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# The Chief Concern of Medicine

*The Integration of the Medical  
Humanities and Narrative Knowledge  
into Medical Practices*

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with Sheila Crow and  
a contribution by Seth Vannatta



THE UNIVERSITY OF MICHIGAN PRESS  
ANN ARBOR

R 121.3  
5341

NLFHSS17/165

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Published in the United States of America by  
The University of Michigan Press  
Manufactured in the United States of America  
© Printed on acid-free paper

2016 2015 2014 2013 4 3 2 1

A CIP catalog record for this book is available from the British Library.

Library of Congress Cataloging-in-Publication Data

Schleifer, Ronald.

The chief concern of medicine : the integration of the medical humanities  
and narrative knowledge into medical practices / Ronald Schleifer and  
Jerry B. Vannatta with Sheila Crow and a contribution by Seth Vannatta.

p. : cm.

Includes bibliographical references and index.

ISBN 978-0-472-11859-5 (cloth : alk. paper)—ISBN 978-0-472-02886-3 (e-book)

I. Vannatta, Jerry. II. Crow, Sheila. III. Title.

[DNLM: 1. Narration. 2. Physician-Patient Relations. 3. Ethics, Medical.

4. Medical History Taking. w 62]

616.07'51—dc23

2012033644

TO OUR STUDENTS AND COLLEAGUES  
AND THE YEARS OF OUR WORKING FRIENDSHIP

# 5

## THE PATIENT-PHYSICIAN RELATIONSHIP

### The Scene of Narration

If, therefore, a physician does nothing more than feel my pulse and put me on the list of those who he visits on his rounds, instructing me what to do and what to avoid without any personal feeling, I owe him nothing more than his fee, because he does not seem as a friend but as a client. . . .

Why then are we so much indebted to these men? Not because what they have sold us is worth more than we paid for it, but because they have contributed something to us personally. A physician who gave me more than was necessary, because he was afraid for me, not for his professional reputation, who was not content to indicate remedies, but also applied them; who sat at my bedside among my anxious friends, and hurried to me at times of crisis; for whom no service was too burdensome, none too distasteful to perform; who was not indifferent to my moans; to whom, although a host of others sent for him, I was always his chief concern; who took time for the others only when my illness permitted him. Such a man has placed me under an obligation, not so much as a physician but as a friend.

—SENECA, *De Beneficiis* 6.16

As we have seen, the patient brings to the clinical encounter a story, the History of Present Illness (HPI). As the physician listens and responds to this story, a special kind of relationship begins to develop between the patient and doctor. At its best, it is personal and professional at once. It is often charged with deeply felt emotion on the part of the patient—fear and anxiety, anger, sadness, or a combination of these feelings—and with empathetic and more or less calm attention on the part of the physician. Usually growing out of the event of storytelling and listening—the very *scene* of narration—the patient-physician relationship is a relationship that often is more than purely professional. Moreover, the relationship between the patient and the doctor is the basis for any future therapeutic endeavor: all future interactions between patient and physician are dependent on this relationship. Literature—the “art narratives” we discussed in chapter 3—provide detailed and well-focused examples (case histories) of the play of narrative and, con-



sequently for the discerning reader, schemas and strategies for recognizing and constructing good patient-physician relationships; they also provide useful examples of poor patient-physician relationships. In this chapter, in addition to vignettes and medical narratives, we present a montage of scenes from novels and short stories that, in their self-conscious artistry, emphasize the salient features of narrative that can also always be found in medical narratives—salient features of the patient-physician relationship, of patients' stories themselves, of the relationship between the teller and the listener (whose roles alternate in the scene of medical narration). We hope to demonstrate the simplest ways that literary narrative can help educate physicians, the ways that it focuses attention on particular aspects of what is or can be enacted in this relationship in the very *scene* of narrative performances. Succeeding chapters in Part 2 examine the role of narrative in medicine with greater attention to the patient's story as such and the "narrative knowledge" it contains, to the ways in which the study of literary narrative can enhance the skills (*techné*) with which the physician listens to the patient by suggesting schemas of understanding and action. In Part III, we examine the ways in which narrative can help health care workers to discern the drama of medical practice and the ethics woven into the everyday practices of medicine. All of these concerns, however, entail and, in fact, embody the different relationships that arise between patient and physician, all of which are at once professional and yet—in their concern for well-being, suffering, grief, and devising a working definition of health—also involve aspects of our lives that go beyond the relationship of a client simply obtaining the skills and knowledge of a professional.

### *Power Differential: Appropriate Uses*

Of necessity, there is a power differential between patient and physician. The patient needs the physician in ways that the physician does not need the patient: the patient ails in relative ignorance, is in a position of supplication, and, to some degree or other, is in a state of concern that warrants seeking out a physician. The physician has gone through remarkably rigorous training in the knowledge and practice of medicine and is simply in a position of power in relation to the patient and his or her ailment. This power differential is proper and, in any case, unavoidable. Yet for narrative, it is particularly odd. As Brian Boyd and others have suggested in describing the work of narrative—this is embodied in Greimas's category of sender

versus receiver—it is usually the teller who possesses the authority over the listener. In the initial narrative between the patient and physician, however, the listener—the doctor—possesses both the authority of her knowledge and also state-sanctioned authority of one sort or another. This might be a function of the fact that the patient's story is "not-yet-complete," and it might very well be that the authority of narrative rests with the power to complete a story, to apprehend its end (see Mattingly 1998: 36–37 for a sense of the formative power of endings). In any case, this power differential at the scene of narration is particularly pronounced in the patient-physician relationship, and in this and the following section, this differential is explored in its appropriate and inappropriate functioning in defining that relationship.

The power differential can be and often is misused, often because it is understood not as a structural aspect of narrative but as a matter of fact between a professional and a supplicant. A sense of the appropriate use of this power might well make this situation clearer, and in this section, we examine it by marshaling reflective narrative responses to this situation. In *Intoxicated by My Illness*, Anatole Broyard, narrating his situation as a patient faced with a life-threatening illness, describes this differential and, in fact, seeks it out, because he wants a very knowledgeable doctor, someone who is "intense enough or determined enough to prevail over something powerful and demonic like illness" (1992: 36). He does not want a physician without authority, but he wants one who brings authority to the shared enterprise—the very deliberation of narrative described in chapter 3—of the patient-physician relationship. (Broyard himself, who died from prostate cancer shortly after he wrote this memoir, was a literary critic and reviewer for *The New Yorker*.) Broyard wants the doctor to be a "storyteller," to turn his illness into a narrative. He desires this narrative to draw him, the patient, into the relationship in a way that facilitates both the doctor's and the patient's participation in the illness/disease and treatment. Broyard observes that this requires the doctor to translate the scientific story into one of "natural" language that the patient can understand. He states, "Astute as [the doctor] is, he doesn't yet understand that all cures are partly talking cures. Every patient needs mouth-to-mouth resuscitation, for talk is the kiss of life" (1992: 53).

The shared enterprise Broyard describes helps him define the ideal doctor, the building of rapport, and the ideal patient-doctor relationship. The literary form he imagines is the heroic melodrama or epic, Dante's *Divine Comedy*, and the doctor assumes the actantial role of Helper.



My ideal doctor would be my Virgil, leading me through my purgatory or inferno, pointing out the sights as we go. He would resemble Oliver Sacks, the neurologist who wrote *Awakenings* and *The Man Who Mistook His Wife for a Hat*. I can imagine Dr. Sacks entering my condition, looking around at it from the inside like a benevolent landlord with a tenant, trying to see how he could make the premises more livable for me. He would see the genius of my illness. He would mingle his demon with mine; we would wrestle with my fate together. Inside every patient, there's a poet trying to get out. My ideal doctor would "read" my poetry, my literature. He would see that my sickness has purified me, weakening my worst parts and strengthening the best. (1992: 41)

Here, as patient, Broyard is describing the qualities of the deliberation narrative gives rise to as the physician assumes the roles of both Helper and Receiver of the narrative (listener). Both the roles we have discussed and the ideal Broyard discusses are schemas of understanding and action.

