

Medicine and literature: writing and reading

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Abstract

The humanities and arts are appropriate areas of study within interdisciplinary medicine. Medicine has long been considered to be both a science and an art. Within each patient, the psychological, emotional, spiritual, and the physical are all inextricably linked. The values, ideas and images of individuals and culture, as well as the way the human body and mind physically function and dysfunction, impinge in an equally inextricable way upon all these elements. The humanities and arts, included within medical study, enable people, the subject of medicine, to be usefully considered in their entirety. Literature has a particularly vital role to play in medicine and health care. It opens up a wealth of experience and knowledge, as well as offering vital understandings of the narrative nature of human lives. A knowledge of the nature of narrative, and the way we understand our lives narratively can be vital for effective communication and understanding of patients' situations. Literature also offers dynamic ethical issues with which to grapple. Expressive and explorative writing is used in professional development, and undergraduate courses. Medical humanities, literature and medicine and narrative medicine are established in the USA and developing fast in Britain.

Medical humanities is about challenging the current model of medicine to become broader, to include scientific understandings alongside the aesthetic and the humanities. Medical and health care practice, education and research is primarily the study and care of the person as an individual. The psychological, emotional, spiritual, and the physical are all inextricably linked in each individual person. The values, ideas and images of individuals and culture, as well as the way the human body and mind physically function and dysfunction, impinge in an equally inextricable way upon all these elements.

'Medicine and health... are human concerns in the widest sense' (Pattison 2003). In order to foster a full understanding therefore medicine needs to draw upon disciplines from the sciences through the humanities to the arts. The humanities study and make sense of the human condition. So the medical humanities are concerned with the human experience

of sickness, health, disease, medicine and health care (Arnott *et al.* 2001). Study of the humanities may not be able to make clinicians more humane (Downie 2003), but it can foster a depth of human and humane understanding, knowledge, and experience.

The humanities are reflective and disciplined enquiries that involve the recording and interpretation of the range of human experience (Evans 2000). The medical humanities encompass history, literature, philosophy ethics, theology, sociology, anthropology, and possibly law. These disciplines offer a multifaceted view; they value the aesthetic as well as reason, focus on meaning as well as emotion, explore ambiguity, uncertainty and complexity as well as theoretical lucidity, offer understanding through synthesis as well as analysis – all integral elements of medicine. Educationally, the medical humanities can enable and develop critical conceptualization and analysis, personal and professional values, reflexivity

and reflective capacities, empathy, collegiality, and teamwork. All these approaches can foster critical evaluation and effective understanding of patients' unique narratives and needs (Charon 2001; Charon & Montello 2002).

It is impossible to understand the nature of knowledge that science gives you without understanding a little philosophy. It is impossible to do science in medicine without knowing the basics of ethics. The practice of medicine within a social context is impossible without knowledge of the culture. History helps you know why you do something the way you do (Bill Noble, personal communication).

Medical humanities education: reflective practice and literature

My students (medical undergraduates) and continuing professional development (CPD) course members (practising experienced medical, health care, clinical psychology and therapist clinicians) learn to reflect deeply upon their practice. They do not answer specific analytic questions about what they did and thought. They use humanities based methods to allow them contact with those areas of practice, thought and feeling to which they need to pay close attention.

Reading literature

My undergraduates study medicine and literature. They read: they learn about sickness, death, dying, bereavement from those great observers of humanity – novelists and poets. and they excitedly discuss what they learn: discussions ranging over ethics and values, practices and philosophies, lay understandings and clinical blunders. They also learn to observe medical practice as writers rather than student doctors: honing wide skills of observation and reflection.

Our great writers present pictures and reflections upon life, human dilemmas, philosophy, deep thinking and insight in story form: accessibly and memorably. Many writers are also medical practitioners (Hudson Jones 1997; Abse 1998; Helman 2003). The fictionality of literature does not devalue depicted issues, as it is created from deep experience.

Poetry offers concise and precise insight, using tropes such as metaphor in a way which no other

written form can: 'Poems profoundly alter the man or woman who wrote them' (Abse 1998). Fiction creates satisfying plot structure, rounded characters, effective description; it can leap over boring bits, tackle issues head on, convey multiple viewpoints, sidestep confidentiality problems, and offer readers the complexity of ambiguity. Clear-cut or final conclusions and summaries are not offered. The reader has to form their own opinions about actions and events, thus developing their own values and ethics.

The students present a literature text of their own choosing to the group. We, the tutors, help them if they are stuck, although this is rare. They each introduce their book and lead the discussion. This makes them the authorities on their chosen text. One commented in evaluation: 'I even felt that we taught you (our tutors) some things, and we were going through something together, and that's precious'.

