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Source: *Soundings: An Interdisciplinary Journal*, Vol. 72, No. 1 (Spring 1989), pp. 137-152

Published by: [Penn State University Press](#)

Stable URL: <http://www.jstor.org/stable/41178470>

Accessed: 04-08-2015 17:14 UTC

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DOCTOR-PATIENT/READER-WRITER: Learning to Find the Text

Rita Charon

THE IMAGINATION IS A POWERFUL instrument in the practice of medicine. The physician's effectiveness increases with empathy, and empathy springs from the ability to imagine the patient's point of view. This encounter hinges on narrative acts: on the patient's ability to tell a story, and on the interviewer's skill in receiving it and hearing its message.

Doctors and medical students have much to learn by applying literary criticism and narrative theory to their work. If physicians can learn to attend to their patients' stories as astute readers, they will more effectively understand what will make the patient better.

The traditional conceptualization of medical work is that the illness is the text. The hospital chart that documents the illness is a literary genre that follows fairly strict rules of form, voice, pacing. The authors of that description are the professionals who look to the patient to supply the material, the conflicts, and the chance for resolution. The patient is one character in a text whose main character is the illness itself.

When a third-year medical student writes the clinical clerk note in the chart, he or she takes on the mantle of the profession and speaks for the team of physicians caring for the patient during the hospital stay. It is a source of great pride for a student to be allowed to write in the chart. Faculty jealously bar

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Soundings 72.1 (Spring 1989). ISSN 0038-1861

students from writing chart entries until the students demonstrate the ability to write in the proper style. It is clear that the writing itself is a powerful learning and socializing experience. Students are molded into the kind of doctor their teachers want by being molded into the kind of writer their teachers want.

A second sense of text in the clinical context is the more liberating suggestion that the patient is the text. In this formulation, described and critiqued recently by G.S. Rousseau,¹ the task of the physician is to read the text supplied by the patient. The patient here is seen as the bearer of the story, and the physician uses an armamentarium of interpretive tools from invasive procedures to hermeneutics to decipher the patient-text. The patient-as-text formulation, though interesting and more to the point of empathic care than is the illness-as-text notion, consigns the patient to the relatively passive role of serving up the story. The physician is in the active role, and the outcome of the reading seems to rely altogether on the powers of interpretation of the doctor.

A third model springs from an old and growing tradition of patient authors like Pepys, Pope, Donne, and Alice James of patient-authors.² In pathography, the patient records and interprets his or her own illness. This recording empowers the patient to control and define the process of pain, suffering, and even the pathophysiology leading to the illness. In this genre, the professionals are consigned to the status of minor characters, more often than not in seedy or unpleasant roles. Rarely do they ascend even to the status of villain except in the aggregate. The important point is that the patient is active as the source of the narrative and as the interpreter of the narrative. This is genuine sole authorship. In this case it is the patient and not the doctor who learns and is shaped through the process of writing.

A fourth model is that of joint authorship. Michael Balint, the British psychiatrist, suggests that the doctor and the patient co-author the story of an illness.³ Both participants choose frames within which the story will be told and heard. They work together, sometimes as one and sometimes in conflict, to include what is pertinent and to exclude what is extraneous. The clinical text, in this formulation, is the synthesis of the patient's sensations and understandings and the physician's in-

vestigations and understandings. When this process—Elliot Mishler calls it the social construction of illness—works well, the story is true to the patient and is clinically useful to the physician.⁴ When this negotiation breaks down or is marked by conflict, the work of healing cannot be done.

Some years ago during a seminar on Literature and Medicine Joanne Trautmann Banks recommended that I write about my patients in a different voice. Since then, when a patient confounds me, saddens me, angers me, distresses me, I find it clarifying to write about the patient from the patient's narrative stance. By adopting the patient's voice, I can more easily follow the lead of the patient in creating the story. I discover that I know more about my patients than I knew I did. I realize what part I play in their illness by describing myself from the patient's point of view. The essential feature is that I allow the patient to become an independent character and then I do as a writer does. I allow the character to act and try to keep up with that action in words. Writing the patient's story gives me a deeper investment in the patient's future. By placing myself within the patient's consciousness, however fleetingly, I can exchange my own perception of events in favor of my imagined version of the patient's perception. What I write then becomes material to test out with the patient.