Broyard describes this encounter from the vantage of the patient, but he also suggests the deliberation from the vantage of the physician, when he describes Dr. Oliver Sacks's discovery of the "genius" of an illness. One such example is the case history of "the colorblind painter" that Sacks presents in *An Anthropologist on Mars*. The "genius" of an illness that Broyard describes is what Sacks calls the "world" of an illness, the fact that a serious illness—especially a chronic illness—becomes part and parcel of the patient's life. (In this, the term "illness" nicely comports with Kenneth Boyd's use of the term [2000], discussed in the introduction to the present book.) For a physician to participate in the patient's illness, the doctor must understand not only the patient's pathology but its attendant emotions and effects on her entire life. The physician must acknowledge the "dis-eased" and, as we have seen, the "concerned" patient, as well as the medical condition that both confront.

Dr. Sacks's discussion of a color-blind painter who had a lesion of the pre-striate cortex is striking in several ways. Dr. Sacks was able to localize the lesion by taking the patient history, performing examinations, and accessing technology. However, his relationship with the patient obviously did not end there. In this case, the doctor continued to develop a caring relationship, helper to hero: in this, he participated in the meaning of the brain lesion for the patient, so that, as Broyard says, the doctor "walked around inside me, trying to see how he could make the premises more livable for me" (1992: 43). Most of all, Dr. Sacks functioned for the colorblind painter as a storyteller, discovering possibilities of narrative meanings of one sort or another—

stories that gave explanation to the patient about his new way of attending the world—where the patient simply saw and felt catastrophe. Kathryn Montgomery Hunter (1991) has coined the term "re-storying" to describe the ways in which a physician "translates" the story a patient presents into other, "medical" stories for other health care workers and for the patient and his or her family. The term combines the concepts of narrative storytelling and the "restoration" of health or well-being. This "re-storying" the patient is a way of building rapport and developing a positive, meaningful relationship with the patient. Such a positive relationship has, almost by definition, positive therapeutic effects in and of itself, insofar as it supports the patient as he adapts to the "new world" of treatment, to ongoing life, or even to the end of life.

Finally, at the heart of the shared enterprise of the patient-physician relationship is the fact that, despite differences in power and differences in motives to enter the relationship, it is always possible for the physician to learn from the patient just as the patient learns from the physician. This fact is at the heart of Dr. Sacks's work both as a physician and as a writer, as it is at the heart of the work of other physicians encountered here and throughout this book: poets such as Dr. John Stone, Dr. Rafael Campo, Dr. William Carlos Williams; literary critics such as Dr. Rita Charon; memorialists and case historians such as Dr. Abraham Verghese and Dr. Oliver Sacks; fiction writers such as Dr. Richard Selzer, Dr. Ferrol Sams, Dr. Anton Chekhov, and Dr. Williams. This is accomplished by means of the alternation between patient and physician of telling and listening to stories: the eliciting of the patient's chief concern has the effect of empowering the patient as storyteller. In fact, focusing on the chief complaint empowers the physician, who, in his position, always knows more than the patient (even when the patient himself is a physician); focusing on the chief concern empowers the patient, who is in the position of storyteller, a Sender who, in "telling events," as Brian Body notes, enacts "an effortful process . . . to direct the attention of others to events real or imagined" (2009: 382).

### *The Paternalism of Power*

The patient-physician relationship ideally might well be structured to be a shared enterprise, just as storytelling itself is a shared enterprise in Walter Benjamin's description (and that of evolutionary cognition). But in fact, the significant power differential between patient and physician often obstructs shared cooperation. The first stories we heard were from our parents and



childhood caretakers, who shared with us knowledge and understanding. But in medicine, "paternalism" is more often than not an obstruction that commonly characterizes and, to some degree, disrupts the patient-physician relationship. This paternalism grows out of the tradition of a male-dominated profession and the egocentric idea that the "doctor knows best." Paternalism is also a consequence of the authoritative nature of the special knowledge of the profession, which implies that the patient is ordinarily ignorant. Finally, some believe, it is a consequence of methods used in medical education that grow out of the assumptions governing scientific positivism (examined in chapter 1). Thus, in many cases, the physician puts himself or herself in the position of parent, while assigning the role of child to the patient.

In his novel *The Woman Who Walked into Doors*, Roddy Doyle portrays a young woman, Paula, who finds herself in an abusive marriage. Her husband, Charlo, beats her frequently, and following particularly severe beatings, he often takes her to the emergency department of the local hospital to be examined. In the emergency department, the physicians and nurses treat Paula with a paternalistic attitude, leaving Paula to play the role of a child, insofar as they do not expect her to have anything of importance to say about her condition.

Someone once told me that we never remember pain. Once it's gone it's gone. A nurse. She told me just before the doctor put my arm back in its socket. She was being nice. She'd seen me before.

—I fell down the stairs again, I told her.

—Sorry.

No questions asked. What about the burn on my hand? The missing hair? The teeth? I waited to be asked. Ask me. Ask me. Ask me. I'd tell them everything. Look at the burn. Ask me about it.

Ask.

No.

She was nice, though. She was young. It was Friday night. Her boyfriend was waiting. The doctor never looked at me. He studied parts of me but he never saw all of me. He never looked at my eyes. Drink, he said to himself. I could see his nose moving, taking in the smell, deciding. (R. Doyle 1996: 164)

The nurses and doctors who treat Paula respond to her as if she were a child. They allow the abusive husband to remain in the room and, in fact, to answer

most of her questions. They call her silly and tell her that she surely must be more careful, that falling down stairs and running into doors are the activities of careless children. Reading this narrative creates empathy for Paula—and it also generates antipathy toward the physicians and nurses, not only for their paternalistic indifference, but for their confederacy in the conspiracy against Paula. Moreover, Doyle's first-person narrative offers a sense of Paula's psychological situation—as an adult, whose life history we know, who is dismissed as a child or a drunk—that is less readily apparent in everyday narratives with different kinds of purposes and ends.

William Carlos Williams dramatizes the abuse of power that often accompanies paternalism within a patient-physician relationship in his story "The Use of Force," by creating a *literal* narrative of a physician and a child. This is also a first-person narrative, with the physician, not the patient, as teller. In Williams's story, a small girl who refuses to open her mouth for examination is forced with a large spoon, as the doctor gets angrier and angrier: "In a final unreasoning assault I overpowered the child's neck and jaws. I forced the heavy silver spoon back of her teeth and down her throat till she gagged. And there it was—both tonsils covered with membrane" (1984: 60). The power of Williams's story is conveyed, at least in part, by its remarkable honesty in its portrayal of the physician's emotions: his affection toward the little girl, his contempt for her frightened parents, and ultimately his uncontrollable anger toward the patient and also toward the larger situation of a small epidemic of diphtheria. "After all," he says, "I had already fallen in love with the savage brat, the parents were contemptible to me" (58). The doctor relates,

The child's mouth was already bleeding. Her tongue was cut and she was screaming in wild hysterical shrieks. Perhaps I should have desisted and come back in an hour or more. No doubt that would have been better. But I have seen at least two children lying dead in bed of neglect in such cases, and feeling that I must get a diagnosis now or never I went at it again. But the worst of it was that I too had got beyond reason. I could have torn the child apart in my own fury and enjoyed it. It was a pleasure to attack her. My face was burning with it. (60)

In this representation of anger, Williams is setting forth an aspect of patient-physician relationships that is outside the "objective," scientific practice of medicine—the doctor's righteous and unrighteous anger. It is righteous because he knows he can possibly save a young life; and it is unrighteous be-



cause he is functioning not as a physician but as his patient's "opponent," her enemy. Negative paternalism can be recognized precisely in the roles of narrative described in chapter 3: to be conscious of the structures of narrative presses physicians (and others) to be consciously self-reflective. (In chapter 10, we will explore a *positive* sense of paternalism that many patients, represented there by Ivan Ilych, seek in their encounters with physicians.)

While Williams's story presents a literal version of "paternalism" in that the patient-physician relationship is also a relationship between an adult and a child, Richard Selzer's story "Brute" is much more disturbing in its representation of a physician's exertion of sanctioned power over a patient. In this story, Selzer's narrator tells a story, "from the distance of many years and from the safety of my little study," of a doctor, who has been on duty for many, many hours and is extraordinarily tired, and a "huge black man" who presents in his emergency room, angry, drunk, under arrest, and with a large deep wound on his forehead. On the stretcher, the patient

strains and screams. But why can he not sense that I am tired? He spits and curses and rolls his head to escape from my fingers. It is quarter to three in the morning. I have not yet begun to stitch. I lean close to him. . . . "Hold still," I say.

