurgitated the events of an illness—to tell a story is to create a story, to suggest causes and effects. Even those patients who want desperately to offer up all the information they possess will necessarily forget some events and not be able to forget others. As Northrop Frye has suggested, this is the function of autobiography—to select for and against events in our life in order to construct a meaningful narrative.<sup>17</sup> This is particularly true (and sometimes problematic) with patients who are convinced they know their diagnosis before arriving at the hospital. These patients often practice particularly tight control over the events of the story avoiding some facts altogether (sometimes even in the face of direct questioning) and highlighting and repeating others.

“All such plotting presupposes and requires that an end will bestow upon the whole duration and meaning,” writes Frank Kermode.<sup>18</sup> In other words, the conclusion of a story allows students and patients alike to create a plot from events that lead up to that conclusion. In one sense, the story must be complete before events can be rendered as meaningful or insignificant, because their significance to the plot depends on their relation to the conclusion. So we are caught in (or empowered by) a hermeneutic circle: “we can understand a whole-- whether it be a whole text or a whole life-- only by understanding first the parts, but we can understand any part or parts only by understanding first the whole.”<sup>19</sup> Students, as co-authors of a patients' stories, are engaged in a form of retrospective editing, always looking forward and looking backward: looking forward from the events in order to come to some conclusion; looking back from the conclusion to re-evaluate the events, their importance, their place in the plot. That is, they continually seek meaning from *and* for the events of the patient's life.

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<sup>17</sup> Northrop Frye, from *Anatomy of Criticism: Four Essays*. (New York: Antheneum, 1957): 8.

<sup>18</sup> Frank Kermode, “Fictions” in *The Sense of an Ending: Studies in the Theory of Fiction*. (London: Oxford University Press, 1968): 46.

<sup>19</sup> Olney, 5.

It is the task of the student, then, to meet the patient's narrative half-way with his or her own, to listen humbly, and then to rearrange, to interpret, and to structure the raw material of memory in a way that produces meaning for both the student and the patient. That is, to create a plot. And what this assumes is that the story has an ending—like the reader who is able at the end of the story to look back and discover new meaning in particular events, the student is only able to structure the patient narrative once he or she has reached its apparent conclusion.

### *Death or Something Like It: The Search for an Ending*

Aristotle wrote that every story must have a beginning, middle and end.<sup>20</sup> But toward what end does the patient narrative move?

“Death,” says Walter Benjamin, “is the sanction of everything that the storyteller can tell,”<sup>21</sup> or as Peter Brooks suggests Benjamin is saying, “death provides the very 'authority' of the tale.”<sup>22</sup> In trying to make sense of a life, all narrative, including the write-up, looks forward to that final hermeneutic piece and exists with the anxiety that the puzzle is not yet complete. “We might say that we are able to read present moments—in literature and, by extension, life—as endowed with narrative meaning only because we read them in anticipation of the structuring power of those endings that will retrospectively give them the order and significance of plot,” says Brooks, and this is why Benjamin argues that a person's life “first assumes transmissible form at the moment of his death.”<sup>23</sup> But for the medical write-up this is likely an unacceptable end to the narrative: most patients, at least, would feel a bit uncomfortable with this notion. What we are left with in narrative medicine, then, is the need for something other than death—a surrogate for death with which the story can conclude.

In his work, *The Sense of an Ending*, Frank Kermode suggests that “to live is to live in a state of crisis.”<sup>24</sup> This sense of crisis, he suggests, is a repetition, a refiguring of finality. That is, each moment of crisis is an ending unto itself. This seems a plausible solution to our problem in narrative medicine particularly because the hospital is often the theater of a person's greatest dramas, and it is not hard to imagine a patient as a person in crisis. However, people in crisis feel acutely the need for origins and ends—they are “in the midst” seeking a pattern that is

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<sup>20</sup> Aristotle, *Poetics*, 99.

<sup>21</sup> Benjamin, 84.

<sup>22</sup> Brooks, 95

<sup>23</sup> Brooks, 94

<sup>24</sup> Kermode, 26.

disallowed by their very position.<sup>25</sup> The sense of crisis, then, is not so much an ending point, then, as it is a beginning.

I suggest that the most appropriate end to the narrative medical write-up, like all life-writing and particularly like autobiography, is the *present* and that the present is marked by the act of narration. H. Porter Abbot has suggested that all stories are told with a sense of the past tense—that is, they all assume that the events they will tell have already happened, that the events are there to be told. This is true, he argues, even of the science-fiction novel set in the future.<sup>26</sup> Another way to say this is that all narration assumes its location in the present. This is particularly true for life-writing and the narrative medical write-up. The life-story is necessarily “an interpretation of the past achieved from the standpoint and according to the needs of the present.”<sup>27</sup>

But the story-telling act is an “even later than ‘afterwards’”, and by coming *after* the end, it sets the end in place. In his study, “Problems in Closure of the Traditional Novel,” D.A. Miller asserts that this fixity is the impetus for narration. He illustrates this idea with a passage from the end of *Great Expectations*, in which Pip considers his last meeting with Estella:

I was very glad afterward to have had the interview [with Estella]; for, in her face and in her voice and in her touch, she gave me the assurance, that suffering had been stronger than Miss Havisham’s teaching, and had given her a heart to understand what my heart used to be.