TEACHING THE EMPATHIC STANCE

I direct a course called "Introduction to the Patient" for second-year medical students at Columbia University. The course introduces students to the voice and the world of the patient and demonstrates how the patient can collide with or be welcomed into the clinical world. The challenge of the course is to coax medical students away from the detached and objectifying stance inevitably produced in them through the reductionism of most of the medical curriculum, without disarming them or rendering them ineffective through over-identification with the patient. In this course I ask that students be self-consciously personal, responsive, and subjective, that they look squarely at their own feelings in meeting and caring for patients, and that they allow the feelings of the patient to register on them. This reorientation toward the personal and affective is an important component in learning to interview and interact with patients

in the provision of health care. What we encourage is the ability to hear on many levels at once and to integrate the factual, affective, emotional, social, metaphorical, and existential.

The best way I have found to integrate these many tasks is to have students write stories about their patients. In one exercise I ask my students to interview a patient with a chronic illness. Some of my patients are asked to come in to the medical school to speak with the students. I know these patients quite well, which is important in the evaluation of the exercise. Students in small groups, accompanied by a clinical preceptor, spend about an hour and a half with a patient. Usually they elect one student to be the interviewer, but all students eventually are able to interact with the patient. It is an informal interview in which the patient is invited to tell the story of his or her illness in any form or chronology or detail. This is not billed as a therapeutic interview or a clinical fact-finding interview. I direct students to focus instead on the patient's own understanding of the illness and to learn how the illness has changed the patient's life.

After the interview, students are required to write an account of the patient's illness using the narrative voice of the patient. The student may use the first or third person in writing the story and may focus on any aspect of the interview. I make it clear that this is not a test of how factually correct students are in repeating the story of the patient, but rather a check on their ability to integrate the facts with the affect and the unstated content of the interview.

This writing exercise complements the more traditional writing of the history of present illness in which an omniscient narrator chronicles the events of a disease. The stories that students write are instead narratives of illness as perceived or at least as described by the patient. The requirement is that they seek the patient's voice.

This exercise accomplishes many goals. Students say that writing the stories allows them to feel the emotions of the patient they describe. They emerge from writing their stories with a sense of sadness, dread, even victory. Generally the students find the exercise difficult, yet they frequently say that the exercise was their first opportunity in medical school to use their imaginations.

Comparing the stories that students write from the same interview demonstrates the selectiveness of attention and the personal contribution of the hearer. At the end of the exercise, we have several versions of one interview with a patient whom I know quite well. We read the stories in the small groups so that students can compare their own approach and interpretations of the interview. The versions are vastly different, contradictory, incongruent in fact and feeling. What does this mean about the students' ability to record, about their powers of observation, about the nature of truth?

The following paragraphs are taken from three student essays drawn from the same patient interview.

I thought I was OK. When I was little in Puerto Rico, maybe 8 years old, I was so scared at night, so nervous, I had to crawl way down in my bed and pull the covers over me to sleep. My brother never saw that huge ball on the ceiling that was going to fall and kill me. My parents were always fighting, my father would hit her and I couldn't do anything and that ball was there every night waiting to crush me. But it got better after a few years and I thought I was OK until my daughter got so sick. The doctors said she had cystic fibrosis and she might die, my beautiful daughter, only 9 years old. I couldn't take it. I wanted to die. I tried twice to kill myself then. I was so nervous all the time and I couldn't drive anymore so we had to move to Manhattan; then I took public transportation to work at the hotels downtown. I worked hard but I was always so nervous.

He was 57 years old; he had gout; he had had an operation for kidney stones; his doctors told him he had had a stroke 10-15 years back; and he had a nervous condition. What did he mean by that last statement? You know, he was always nervous, anxious, he didn't feel calm. It started when his youngest daughter, then 9 years old, became severely ill. His voice broke as he recalled this painful event of his life. She had been sick for over a year and required constant attention. "But now," he said proudly, "she is 27 years old and completely recovered." [More than one student in the classroom made a quick calculation. Hmmm . . . 18 years ago and he sounds as if she almost died last week. . . .]

