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The Literary Agenda

Is Literature Healthy?

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for John and Sylvia

33. Marilyn J. Field and Christine K. Cassell (eds) *Approaching Death: Improving Care at the End of Life* (Washington D.C.: National Academy Press, 1997), p. 2.
34. Atul Gawande, *Being Mortal: Aging, Illness, Medicine and What Matters in the End* (London: Profile Books Ltd, 2014), p. 1.
35. William James, *The Varieties of Religious Experience*, 1902 (Harmondsworth, Middlesex: Penguin Books Ltd), p. 162.
36. Martin E. P. Seligman, *Learned Optimism: How to Change Your Mind and Life* (New York: Vintage Books, 1990), pp. 7, 76, 207, 283.
37. Martin Heidegger, *Being and Time*, 1953 (New York: SUNY Press), p. 123.
38. Maxim Gorky, 'A Letter', Reminiscences of Leo Nikolaevich Tolstoy, translated by S. S. Kotliansky and Leonard Woolf, 1920 (Adelaide: University of Adelaide, 2014).
39. Thomas Nagel, *The View from Nowhere* (Oxford: Oxford University Press, 1986), p. 225.
40. Blake Charlton, Abraham Verghese, 'Caring for Ivan Ilyich', *Journal of General Internal Medicine*, Jan 2010, 25(1): 93–5.
41. One key lesson the work teaches, says a recent clinical symposium on end of life issues ('*The Death of Ivan Ilyich: A Blueprint for Intervention at End of Life*', 2011), is the crucial importance of honesty of diagnosis in supporting the patient in the classic stages from denial to acceptance (as established in Elizabeth Kubler-Ross's *On Death and Dying*, 1969). The value of this novella in medical training is more practical than the latter text, Warren Lee Holleman has argued, in that 'it help[s] students understand how patients die, what helps, and what hurts, so as to prepare them for their hospital rotations'; 'Death education in American medical schools: Tolstoy's challenge to Kübler-Ross', *Journal of Medical Humanities*, March 1991, 12(1); pp. 11–18, p. 5.
42. Marilyn J. Field and Christine K. Cassell (eds), *Approaching Death: Improving Care at the End of Life* (Washington D.C.: National Academy Press, 1997), p. 2.
43. Robert Coles, *The Call of Stories: Teaching and the Moral Imagination* (Boston: Houghton Mifflin, 1989), p. 167.
44. Wilfred R. Bion, *Attention and Interpretation* (London: Maresfield Library, 1970), p. 81.
45. R. F. Christian (ed & trans), *Tolstoy's Letters*, 2 vols (London: Athlone Press), vol. 1, p. 296.
46. Wilfred R. Bion, *Attention and Interpretation* (London: Maresfield Library, 1970), p. 81.

2

Telling a New Story

*Literary Narrative and Narrative Medicine***In Favour of Story**

Christopher Dowrick, my Liverpool colleague, a professor of primary care and himself a GP, describes in *Beyond Depression* a visit to his surgery from Ian, a retired British Army restaurateur with three grown-up children, whose heavy drinking is exacerbating his diabetes and high blood pressure and who, more recently, has been suffering blackouts. He is sleeping badly, often irritable, rarely goes out of the house and is alarmed to find he can no longer be bothered to see his children. He puts his situation in simple common language: 'You see doc, basically the problem for me is I just can't see any point in getting up in the morning any more':

He talks about his loss of ability, his painful feet and the complications of his diabetes, present and to come. He talks about his loss of purpose, how he used to be a good restaurateur and a good father but he has no role in either arena now. All he can see now is a slow, inexorable path toward death. His problem now seems to me to be beyond the reach of medicine and to go way beyond the reach of any formal diagnosis. Ian and I are facing a profound existential question: what, actually, is the point in his being alive?!

In an everyday routine surgery, this GP deals here not with the absolute pain of death but with the pain that does *not* kill while it can surely defeat all sense of purpose in going on living. In place of the increasing certainty of death which confronted Ivan Ilyich, this patient faces the insupportable prospect of a continued but apparently worthless life. The man no longer has a function or occupation,

as father or restaurateur; he has no purpose to make every morning part of a life story rather than just a matter of time after time. As Dowrick recognizes, such suffering no longer fits into the body as a mere symptom, nor into the world as a medical diagnosis. What we call depression is perhaps really the name we give to the problem of a person outliving his or her sense of 'fitting', or never having had a place or form.

What is humanly required in such situations is precisely a *general* practitioner, one who, by contrast with the medical specialist, is prepared to see beyond what specialist medicine alone can offer. Generalism, here, means taking seriously the human trouble which does not have a ready name or diagnosis. It is a willingness to enter the inchoate and indeterminate areas of individual experience where technical efficiency and skill alone are out of place or redundant.

It was creation of the hospital in the nineteenth century that began increasingly to give rise to the specialist consultant. The pressure of large numbers of patients had introduced, into an urgently required system of collectivized care, a new emphasis on finding the common characteristics of the same disease in different people, in order to identify, through systematic biomedical experiment, the most widely effective treatment. These advances are of course, as I have said earlier, sensible and admirable, part of the necessary systematization and specialization of processes for which we are all at various times most grateful, and which bring much relief to suffering. Increasingly, even so, the expert physician's commitment to diagnostic classification and scientific objectivity made him or her a specialist in respect of the *disease*, not the patient. But for the traditional family doctor, whose role hospital medicine began to replace, the reverse had been true; before the availability of sophisticated technology such as stethoscopes and thermometers for physical examination, a doctor's practice was based entirely upon an intimate knowledge of patients' circumstances. Though under severe time pressure with fifteen-minute appointment slots, the modern GP may still be able at best to continue this humane tradition, remaining close to communities, and observing illness within the particular life contexts.

Yet, as biomedicine has made its enormous technical advances, seeking to fit the full range of presenting symptoms to clinical taxonomies which explain, treat and cure them, today's GP, almost

paradoxically, is a generalist *against the grain*. More specialists has meant more diagnoses, and more diagnoses has meant that more people previously considered relatively normal and healthy are included within the definition of treatable or preventable disease. At the same time, the demise of religious and philosophical justification for the sheer arbitrariness of human suffering has made illness one of the few validated expressions of unhappiness. In these circumstances, says Iona Heath, former President of the Royal College of Physicians, a GP is tasked with 'holding the border' between a subjective sense of illness and scientific disease categories where there exists 'the huge undifferentiated burden of human distress'. There the indeterminacy of illness that specialists cannot easily categorize also makes for the benign indeterminacy of doctorly function.

Heath worked as an inner city GP in North London for thirty-five years. As writer and editor for the *British Medical Journal* and as executive member of the World Organization of Family Doctors, she has campaigned tirelessly in her writing and in her public roles for the kind of humane and holistic approach to health care which her own everyday practice has always instinctively embodied. Her decision to become a GP was confirmed by her unhappy experience of hospital rotations as a trainee: 'I realized I like to see people in their own clothes and homes rather than the way they become depersonalized in hospital, however hard you try.'² Her long experience in general practice has taught that the doctor's first task and duty is very simply to listen to the patient's vulnerably uncertain sense of 'something being wrong'.

The words well up, not from a standardized bodily object defined by biology, but direct from the symptoms of a unique human subject created by biography. Lives wound bodies and wounds leave deep bodily scars that never fully heal. Patients' presentation of their symptoms *emerge* rather than *result* from their experience of the symptoms themselves.³

It is this primary personal data—the patient's raw expression of deeply felt unhealed wounds—upon which the doctor must first rely, not in place of effective care but in order the more accurately and usefully to provide it. If the untidy symptoms do not fit the medical

theory, it is the theory that has to be revised or discounted, not the patient's experience. 'Doctors need always to remember that what the patient feels is the reality on which they must base their practice.'⁴ This is what 'primary care' really means here.

Heath's account of the vital importance of personal biography is at once a description and a defence of the rationale of what has become known as narrative-based medicine, as it is practised in the US and UK today. Fundamentally, narrative medicine seeks the reorientation of the doctor's attention toward the person, not the pain. A patient such as Ian has only symptoms to point to, and, in a secular world, only a doctor to turn to. The doctor, in such circumstances, is as much pastor as medic, and is listening to a personal story, not just a list of presenting symptoms preparatory to producing a patient record. More than anything else, says Arthur Kleinman, an early pioneer of narrative medicine, it is the separation of the illness from its sufferer in the modern transformation of the medical care system, that has alienated the ill from their professional caregivers and the latter from the ancient reward of the profession—the capacity to do good for another. Chronic illness like Ian's is not only inseparable from a life history: it actually *is* still a life, its embodied experience. Caring for the patient's story is not a peripheral task but constitutes the very point of medicine.⁵

What is more, the patient himself or herself cannot do without a sense of story. 'To be ourselves we must *have* ourselves — possess, if need be re-possess, our life-stories' says Oliver Sacks.⁶ An extreme example dramatizes what is nonetheless commonly important. In 'The Lost Mariner', Sacks gives an account of Jimmie, an intelligent and high functioning forty-nine-year-old man whose memory of his life had stopped, thirty years earlier, in 1945. His psycho-neurological disorder was caused in part by the trauma of being discharged from the navy; without purposeful work and habitual structure he had 'gone to pieces'. It was also the result of the heavy drinking and severe alcoholism that followed. Jimmie's condition meant that he had vivid and affectionate recollection of his boyhood and naval service as a radio operator on submarines, but no memory of anything following, including the very recent past. 'He is a man without a past (or future), stuck in a constantly changing meaningless moment: a pit into which everything, every experience, every event, would fathomlessly drop.'