"You fuckin' hold still," he says to me in a clear, fierce voice. Suddenly, I am in the fury with him. Somehow he has managed to capture me, to pull me inside his cage. Now we are two brutes hissing and batting at each other. But I do not fight fairly.

I go to the cupboard and get from it two packets of heavy, braided silk suture and a large curved needle. I pass one of the heavy silk sutures through the eye of the needle through the center of his right earlobe. Then I pass the needle through the mattress of the stretcher. . . . I do exactly the same to his left earlobe. . . .

"I have sewn your ears to the stretcher," I say. "Move, and you'll rip 'em off." And leaning close I say in a whisper, "Now *you* fuckin' hold still." . . .

Even now, so many years later, this ancient rage of mine returns to peck among my dreams. . . . How sorry I will always be. (Selzer 1996: 61–63)

In this story, Selzer represents an encounter between physician and patient that is hardly a relationship but purely a technical transaction, in which, as in Williams's story, the physician *positions* himself as the patient's "opponent" in a scene that simply narrates conflict.

On reflecting on this story, Dr. Selzer describes reading or teaching "Brute" as representing "a lost opportunity for grace" (Vannatta, Schleifer, and Crow 2005: chap. 2, screen 14). As we shall see in chapter 6, Dr. John Stone ends his poem "He Makes a House Call" similarly, with a description of the patient-physician relationship in terms of the relationship between a saint and his or her faithful caretakers. In a moment, we examine Flannery O'Connor's use of religious themes to enact conceptions of personhood and relationships among people, which, through its narrative form, can help us understand the qualities of the patient-physician relationship. The religious language of all these representations are related to Broyard's description of illness as something "demonic"; such religious language gathers up the "feel," so to speak, of the shared enterprise of doctoring, even when the participants are not equally powerful. Moreover, such language suggests a narrative, a story, of redemption, restoration ("re-storying"), community—or narratives of the violations of these things. The values of redemption, restoration, and even community often seem to be the end and goal of these explicit and implicit narratives, demanding, as in Selzer's powerfully disturbing story, a moment of reflection in the hurry of events. The religious language used in them is a call for such reflective moments. (Precisely this intuitive sense of the "redemptive" nature of health care makes both Williams's and Selzer's stories so horrifying.) Moreover, the religious language offers a different schema of understanding from that of the all-knowing (paternal) physician and supplicating patient. These "cases" of patient-physician relationship in Doyle, Williams, and Selzer set forth what Thomas Nickles calls "both small schemas that are operationalized cases and larger, organizing schemas" that allow for the construal of new endings growing out of the narrative situation of the patient-physician encounter (1998: 79).

A subtler form of power and paternalism is a general arrogance often displayed by physicians, which is, again, more easily discernible in art narrative. In her story "The Interior Castle," Jean Stafford tells of a woman undergoing nose surgery following an automobile accident. The procedures are exceptionally painful. The author portrays the experience of the pain from the patient's perspective. In this narrative, the doctor never validates the pain, does not invest time or energy in developing rapport, and demonstrates no empathic understanding of the patient's horrible pain. The patient, Pansy, we are told, "fought two adversaries: pain and Dr. Nicholas." The doctor tells her there is no danger—"There is no danger," he says. "Do you think for a minute I would operate if there were?"—even though he wonders to himself



"if she knew in what potential danger she lay." This patient-physician relationship results in only technical manipulation of the nose and virtually no caring for the patient.

Before the operation, Dr. Nicholas jokes with his patient: "All set?" the surgeon asked her, smiling. "A little nervous, what? I don't blame you. I've often said I'd rather break a leg than have a submucous resection." And during the operation, while he proceeds, Pansy is

in such pain as passed all language and even the farthest fetched analogies. . . . She was claimed entirely by this present, meaningless pain and suddenly and sharply she forgot what she had meant to do. She was aware of nothing but her ascent to the summit of something; what it was she did not know, whether it was a tower or a peak or Jacob's ladder. Now she was an abstract word, now she was a theorem of geometry, now she was a kite flying, a top spinning, a prism flashing, a kaleidoscope turning. (Stafford 1969: 179-83)

This narrative of the pain experienced during conscious manipulation of the nasal fracture and its reconstruction represents the experience of pain from the perspective of the patient, even as the narrative provides the physician's arrogant oblivion to his patient's experience. The story provides the doctor or the student of health care a pristine account of the arrogant detachment of the doctor and of the experience of the patient, as well as a starting point from which to begin developing patient-physician relationships. Stafford's ability to provoke empathy in her narrative even while the physician exhibits none helps the doctor or medical student to recognize the need for empathy, for verbalizing and acting on that empathy, so that in the future, his or her patients might have a different subjective experience of the pain so often necessary in their relationships with physicians.

An even more striking representation of arrogance is Flannery O'Connor's story "The Artificial Nigger." (The very title of this story—its use of the ignorant and abhorrent language of its chief character—underlines its representation of arrogance.) This story does not focus on a patient-physician relationship. Rather, it narrates the relationship between Mr. Head and his young grandson, Nelson, as they pursue a visit to Atlanta from the rural south, in another version of *literal* paternalism. What is striking about this story is not only the arrogance with which Mr. Head treats his grandson—he thinks of himself as "a suitable guide for the young" and, in the end, betrays his grandson to save himself—but the way O'Connor leads her readers to

think of *themselves* as better educated, more perspicacious, and simply more fully human than these country "rednecks." She does this by her language: the narrator says "Negro," while Mr. Head uses the viscerally derogatory term; and throughout the narrative, there is the educated, sophisticated language of the narrator—who mentions Dante and Virgil and seems to have a working sense of Catholic theology that is clearly beyond the understanding of her Southern Baptist protagonist. In fact, reading this story in conjunction with "The Interior Castle" calls attention to the gap in discourse between the knowledgeable, scientific language of the physician (his "submucous resection") and his frightened patient. Here, the categorical distinction in narrative between the story (plot) and the discourse (narration)—the tale and the telling, as discussed in chapter 3—is the motor of the story's power. (Practicing physicians do not need the technical distinction as long as they can use the schema of the "two temporalities" of narrative, the temporal action of the story and the temporal action of its telling [Kreiwirth 2000: 313], in allowing themselves to be consciously aware of the organization of their patient's story and its meanings. Moreover, this distinction manifests itself in action, such as verbally responding to the *manner* of the patient's responses.)

Finally, "The Artificial Nigger," like so many of O'Connor's stories, is about Christian revelation and redemption. At the end—in a language of Catholic theology foreign to that of Mr. Head—readers learn of Mr. Head's salvation and, in this recognition, might also perceive their own sin of arrogant pride.

Mr. Head stood very still and felt the action of mercy touch him again but this time he knew there were no words in the world that could name it. He understood that it grew out of agony, which is not denied to any man and which is given in strange ways to children. . . . He stood appalled, judging himself with the thoroughness of God, while the action of mercy covered his pride like a flame and consumed it. . . . He realized he was forgiven for sins from the beginning of time, when he had conceived in his own heart the sin of Adam, until the present, when he had denied poor Nelson. He saw that no sin was too monstrous for him to claim as his own, and since God loved in proportion as He forgave, he felt ready at that instant to enter Paradise. (O'Connor 1996: 269-70)

This story works, so to speak, by situating its readers in relation to the narrative's characters in such a way that they are able to recognize the characters' arrogance as their own. Such recognition is created by shifting narrative



"positions"—for characters, readers, and even tellers of stories—and it is crucial to one way in which literary narrative conveys knowledge and insight that is important to medical education and practice. Dr. Stone explicitly shifts his position at the end of "He Makes a House Call" by likening patient to saint; Dr. Selzer does so implicitly at the end of "Brute" and explicitly in his comments on the story. O'Connor does so at the end of this story by numbering Mr. Head among the redeemed, one of the saved. Such shifting of position—which is, in fact, shifting from one provisional schema-based understanding to another—helps create explicit awareness of what we are calling the very scene of narration.