She was so young and I was very afraid. The doctors said she was very sick. The cystic fibrosis made it hard for her to breathe. When she came home, she needed oxygen in a tent over her bed. Every morning, I followed the doctor's instructions and gave her pats all over her body, seven different positions. I did this again in the afternoon. I wanted to show that one doctor how I did it

to be sure I was doing it right but I couldn't ask him because he was too busy and he was good for my daughter. If he got mad at me, then he would not have helped her so much. My father would get mad when I was young. He would frighten me and sometimes hurt me. But not like he hurt my mother. When my daughter got sick was the first time when the pain was too much and I stopped working a while. It hurt through my arms and even in my legs when I patted her. I think sometimes my belly too. Sometimes I would cry while I was patting her. I didn't want her to die and I knew if I did not help her, she would die. Oh, she's okay now, 27, married with two kids. She's working. All better now.

These stories differ in details of fact, imagery, meter, and point of view. They differ in the juxtaposition of statements and events as told by this patient. Some students preserved the metaphorical speech and sense of narrative; others did not. These differences add up to differences in meaning ascribed by the patient to his illness and the illness of his family members.

The first student made a connection between the patient's illness and both his fear of his father and his crushing inability to protect his mother. The words "so nervous" are used to describe both his childhood sickness and his current poor health, suggesting that the patient perceives a continuum between the two. The repetition of the phrase, "I thought I was OK," makes sense of the daughter's illness in this patient's system of meaning. When his daughter got sick, it recapitulated his earlier experiences of his own nervous illness. He in turn became ill again. Her impending death very literally almost took his life as well.

The second student heard a much different version. In this version, the daughter's illness is the inciting event for the patient's illness. This student describes the patient's fear of his father elsewhere in the piece, but does not tie the two together in imagery or plot.

The third student's version ties the daughter's illness affectively to the patient's fear of his father. The patient's pain at his father's hand is equated to the pain he felt at his daughter's sickness. The language (pats over her body, seven positions) hints at sexual associations as well. This student goes even further. He connects the fear of the father to the fear of doctors, equating the dreadful authority of the father with the fearful

authority of a doctor who could abandon him and his daughter if angered.

I will come back to these paragraphs later. It is worth noting now, however, that the level of detail and personal material expressed by this patient is not atypical. When medical students or doctors ask patients to tell them what the problem is, patients often speak of childhood events, present-day conflicts, deep sorrows and wounds. This man, in fact, was describing to these students his case of gout. Medical histories don't stick to the facts.

In order to do simple medicine, one has to be able to understand complex narratives. If students' abilities to recognize complex narratives are developed, the students may be more attuned to patients' attributions of illness, the life contexts within which these illnesses take place, the ordeal of being sick, and the many ways there are to heal. By asking students to recognize and adopt the patient's voice through writing, I ask them to seek out the patient's perspective, the coherence that a patient gives to a set of events, and ultimately the meaning that the patient attaches to it all.

FROM PRACTICE TO THEORY

Since I discovered the usefulness of writing about my patients, I have become curious about why it works so well and what precisely it does. Rather than proceeding from theory to practice, I go backwards from the practice to find a coherent theory that explains why it works.

The Diagnostic Novel

Walker Percy, the novelist and physician, speaks of writing diagnostic novels. Percy's characters are driven by the uneasy certainty that something is wrong. They focus and resolve questions of meaning in their lives through diagnostic enterprises. Percy was trained as a physician but never practiced medicine. Nonetheless his characters benefit from his clinical training. He imparts to them his resolve to get to the bottom of things: "Part of the natural equipment of the doctor is a nose for pathology. Something is wrong. What is it? Where is the lesion?"⁵ The stance the doctor takes in answering these questions is one of charged alertness, finely focused concentra-

tion, perceiving all that can help to answer the question but never losing sight of the reason for all the activity. The doctor sitting in a room with a sick patient acts as a lens, intensifying through concentration whatever light there is to be had.

All fiction, Percy says, is diagnostic. The mandate of the writer is to figure out who is sick and what is wrong. "Something is indeed wrong, and one of the tasks of the serious novelist is, if not to isolate the bacillus under the microscope, at least to give the sickness a name, to render the unspeakable speakable The entire enterprise of literature is, like that of a physician, undertaken in hope. Otherwise why would we, writer and reader, be here?"⁶

The relationship between the writer and the reader and the relationship between the patient and the doctor have much in common. That is why it makes sense to have students write. They share a common ground in the way they listen to voices, discover narratives, create stories, and choose an audience. The doctor, after all, is the audience. The patient is the source and teller of the story. The doctor is the reader.