Sacks hoped the man himself might not be aware of his own lack of continuity:

'How do you feel?'

'How do I feel,' he repeated, and scratched his head. 'I cannot say I feel ill. But I cannot say I feel well. I cannot say I feel anything at all.'

'Are you miserable?' I continued.

'Can't say I am.'

'Do you enjoy life?'

'I can't say I do...'

I hesitated, fearing that I was going too far, that I might be stripping a man down to some hidden, unacknowledged, unbearable despair.

'You don't enjoy life,' I repeated, hesitating somewhat. 'How then *do* you feel about life?'

'I can't say that I feel anything at all.'

'You feel alive though?'

'Feel alive? Not really. I haven't felt alive for a very long time.'

His face wore a look of infinite sadness and resignation.⁷ For Sacks, the litmus test for ascertaining whether Jimmie actually experiences his own suffering is the capacity to feel intensely. What he finds instead is the feeling of *not feeling anything*, of not even feeling alive, in the absence of a story to make life or feeling *matter* to the man in any way. Not to know one's own story—the inner narrative whose sense *is* our lives' (p. 105)—is the deepest and saddest illness of all. In *Permanent Present Tense*, Suzanne Corkin tells the story of Henry Gustave Molaison who at the age of twenty-seven underwent a psychosurgical procedure that went disastrously wrong, leaving him without long-term memory. He had to have written on a piece of paper the fact that his father had died to explain to him his vague sense of unhappiness at times. 'He often asked when his mother and father were coming to visit him.... One of our lab members noticed that he had written two notes to himself, which he kept in his wallet, one saying "Dad's gone", and the other "Mom's in nursing home — in good health".'⁸ The notes protected him from the anxiety of not knowing.

It was the GP and psychotherapist, Michael Balint who above all, in the 1950s, recognized that the patient case-history could be a

powerfully tangible tool in reshaping the expert-dependent scientific model of evidence-based diagnosis. Balint was a Hungarian Jew, the son of a physician, who completed medical studies himself in Budapest before becoming a leading figure in psychoanalysis. In 1938, when political conditions made it impossible for Balint to practise, he and his wife emigrated to England. Balint's parents remained in Hungary, committing suicide to avoid capture by the Nazis in 1944.

Balint's work is acknowledged by all key protagonists in the narrative movement in medical care as a prior, even founding, practical model. The famous 'Balint groups' brought together GPs once a week over several years to discuss their everyday practice by looking together at a series of patient histories. The experiment is recorded in Balint's seminal work, *The Doctor, His Patient and the Illness*, first published in 1957. The chief aim of this work was remedial: to ascertain 'certain processes within the doctor-patient relationship... which caused both the patient and the doctor unnecessary suffering'.⁹ Specifically, Balint was concerned with the common situation resulting from the lack of a simple cure; the doctor responsibly makes a priority of locating an organic foundation to the patient's problem; examinations often prove negative or inconclusive; the patient becomes more fearful and helpless at not being able to name the illness; the doctor feels guilty at not being able to bring relief to the patient.

What Balint saw were individuals who, being socially isolated in anonymous city settings, were increasingly prone to visit the doctor not just with physical complaints but also 'to complain'. 'I have deliberately left the verb without an object, because at this initial stage we do not know which is the more important, the act of complaining or the complaints that are complained of' (*Balint*, p. 2). The ancient meaning of complaining is not of course to do with customer service but lamentations of sorrow that cry out *because* they cannot be cured. Meanwhile, GPs were gaining increased access to powerful diagnostic and investigative facilities, such as thermometers and stethoscopes, providing quick and effective explanations for these complaints. While such speed might sometimes answer to the patient's vulnerable need for their problem to be named and diagnosed, there was an attendant risk that such solutions could leave the patient's 'deep burning problems' unexpressed and unresolved.

The doctors who attended the discussion groups provided recent case histories, presenting concrete clinical observations of individual patients. But they were encouraged from the beginning to include as full an account as possible of their emotional responses to the patient and the patient's problem. 'At the outset, I had some idea that, psychologically, much more happens in general practice between patient and doctor than is discussed in the traditional text books' (*Balint*, pp. 2-3). The longitudinal case histories, often following the development of a case over two or three years, combined clinical testimony with moving personal biography. As Iona Heath, who was herself a Balint group member in the 1970s, powerfully observes: 'For many patients the general practice record... is the only sustained concrete documentation of their lives'.¹⁰

One doctor, for example, provided the case history of Peter, a young man in his twenties, who, married for three weeks, suddenly began to suffer headaches so severe he was unable to walk, and had to be admitted to hospital as an emergency case. The symptoms recurred a year and a half later when his wife also began visiting the doctor with what appeared to be fertility problems. The doctor's interpretation was that neither Peter's symptom nor the timing were arbitrary. Peter's mother had died when he was three and, his father being an invalid and blind, Peter and his two elder brothers were sent to an orphanage, where Peter was neglected and bullied by his siblings. On leaving the orphanage at fourteen, and from then until adulthood, Peter became sole carer to his disabled and demanding father. The sudden onset of Peter's headaches happened, therefore, when for the first time in his life, Peter, as a married man, was no longer pushed around, was free of near-intolerable burdens and, above all, had had his own disregarded need for love finally met. The way Peter exceeded his headaches—'pain behind the eyes', the feeling of 'something wrong with the brain'—was really, the GP concluded, a kind of atoning symptom, closely associated with his father's needs, for the colossal guilt of his new-found happiness. Recurrence of the symptoms when his wife wished to have a child was an involuntary sign that Peter was still convalescing from the appalling emotional privations of his own childhood and adolescence, and was himself desperately needy and immature. He was unable to tolerate the prospect of becoming a father himself or of sharing everything with a child. Thus

can the medical history bear witness to how a single, definite, generally common symptom can have compressed within it the pain and need of an entire individual life. More, it was the doctor's communicated understanding, and the patient's reciprocal recognition, of the meaning of these symptoms which, in time, helped Peter to overcome them, where the standard treatment, codeine, had made no difference. The next entry of the case history records the birth of a child (*Balint*, pp. 138-48).

The crucial finding which emerged from the experimental Balint groups was that the doctor's responses to the patient often affected the very form of the illness from which the patient suffered.

By far the most frequently used drug in general practice was the doctor himself. It was not only the bottle of medicine or the box of pills that mattered, but the way the doctor gave them to his patient - in fact, the whole *atmosphere* in which the drug was given and taken. (*Balint*, p. 1)

Since patients benefit from many varieties of 'the drug doctor', the doctor has to be allowed great freedom in practising according to his or her individuality. But a good 'atmosphere'—one which makes for the best possibilities for effective therapy—will always involve the doctor's responding to the patient's need to be taken seriously. This means holding back on giving either a prematurely definite physical diagnosis or a negative finding ('nothing wrong'). The key principle is that 'the doctor must not be in a hurry' and, above all, 'must not get ahead of his patient *emotionally*'. The atmosphere has to be one in which patient and doctor can 'grow together into a better knowledge of one another', tacitly 'bound thenceforth by tenuous, not strictly speaking medical grounds'.

This deep personal understanding is, for Balint, the essential element too often missing in the traditional physician-patient relationship. 'The technique of medical history-taking amounts to a systematic questionnaire. Unfortunately no such systematic questionnaire exists yet in the field of the pathology of the whole person, the true field of general practice':

It is still doubtful whether it is possible to develop such a system in this field, especially for the 'unorganised' stages of an

illness.... Our experience has invariably been that, if the doctor asks questions in the manner of *medical history-taking*, he will always get answers—but hardly anything more. Before he can arrive at what we call 'deeper diagnosis', he has to learn to *listen*. During the process he will soon find out that there are no straightforward direct questions which could bring to light the kind of information for which he is looking [emphasis in original]

By 'unorganised', Balint means that stage of the illness where patients 'first create and grow the illness on their own, out of themselves'. Patients consult doctors, he felt, only when they have subconsciously converted their struggle with a problem into an illness about which they feel able to complain. Complaining about the actual problem may have been too shameful, embarrassing, unpleasant, frightening, painful. The doctor's task is to listen for the original problem in place of which the patient offered an illness. The middle-aged man with vertigo is unhappy in marriage; the mother who suffers recurrent sore throats and has a mildly asthmatic child feels lonely and helpless; the adolescent girl with an unsightly skin rash and swelling of the legs has been caring long-term for a seriously ill parent. This kind of listening is very different from history-taking.

History-taking is concerned almost exclusively with objective events or with events that can easily be expressed in words; and towards such events, both doctor and patients can adopt a detached 'scientific-objective' attitude. The events we are concerned with are highly subjective and personal, often hardly conscious, also, as often as not, there exists no unequivocal way of describing them in words. Nevertheless these events exist and, moreover, they profoundly influence one's life.