When we read Flannery O'Connor's stories—a story like "The Lame Shall Enter First" as well as "The Artificial Nigger"—we encounter a narrative that is organized in such a way that we are forced to consciously assume the role of the listener-reader (the "Receiver" in Greimas's terminology). In assuming that role or position in relation to the narrative at the end of "The Artificial Nigger," we suddenly realize that Mr. Head, this hillbilly than whom we think we are so much smarter, is capable of being saved and that we are no better than he is. At the end of "The Lame Shall Enter First," we see that Mr. Sheppard, who is a more or less educated man who believes in science and natural explanations of phenomena, is shocked by the suicide of his son, and we are shocked, too. The art of O'Connor's narrative is to situate her readers in the position that her characters assume—as Receivers of their stories' meanings—and such positioning forces the listener to attend to her own responses. When Aristotle describes tragedy in terms of pity and terror, he is doing the same thing. He is defining tragedy in terms of the response of the listener.

Using O'Connor's story to teach medical students about arrogance works particularly well for several reasons, one of which, paradoxically, is that there are no doctors or patients in the story. This nonmedical narrative then, allows students to discuss arrogance in the abstract—the schema of arrogant judgmental power that assumes rather than listens and that allows itself to lie to and manipulate patients, as Mr. Head manipulates his grandson. Physicians and students can discover for themselves, through discussion or reflection, that the concept applies to doctors, that their relationships to patients are analogous to Mr. Head's relationship to his grandson insofar as it exhibits paternalism and power. The story's stark and offensive title allows the student to explore the meaning of titles in literature—this is another feature of "art narrative," as opposed to, say, "Mrs. Jones's story"—here emphasizing the importance of vocabulary in the title's offensive language. This literary

issue is very important in achieving the goal of narrative competence for the physician, because the language of the physician is, in fact, often so different from the language of the patient. Like art narrative more generally, O'Connor's story can be used to teach several lessons at once. Arrogance takes the forms of rationalization (Mr. Head's repeated rationalizations in this story, as in "The Use of Force" and also O'Connor's "The Lame Shall Enter First"), of betrayals of trust (Mr. Head's denial of "his likeness," as the story says), of smug superiority born of having the access to "correct" language, or of assuming that one's charge (whether it be one's patient or grandson or even the characters in a narrative) has nothing to teach one. O'Connor's story presents and represents a schema of arrogance in terms of knowledge, action, attitude, and language and, less explicitly—but no less forcefully—than Grace Paley, represents the scene of narration altogether.

### *Case-Based Reasoning: The Development of Rapport*

Representation of the scene of narration—our description of the event of the patient-physician relationship—not only encourages the recognitions that we have described in O'Connor and others (all of which focus on the witness who learns); it also encourages the kind of relationship between teller and listener established on what Brian Boyd calls narration's "*telling events*," an effortful process we undertake only to direct the attention of others to events real or imagined" (2009: 382). Such "telling events" forge relationships between the teller and the listener: this is the import of Robin Dunbar's (1996) contention that "gossip" describes the evolutionary adaptive function of language, that of forging relationships between members of a community. The narrative a patient brings to the patient-physician relationship is hardly gossip, but it does create a scene for the establishment of relationship beyond an impersonal client-professional interaction; that is, the scene of narration is the site of (possible) rapport. Encouraging physicians to develop rapport with the patient early in the relationship is one of the goals of medical education, because such rapport is required to build an effective patient-physician relationship. Rapport is usually defined as agreement and harmony between people, a close and trusting relationship. Each of the preceding stories by Williams, Selzer, and Stafford demonstrates this need by its felt absence. O'Connor demonstrates this need by offering a story in which Mr. Head comes to acknowledge his grandson as a valid person. Dr. Stone acknowledges rapport through the language of religious experience. Most medical



schools use a variety of methods of developing this skill, including practice with simulated patients or experiential learning. The use of literature in teaching strategies for achieving rapport with patients is relatively new. It is a method that is contextual in nature. In this situation, what we mean by *contextual* is that the literary text provides a context—a vicarious experience—within which the reader/listener can recognize and even feel harmony, agreement or disagreement, trust or distrust with characters or with the author/teller.

Among other functions, storytelling—literary and nonliterary narrative—presents and represents situations of personal value and interpersonal relationships, the “cases” of the case-based reasoning Thomas Nickles describes (1998). In literary narratives, the represented situations of events and feeling provide the reader with a learning environment devoid of the learner’s ego investment. Represented situations provide the reader with rich contexts in which he or she is allowed to imagine the story. The reader can reflect on, write about, and discuss the content of the story and develop analyses, connections, and analogies to his own life experiences—in relation to physicians, to clinical situations—without actually experiencing it. The reader encounters a “case” of the development of rapport between the physician and patient in the context of more or less rich interpersonal relations. Such an encounter with narrative is very different from the abstract descriptions or definitions of the elements of interpersonal relationships that are often presented in lectures or textbook discussions. In O’Connor, as we suggested, the situating of the reader in relation to the events of narrative locates the reader both inside and outside the racist south of the 1950s, inside and outside the “redneck” mentality, inside and outside the conflict between the narrator’s reflective theology and the characters’ unreflective responses to the world. This allows readers to imagine themselves in situations and vicariously experience the emotions that arise out of those situations, unhampered by the dismissive shorthand of stereotype. Such shorthand grows out of the unreflective attribution of narrative roles—“actantial” roles—to characters that allows, for instance, physicians to dismiss the lower-class Paula so easily as, in her drunkenness, the *opponent* to the physician-hero seeking health. Such shorthand is based on stereotypical schemas, and it governs narrative insofar as the (more or less *unconscious*) structures of narrative govern our apprehensions of narrative knowledge. Yet when these schemas are *consciously* apprehended, they are able to provoke critical judgment—both intellectual and emotional—of those situations. In other words, they are apprehended as *provisional*. Moreover, such conscious understanding—even resulting from

the stereotype “shorthand” of schemas—allows for richer apprehensions of the representations of situations of interpersonal relationships and interpersonal actions, provoking self-conscious emotional responses that learners can often recognize again in actual clinical situations. Such emotional responses are provoked outside an actual interpersonal encounter, and as “cases” of *emotional* experiences rather than *event* experiences, they can be more consciously apprehended. (In chapter 9 we offer a more detailed analysis of the functioning of the vicarious experience provoked by narrative that we are describing here.)

The relationship between patient and physician functions more effectively when rapport is developed. This requires the doctor to listen to the biomedical and psychosocial aspects of the patient’s story, hear the patient’s concerns, and listen carefully to the illness narrative. But besides the patient’s story and the doctor’s listening, some connection, some exchange, hopefully will occur between patient and physician. This will demand of the physician less control and some emotional investment. As Anatole Broyard says, “It may be necessary [for the physician] to give up some of his authority in exchange for his humanity, but as the old family doctor knew, this is not a bad bargain” (1992: 57). Dr. Ferrol Sams’s narrative “Epiphany” provides, in its “*telling events*,” both the representation and the provocation of the development of rapport at the scene of narration. In this narrative, Dr. Goddard is treating an uneducated, poor ex-convict, Gregory McHune. Rapport is required in this relationship, as it is in most, because future effectiveness of treatment depends on it. (Sams’s narrative represents this as well.) Dr. Goddard recognizes the social and educational gap that exists between himself and his patient and is careful not to let it affect their interaction. Gregory’s response to Dr. Goddard initially demonstrates that the patient feels rapport with the doctor.

Back in the treatment room he handed Gregory McHune two small boxes. “We didn’t have any more samples of Vasotec, but here are some pills that are good. This is Tenormin and it’s in a form that you only have to take one a day. Take one every morning and don’t forget, you promised to see me in two weeks.”

“I won’t forget, Doc, but hell, you didn’t have to do this. I’m a pore man, but I ain’t no charity case.”

“You’re accommodating your habits and wishes to mine, Gregory, and I’m trying to accommodate mine to yours. I’ll see you next week.”