Patients autograph their books for their doctors, not the other way around. Patients affix their most personal signs to their communications with their doctors. To recast the relationship in terms of writer/reader clarifies this. I have just described an exercise in which the student-doctor is asked to write the story. To ask the student to write the story does not confound or contradict the statement that the doctor is the reader, because the act of writing is one member of an integrated pair of acts. No matter that in patient care the patient is writer, the doctor reader. In this exercise we teach the doctor to read by drawing attention to the act of narration itself.

Readers and Writers

Eudora Welty emphasizes the close link between reader and writer, between reading and writing.

Indeed, learning to write may be a part of learning to read. For all I know, writing comes out of a superior devotion to reading Both reading and writing are experiences—lifelong—in the course of which we who encounter words used in certain ways are persuaded by them to be brought mind and heart within the presence, the power, of the imagination. This we find to be above all the power to reveal, with nothing barred.⁷

If a doctor, then, is a reader of sorts, he or she shares with the writer-patient an encounter in words with the power to reveal. The idea that the doctor is a listener to stories is a familiar one in the psychoanalytic tradition. Donald Spence, a psychoanalyst, writes about the process of discovering the patient's meaning through his or her words.

Empathic listening takes the same form. As we listen to the patient and become accustomed to his manner of speaking, we learn to hear his store of private meanings reflected in the words he uses. We listen on at least three levels—to the sense of his message, to the words he is using (and misusing), and to the gradually accumulating private meanings that become clear. . . . Listening in this manner is similar to making a close reading of a poem; it attempts to get "behind" the surface structure of the sentence and to identify with the patient as he is expressing the thought.⁸

So the connection between reading and caring for patients has a place in the theoretical frameworks of medicine, but it has yet to have a discernible impact on the practice of non-psychiatric medicine. It will be of great comfort to patients when these things *are* understood by the internists, the pediatricians, the obstetricians, the geriatricians who accompany us all through pain, illness, and uncertainty.

Once the reader-writer relationship is recognized as analogous in useful ways to medical practice, physicians may turn to literary criticism and narrative theory for help in understanding their work. Where should they begin in the maze of controversies, the strange language, the fiercely held beliefs? Physicians can profit from a suggestion made to literary critics by Wallace Martin in his elegant introduction to narrative theory that they "try to determine why and how we read stories as we do—asking not what they are in the abstract but determining what competence we intuitively exercise when reading them."⁹

We all know that we have competence as readers. It is of use to articulate what we do as readers to uncover the meaning of stories, either written or told, either "fiction" or historical, and reader-response criticism helps to do that. Wolfgang Iser describes the reader in *The Act of Reading* as a collaborator with the author in realizing the text. Textual structures and structured acts of comprehension are, according to Iser, the two poles of the act of communication. The act of reading is the process by

which the author's text becomes incorporated into the reader's consciousness. "This 'transfer' of text to reader is often regarded as being brought about solely by the text. Any successful transfer, however—though initiated by the text—depends on the extent to which this text can activate the individual reader's faculties of perceiving and processing."¹⁰

Several features of reading as described by reader-response critics are worth noting. Reading is an active process of concentrating meaning against a gradient. The text is not merely imprinted upon the reader, but rather "taken up" and thereby transformed. It is also an activity of pleasure, the pleasure being proportional to the work. "Thus author and reader are to share the game of the imagination. . . . The reader's enjoyment begins when he himself becomes productive, i.e., when the text allows him to bring his own faculties into play."¹¹ The epistemological conflicts between relativity and relational knowledge must be raised, and the reader-response stance takes them face on. Questions of objectivity, intersubjectivity, and truth inform the search for meaning both in literary texts and in patient care.

Wayne Booth helps us to place the reader in the act along with the other players. "In any reading experience there is an implied dialogue among author, narrator, the other characters, and the reader. Each of the four can range, in relation to each of the others, from identification to complete opposition, on any axis of value, moral, intellectual, aesthetic, and even physical."¹² The relationship among reader, writer, character, and plot becomes complex and generative. The meaning of a narrative, either spoken or written, will be found among the author's intent, the reader's disposition, the characters' interrelationships, and the language itself. For physicians to think of their work with patients in these terms opens up cramped quarters. By looking at specific features of the act of reading (aesthetic distance, point of view, and construction of meaning), we can more clearly articulate the physician's task in listening to a patient, and can perhaps more clearly see the interplay among all who sit in our little rooms.