These powerful hidden events constitute the 'more' which standardized questions can never elicit because this human matter often does not have substantial, expressible or easily tolerable reality for the patients themselves. What is really being demanded by patients when they visit the doctor is permitted space for 'the sincere opening up of a life, with all its miseries, petty and profound fears, frustrated hopes, few and often very precarious joys'. The patient must speak in his or her own way and, crucially, in his or her own time, such that there

'grows', in place of an illness, an inner momentum powerful enough to overcome the protective resistances of embarrassment or shame. The doctor must speak 'only when something is really expected from him—not prescribing "the right way", but opening possibilities for the patient to discover some right way for themselves'. But the doctor's tactful witnessing presence is nonetheless vital to helping the patient 'realize his or her *real* problems'. It is because medicine tries to *ignore* these problems of the apparently undiagnosable or incurable, says Balint, that a great deal of further, needless suffering has spoiled the doctor-patient relationship. What the effective doctor essentially gives to the patient is the atmosphere in which the 'really real' can authentically emerge. It is no accident or surprise that Balint was a pupil of Wilfred Bion when he first trained at the Tavistock Clinic in the 1940s.¹¹

Balint's legacy to narrative medicine, as it emerged in the final quarter of the twentieth century in the UK and the US, was essentially twofold. Firstly, his practical and theoretical model encouraged into general practice the tradition and skills of psychotherapy. Hitherto, psychotherapy had been the only area of health in which talking and listening were understood to be an intrinsic part of diagnosis and treatment. In that context, there has always been a close procedural relation between narrative and psychotherapy. The patient brings to treatment an incomplete or incomprehensible story and the therapist assists in reconstructing the underlying unconscious elements or what is missing from the half-known narrative. For Balint, the GP who remains true to his or her calling as family doctor, has an incomparable advantage over the psychotherapist because of the close, constant contact and much wider range of possible relations with the patient. At any moment, the GP can switch from being medical advisor to being counsellor, neighbour or friend. 'Listening for right answers' need not be confined to a formal consultation but can be a continuous process and extend over a lifetime.

Secondly and crucially, Balint's work showed that the doctor's account of the patient was itself indispensable human evidence, though not in the way evidence was often calculated. It is this key recognition that was picked up by the founders of narrative medicine in the last quarter of the twentieth century. One decisive impetus to the narrative movement in the 1970s and 1980s was the rise in

evidence-based medicine, and, most especially, of the Randomized Controlled Trial (RCT). 'Evidence', in RCTs, is derived from systematically collected data and large population samples, with the aim of deducing epidemiological laws and maximally applicable treatment methods. The RCT is a scientific experiment, in which the people being studied are randomly allocated either to the particular treatment to be tested, or to a control group where no treatment or a previously tested treatment is administered, so that the two groups can be compared. This method is now the 'gold standard' in medical research for establishing the efficacy of medical interventions, including adverse reactions and side-effects. It was the logical outcome of the drive to put technological progress in the service of maximum efficiency and economy.

The statistically aggregated type replaces the anecdotal patient report of symptom as the basis for clinical diagnosis. As Trisha Greenhalgh puts it, in what has become the core text in the field of narrative medicine:

In large research trials, the individual trial participant's unique and many-dimensioned experience is expressed as (say) a single dot on a scatter plot, to which we apply mathematical tools to produce a story about the sample as a whole. The *generalizable* truth that we seek to glean from research trials pertains to the sample's (and, it is hoped, the population's) story, not the individual trial participant's stories. The truths established by trials cannot be mechanistically applied to individual patients or episodes of illness whose behavior is irremediably contextual.¹²

For Greenhalgh, narrative is demanded as much epistemologically as humanistically. The mission of narrative-based medicine is not to reject the principles of clinical epidemiology or to demand an inversion of the hierarchy of evidence so that personal anecdote carries more weight in clinical decision-making than the Randomized Controlled Trial. Rather, the position is that, without the inclusion of the patient's subjective dimension, the reliance on objective explanation alone is unscientific. 'The valid application of empirical evidence *requires* a solid grounding in the narrative-based world'¹³ [emphasis in original].

Nonetheless, being irreducible to a dot or statistic, while often not being susceptible to standardized treatments, the individual may be able to do no more than insecurely hold together the amorphous

content of a complexly particular life. An authentically engaged understanding of that life and self might yield not answers but the terrifying lack of them, a sense of the profound ill-fittedness of this person's needs to what is possible for the doctor to prescribe.

For Arthur Frank, in his seminal text, *The Wounded Storyteller*, it is precisely because an individual's story might not fit into anything except itself, that the ill person needs to tell it every bit as much as the physician needs to hear it. Illness brings sudden change and often chaos, more or less, to the sufferer. Thus vulnerable as never before, patients within the hospital system accumulate entries on medical charts that become the official story of their illness and they can begin to think of themselves as no longer people, but as cases. The question 'How are you?' needs a context wider than the medical report if only to enable the patient personally to feel and to suffer the loss of habitual routines and separation from past experience. Health care requires recognition that this is still a personal life and not just one crippled by incurable or progressive illness.¹⁴

Substituting personal narrative for the conventional medical report is really like putting literature into medicine in a practical way. As Frank suggests, the difference between the standard case history and the patient's own story is very often this: the patient tells his or her story at the point when, with the onset of illness, the story of the person's life seems ended but the life itself carries on. At its best, personal biography occupies the same terrain as literary story; it is more a probing than a precision tool—a way of feeling out where a person is in life, and where he or she may be going. At the same time, the listening doctor, like the reader, must attend to what is individual, unique, particular. The 'narrative practitioner', says Rita Charon in *Narrative Medicine*, uses 'the narrative skills of recognizing, absorbing, interpreting and being moved by the plights of patients in all their complexity'.¹⁵ When doctor and patient thus occupy, from different needs or perspectives, the place of the novelist, then what we call 'literary' in story has a real-life presence in medical practice.

At the same time, the sense of alienation an ill person suffers is not just the fault of the hospital or depersonalizing medical care. Illness brings with it a consciousness for the first time of not simply inhabiting but of being, a body. In health, our attention is directed outwards, to life situations that are not about the body, where the body's perceptions

tell of the world, not of itself. When, in illness, the body's functioning is no longer mere background, this is not just a reversal of priorities but a disturbance in the very structures of self-orientation. Carl Edward Rudebeck cites the case of Rachel, diagnosed with diabetes at the age of ten. When the need to give herself injections is explained, she thinks: 'I will be digging holes every day in my own skin.' Suddenly the body is not the medium of her own life, but itself an existing thing. 'My own skin' is a stunned recognition of herself as vulnerably physical. Moreover, the 'I', which only hours before was simply at home in the body, now exists in alienated and aggressive relation to it. The separation of the 'I' that 'digs' and the 'my' that feels it is a symptom of Rachel's being split between identification with the disease and its treatment, on the one hand, and her primary need for protection from it (her skin's biological *function*), on the other. The nature of her illness means that Rachel no longer feels whole in any sense.¹⁶

Yet Rachel's brokenness is still instinctively expressible here in the child. But in the adult it is often too hardened or too deep for ready access. Then, it is the very struggle for expression that is more palpable rather than a readily available personal story.

The classic text on the special role of the doctor in relation to people's buried lives is John Berger's *A Fortunate Man*, published in the 1960s. Combining visual image, essay and memoir, and thus pitched somewhere between the novel and photojournalism, it tells the real-life story of John Sassall, an English country doctor practising in an impoverished rural community. Early in the book, Berger recounts Dr Sassall's visit to a new patient, a woman in her late twenties, who has recently moved to the area with her husband and three children, and is squatting in an abandoned farmhouse in abject poverty, cold and squalor. The woman has been getting out of breath and, when she bends down to pick something up, she can barely stand up again. 'Doctor, can a woman of my age have heart trouble?' she asks. Examining her chest, Sassall promises she does not have a serious heart disease. Then he asks whether she and her husband intend to stay in the area and what they would think if he tried to get them better housing: 'You have to ask Jack about that. We do everything fifty-fifty':

'You can't go on like this. You know that don't you? We've got to get you out of here -'

'There's lots more unfortunate than us,' she said.

The doctor laughed, and then so did she. She was still young enough for her face to change totally with her expression. Her face looked capable of surprise again. [...]

'Where were you living before you came here?'

'In Cornwall. It was lovely there by the sea. Look.'

A photograph showed herself in high-heeled shoes, a tight skirt and a chiffon scarf round her head with a man and a small child walking along a beach.

'That's your husband?'

'No that's not Jack, that's Cliff and Stephen.'

The doctor nodded, surprised.

'I'll say that for Jack,' she continued, 'he never makes no distinction between the kids that are his and those that are mine like. We share fifty-fifty. He's better to Steve than his own father. It's just that he can't touch me.'¹⁷

It is not the stethoscope but the photograph that begins to uncover the true source of the woman's heart trouble and the real depth of her privation. The sudden presence of the woman's past releases a buried personal strata which, once touched off, swiftly dismantles her default marital attitude ('we do everything fifty-fifty'). It summons a more vulnerably expressive and personal mode in which scrupulous fairness is replaced by a confusing emotional mix of hurt at her husband's coldness, and honest appreciation of his worth as a father. All this happens at all, because the doctor risks breaching the woman's stoic defences—'There's lots more unfortunate than us'... The doctor laughed, and then so did she.' Her instinctive response is what first encourages him to ask the question which invites personal story—'Where were you living before?' The photograph now renews *his own* capacity for surprise at *her* hidden potential—not for change of demeanour merely, but for a wholly different form of life. Here is one of those essential but unpredictable ingredients of what Balint calls 'atmosphere', a mutual openness to the live promptings of the moment.

She looked at the photograph holding it out at arm's length.

Still holding the photograph, she let her arm fall on to her lap, and looked at the doctor, her eyes now angry.