Miller comments that

this declaration of finality is what most immediately motivates a *further* narrative development, taking place even later than “afterwards”: I mean Pip’s decision, omitted but fully presupposed by the text, to write his autobiography. The end of narrative thus proves only its rebeginning, as the life concludes in a desire for the life story.<sup>28</sup>

It is important here to note that the life Miller refers to is not in fact over in one sense. Pip is very much alive and able to tell his own story. But in another sense, it has reached its conclusion, and that conclusion is marked by the desire for what comes after the conclusion. Therefore, we

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<sup>25</sup> Kermode, 7, 17.

<sup>26</sup> H. Porter Abbot, "Futures," (Paper Read at the conference "*Contemporary Narrative Theory: The State of the Field*" at Ohio State University, Oct. 25-25, 2003).

<sup>27</sup> Olney, 19.

<sup>28</sup> D.A. Miller, “Problems of Closure in the Traditional Novel.” In *Narrative Dynamics*. Ed. Brian Richardson (Columbus: Ohio State University Press, 2002): 280.

might take exception to Walter Benjamin's formulation: Death is not necessarily the sanction of everything the storyteller can tell. The act of telling is the sanction of everything the storyteller can tell. It is telling that truly gives "a sense of an ending."

*A/P: Assessing a Narrative / Planning a Patient:*

In medicine, we cannot be satisfied with theory. All our endeavors must find their justification in practice and outcomes. Therefore, we must consider the function of the narrative medical write-up.

First, the narrative medical write-up gives the patient a listener. It allows him to *tell* and thereby gives him an ending. It allows those "in the midst" to fix the ongoing crisis in the past. It fills the "need to embark on the autobiographical conquest of authority and control"<sup>29</sup> over the chaos of life. This is I suppose why so many of us would assert that there is something therapeutic just in being listened to.

In his short story, "Misery: To Whom Shall I Tell My Grief," Anton Chekov, a medical doctor, relates the plight of a sledge-driver, Iona Potapov, whose son has died. After trying to tell the story of his son's death to a number of his passengers, Iona finally finds a listener:

He puts on his coat and goes into the stables where his mare is standing. He thinks about oats, about hay, about the weather . . . . He cannot think about his son when he is alone . . . . To talk about him with someone is possible, but to think of him and picture him is insufferable anguish . . . .

"Are you munching?" Iona asks his mare, seeing her shining eyes.

"There, munch away, munch away . . . . Since we have not earned enough for oats, we will eat hay . . . . Yes, . . . I have grown too old to drive . . . My son ought to be driving, not I . . . . He was a real cabman. . . . He ought to have lived . . . ."

Iona is silent for a while and then he goes on:

"That's how it is, old girl. . . . Kuzma Ionitch is gone. . . . He said good-bye to me . . . . He went and died for no reason . . . . Now, suppose you had a little colt, and you were mother to that little colt . . . . And all at once that same little colt went and died . . . . You'd be sorry, wouldn't you? . . ."

The little mare munches, listens, and breathes on her master's hands. Iona is carried away and tells her all about it.<sup>30</sup>

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<sup>29</sup> Miller, 281

<sup>30</sup> Anton Chekov, "Misery: to Whom Shall I Tell My Grief?" Trnsl. Constance Garnett, in *On Doctoring: Stories, Poems, Essays*, ed. Richard Reynolds and John Stone (New York: Simon and Schuster, 1995): 49.

Alone, or even surrounded by people unwilling to listen to his story, Iona is in "insufferable anguish," because he is still in the chaos of being "in the midst." The little mare allows Iona to "think about his son" simply by the act of listening. Take note—our first task as physicians is to listen. Iona's horse offers nothing but an ear, but in doing so she offers him a certain kind of peace. As physicians, we allow our patients to seek meaning in the midst of crisis simply by listening.

But Iona's little mare is also an empathetic listener. Even as Iona tells his story, he feels the need to imagine that his horse could feel the same pain. "You'd be sorry, wouldn't you?" Iona asks his little mare. Patients ask their physicians this same question in every encounter whether they ever say the words or not. By listening well, sometimes without saying a single word, physicians answer, "Yes. I would be sorry too."

The final point I would like to make about this act of listening is that it involves touch. Notice that it is when the "the little mare munches, listens, and *breathes on her master's hands*"<sup>31</sup> that "Iona is carried away and tells her all about it." Patients long to tell their stories not to an outside observer but to one who has entered the story. When a physician sits beside the bed, feels the contours of the patient's stomach, listens to the beating of the patient's heart, the whining of the patient's intestine, the drama of the patient's life and illness, and listening, touching seems to understand, he or she allows the patient to be carried away—to tell all about it and find solace in the midst of chaos.