AESTHETIC DISTANCE

One of the first competencies that a reader exercises is the arbitration of the conflict between identification and detachment. This conflict is central for doctors as well. Hans Robert Jauss writes: "Identification in and through the aesthetic attitude is a state of balance where too much or too little distance can turn into uninterested detachment from the portrayed figure, or lead to an emotional fusion with it."¹³ Is this not what we owe our medical students, to model ways for them to avoid either of these pitfalls? How do we do it? When my students write about their patients, their task is both to distance from and fuse with their "heroes" (and isn't it a bonus to have the students at this level in their training regard their patients as their "heroes?"). Though they do not experience themselves as effective clinicians at this point, they can experience themselves as effective readers. With minor modifications (which themselves raise good questions about the physician's pleasure and self-discovery in the care of patients), one can listen to Jauss transposed into the clinical setting as if in response to these questions. "For neither mere absorption in an emotion nor the wholly detached reflection about it, but only the to-and-fro movement, the ever renewed disengagement of the self from a fictional experience, the testing of oneself against the portrayed fate of another, makes up the distinctive pleasure in the state of suspension of aesthetic identification."¹⁴

CONSTRUCTING MEANING

The acts of the reader are complex, and the theories about them are in robust controversy. This is not the place to recreate all the arguments about reader-response or to outline the deconstructionist stand. Suffice it to say that those arguments are useful for medical people to overhear. The conflicts about whether the meaning exists in the mind of the writer or the eye of the reader, and whether texts are "readable" or not—all these have profound implications when transposed into the clinical idiom. One must at least recognize that these issues are problematic. That recognition would go far toward correcting some of the most heinous and damaging mistakes of doctors: the replacement of a patient's story by the doctor's own agenda on the one hand and the doctor's inability or dis-

interest in finding the coherence of the patient's story on the other.

In the debate over where and how meaning emerges in narrative, Martin offers useful words for clinicians: "We cannot know what a narrative is except in relation to what it does, and while the purposes of readers and writers vary, they are inseparable from questions of value and meaning. . . . Perhaps the creation of meaning is a cooperative enterprise, reader and writer both contributing a share."¹⁵ This statement echoes the assertion of Balint and Mishler that the doctor and patient construct the illness together. It brings to mind as well Freud's conflict between construction and reconstruction as molds for his analytic theory. How important is it to capture historical truth? Freud attempted to be loyal to his archaeological model of discovery of the analysand's actual past. However, his later writings concede that analytic interpretation contains elements of *de novo* construction as well, not rooted in suppressed events in the patient's past, but rather the result of the analyst's creative search for the narrative thread in the patient's utterances.¹⁶

These theories converge in their insistence on the personal contribution of the hearer/reader/therapist. If the doctors contribute to what gets heard, then the doctors must understand their contributions. Clearly, the self-understanding of doctors is not meant to eclipse their understanding of patients. Rather, self-awareness is an important instrument in caring effectively for patients. By pointing to the role of self-knowledge in the listening and the reading and by offering ways for doctors to understand their own searches for meaning, we can help doctors and students to apprehend the true text in interactions with patients.

Point of View

Virginia Woolf, in describing her feeling as she reads a short story by Chekhov, brings to light the process by which meaning emerges when we read and hear stories.

The emphasis is laid upon such unexpected places that at first it seems as if there were no emphasis at all; and then as the eyes accustom themselves to twilight and discern the shapes of things in a room we see how complete the story is, how profound, and how truly in obedience to his vision Chekhov has chosen this,

that, and the other, and placed them together to compose something new.¹⁷

My students asked themselves, "Now what does his father's beating him 49 years ago have to do with his daughter's getting sick from cystic fibrosis, and why is he talking about all his doctors so harshly, and what has this got to do with gout?" They might not have asked themselves such fruitful questions had they not had to write the narrative. They were the ones peering into the twilight in which there seemed to be no emphasis at all. In their listening and then later in a more dramatic fashion in their writing, they had to put themselves into the consciousness of this man and wonder, "Why this now, why that detail spoken, why these events as if they were yesterday?" These are the questions I want them to ask of themselves and of their texts. They are, in short, the kinds of questions that experienced doctors learn to ask. As the students write, they grasp that the words chosen mean something, that the order of the words (i.e., the speech) means something, and that the juxtaposition of associated thoughts—whether or not the foundation of their association is known—means something.