'It just doesn't mean anything to me. It doesn't touch me. I know what real love is like, you see. With the father of Stephen, when I got Stephen, it was beautiful. I know what they mean when they say it is the most wonderful thing in the world, it was like that when I got Stephen and he wanted me like that. And I shall never forget it—I lie awake and think of it yet—because it has never been like that again when it was like heaven when I got Stephen.'¹⁸

This woman does not simply 'tell the story' behind the photograph; rather, this is a triggered happening, closer in form to Thomas Hardy's poem 'The Photograph': 'Then I vented a cry of hurt, and averted my eyes; / The spectacle was one that I could not bear, / To my deep and sad surprise'. It is as though for the first time, in that long silent gaze upon her lost life, she begins to allow into consciousness some true measure of what its loss really means. Personal story is here a form for thinking into experience which does not permit of simple or straightforward telling. For the memory of what was 'beautiful' includes conventional sexual fulfilment, of course. But it also involves a knowledge of 'real love' wherein, in recollection of this 'heaven', not only her husband (Jack) but also her lover (Cliff) are displaced by her son (Stephen), to whom they are both now 'father'. This is not consolation so much as some deep primal knot. Only the woman's hesitant articulation, drawn from the profound capacity angrily to suffer her frustration as much as to feel her deep love, can justly gather or order these elemental matters. 'It has never been like that again' is a terrible summation. But it is also new-sprung realization. In this, more than all, she shows herself 'capable of surprise again'. Precisely in not being formally literary, this ordinary person's story helps show what literary thinking itself is really for: recognizing and refining what humans need, even what they can sometimes do in life itself, by way of expression and search.

'The doctor's business', says Dowrick emphatically, is not only to listen to the ill person's story, but 'to help the patient find some meaning and purpose out of seemingly undifferentiated suffering and distress'.¹⁹ When medicine thus stretches to include within itself what is not open to definite cure, then it is indeed more art than

science. Rita Charon quotes the American twentieth-century literary critic, R. W. B. Lewis:

'Narrative deals with experiences, not with propositions.' Unlike scientific or epidemiological knowledge, which tries to discover things about the natural world that are universally true, narrative knowledge enables one individual to understand particular events befalling another individual not as an instance of something that is universally true but as a singular and meaningful situation.²⁰

It is not that scientific understanding is simply forgotten in narrative medicine. Rather, narrative practice enables background general principles and expertise to be *sunk back into* singular cases.

It is no coincidence that doctors such as Iona Heath and Chris Dowrick, and those in the narrative medicine movement generally, should look to the arts, and to literature in particular, as an indispensable guide for their work. Like general practice itself at its most concerned, says Iona Heath, great literature 'is grounded in the intransigence of nature and the contingency of experience and allows no room to good intentions and wishful thinking'.²¹ It is not simply that these doctors learn from literary works or re-apply to their own practice narrative techniques they find within them. It is rather as though they are already analogous to novelists—novelists of practical life—inhabiting the same intractable areas and using what is sometimes over-narrowly thought of as literary thinking in non-literary settings.

What is crucial is to understand what literary thinking is, whether in literature or life, what help it offers, and how it is best understood and practised.

Against Narrative?

In their conclusion to the opening chapter of *Narrative-Based Medicine*, Trisha Greenhalgh and Brian Hurwitz warmly acknowledge the crucial founding influence of the Balint tradition: its recognition that illness is embodied in a particular, unique individual; that subjective experience of illness is not mere data for medical propositions; that personal suffering needs acknowledgement, elicitation, and witness.

Yet they also lament that this legacy 'has not, for the most part, led to measurable changes in the way medicine is practised or accredited, and has not given rise to a significant programme of systematic research into the analysis and therapeutic use of narrative in the consultation'.²²

As my previous section suggested, *Narrative-Based Medicine* explicitly offers itself as 'redressing that deficit' and laying the foundation for the legitimization and systemization of the practice as an alternative, and not merely secondary, model of medical care. It is a key step in the establishment of narrative-based medicine as a recognized discipline.

Yet my own concern in this section is what might also be lost from the successful institutionalization of narrative medicine's mission. What has happened, I wish to ask, to the idea of 'narrative' as it has undergone semi-incorporation into mainstream academic and clinical medicine? Everyone agrees—perhaps too readily—how important is story as the key expressive form for human accounts. But what does narrative as an entity or process mean to health practitioners and what does it do for their patients?

Establishing the practice of narrative medicine has faced two key and related challenges. First, the difficulty of embedding a person-centred practice within a medical culture to which it exists in resistant opposition. Medical students who respond warmly to richly diverse and nuanced doctor and patient stories in training, are no less vulnerable, in busily demanding hospital practice, to the power of a general unifying medical language which offers to patients a homogeneously rationalized and medicalized experience in place of their own.²³ Second, there is the issue of conferring upon narrative medicine the status of a formal discipline with its own general principles. Such theoretical robustness offers protection against the characterization of narrative medicine as a species of allegedly 'soft' (bad) as opposed to 'hard' (good) medical science. This is the same sort of strong theoretical defence that literary studies itself has sought in order to avoid the ever-lingering charges of liberal humanism and belles-lettres subjectivism. Indeed, narrative medicine has made use of theories of narrative in literature, as well as in philosophy, anthropology, and social science, to give academic gravitas and grounding to itself as a discipline rather than a vague or ill-defined 'approach'. But a practice that

emerged, and which by definition operates amid the particularities of both situation and relationship, and which, as we have seen, is committed to rescuing or attending to the 'not-fitting' in human experience, is itself inimical to rigid conceptual frames.

Let me return, by way of illustration of this latter point, to the very sources of the narrative movement: Balint's research with GPs. His salient findings, in respect of how to arrive at a 'different, deeper, more comprehensive' understanding of the patient's suffering, began with the recognition that 'structuring the doctor-patient relationship on the pattern of a physical examination inactivates the processes the doctor wants to observe'.²⁴

The doctor must work, therefore, from a different place. Balint's guidance in this matter is presented in two successive chapters. 'How to Start', from which I quoted earlier, demonstrates the crucial importance of 'listening', as distinct from the traditional medical history-taking. The instruction that the doctor must '*learn to listen*' and learn by *doing* it, is an austere one, the first rule in demanding a more exacting form of diagnosis. In 'When to Stop', 'the important factor', says Balint, 'is difficult to describe':

Perhaps it might be called a sense of proportion. A 'long interview' is a give-and-take affair. The patient gives a great deal to his doctor, his confidence, some jealously guarded secrets, which may sometimes appear insignificant or even puerile to an outsider, but mean a great deal to him. If not enough happens to restore the balance, the patient is bound to feel despoiled, robbed or cheated.... It is exceedingly difficult to state exactly what it is that restores the balance, so that after the 'long interview' the patient feels understood, relieved, or even enriched, instead of being despoiled or cheated. The difference is not what is called 'correct interpretation' though correct interpretation forms a part of it. Neither is it 'reassurance'.... Perhaps the best that I can offer is to say that an experienced doctor has some idea 'when to stop'.²⁵

As a taxonomy of 'How to's' these are wonderfully *indefinite* precepts: 'difficult to describe', 'exceedingly difficult to state exactly' 'the difference is not what is called "correct interpretation"', but, says Balint, it is not *not* that either. The only certainty, as we saw in 'How to Start', is

the out-of-place-ness of the certainties of medical knowledge itself. 'Our experience has invariably been that, *if the doctor asks questions in the manner of medical history-taking, he will always get answers - but hardly anything more.*' To 'listen' is not just the first but the only rule. Every other procedural propriety must take its cue, colour and tone from this attentiveness to the particularity of the relationship and the present moment of disclosure itself. This is the art of the implicit and the tacit. Upon the doctor's having this talent or not, more or less, depends the surrounding atmosphere. The doctor partly brings this with him or her, as personal influence, and for that reason alone, atmosphere, 'far from being standardized', is always—for better or worse—irreducibly itself, uncategorizable and unique. But this special atmosphere can also be something created, in the moment:

While discovering in himself an ability to listen to things in his patient that are barely spoken because the patient himself is only dimly aware of them, the doctor will start listening to the same kind of language in himself'.²⁶

'To listen to things in his patient'; 'things' is wonderfully indefinite here, a sign of attunement to the nebulous content of the patient's experience, to the 'meaning' inside what externally 'might appear insignificant or even puerile'. But listening to the patient out there is simultaneously a listening in here, a delicate and involuntary instrument for finding the hidden content, the very language, from within the doctor's own inner self. What Balint calls 'atmosphere' is something like a third presence, or listened-for voice, that is called into being for both persons together.

What demonstrably lies behind the narrative medicine movement is a will to create precisely the non-bureaucratized, non-standardized, non-institutionalized spaces for events of human expressiveness or truth—'beingness' as an early disciple of Balint's put it—which Balint's research witnesses and advocates. To this day, Balint's practice-based research remains an indispensable model for practitioners and teachers in this field.²⁷

Yet what has been taken from Balint's work is his emphasis not on the creation of 'atmosphere' but on the giving of case history, when Balint himself never uses the terms 'narrative' or 'story'. In part, this exclusive concentration on story has been deliberate, as John Launer

explains in his account of the relation of narrative approaches to the Balint tradition in *Narrative-Based Primary Care*. Narrative in medical practice has wanted to resist the 'paternalistic' assumptions and invasive questioning and procedures used in psychoanalytic approaches to care. It has also sought to broaden the contexts for understanding patient health, looking beyond the psychological to include, for example, the social and environmental conditions in which a person lives. Narrative-based medicine has thus defined itself almost equally against its closer partner, psychoanalysis, as against its greatest antagonist, Evidence-Based Medicine, which seeks to derive generalizable scientific laws from the statistical analysis of vast samples of impersonal data. Narrative occupies a middle ground between the 'expert' interpretation associated with both camps, and, Launer argues, offers a form of understanding and a language democratically available to all.²⁸

What this process of embedding narrative in medicine means, however, is that Balint's key instruments for finding the patient's personal reality—'listening' and, especially 'atmosphere'—have become conceptually (if not always actually and practically) subordinated to an emphasis on narrative as the chief elicitation tool. The effect of substituting for Balint's mode of attentive listening the autonomy of the storyteller runs the risk of denying to the patient, I will argue, what he or she is really in search of, and most needs.