But what listening also does is allow the patient to *retell*. That is, it allows the patient to create an alternative meaning from the events of his life by giving him opportunity to tell the story a different way.

As Rita Charon has suggested, patients present themselves to their physicians as texts to be read.<sup>32</sup> *Themselves as texts*. If this is true, then I suggest that the retelling is not only a presentation but a literal recreation of the patient's self, that rewriting is, on one level, a refashioning of the self. It is an opportunity for the patient to *be* a different text. I recognize that this is only slightly different from the desire for telling, but the attraction of retelling is that "all the events over which you had no control are at last subject to your decision,"<sup>33</sup> through new

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<sup>31</sup> Emphasis mine.

<sup>32</sup> Charon, "Literature and Medicine," 24.

<sup>33</sup> John Berger, *A Fortunate Man: The Story of a Country Doctor* (New York: Holt, Rinehart, and Winston, 1967): 159

selection, new order, new context, new emphasis—new plot. Telling seeks meaning. Retelling seeks *new* meaning.

Students and physicians do not only listen to patients retell their stories, they also retell the stories themselves. Roy Schaeffer, a psychiatrist, writes that

People going through psychoanalysis—analysands—tell the analyst about themselves and others in the past and present. In making interpretations, the analyst retells these stories. In the retelling, certain features are accentuated while others are placed in parentheses; certain features are related to others in new ways or for the first time; some features are developed further, perhaps at great length.<sup>34</sup>

In other words, the analyst re-plots the story of the patient's life. Schaeffer suggests later in his essay that the act of psychoanalysis reveals "another reality" and that "this second reality is as real as any other."

This of course is exactly (or almost exactly) what we are doing with the narrative medical write-up, though it is being practiced primarily in internal medicine and surgery departments. Howard Brody suggests that physicians are fixing "broken stories."<sup>35</sup> The process that Schaeffer and Brody are describing is precisely the editing process that I discussed earlier.

By creating that new plot and offering it to the patient, the student is also implicitly offering him limitless alternative narratives. The student is saying to the patient (and to himself) that there are any number of possible narratives which could have been told. If we accept the terms of Schaeffer's essay, we are left with a limitless number of stories that are "real as any other."

Perhaps he should have said that the alternative story is as *un*-real as any other. It seems to me that what we do as physicians is to offer broken stories in place of broken stories.

But there is no fault in this. Broken stories are all the physician has to offer. We are all "in the midst," and none of us, patients nor doctors, can see but as through a

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<sup>34</sup> Roy Schaeffer, "Narration and the Psychoanalytic Dialogue," *Critical Inquiry*, 1(1980):25.

<sup>34</sup> Schaeffer, 50.

<sup>35</sup> Howard Brody, "My story is broken; can you help me fix it?": medical ethics and the joint construction of narrative," *Literature and Medicine* 13(1994): 79-92.

darkened glass. Realizing that we are not getting the whole picture, we hope that these broken stories will help us see more clearly.

The stories the physician tells are not only for the patient—they are for the physician as well. The power of the narrative medical write-up depends on physicians understanding themselves as characters in a story—a story equally their patients' and their own. The write-up helps students to perceive their role as characters in and retellers of someone else's story, but it also allows them to retell and seek meaning for their own stories. After all, the hospital is the place where *their* greatest dramas are played as well.

### *Conclusion*

What then is the ultimate goal of the narrative medical write-up? Although it has many clinical applications, the write-up is chiefly an educational tool, and if it is to be successful, it must contribute to the training of better physicians.

In a recent address to surgical educators, the director of the Division of Education of the American College of Surgeons laid out six core surgical competencies: medical knowledge and patient care; interpersonal communication skills and professionalism; practice-based learning and improvement and systems-based practice.<sup>36</sup> The inclusion of communication skills in this list of competencies reflects a trend in medical education, which is evolving to address the needs of today's physicians in training, who must competently interpret patient data *and* experiences. The narrative medical write-up is a powerful educational tool designed to attain that goal.

I am reminded of the passage from Ian McEwan's *Atonement* that serves as an epigraph to this article. Robbie Turner, the idealistic pre-medical student of the novel, has two intellectual passions, literature and medicine; and his copy of *Gray's Anatomy* lies open on his desk next to books of poetry. "For this was the point, surely," writes McEwan. "He would be a better doctor for having read literature."

Narrative medicine asks students not only to read but also to create fiction and poetry. And this is the point, surely: students will be better doctors for having written literature.

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<sup>36</sup> Ajit K. Sachdeva, "Beyond the Competencies: The Changing Paradigm of Continuing Education in Surgery," (<http://www.surgicaleducation.com/pps/020changingparadigm.pps>): 2004.

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