“I’ll sure be here.” There was a pause, almost of embarrassment. “I ain’t



never run into no doctor like you before." He hesitated, "If you care, I care."  
(Sams 1994: 12)

Throughout the narrative, Sams portrays Dr. Goddard as caring for his patient. It becomes clear that the doctor develops an emotional connection to the patient, the harmony and agreement of rapport. The doctor's care and connection takes the forms of respect and honor for the patient's story, taking the time to listen carefully, and, finally, responding to his patient in terms of the values and vocabulary that the patient brings to the doctor-patient encounter.

Rapport is a relationship built on trust and emotional affinity. The physician has the responsibility to demonstrate genuineness, honesty, and commitment. The patient will respond to this honesty emotionally. This forms the beginning of a relationship based on rapport. It is incumbent on the physician to investigate the uniqueness of every patient and find ways to relate to the qualities that define that particular patient. Rapport is more easily developed with patients who are like the physician—when the patient and physician are of same gender and similar cultural background, age, and interests. When the patient and physician are not similar, development of rapport can be more difficult to achieve. Reading literary narrative—especially in group settings that allow the expression of different understandings and points of view—has a role to play in the education of physicians about development of rapport. Literature provides a wealth of experience—*vicariously* experienced "cases"—with other cultures, gender roles, and socioeconomic groups that the physician may never have experienced. Narrative is about something particular and therefore creates memories and images in the reader's mind that often provoke an emotional response. Both the images and the emotions of narrative that can give rise to vicarious experiences are stored in memory, just as the "cases" of the case-based reasoning Thomas Nickles describes comprise "memory stores" (1998: 79). This library of images and emotions, built up over time in response to the more or less disinterested engagement with art narrative, is available to the physician when a patient reminds him of some character—or, really, some narrative *role*—from narrative read in the past. Such case-based memory stores can fortify understanding and emotion for the encounter at hand, both of which can contribute to the establishment of rapport.

Rapport is essential to the shared enterprise of the patient-physician relationship and its collaborative nature. Once it is established, the physician conceives of his work with a patient as a relationship, a *collaborative* and

*deliberative effort*, and the nature of his role and the weight of his burden change. Building rapport—creating harmony, agreement, and trust—is reciprocal in nature. Dr. Jerry Vannatta narrates the following encounter in his practice of internal medicine that resulted in the establishment of rapport between himself and a patient.

I came to this whole interest in narrative, literature, and the practice of medicine through an experience I had in my own practice. I'm a general internist, and I had an elderly African American woman who came back to the office for an office visit after having been in the hospital. I didn't get to know her real well in the hospital, because she was cared for primarily by the residents and the medical students on my service, but when she came back for an office visit, I was providing the care. And she rapidly told me that she was having trouble getting her medications. As I was interacting with her, there was just really no connection being made. That makes me so uncomfortable when I'm really not connecting with the patient, so, as I usually do when I'm not connecting well, I backed up and sort of took a psychosocial history. I basically just said, "Tell me about your life."

She began to tell me a story about having grown up in east Texas on a sharecropping farm where her father was a sharecropper. When she was fifteen, her father made her marry a man who was twenty-one. It really wasn't the man she wanted to marry; she was in love with a sixteen-year-old, but he made her marry the twenty-one-year-old because he could provide for a living. In fact, she said to me during the story that "he wasn't very good at making a living, but he was sure good at making babies," and she had seventeen of them. I thought at the time she said that, "My goodness, that could have rolled right out of a wonderful novel or short story." She went on to say that she oftentimes, to make ends meet, walked two miles to a white man's house to do domestic work and two miles back. She told me that sometimes the white man would give her a dozen eggs, and sometimes he would give her a two-gallon pail of milk to carry back to the family. Then she looked at me and said, "Doctor, have you ever carried a two-gallon pail of milk two miles?" In fact, I did grow up on a farm, and I can remember carrying those galvanized pails of water around the farm to the chickens and whatnot, and I could just see that wire handle just burying itself and cutting into her hand.

More important, I was thinking that I was seeing a younger version of this patient carrying this pail of milk on a dusty, sort of rocky road, probably with not very good shoes. And as I was thinking about her feet, making this



journey back, I began to think of this novel, Toni Morrison's novel *Beloved*, which I had just read a few months earlier, the most remarkable novel I had ever read, a very disturbing story about slavery in America. The protagonist, Sethe, is running from slavery. She's pregnant, she's trying to escape, she's tired, and she's about to deliver a baby. She's hiding up under a bush, and a little white girl finds her. One of the things that's striking about that scene is her swollen, bleeding, and pussy, infected feet. The image of those feet came back to me in a flood. The emotions that I had felt, I think, when I read the novel were seemingly stored in memory. Along with the image of the feet, these emotions came flooding back to me. And the remarkable thing that happened in the room was that those emotions were available to me to be able to connect with this lady. It was not that she was a slave, but she was telling me a story about her economic enslavement, and somehow they connected. I don't know how that works, but it happened nonetheless. It was an experience that was dramatic for me, and from that point on, we began to make a more meaningful connection, and we engaged in a sort of rapid problem solving about her ability to buy her medications and get them so that she could take them. At the end of the interaction, we stood up to leave, and a remarkable thing happened, which usually doesn't happen in my practice: we embraced. She knew that a wonderful relationship had begun, and so did I.

In this vignette, physician and patient develop rapport based on a scene of storytelling where teller and listener find common understanding and experience by means of the limited number of narrative roles and actions. More specifically, in Dr. Vannatta's experience with this patient, the work of establishing rapport was most likely accomplished by the activation of the narrative memory store changing his countenance (which was recognized by the patient), even as that memory of roles and actions of Morrison's novel also provided him with unspoken content of the patient's story. In any case, in this account, Dr. Vannatta is describing the *effectiveness* or *consequence* (as mentioned in chapter 1) of narrative, here accomplished (in part) by the kind of identification of listener with plot analogous to the ways we described O'Connor surprising her readers by leading them to identify with Mr. Head at the end of "The Artificial Nigger." Dr. Vannatta is here narrating a "telling event" (a narrative detail): in this case, his encounter with the protagonist's feet in reading Morrison's *Beloved*. Such a narrative detail allows for identification of characters across three narratives: the patient's, Morrison's, and Dr. Vannatta's own farm memories. This identification is not so much person-

to-person as it is role-to-role—with the protagonists struggling against recognizable obstacles (the heavy pail)—so that the relationship between teller and listener is mediated through narrative forms. Throughout the chapters of this book, but especially in chapter 8, we will have occasion to analyze more closely the ways that narrative accomplishes this kind of humanistic understanding. Here, though, is what might well be the base of humanistic understanding, insofar as it is the base of schemas, namely, the *case* as a memory store: if, in fact, as Nickles argues, "schema instances have a similar twofold nature, functioning both as memory stores and as procedures for applying that knowledge" (1998: 79), the functioning of schemas as memory stores highlights the manner in which exemplary cases are the particular base to the more general schema memory and schema experience.

In a more formal art narrative, Richard Selzer narrates the creation of rapport based on a single meeting between a retired doctor and an obviously chronically ill young boy, who meet in the atrium of a hospital in his story "Atrium: October 2001." The doctor develops rapport with the boy by exchanging death stories. (Unlike this aesthetic "art" narrative in the *Beloved* vignette, Dr. Vannatta never shares his stories of either the farm or the novel with his interlocutor.) These narratives serve to establish a relationship—a friendship of sorts—based on honesty, trust, and agreement and their reciprocity, which, like that of narrator and character in O'Connor or daughter and father in Paley, underlines the formal artistry of literary, rather than ordinary, narrative (though the *Beloved* vignette Dr. Vannatta related is extraordinary in its own way). The honesty of the old man and dying boy is established on their shared sense of mortality.

In Dr. Selzer's story, the retired doctor, lunching in the atrium of the hospital, becomes acquainted with the boy, Thomas. The doctor and the boy develop rapport that is deep, meaningful, and reciprocal, even though they have just met. The rapport is reciprocal because the boy asks for a story, and the doctor recognized, honestly and without shame, that the boy, even at his young age, is facing the stark reality of death. In their first encounter, the doctor is the teller and shares a story about what his last day on earth will be like. This narrative is much like those of Chekhov (and his "loaded rifle") in that it contains telling detail: the fragrance of the forest; the sounds of the trees; the sensation of a breath, with its poetic rhythm.