Here, for instance, is a Balint case history where the doctors in the study agree that it would be wholly a mistake simply to accept the patient's own account. For this story is so 'set' as to be of a different species to the encouraged personal narrative messily arising on the spot out of proper doctorly help.

Miss F, a twenty-four-year-old secretary, the only child of an upper-middle-class family, had been ill for almost a decade, since an attack of food poisoning which affected several girls, all of whom, apart from Miss F, returned to normal school life after a few days. She gave this account of the history of her condition on application for the psychiatric treatment to which she was referred by her GP.

When I was fifteen at boarding school I had food poisoning, but only fairly slightly. I became very thin indeed and worried myself a good deal because I worried I should get behind my

form in work. In fact I had a nervous breakdown and my hair fell out badly. I stayed at home for a year and gradually put on weight, returning to a smaller boarding school when I was much fitter. It was at this school that I began to notice my legs swelling and they became gradually worse over a period of time until my doctor prescribed Mersalyl [mercury] injections but these only slimmed my legs temporarily. Since that time I have had numerous injections also to get my monthly period going again (which completely disappeared after the food-poisoning when I was fifteen). About a year or eighteen months ago I started a very nasty irritable rash. The skin specialist diagnosed this as due to nervous tension. This will not go altogether and seems to come in spasms especially if I am going to a party and want to be clear. I find it very difficult to relax and I work myself up very much when going to a party or anything. I find I lack confidence. I broke off an engagement nine months ago as I felt my fiancé was losing interest in me. This upset me a great deal and my rash increased, and also the swelling of my legs. I felt it was due to my legs and the unsightly rash that I lost my boyfriend.²⁹

For Balint, profound personal reality, in Miss F's case, is occluded by the patient's more limited and superficial accounting of what is wrong. She has not only told this story before; the more she tells it the closer it comes to a clinical re-telling. The tendency of her whole account is always for the visible physical *symptoms*—the rash, the swelling—to be turned back into *cause*: 'I felt it was due to my legs and the unsightly rash that I lost my boyfriend'. The whole narrative veers unevenly between physical and psychosomatic explanations, between temporally definite and invisibly 'nervous' origins. Thus, underlying causes do not emerge from within herself with the certainty of personal discovery; rather cause and effect are improvised from within the story sequence.

Yet this account is incoherent just because it is a narrative seeking coherence or tangible explanations—*this causes that*—which it cannot stably find and cannot cease looking for. One senses this version of Miss F's story could carry unstoppably on and on in its knock-on sequence—I am ill, ugly, and undesirable, this makes me worry and

makes me worse, but the cause is really organic and I need medicine to cure it—until it turns into and actually constitutes her life story. This is in fact what happened. After four psychiatric treatments, Miss F reverted to long-term use of injections and drugs and collecting doctors.

For Balint, it is not only that 'depth' always takes absolute priority over the linear dimension of story. It is a depth of being of which the patient himself or herself may be 'only dimly aware', and by definition unable to translate into straightforward causal narrative. Story, that is to say, is not the *necessary*, and may not be the *available* form.

Indeed, as Miss F's case shows, albeit in a narrative still inflected with the rigidities of a standard medical view, autobiographical story may be the *wrong* mode. Intrinsicly, if inadvertently, that is to say, the stories we tend to tell of ourselves are liable to *betray* deep-lying personal truth. So Galen Strawson argues, in 'Against Narrativity', where he takes issue with the widespread advocacy of self-storying as a radically reconstitutive and enabling practice, and attacks its potentially disauthenticating or distorting relation to human experience. Narrative's most pernicious tendency, he says, is precisely to falsify self and experience:

Telling and retelling one's past leads to changes, smoothings, enhancements, shifts away from the facts, and recent research has shown that this is not just a human psychological foible. It turns out to be an inevitable consequence of the mechanics of the neurophysiological process of laying down memories that every studied conscious recall of past events brings an alteration. The implication is plain: the more you recall, retell, narrate yourself, the further you risk moving away from accurate self-understanding, from the truth of your being. Some are constantly telling their daily experiences to others in a storying way and with great gusto. They are drifting ever further off the truth.³⁰

The tendency to look for story or narrative coherence in one's life is ironically, he argues, 'a gross hindrance to self-understanding; to a just, general, practically real sense, implicit or explicit, of one's nature'. Because it is a fact of human psychology that conscious recall of past events brings alteration, one is almost certain to get one's

'story' wrong, to create only another stereotype in place of a medical one. The problem of studied articulation and over-conscious knowing of one's story might well be intensified in medical settings where the telling of patient stories is officially sanctioned.

Moreover, the very capacity for narrative form to substitute for content might be damaging, for masquerading, in Hannah Arendt's phrase, as 'mastery' of experience. 'Narration of the past,' she wrote, 'solves no problems and assuages no suffering: it does not master anything once and for all. Rather, as long as the meaning of the events remains alive... mastering of the past can take the form of ever recurrent narration'.³¹ All too often, stories become for the most of us who are not novelists a formulaic or conventional account which in its very extendedness overtakes its own teller, producing a normalized and overly consistent coherence inappropriate to a creature incapable (for better and worse) of *wholly* knowing the shape or purpose of its own life.

So tepid or predictable a version of personal story is a far cry of course from the depth and richness that narrative medicine is actually seeking, and for which literary narrative is always its prior model. Both Rita Charon in *Narrative Medicine*, and Trisha Greenhalgh and Brian Hurwitz in *Narrative-Based Medicine* find a defining touchstone for the theoretical framing of narrative medicine in the important distinction made by the early twentieth-century pioneer in the field of literary reading and teaching, Louise Rosenblatt. 'Literature,' she said 'provides *living through* not simply *knowledge about*'.³² This then, as we have seen, is what narrative medicine essentially borrows from the literary field: a keen valuing of a language which encompasses and transmits the lived experience of individual being in opposition to the 'knowledge about' mode exclusively prioritized by biomedical science. 'Narrative offers a possibility of *understanding*,' as Greenhalgh and Hurwitz put it, 'which cannot be arrived at by any other means'.³³

But what is most worrying for me in this present book is that narrative medicine seems not to recognize or acknowledge the difference between the deep-textured understanding offered by what Rosenblatt calls 'the literary experience' (p. 24) and the more simple and direct one produced by confessional autobiography. Narrative medicine, in other words, does not always sufficiently discriminate between the simple *literal* and the more multi-layered *literary* story. Instead, an

impoverished and over-simplified definition of narrative comes to stand for all. According to Rita Charon:

When we try to understand why things happen we put events in temporal order, making decisions about beginnings, middles and ends or causes and effects by virtue of imposing plots on otherwise chaotic events.... By telling stories to ourselves and others – in dreams, in diaries, in friendships, in marriages, in therapy sessions – we grow slowly not only to know who we are but also to become who we are.³⁴

But these 'decisions' are indeed impositions. 'Narrative' undergoes precisely the processes of standardization here that its incorporation in medical practice is designed to modify. Storytelling, as illustrated and defined here, does not belong to the literary at all, except reductively. More, in making 'story' an imposed fiction, this does wrong to life as well as to literature. We know from Bion that deeply personal experience—the reality of 'who we are'—is not susceptible to facile 'knowing' or tidy expression, other than distortingly. There is always, Bion says, an available terminology to be found in material that is superficial and easily accessible to consciousness. The problem of finding the right word, he goes on, 'is analogous to that of the sculptor finding his form in the block of his material, of the musician finding the formula of musical notation within the sounds he hears, of the man of action finding the actions that represent his thoughts'.³⁵ Form is not applied but found; authentic story reveals the form hidden within experience. It is hard, struggling work; it is, Bion suggests, one of the most profoundly creative acts of being alive.

Indeed, for Balint himself, the founder of story in medicine, the kind of 'putting in order' which defines Charon's idea of story comes far too easily to be commensurate with actual experience. 'The mind is multi-dimensional to an impossible degree whereas any description is limited to one dimension':

Language can describe only one sequence of events at a time; if several occur simultaneously, language has to jump to and fro among the parallel lines, creating difficulties, if not confusion, for the listener. A further, almost insurmountable complication is caused by the fact that mental events not only take place

simultaneously along parallel lines, but influence each other profoundly.³⁶

Neurologists tell us that we are programmed to tell stories, and that the will to 'impose' order on chaos is part of our biological hard-wiring.³⁷ But then our creaturely disposition, at brain level, is apparently at odds with our mind's experience of what happens to us. Experience possesses a complex simultaneity and multiplicity which is of a wholly different order from the linearity and singularity of conventional ideas of story.

The danger of the single story, says novelist Chimamanda Adichie, is that it *creates* stereotypes as much as it conforms to them. Born into a conventional middle-class family in Nigeria, Adichie had always felt pity for the family's live-in house-boy because all she had ever been told about him was that his family was very poor:

One Saturday we went to his village to visit, and his mother showed us a beautifully patterned basket made of dyed raffia that his brother had made. I was startled. It had not occurred to me that anybody in his family could actually make something. It had become impossible for me to see them as anything but poor. Their poverty was my single story of them.

The problem with the stereotyping single story, Adichie concludes, is not that they are untrue, but that they are incomplete. 'They make one story become the only story'.³⁸

Adichie's account is an explanation of why she became a novelist. For in literary narrative the possibility is always open for the formal default or definitive story to give way to the complex and overlapping realities that is the real form of experience.