The students *had* to adopt the patient's point of view. With the little that they knew about him, they had to imagine a plausible connection among the disparate things he told them. When we look again at the paragraphs from the three students' stories, they reveal varying degrees of ability to see from the patient's point of view.

The first student uses a first-person narration in the past tense, giving the patient's story as he gave it, with the exception of having normalized the chronology. The piece opens and closes with paragraphs in a interior monologue form:

So many doctors. I'm so nervous—I hope I'll be able to answer their questions. Oh, I wish I'd learned to speak English better—I'm afraid they won't understand me.

And the conclusion:

I can't understand why I feel so weak and why I have these new pains in my chest. It feels like burning inside and somewhere deep, in the muscles. Why can't the doctors tell me what's wrong?

She achieves access to the consciousness of the character by incorporating the interior monologue, offering readers the chance to look through the character's eyes at the world.

The second student takes another path. He chooses a third-person narrator outside of the consciousness of the character. His narrator is, in fact, himself and his classmates. The parenthetical comments and the quoted interior monologue of the *students* attest to his refusal or failure to give voice to the character. The judgments of the students achieve equal billing with the dialogue of the patient. In fact, the thoughts of the students become part of the plot of this story. This story, although it reflects a sharp awareness of the process of the interview, does not achieve the patient's point of view at all.

The third student uses a first-person past tense similar to the first example. However, his character reports events in non-chronological order, preserving the patient's subjective experience of time in associating his daughter's illness and his father's anger. This writer shows a greater degree of subtlety in revealing the consciousness of the narrator.

In all three examples, the student-authors struggle with point of view. They must choose their stance. They are engaged in the processes described by Iser and Booth of uptake, creativity, and dialogue. When the students take pen in hand, they have to confront their own ability to make sense of the story told by the patient. They have to push to the limit their flexibility and imagination. Their choice of point of view crystallizes the balance of power between themselves and the patient. It may be that there is a connection between where they stand as authors and where they will eventually stand as doctors.

SUMMARY AND FUTURE WORK

We need to conceptualize in human terms what it means to doctor, what it means to be with sick people in ways that help them. It is no longer enough, more and more people are convinced, to offer only medicines and surgeries.

If, in fact, one is justified in conceptualizing the patient's story as the text and the doctor as the reader, literary and narrative theory offer great help to doctors in thinking through their task and finding ways to help their patients. Applying lit-

erary theory to medicine brings up interesting and fruitful questions about truth, imagination, and process that are too often entirely ignored in thinking about medicine.

The reasons I read are the reasons I care for patients. Both activities allow me to witness the movement toward self-understanding. Both activities nurture my own search for meaning through the immersion in the lives and searches of others. When Walker Percy describes the novelist, he could be describing medicine as well:

The contemporary novelist, in other words, must be an epistemologist of sorts. He must know how to send messages and decipher them. The messages may come not in bottles but rather in the halting and muted dialogue between strangers, between lovers and friends. One speaks, the other tries to fathom his meaning.¹⁸

The next step in my writing assignments for medical students will be to ask students who are themselves caring for patients on hospital wards to write their patients' stories as an adjunct to their writing in the hospital chart. Perhaps with narrative force behind them, students will develop into physicians who can hear the full stories and who will try to fathom the meaning of what they hear.

In "The Middle Years," Henry James describes the haunting relationship between Dencombe, the dying writer, and Doctor Hugh, his optimistic and fiercely loyal reader. It is the attentiveness of the doctor/reader that gives Dencombe a sense of his own worth. I speak for readers and writers, doctors and patients when I quote Dencombe's deathbed words:

We work in the dark—we do what we can—we give what we have. Our doubt is our passion and our passion is our task. The rest is the madness of art.¹⁹

NOTES

This paper is part of research supported by a May Rudin Fellowship in Social Medicine awarded through the Center for the Study of Society and Medicine, Columbia University. I gratefully acknowledge this aid.

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