I have just finished eating lunch, and I'm sitting on a bench on the atrium a few paces from the fountain with its murmur and glitter. In a wheelchair quite nearby sits a thin, pale boy. He's bald. His lips are crusted and with a



sore at either corner of his mouth. Intravenous fluid drips into his left arm. The bottle hangs from a metal pole attached to the wheelchair over his head. In his lap a plastic bottle of water with a straw. Now and then the scabbed lips flutter apart, and he takes a sip of air, then another. He looks to be about ten years old and weighs, perhaps, eighty pounds.

"What's that you're getting in the IV?" I ask. He glances for a moment at the bottle on the pole.

"It's my pet," he says. "Follows me wherever I go."

"More like your guardian angel." He reacts not at all to this statement. I try again. "Something like a Hospital God. You know, like the ancient gods of the heart."

"Lares and Penates," he mutters. "You a doctor?"

"I used to be, long ago. Retired. I got old."

"A condition I will never have to face." I am shocked at the tone in which he says this. It is devoid of inflection or irony. I search all over my mouth for something to say. For a long moment we are silent. . . .

"What will you do on your last day on earth?" [he asks me.]

"My last day?"

"The day you're going to die."

"Can we talk about something else?" He gives a tiny shake of the head. The huge eyes insist; beneath them are smudges of violet. I'm caught and fluttering in that merciless gaze. He raises the water bottle to his lips and takes a tiny, excruciating sip.

"Life hurts," he says. "I measure out the time by sips, see how few I can get along with." (Selzer 2004: 146-47)

Dr. Selzer tells the boy a story of his own dying—he tells it twice—of how a former student who is now "a great surgeon" takes his dying mentor to a quiet, wild woods, "a pious forest" where "great old trees are deeply rooted in the earth and their canopies sway overhead." There, Dr. Selzer imagines dying quietly as night falls, coming with "a feeling of imminence" as he feels darkness enter his body. Then he seems to die in a manner that is indistinguishable from sleep: "I am the whispering of leaves, more guessed at than seen" (250). The boy, thinking of his own impending death, loves this gift of the narrative of how an old man might die, so much that he asks him to tell it again.

The rapport is reciprocal, and the narrative enacts this reciprocity: the boy sends a letter, delivered posthumously on the following day, relating his death to be just as Dr. Selzer imagined his own would be. The doctor provided a

beautiful and poetic narrative gift to this enlightened fourteen-year-old boy, a story of dying with grace. The boy was grateful for this gift, and the doctor was transformed by the relationship with Thomas: "He is unto me like a fountain in my mind, a place where it is always cool and fresh and where I can go to partake of its coolness" (252). A story such as this—it is implicit in the *Beloved* vignette as well—*enacts* the scene of narration insofar as it describes the ways that storytelling as a formal activity forges felt relationships between teller and listener. Such relationships might well be, as Robin Dunbar has argued (1996), the very "purpose"—the *functional reality*—of narrative, its ability to create bonds between people as they tell and listen to narrative.

### Empathy and Narrative

Rapport is an aspect of relationships between people that includes trust, honesty, and the assumption of goodwill between the parties involved. These things, as we have seen, can be represented and provoked in literary narratives and the implied narratives of poetry. There is another quality, akin to rapport, that physicians can bring to or develop within their relationships with patients. The quality of empathy is, in many ways, at the base of rapport. This section explores the quality of empathy in terms of the knowledge and experiences it provides, the ways in which people might learn to be attentive to it, and the manner in which literature can help us recognize and nurture it. Still, the definition of empathy has been the site of some conflict. Suzanne Keen has defined it as "a vicarious, spontaneous sharing of affect"—the "I feel what you feel" of empathy as opposed to the "I feel a supportive emotion about your feelings" of sympathy—even though she notes that most psychologists believe that empathy is "both affective and cognitive" (2006: 208-9). In fact, Keen cites a study, supported by fMRI data, that demonstrates that "a person perceives that she feels another's pain, while not literally experiencing the identical sensations"; the study concludes that "empathy is mediated by the part of the pain network associated with pain's affective qualities, but not its sensory qualities" (Keen 2006: 211, citing Singer et al. 2004: 1157). For physicians, it is most important to think of empathy as a cognitive activity rather than an event of feeling (affect) and, as Keen suggests in discussing novelists and art narrative, as the cultivation of "*role-taking skills [that] make them [she means novelists, but we would include regular readers as well] more habitually empathetic*" (2006: 221).

The following vignette, a dramatic narrative of an everyday encounter



between a physician and his patient, offers an enactment of empathy, which can help us to see the role of narrative in empathy and its contribution to rapport and the establishment of a fruitful patient-physician relationship.

DR. ORWIG: Miss Silcox?

MS. SILCOX: Linda, yes . . .

DR. ORWIG: Linda, I'm Dr. Orwig.

MS. SILCOX: It's nice to meet you.

DR. ORWIG: Tell me, what brings you in today?

MS. SILCOX: (*heavy sigh*) Well, I came because I'm tired. I'm inordinately tired and I know that you don't know me, but . . . I'm not usually tired. And nothing I have tried has been helpful.

DR. ORWIG: (*with a look of concern, touching her arm*) Tell me a little bit more about that.

MS. SILCOX: Well, I first noticed it probably eight or ten weeks ago, when I was running with my friends. Now we've been running the same course for . . . I don't know . . . eighteen years, and it's only three miles, and I started saying, "Could we just walk this block?" or "Could we just slow the pace a little bit?" because I just couldn't keep up. And finally it got to the point where I just had to give it up. I couldn't keep up. I couldn't do it. I thought the net effect of that would be that then I'd have the energy I used to spend running to do other things. But I'm just tired anyway. And now I don't see my friends, I don't go running. I don't really do anything fun anymore, 'cause I just barely have the energy to do the things I have to do to get through the day.

DR. ORWIG: Wow, it sounds like this really changed your life.

MS. SILCOX: It's horrible. It's changed it a lot. And I'm pretty sure something's wrong with my body.

As Dr. Orwig enters the room, he recognizes the patient and introduces himself. He then listens carefully as Ms. Silcox tells her story regarding fatigue. He recognizes that the primary emotion here is sadness and that her chief concern is loss—the loss of the ability to run with her friends. This psychosocial information is used to understand the patient's plight. Her particular plight is that she has lost this very important part of her social life and support system. He notices her great sigh and sad face and nonverbally acknowledges them with a small gesture. Moreover, he verbally acknowledges her loss by saying, "Wow, it sounds like this really changed your life." Dr. Orwig responds to all of the information his patient presents, both verbal and non-

verbal, before pursuing and facilitating her biomedical story. He understands that this demonstration of empathy—that is, verbal and nonverbal responses to her narrative that demonstrate the *cognitive* apprehension of the patient's feelings and concern—is important in creating rapport with his patient and in further elucidating her story. By Dr. Orwig's explicit verbal and physical responses to the patient's concerns, the patient knows he cares about her and understands her plight. Empathy is both a feeling and a form of understanding, both affective and cognitive, but to function in the patient-physician relationship—or, for that matter, in many other interpersonal relationships—it needs to be made as explicit as possible within the interpersonal encounter at the scene of narration.

Empathy belongs to the domain of emotions and narrative understanding. It does not spring forth from the logico-scientific study of medicine. As we have said, empathy is an affective as well as cognitive *understanding* of another's feelings, pain, or concern.<sup>1</sup> When the doctor responds—verbally, or through acts or gestures of kindness—on the basis of this understanding of another's pain, the patient knows the caring of the physician and has positive evidence of it. Responding verbally and/or through acts of kindness is important because the empathetic understanding by the physician may go unnoticed by the patient and, therefore, have no effect on the relationship. In most cases, as in Sams's "Epiphany" and in the encounter between Dr. Orwig and Ms. Silcox, the physician's empathy is a constituent element of doctor-patient rapport—sometimes its cause, sometimes its effect. As such, it promotes trust, honesty, and goodwill in the patient-physician relationship.