So, in order to demonstrate what literary narrative actually is and does, I choose a work that seems to me the fairest test case in this context. *Janet's Repentance* is the final novella in *Scenes of Clerical Life*, the first published fiction of the nineteenth-century pioneer of literary realism, George Eliot. This is the work where George Eliot first showed she had learnt her craft as a realist. It tells the story of Janet Dempster, a desperately unhappy wife, who, long the victim of her brute drunken husband's violence, and, childless and often alone, has herself been driven to the consolation of drink and is now an alcoholic. One scientist

has claimed that George Eliot's portrayal of Janet Dempster gives a far more accurate depiction of Type 1 alcoholism, associated with high 'reward dependency' and 'harm avoidance', than does the typology given in the Diagnostic and Statistical Manual of Mental Health Disorders (DSM), from which these categories derive.³⁹ This unflinching accuracy in relation to a stigmatized issue (especially in the nineteenth century and especially in a middle-class woman) is a measure of how, even explicitly, this novella is defiant of standardized norms and, as George Eliot herself puts it, of those 'facile' generalizations which 'prejudge individuals by means of formulae, and cast them . . . into duly lettered pigeon holes' (*Janet's Repentance*, Chapter Eight). Indeed, this fiction rests on precisely the belief that underwrites narrative medicine at its finest: 'The only true knowledge of our fellow-man is that which enables us to *feel with him* . . . the life and death struggles of separate human beings' (*Janet's Repentance*, Chapter Eleven, my emphasis). George Eliot made one of her greatest realist creations out of what otherwise would have been mere stereotype.

The climax of Janet's story is the moment when she defies her husband, almost daring him to kill her. Instead, in the dead of a bitter winter's night, Janet is 'thrust out from her husband's home in her thin night-dress, the harsh wind cutting her naked feet':

When Janet sat down shivering on the door-stone, with the door shut upon her past life, and the future black and unshapen before her as the night, the scenes of her childhood, her youth and her painful womanhood, rushed back upon her consciousness, and made one picture with her present desolation. The petted child taking her newest toy to bed with her—the young girl, proud in strength and beauty, dreaming that life was an easy thing, and that it was pitiful weakness to be unhappy—the bride, passing with trembling joy from the outer court to the inner sanctuary of woman's life—the wife, beginning her initiation into sorrow, wounded, resenting, yet still hoping and forgiving—the poor bruised woman, seeking through weary years the one refuge of despair, oblivion:—Janet seemed to herself all these in the same moment that she was conscious of being seated on the cold stone under the shock of a new misery. (Chapter Fifteen)

'We are condemned', says Raymond Tallis, 'to live in a world made up of tiny moments, linked by And Then, And Then.'⁴⁰ But here, just for a moment, Janet's life is released from apparently arbitrary consecutive extension to make, agonizingly, 'one picture': Child, girl, bride, wife, woman have simultaneous, and all too painfully connected, reality. For a space, Janet is in complete possession, temporarily, of everything her unfulfilled life is not, will never be, and yet still might have been. This is the deepest human reality of all—when experience is no longer containable within habitual ordinary categories, and none of the normal rules applies. How could these all be part of the same narrative? All this time the narrative remains bound to the limiting framework of common language and ordinary event. Janet is still seated on the cold door-stone, an unhappy wife, in a small provincial town. But she inhabits a reality both tied to and 'more than' the mundane human material out of which it emerges.

So, when Janet awaits the coming of daybreak:

The future took shape after shape of misery before her, always ending in her being dragged back again to her old life of terror, and stupor, and fevered despair. Her husband had so long overshadowed her life that her imagination could not keep hold of a condition in which that great dread was absent; and even his absence—what was it? only a dreary vacant flat, where there was nothing to strive after, nothing to long for. (Chapter Sixteen)

Janet has left a bad story—her abusive husband and unhappy marriage. Better if she had walked out herself, of course, but even this way there is a chance for a new life away from her husband. But this does not feel like a second chance. Instead Janet finds she cannot get out of her own story of internalized punishment and pain. Even now, as day is literally following night, Janet must be 'dragged back again', the only future 'before her' an unending repetition of her past self and life. It feels as though she will turn to drink again, all the more certainly now to replace or evade the very absence of the dread which had driven her to drink in the first place.

The novella's imaginative duty is to the inner aftermath which cannot fit into a straightforward narrative of escape or loss. It is an experience that (like Ian's sense of 'no point' in Chris Dowrick's case

history) might otherwise be lost to subterranean inwardness, and for which there so often is no external voice or witness in ordinary life. 'No eye rested on Janet as she sank down on the cold stone, and looked into the dismal night. . . . Oh, if some ray of hope, of pity, of consolation, would pierce through the horrible gloom.' This is what the literary imagination is for in George Eliot's work: to find the intimately personal story that is occluded by the gross and definite one.

It is no easier when Janet's husband is now dead, and she seems fully embarked on a new life. She is still fighting her addiction and vulnerable to discouragement and fear at the mere prospect of returning home to the 'vacant dining room'. When she inadvertently discovers a decanter of the dead Dempster's brandy hidden in a drawer, desire overwhelms her, and she dashes it to the ground and flees:

Where should she go? In what place would this demon that had re-entered her be scared back again? . . . Now, when the paroxysm of temptation was past, dread and despondency began to thrust themselves, like cold heavy mists. . . . The temptation would come again — that rush of desire might master her the next time — she would slip back again into that deep slimy pit from which she had once been rescued, and there might be no deliverance for her more. (Chapter Twenty-five)

Again, it is when the crisis is ostensibly past, when the temptation is over and actually conquered, in the interstices of conventional story, that Janet feels at her most powerless. Janet's real needs are as undefined as that 'vacancy' which frightens her so. Yet she is so full of those needs that she has no sense of how well she has done in not giving in to them—in smashing that bottle instead of drinking it. She feels only the fear of temptation and nothing at all of her great achievement in resisting it. Think of the story a real-life Janet would tell of her own life. It could only be a victim's: I am an alcoholic, an abused wife, a failure. I am always afraid I will drink again. Only the novel, by subvocally capturing the deeper reality of hidden struggle, with its agencies and its brave resistances, can find in Janet's story something other than defeat.

This prose might be regarded, I say, as the original prototype of narrative medicine, hearing the suffering of human creatures, capturing what lies behind the bald narrative facts of all too ordinary and

common alcoholism, abuse, and depression. The scientist who admired the portrayal of Janet ventured that were George Eliot alive today she might well have been a doctor, so intense is the humanity of her understanding of human suffering.

But as a novelist, not a doctor, George Eliot had her own delicate instrument for finding, as Balint with his patients, her creatures' secret inner lives. In formal terms, these passages offer instances of free indirect discourse—that mode of narration which belongs neither internally to character, nor externally to narrator, but exists between the two: It isn't 'Where should I go?' but 'Where should she go. . . . The temptation would come again'; 'What was [her husband's absence]?; only a dreary vacant flat, where there was nothing to strive after, nothing to long for'. Free indirect discourse tells the experience of a person's life, as he or she never quite lives it.⁴¹ For neither free indirect discourse, nor the so-called omniscience of author-narrator, are of course truly 'there' for Janet herself in any sense. The character does not know of an author; she cannot see or hear her own thoughts as the reader does. This is not fictive naivety or simplistic realist convention. It is a belief in what is there even when—especially when—humans cannot realize it as characters in life.

In this novel, free indirect discourse takes the place of the ancient religious practice of confession—occurring in the novel at just those crises when Janet's literal confessor, the minister Tryan, is absent. At once a descendant and a secular replacement for religious discourse, free indirect mode was to become the realist novel's most sophisticated tool for emotional attunement, for listening in to its creatures, hearing thoughts that are often inadmissible or unavailable to the individuals who most need to have or hear them. For we do not have access to, we can barely hold, all that we contain. This is not a deficiency, but one of the rules.

One thing that Janet does not know is that her second story has already begun, much earlier and more quietly. This is when she first encounters Tryan, the Evangelical minister, whose teachings she and her husband had opposed through party interests. She overhears him comforting a dying parishioner.

Janet was surprised; the tone and the words were so unlike what she had expected to hear. Mr Tryan had his deeply-felt troubles,

then, like herself? . . . The softening thought was in her eyes when he appeared in the doorway, pale, weary, and depressed. The sight of Janet standing there with the entire absence of self-consciousness which belongs to a new and vivid impression, made him start and pause a little. Their eyes met, and they looked at each other gravely for a few moments. Then they bowed, and Mr Tryan passed out. (Chapter Twelve)

Her surprise at his depth of feeling begets his own startled sense of something newly serious in her. For the instant they can see one another truly, because, thus momentarily, they are 'unlike' themselves. It is a happening so passing and slight as hardly to qualify as an event at all. Yet, at a moment of deepest trial, the recollection of this fleeting instant alone has power to save Janet:

She suddenly thought—and the thought was like an electric shock—there was one spot in her memory which seemed to promise her as an untried spring, where the waters might be sweet. That short interview with Mr Tryan had come back upon her—his voice, his words, his look. (Chapter Sixteen)

The tiniest emotional shocks not only reverberate through time but have power virtually to create a new life. This is something within personal narrative that is not just narrative or a conventional view of a known opponent—something closer to the lyric intensity and emotional fulfilment of poetry. The moment of initiation really constitutes consummation, though neither Janet nor Tryan can know it. For this is a love story which, non-stereotypically, is unable to fulfil itself in time. Even at the point of Tryan's death, 'the time was *not yet* come for Janet to be conscious that the hold he had on her heart was any other than that of the heaven-sent friend' (Chapter Twenty-seven).

Literary prose registers not only the prosaic reality but the poetry that exists hiddenly and precariously within the prose of life. 'Depend upon it,' says George Eliot, in the first story of *Scenes of Clerical Life*, 'you would gain unspeakably if you would learn with me to see some of the poetry and the pathos, the tragedy and the comedy, lying in the experience of a human soul that looks out through dull grey eyes, and that speaks in a voice of quite ordinary tones' ('Amos Barton',

Chapter Five). This is how narrative implicitly gives notice that poetry, rather than narrative, is in some version of itself the highest and best index of how humans are always bigger and more complex than the story they inhabit.

It is to poetry, then, that I now turn in order to demonstrate that the lyric mode is at least as essential as narrative in releasing experience from the bondage of inarticulacy or conventionalism. In what follows, the poet, Elizabeth Barrett Browning, is not an author separate from a character in her story, but herself writing from within the thick of experience.

Elizabeth Barrett's relationship with Robert Browning exists in the popular imagination and often in biographical accounts as a sudden drama of happiness and a great love story. Elizabeth Barrett suffered long years of invalidism and of seclusion, in which she was subject to the idiosyncratic obsessions of a neurotic-possessive father; and, latterly, to grief and guilt over the death of her younger brother. Then, at the age of forty, following a two-year secret courtship, she left home and family for a life with Browning in Italy where, as wife, mother and poet, she flourished until her death.

The intimate autobiographical records, however, uncover what really lay behind these bald contours, long conventionalized as narrative in Rudolph Besier's sentimental play-made-film *The Barretts of Wimpole Street*. The famous correspondence between the couple shows this love story to have been a slow, painful, almost involuntary and vulnerable journey, full of resistances and refusals to the change that love both offered and seemed to demand. When Browning first declared his love for her, Elizabeth Barrett 'recoiled by instinct and at the first glance, yet conclusively'. His 'wild speakings', she wrote to him, must 'die out between *you and me alone*, like a misprint between you and the printer.' 'I must not . . . I will not see you *again* — and you will justify me later in your heart.' She was as moved by the power of his love as she was fearful of its capacity to last. 'It affects me and has affected me, very deeply, that you should persist so — and sometimes I have felt you might mistake, a little unconsciously, the strength of your own feeling'. Though doubtful of it, she could believe in his love for her far more readily than she could believe herself to be worthy of it:

What could I speak that would not be unjust to you? Your life! if you gave it to me and I put my whole heart into it; what should I put but anxiety, and more sadness than you were born to? What could I give you, which it would not be ungenerous to give?

Neither love given, nor love received, could be counted by Elizabeth Barrett as a simple and certain good. For, above all, love was not the ecstatic fulfilment of a conventional single person's narrative, but the bewilderment of having believed yourself to be in one quite definite story, only suddenly to find yourself in another. 'I had done living, I thought,' she told Browning, 'when you came and sought me out.' 'My life was ended when I knew you, and if I survive myself it is for your sake.' Thus to live or begin again in a different form and order seemed more a kind of reckless and frightening temptation than rap-
turous release:

Shall I tell you? it seems to me, to myself, that no man was ever before to any woman what you are to me - the fulness must be in proportion, you know, to the vacancy... and only I know what was behind - the long wilderness *without* the blossoming rose... and the capacity for happiness, like a black gaping hole, before this silver flooding. Is it wonderful that I should stand as in a dream, and disbelieve — not *you* - but my own fate? Was ever any one taken suddenly from a lampless dungeon and placed upon the pinnacle of a mountain, without the head turning round and the heart turning faint, as mine do?

The correspondence seems to say all that could be said in terms of honest written expression of love.⁴²

Yet even while Elizabeth Barrett was personally confessing her love in almost daily correspondence, she was also secretly writing the love-sonnet sequence which was to become *Sonnets from the Portuguese*. The sonnets were never intended for publication and were not read by Browning himself until several years after their composition. Yet, like the letters which they were composed alongside, they are intimately addressed to Robert throughout. Why did Elizabeth Barrett do this? Why, that is to say, did she feel the need to say in poetry what she was already saying in recognizably similar language and in 'live' form in the letters?

The answer lies within the poems themselves. At the close of a sonnet from very early in the sequence, Elizabeth Barrett rehearses her peremptory rejection of Browning's first declaration of love: 'Stand farther off then. Go!' In the letters, she had meant to cancel once and for all the 'misprint' of his commitment to her. Yet here she reprises the refusal at the very opening of the subsequent sonnet, as though making space, in print, for all that is *not* concluded within herself.

Yet I feel that I shall stand
Henceforward in thy shadow. Nevermore
Alone upon the threshold of my door
Of individual life, I shall command
The uses of my soul, nor lift my hand
Serenely in the sunshine as before (Sonnet 6)

'Yet' emerges in sudden surprise that even separation now won't be complete. This does not feel to her like a story too good to be true but closer to a story she may not want. 'Nevermore/Alone'. In the merest turn from one line to another, the threshold and transition from one story to another is thus sharply and visibly crossed, and the feeling is as much one of loss and uncertainty as of gain: loss of singlehood, of lonely individuality, of one's very own life. It might not be much of a life but it is mine, this sonnet seems to say. How do I know this new one will be better?

This is why the letters were not enough. Robert Browning's love had given Elizabeth Barrett the promise of an unlooked-for second life. Without self-belief enough as yet to support its own self-emergence, the poetry offered a form in which this coming-to-life self could reside and do its consolidated thinking ahead of its full and secure realization in her. Poetry is here a preparation in transition for becoming the narrator of her own story. It gave a structure for expressive being not just in relation to Browning but for herself in the midst of change. This is not a provisional self but one fully present and alive in the strange place of movement and change *between* the old self of the lampless dungeons and the love fulfilment of the mountain top.

The resonant spaces of these sonnets make room for the delicate interstices and minute transition points for which conventional story has no time or form. The poems, to use Elizabeth Barrett's own expression, are 'a place to stand and love in for a day' (Sonnet 22),

protected from time and the hour even in going along with it. In this sense of created 'place', these poems are paradigmatic of what Balint really means by 'atmosphere'. They make possible a way of thinking and a place for thinking that the world would certainly discourage and for which it would have no appropriate tone. Where else might a middle-aged woman in love for the first time securely express her fears at the unprecedented change love has wrought in the mode that is emotionally most fitting—the fragile tones and language of a child?:

If I leave all for *thee*, wilt thou exchange
And *be* all to me? Shall I never miss
Home-talk and blessing and the common kiss
That comes to each in turn, nor count it strange,
When I look up, to drop on a new range
Of walls and floors, . . . another home than this? (Sonnet 35)

Where else would these vulnerably childlike misgivings simultaneously discover the deep test and terms of grown-up love? It is an exchange not merely of feeling, but of child for adult self, common for exclusive kisses; *all* for *all*.

Above all, the poem is a protective casing and stimulus for the tacit emergence of the woman who fits neither the world's nor her own prior forms: 'Yes call me by my pet-name,' she says in a late sonnet and immediately regrets that she cannot answer with 'the same heart' as when a child.

Yet still my heart goes to thee . . . ponder how . . .
Not as to a single good, but all my good!
Lay thy hand on it, best one, allow
That no child's foot could run as fast as this blood. (Sonnet 34)

In the thought spaces and in the very pulse of the poem, 'my heart' finds, suddenly and acceptingly, an essential vitality that is neither child's, nor old maid's. This is how this sequence discovers for Elizabeth Barrett a new story in between the old one of dutiful daughter or loveless spinster.

For when the sequence begins, this love story is not yet a narrative. That is why it is written wholly in the present, rather than as retrospective summary. What these sonnets really record and make possible is the coming, in the midst of uncertainty, of a sudden burst

of recognition which says: 'This is what I am now. This is what is really happening'.

And when I say at need
I love thee . . . mark! . . . *I love thee!* . . . in thy sight
I stand transfixed, glorified aright,
With conscience of the new rays that proceed
Out of my face toward thine. (Sonnet 10)

The tiny gaps are an involuntary signal of surprise at overhearing her own words ('*I love thee* . . .'), as if writing them down unexpectedly makes them true to her as no 'misprint'. Then comes the accepting embodiment of those words—'mark! . . . *I love thee* . . .?'—a commitment to a self that *can* live out the narrative those words initiate and imply. In the space between the first and second pronouncement, it is as if the words are finding power to *be* as well as to *feel*, that flash of transformation she describes in the final lines of this sonnet:

And what I *feel*, across the inferior features
Of what I *am*, doth flash itself, and show
How that great work of Love enhances Nature's. (12–14)

Elizabeth Barrett had felt she was an unlovable woman, but love now made her beautiful—not just conventionally, out of the love that he gave her, but rather out of the love she felt for him, transforming the very features of her face.

It is no wonder that Elizabeth Barrett calls poetry in this sequence 'medicated music'. Poetry can find a place for what can otherwise look so small and transitory in the world—a look, a word, a tone of voice—and give such things their true size and meaning. It is as if, in the space between the lover and her addressee, an inner voice of truth has power to reveal itself, at just the right time, to the person who needs it—something like a pure version of what free indirect discourse offers in the novel. For without these moments of triggered surprise Elizabeth Barrett cannot realise her own story as a loved woman—cannot accept this as indeed a love story and a good one. Then Elizabeth Barrett's ability authentically to have her own story can really begin: 'I love thee!'

What I am concluding here is that the more vitally transformative personal event at periods of unhappiness, might not be the conventional

narrative confession of a 'single story' but the sudden triggered surprise of realization—the version of 'poetry' that those who are not poets experience when their life comes back to them in a sort of revelation of memory. Narrative, I conclude, is not sufficient, may even be distorting.