Steven Johnson surveys experimental work in cognitive psychology that demonstrates empathetic understanding in children as young as four. (Keen 2006 cites this work as well, as we did in chapter 2 in relation to theory of mind.) "Human beings are innate mind readers," he writes, explaining, "Our skill at imagining other people's mental states ranks up there with our knack for language and our opposable thumbs. It comes so naturally to us and has engendered so many corollary effects that it's hard for us to think of it as a special skill at all. And yet most animals lack the mind-reading skills of a four-year-old child. We come into the world with a genetic aptitude for building 'theories of other minds' and adjusting those theories on the fly, in response to various forms of social feedback." Johnson goes on to argue that our very sense of self-awareness—our sense of personhood altogether—is a function of the social-communicative skills of mind reading, skills of empathetic understanding. "Only when we begin to speculate on the mental life of others," he notes, "do we discover that we have a mental life ourselves." "Among the



apes," Johnson writes, "we are an anomaly in this respect: only the chimps share our compulsive mixed-sex socializing. (Orangutans live mostly solitary lives; gibbons as isolated couples; gorillas travel in harems dominated by a single male.) That social complexity demands formidable mental skills: instead of outfoxing a single predator, or caring for a single infant, humans mentally track the behavior of dozens of individuals, altering their own behavior based on that information. Some evolutionary psychologists believe that the extraordinary expansion of brain size between *Homo habilis* and *Homo sapiens* (brain mass trebled over the 2-million-year period that separates the two species) was at least in part triggered by an arms race between Pleistocene-era extroverts." As Johnson reports, some researchers have isolated "mirror neurons" in chimps that fire when a chimp performs a particular activity (e.g., putting food in its mouth) and that also fired "when the monkey observed another monkey performing the task." Such "synchronic" firings for self and others, he speculates, might well be "the neurological root" of empathy, "which would mean that our skills were more than just an offshoot of general intelligence, but relied instead on our brains' being wired a specific way." Johnson goes on to suggest that people suffering from autism might well "suffer from a specific neurological disorder that inhibits their ability to build theories of other minds" (2002: 196–202; see our discussion of mirror neurons in chapter 2, n. 2, as well as Iacoboni 2009).

In an interview, Dr. Rita Charon defines *empathy* as a combination of cognitive and emotional *understanding*—a kind of "recognition" of the humanity, and the human suffering, of another person. "Empathy," she has said, "is the method, or the tool, that gets you toward engagement. Empathy is that ability to recognize the plight of another person and to be moved by it. Empathy does not require that I have experienced what the patient is experiencing" (Vannatta, Schleifer, and Crow 2005: chap. 1, screen 35). The "recognition" discussed by Dr. Charon is a type of understanding of the patient's plight that we are describing in this chapter and that many of the narratives we have cited represent and provoke.<sup>2</sup> Such recognition also entails being willing to invest one's self emotionally in the patient and her story in a direction, as Charon says, toward engagement. When the physician and patient engage in this manner, they experience a deeper, more meaningful relationship—one built on mutual understanding, trust, and a kind of identification. This engagement describes rapport and is established through the development of empathetic recognition and understanding.

The imaginative understanding of the whole situation<sup>3</sup> in empathy—the

scene of narration in the patient-physician relationship—links it powerfully to the goal of grasping the meaningful whole of narrative. For this reason, "cases" of literature and literary narrative are particularly effective in representing and provoking empathy. Empathy is a response and an emotion generated by an act of recognition, as Dr. Charon has said. Such recognition can be provoked by an image (e.g., Sethe's feet in the *Beloved* vignette), an imaginative identification (e.g., that between the doctor and Thomas in Selzer's story), or a sense of a "whole" story falling into place (e.g., O'Connor's description of "the action of mercy" at the very end of "The Artificial Nigger" [1996: 269]). The recognition may be in the form of visual input or narrative comprehension as created by an author or by the physician as he organizes data—stories and facts—presented by the patient. The recognition may even result from vicarious memories gained through works of literature or art previously experienced. (We discuss vicarious experience of narrative more fully in chapter 9.) Experienced empathy for an ill patient may be gained through becoming ill oneself or by reading about such an experience, in, for example, *The Death of Ivan Ilych*. As one reads Tolstoy's *The Death of Ivan Ilych*, it is impossible not to recognize the agony Ivan feels as he is poorly understood by his doctors, family, and friends, because Tolstoy makes explicit what is usually implicit, namely, the particular feelings and responses Ivan has to his illness and to the ways those in his life respond to his illness: the failure of Ivan's family to recognize and acknowledge his plight—their failure to exhibit empathy for the suffering that is part of Ivan's and all our lives—is a significant cause of his suffering. Tolstoy's story provides insight into Ivan's plight, and through its narrative language and events, the reader vicariously experiences Ivan's desires to be understood.

### Teaching and Learning Empathy

In the patient-physician relationship, empathy as experienced by the physician allows her to "connect" with the patient, to develop or acknowledge the feelings of harmony, agreement, and trust that characterize rapport. It also helps the physician to attend to the patient's concerns and, in many instances, facilitates diagnosis. When these feelings are demonstrated in language or by acts of kindness, they deepen and enrich the therapeutic experience for both the patient and the physician. Empathy helps the physician find meaning in the relationship between doctor and patient. Empathy is also more readily



demonstrated by some individuals, as if it is built into their personality structure. For those to whom empathy is second nature, the study of literary narrative can provide experiences that validate their impulses to connect with and comfort others. For those who, for a variety of reasons, do not readily feel or acknowledge their own feelings of empathetic understanding, active algorithms—*schemas*—can guide the physician. Physicians can be taught to express empathy by means of schematic rules of behavior like the following:

1. Attend to the *chief concern* of the patient: listen for it or, as we are suggesting, make it an explicit part of the protocols of the History and Physical Exam.
2. When the concern is expressed, explicitly *acknowledge* its importance (as did Dr. Orwig, e.g., in saying “Wow, it sounds like this really changed your life”).
3. Paraphrase the expressed concern so that the patient will explicitly know her concern was heard and understood. (See checklist 5, “Patient Engagement,” in appendix 2.)

Many believe that empathy is a character trait that one either possesses or does not possess. But in fact, empathy is an event that takes place within a relationship—at the scene of narration we are describing here. As a relational event, like narrative itself, it thrives on feedback and interchange. When, as children, we told Sally that Johnny liked her and then told Johnny that Sally liked him, we often found Sally and Johnny becoming friends just because they had a sense of one another's care in the *active* (if perhaps not fully conscious) responses to this knowledge. In a similar fashion, a physician's *expressed* empathy often leads to its cognitive and affective reality—its *functional reality*—in the warmth of a patient's response. Moreover, such expressions and fact can be learned to be *habitual* through their *repeated action*. Empathy, in fact, is an important aspect of *phronesis*, and it contributes to the physician's development of himself as a *phronimos*.

*The question of sincerity:* Here and in chapter 6 (see especially “Story Filters”), we are presenting *schematic* responses and questions that physicians can and should bring to the scene of narration—to the *active* engagement of the narrative of the History of Present Illness—which is at the heart of the patient-physician relationship. In his consideration of ethics, Aristotle makes perfectly clear that his practical syllogism *ends* in action rather than ideas or feelings (cognition or affect). The *active*

engagement that we are arguing is a *constituent feature* of narrative: the deliberation of narrative, the witness who learns, the “telling” relationship between teller and listener; the very “experience” of the intersubjectivity of narration, and the felt sense of “experience” that narrative give rise to all participate in active engagement, and they are acts that, taken together, create the *functional reality* described in chapter 1. In this instance, they are acts that provoke engaged responses and create the functional reality of empathy. In other words, these responses and questions to the patient's story are *acts* of kindness and *gestures* of comfort that—like the *active* inclusion of the chief concern in the protocol of the History and Physical Exam—can and should be the beginning of therapy. They are practical and ethical *actions* that take their place within schema-based medicine that might benefit from—and, we believe, *give rise to*—the feeling and understanding (affect and cognition) of empathy, but the sincerity or intensity of the feelings and understandings they express do not have to correspond to feelings and understanding. Rather, *they are acts arising out of (and as an integral part of) engaged narrative; these acts, in themselves and in the responses they provoke, are functionally real empathy.*

The efficacy of empathy in making a difference in care is multifold. It fosters the patient's honest storytelling (as opposed to the woman with hypotatremia); the physician's attentive listening; and, most important, the diagnosis that arises from the patient-physician encounter. Dr. Rafael Campo has described his use of a poem by David Baker directly as the facilitator of a relationship between himself and a patient. In this instance, the poem, which was about the same illness the patient had, allowed the doctor and patient to access a common language for developing a narrative about the patient's plight to which they could both relate. The act of sharing the poem with the patient was an act of kindness, or empathy, and Dr. Campo states that it granted his patient the ability “to articulate to me in a more clear way what she was going through,” and that it granted him, as her physician, the ability to gain “insight into what she was going through” (Vannatta, Schleifer, and Crow 2005: chap. 2, screen 40).