The concern of the next chapter is with how to get the experience of poetry-like triggers into the world which is not poetry. This means not merely considering how to get the poetic moment accepted as an idea in the context of mental health needs. It really means considering how to get poetry back into the idea of life, and back into use there, as a form of thinking and experiencing vital to human flourishing.

The next chapter will thus be turning to real people reading poetry aloud, live, together, in small groups. I close now with a brief preview of what poetry is in those who are not poets.

Evelyn, now almost sixty and single, has had cerebral palsy from birth. An injury thirty years ago, while caring for her alcoholic mother, left her further disabled. She often feels very alone and describes her sense of loneliness as 'that horrible feeling when you feel you have a ton weight on your chest, as if something is crushing all the feelings out of you'. Here, we see Evelyn reading for the first time Ben Jonson's seventeenth-century poem, *Ode To the immortal memorie, and friendship of that noble paire, Sir Lucius Cary and Sir H. Morison*. It is a poem of consolation to Cary on the death, in his youthful prime, of his friend, Morison:

life doth her great actions spell,
By what was done and wrought
In season, and so brought
To light: her measures are, how well
Each syllabe answer'd, and was form'd, how faire;
These make the lines of life, and that's her aire.

It is not growing like a tree
In bulke, doth make man better bee;
Or, standing long an Oake, three hundred years,
To fall a logge, at last, dry; bald, and scare:
A Lillie of a Day
Is fairer farre, in May,
Although it fall, and die that night;
It was the Plant, and flowre of light.

Evelyn noticed how 'flowre of light', repeated 'brought/to light' from the preceding verse; and how that last line, her favourite in the poem, came after 'die that night'. She said: 'It makes you still see the daytime and the flower – you still see it even though you know it's already dead: "It was the Plant", "A Lillie of a Day"'. This is good reading, because Evelyn is in tune with how the poem is holding onto something that the 'season', in its passing, cannot. She also intuits that it is the poem's quietly echoing backward-forward repetitions—light/light, as well as faire/faire and falls/falls—which delicately counterpoint and minutely halt, just for a second, time's onward movement. Evelyn herself went on:

I always have fresh flowers in the house, maybe only a little bunch. But it was what my dad did, for my mother. Sometimes, when I get very depressed I go and do something or think about something where it was happy, before my mum died and things like that. It can be the smallest thing. The other week I was sitting out in the garden one morning early and the lad down the street let his birds out to fly: about a dozen of them, all white, and they were only flying around the roofs, going from his house up to mine and they were circling back, but it was just lovely – it was lovely just sitting watching them glide and they are on the wind, like blossoms.

Such a moment, like the flowers she keeps deliberately in view, help 'remind' Evelyn, as she put it, that 'I have got happiness inside me somewhere locked away'. It is the same with this poem, she said.

What is important here is that the poem is not merely an encouragement to Evelyn to 'remember the good times', 'what was done and wrought'. Rather, it offers a 'reminder' of some present dimension of experience 'locked away' inside which still requires and claims, even amid the bad times, its right expressively to exist—its 'season' in which to be. Even within what Evelyn sometimes feels is her over-prolonged and damaged existence, the poem trips off an alternative scale and 'measure' for the worth of 'the smallest thing'. And, crucially, this quick revaluing of experience is transmitted via the poem's own short, faire-form'd 'lines' and tiny 'syllables'. As the poem says:

In small proportions, we just beauties see:
And in short measures, life may perfect bee.

Longer would spell it out but make it thinner.

Notes

1. Christopher Dowrick, *Beyond Depression*, 2nd ed (Oxford: Oxford University Press, 2009), p. 160.
2. From an interview for the *Student British Medical Journal*, 2011: *Student BMJ* 19:d3338.
3. Iona Heath, 'Divided We Fail': The Harveian Oration, 2011 (London: Royal College of Physicians, 2011), pp. 8–13.
4. Iona Heath, 'Following the Story: Continuity of Care in General Practice' in Trisha Greenhalgh and Brian Hurwitz (eds), *Narrative-Based Medicine* (London: BMJ Books, 1998), pp. 83–92, p. 86.
5. Arthur Kleinman, *The Illness Narratives* (New York: Basic Books, 1988), pp. 60, 87, 253.
6. Oliver Sacks, *The Man Who Mistook His Wife for a Hat* (London: Picador, 1986), p. 105.
7. Oliver Sacks, *The Man Who Mistook His Wife for a Hat* (London: Picador, 1986), pp. 34–5.
8. Suzanne Corkin, *Permanent Present Tense: the Unforgettable Life of the Amnesic Patient H.M.* (New York: Basic Books, 2013), p. 205.
9. Michael Balint, *The Doctor, His Patient and the Illness* (London: Pitman Publishing Ltd, 1957), p. 4. Hereafter *Balint*.
10. Iona Heath, 'Following the Story: Continuity of Care in General Practice' in Trisha Greenhalgh and Brian Hurwitz (eds), *Narrative-Based Medicine* (London: BMJ Books, 1998), pp. 83–92, p. 83.
11. See chapters 11–13 of *The Doctor, His Patient and the Illness* (pp. 107–71) for Balint's discussion of the doctor's 'atmosphere'.
12. Trisha Greenhalgh, 'Narrative Based Medicine in an Evidence-Based World', *Narrative Medicine*, p. 251.
13. Trisha Greenhalgh, 'Narrative Based Medicine in an Evidence-Based World', *Narrative Medicine*, p. 263.
14. Arthur W. Frank, *The Wounded Storyteller* (Chicago: University of Chicago Press, 1995), chapters 1–3.
15. Rita Charon, *Narrative Medicine* (Oxford: Oxford University Press, 2008), p. 269.
16. C. E. Rudebeck, 'The Body as Lived Experience in Health and Disease', in *Medical Humanities Companion*, Volume One: *Symptom*, ed. by Martin Evans, Rolf Ahlzen, Iona Heath and Jane MacNaughton (Oxford: Radcliffe Publishing, 2008); see also Volume Two, *Diagnosis* (2010), pp. 1–3.
17. John Berger, *A Fortunate Man*, 1967 (Cambridge: Granta Books, 1989), pp. 36–7.
18. John Berger, *A Fortunate Man*, 1967 (Cambridge: Granta Books, 1989), p. 37.
19. Christopher Dowrick, *Beyond Depression*, 2nd ed (Oxford: Oxford University Press, 2009), p. 207.
20. Rita Charon, *Narrative Medicine* (Oxford: Oxford University Press, 2008), p. 9.
21. Iona Heath, 'Divided we Fail: The Harveian Oration 2011' (London: Royal College of Physicians, 2011), p. 11.
22. Trisha Greenhalgh and Brian Hurwitz (eds), *Narrative-Based Medicine* (London: BMJ Books, 1998), p. 14.

23. Somewhere between the first and final year of medical education, undergraduate students exchange a native facility for appreciating patients' narratives for the learned expertise of constructing a medical history. 'Interviewing Skills of First-Year Medical Students', *Journal of Medical Education* (1986) 61: 842–4.
24. Michael Balint, *The Doctor, His Patient and the Illness* (London: Pitman Publishing Ltd, 1957), p. 121.
25. Michael Balint, *The Doctor, His Patient and the Illness* (London: Pitman Publishing Ltd, 1957), p. 136.
26. Michael Balint, *The Doctor, His Patient and the Illness* (London: Pitman Publishing Ltd, 1957), p. 121.
27. J. Donald Boudreau, Stephen Liben, Abraham Fuks, 'A faculty development workshop in narrative-based reflective writing', *Perspectives on Medical Education* (2012) 1:143–54 DOI 10.1007/s40037-012-0021-4.
28. John Launer, *Narrative-Based Primary Care* (Oxford: Radcliffe Medical Press Ltd, 2002), Ch 15, pp. 203–14.
29. Michael Balint, *The Doctor, His Patient and the Illness* (London: Pitman Publishing Ltd, 1957), pp. 76–80.
30. Galen Strawson, 'Against Narrativity', *Ratio* (new series), 2004, 14:428–52, p. 447.
31. Hannah Arendt, *Men in Dark Times*, 1968 (London: Penguin Books Ltd, 1973), p. 29.
32. Louise M. Rosenblatt, *Literature as Exploration*, 1938 (New York: The Modern Language Association of America, 1995), p. 38.
33. Trisha Greenhalgh and Brian Hurwitz (eds), *Narrative-Based Medicine* (London: BMJ Books, 1998), p. 6.
34. Rita Charon, *Narrative Medicine* (Oxford: Oxford University Press, 2008), p. i.
35. Wilfred Bion, *Learning From Experience* (London: Maresfield Library, 1989), p. 116.
36. Michael Balint, *The Doctor, His Patient and the Illness* (London: Pitman Publishing Ltd, 1957), p. 172.
37. David J. Linden, *The Accidental Mind* (Cambridge, Mass: Harvard University Press, 2007), pp. 225–32.
38. Chimamanda Adichie, 'The Danger of a Single Story', TED talk, 2009.
39. J. W. Bennett, 'The Apprenticeship of George Eliot: Characterisation as Case Study in *Jane's Repentance*', *Literature and Medicine*, 1990, 9:50–68.
40. Raymond Tallis, 'Language, Literature and Human Consciousness', *The Reader*, 38, 2010, pp. 63–71, p. 66.
41. D. A. Miller, *Jane Austen, or, The Secret of Style* (Princeton: Princeton UP), 2003.
42. See 'The Courtship Correspondence' in Josie Billington and Philip Davis (eds), *Elizabeth Barrett Browning: 21st Century Oxford Authors* (Oxford: Oxford University Press, 2014).