In addition to facilitating the treatment of patients, the doctor's empathetic understanding can also bring certain rewards to physicians themselves. Physicians who train themselves to be more empathic almost universally report higher job satisfaction. Thus, Dr. Charon suggests that the engagement to which empathy leads the physician is what the patient needs. The patient then gains from the relationship as a result of this “recognition and under-



standing" by the doctor. This patient satisfaction is obvious to the physician, and, in return, physician satisfaction is improved as well. It seems, then, a paradox that when physicians work hard to find ways to "connect" with their patients, they commonly receive more out of the resulting relationship than they invested. For most physicians, this return on investment—the ability to adequately care for others—is one of the reasons they entered medicine in the first place.

It has been noted by many observers that physicians as a group tend to be lacking in empathy and its demonstration. Common wisdom says that the logico-scientific organization of medical education, the time-stressed schedule of medical school, and the emotional cost of dealing with suffering, disease, and death tend to decrease empathy in a medical trainee. Some observers even believe that this distancing is, to some degree, necessary in order for the medical student to become a mature, competent physician. However, many physicians report, and most patients agree, that physicians as a group need to express more empathy toward their patients. Medical schools, it seems, need empathy training or education in their curricula. In his poem "What I Would Give," Dr. Rafael Campo describes the desire to give empathy to his patients.

#### WHAT I WOULD GIVE

What I would like to give them for a change  
is not the usual prescription with  
its hubris of the power to restore,  
to cure; what I would like to give them, ill  
from not enough of laying in the sun  
not caring what the onlookers might think  
while feeding some banana to their dogs—  
what I would like to offer them is this,  
not reassurance that their lungs sound fine,  
or that the mole they've noticed changed is not  
a melanoma, but instead of fear  
transfigured by some doctorly advice  
I'd like to give them my astonishment,  
at sudden rainfall like the whole world weeping,  
and how ridiculously gently it  
slicked down my hair; I'd like to give them that,  
the joy I felt while staring in your eyes  
as you learned epidemiology

(the science of disease in populations),  
the night around our bed like timelessness,  
like comfort, like what I would give to them.

(Campo 2002: 16)

In discussing this poem in an interview, Dr. Campo suggested that empathy can indeed be taught and learned: "To me, that's a poem about empathy, and really, that's, I think, what this other poem that I shared with my patient was about also. And that's what poetry, I think, can express. I often find colleagues will say to me, 'Well, you can't teach compassion, you can't learn to be more empathetic.' And I think, actually, by reading poetry, by immersing ourselves in these narratives, these biocultural narratives, if you will, to use sort of a fancy academic-sounding phrase, that indeed we can, we can become more empathetic. We can learn to be more compassionate, or at least be able to express compassion, perhaps, more effectively" (Vannatta, Schleifer, and Crow 2005: chap. 2, screen 4).

In a fashion similar to Dr. Campo, Dr. Richard Selzer suggests that empathy can be learned and taught through practices of writing. If medical education teaches vocabularies that, in their scientific precision, are specialized and technical to the point of reducing patients to conditions, we should take care to find a common language with and for patients as a way of discovering the "whole situation" of empathetic understanding. Thus, in an interview, Selzer noted that

the doctoring informed my writing, and that was obvious. But did the writing inform my doctoring? And, I think it did, but it was more subtle, so that I, wasn't conscious of it at any time. I knew I was different. Everybody else knew I was different. That was obvious. And when I made rounds, my remarks to the students and the interns and the residents and the nurses were those of a writer. It pertained to the medicine, but I was writing. And furthermore, since I had no time to study writing or to practice it, really, I used my speech, my daily speech, ordinary speaking as an instrument to educate myself so that I spoke as I wrote, which I think is still the case in some, I mean you can see that even now. And it was interesting because when my books began to be published and the medical world finally adopted them, many people would ask to come on rounds with me. Some of my readers would ask to come on rounds with me so that they could hear it firsthand. I hope this doesn't sound egotistical, but I knew that I had blazed a trail. I was aware of it. (Vannatta, Schleifer, and Crow 2005: chap. 1, screen 45)

Still, reading literature—encountering cases and studying narrative schemas—is a much more readily available resource for students, doctors, and other health care providers than writing. The patient stories they encounter every day are narratives—presented through language shaded by diction, interpreted through metaphor, and communicated with emotion. They take their place among the storytelling all people share. By teaching literature to medical students and residents—or, more simply, by providing the schemas of narrative understanding and awareness that we are presenting in this book—we can help them gain competence at attending to narratives. As texts such as *The Death of Ivan Ilych*, *The Plague*, the stories of Dr. Williams, and the poems of Dr. Stone are encountered and studied, readers learn to hear and interpret patients' narratives more competently. The reading of experiences other than our own, such as Toni Morrison's *Beloved* or Leo Tolstoy's *Death of Ivan Ilych*, lays the ground for an emotional connection with patients and suffering that we may not have otherwise experienced. In the example of *Beloved*, the experience of slavery is vividly and vicariously experienced. This vicarious experience of the novel itself, and the actual experience encountered at the scene of narrative (particularly when people come together to discuss the book and their responses to it), build memories, which can be called on in the future to help establish an empathetic understanding of and connection with the patient.

A final narrative example of a physician showing remarkable empathy and courage in face of overwhelming crisis—presented at the conclusion of this chapter that has attempted to build various narrative "cases" into a sense of the scene of narrative altogether—is that of Dr. Rieux in Camus's *The Plague*. This novel *universalizes* the condition of illness and makes medical responses to widespread illness—including empathy, rapport, and even identification—its explicit narrative action. Moreover, it also makes the representation of illness—the language by which it is presented—work to provoke empathetic responses in readers. Dr. Rieux, the narrator, usually communicates his observations in the objective language of the logico-scientific domain (he even represses his own first-person relation to the story he tells), but occasionally his observations are in the emotive-cognitive language of narrative knowledge, which reflects his empathy even as it provokes it in his reader/listeners.

And just then the boy had a sudden spasm, as if something had bitten him in the stomach, and uttered a long, shrill wail. For moments that seemed endless he stayed in a queer, contorted position, his body racked by convulsive

tremors; it was as if his frail frame were bending before the fierce breath of the plague, breaking under the reiterated gusts of fever. Then the storm-wind passed, there came a lull, and he relaxed a little; the fever seemed to recede, leaving him gasping for breath on a dank, pestilential shore, lost in a languor that already looked like death. When for the third time the fiery wave broke on him, lifting him a little, the child curled himself up and shrank away to the edge of the bed, as if in terror of the flames advancing on him, licking his limbs. A moment later, after tossing his head wildly to and fro, he flung off the blanket. From between the inflamed eyelids big tears welled up and trickled down the sunken, leaden-hued cheeks. When the spasm had passed, utterly exhausted, tensing his thin legs and arms, on which, within forty-eight hours, the flesh had wasted to the bone, the child lay flat, racked on the tumbled bed, in a grotesque parody of crucifixion. (Camus 1975: 214–15)

In this passage, Camus—and, we learn, his narrator Rieux himself—*narrate* the seeming immediate sensations of pain in a way that allows them to be cognitively and affectively apprehended. Metaphors of breath and wind, shipwreck, and fire build up to the use of the figure of Jesus—called to mind by the reference to a "grotesque parody of crucifixion"—to describe the suffering child. The young boy's suffering is turned into a narrative of shipwrecked burning, so that his condition—fever, convulsions, pain—becomes a story in which the narrator, Dr. Rieux, and the reader can imagine themselves in the same position of the child. The final image of parodic crucifixion calls up the narrative of a life of unprovoked and undeserved suffering. The religious imagery here—like that of Dr. Stone and Flannery O'Connor—provokes feelings of empathetic understanding.