These students have said: 'this is the first time I have been asked what I THINK'.

Reading literature can widen experience and knowledge about the human condition, help develop individual values, and improve communication and understanding (Evans 2003a). It has transformative power: the understandings and insight engendered can alter perceptions permanently. Through literature we can experience and reflect upon things that are totally different from anything we'll ever experience in our own lives: situations, incidents, and issues; cultural and social norms and expectations; different or alien ways of thinking and being; emotions and their effects upon people.

Life-as-it is-lived is a jumble: causes and effects are inconclusive, or difficult to disentangle, and our knowledge and perceptions are inevitably partial or even fragmentary [Sartre 1938 (1963)]. Literature can offer digestible slices of life's ambiguities with satisfying plot structures to enable us to make some sort of sense of them, and form judgements. Literature:

- sets up meaningful ethical quandaries, and offers direction towards resolution;
- provides plotted clues, links, and progressions in a comprehensible structure;
- often offers no solutions to ethical dilemmas – this is up to the reader;
- is a process of *as if*. *If I were this character or that, what would I feel think, and ethically do?*

- gives readers authority to make judgements and conclusions.

Reading sharpens ethical wits: weighing, judging, developing and refining personal values, what is the *right* decision according to readers' own principles and values. Although literature concerns unknown characters in a fictional situation, the events and people are related to *as if* they were real. There is human continuity between me and these characters, however, bizarre or different. There is a little Dracula in me, respectable wife and mother of two that I am. As I read about the goings on *there* – in the fiction – I am empowered to think afresh about issues *here* in my everyday life.

Literature offers aesthetic distance, allowing readers to suspend immediate habitual value judgements while reading. Readers do and think, go places with characters they never go outside the book (and possibly would not want to). Readers are enabled to experiment with very different values; having become involved in this way, they ponder afterwards according to their own principles. Literature often offers few answers or judgements, but presents situations which inevitably pose questions. Readers develop possible answers, and even more questions: a dynamic process.

Fiction readers are invited into other's way of understanding and perceiving the world, and their relationship to it. They have to be critical of the point of view offered by the text's narrator, and imagine how the situation appears from other characters' perspective. Writers like Virginia Woolf, who use shifting points of view, get into the deep thoughts of a range of characters, and offer valuable insight into how a situation is viewed very differently by each. This is a privilege not encountered outside literature: fictional characters' minds, bodies, and souls are open to scrutiny, with even less privacy than patients.

Literature can enable clinicians to relate closely to characters' pain and their emotional and social response to it 'at the remove of the imagination' (Charon & Montello 2002), in a way they could not possibly afford to with their patients. This can develop understanding of the impact on patients of, for example, illness, disease, diagnosis, treatment, pain, disfigurement, hospitalization, terminal diagnosis, or suffering.

An intelligent contact with stories, whether in fic-

tion, drama or poetry, can develop interpretative and narrative abilities, perspectival vision (Charon & Montello 2002), and communicative powers (Brody 1994, 2003; Frank 1995). These skills are essential for obtaining a picture of, for example, patients' view of their condition and its role in their life, the response of relatives, and others in their social situation, or their reaction to a diagnosis. Clinician and practitioners will thus be more able to support patients in understanding and being positively involved in their condition and treatment.

All this is with the help and guidance of our best thinkers, because they are the writers of our best literature – Sartre, Woolf, Dostoyevsky, Sophocles, Kafka for example. Plot, characterization, and scenes are based on deep understanding and direct experience of the human condition, and place. Literature's fictionality does not make it any less valid; in fact more valid because only interesting and thought-provoking issues are presented. Readers connive in literature's fictional realities and appreciate how it can miss out the boring bits, and go straight for the heart of the matter.

But this kind of reading takes commitment and critically reflective energy; habitually held views need to be questioned and perspectives broadened.

Literature cannot alone create more ethical and sensitive clinicians. Literature's issues and situations, if actively considered and discussed, can develop understandings of narrative causes and effects, characters' actions, and the way these interact, widen perception, and provide experience of vital ethical tussles. Readers engage critically to increase empathy and understanding of, and competence (Charon & Montello 2002) with, the infinitely complex human condition.

Reflective writing for professional development

My medical CPD course members write; in a very simple writing process borrowed from novelists and poets (Bolton 1999, 2001a,b). This makes them cry, laugh, become very angry or rather embarrassed. They are enabled to tackle issues they had hitherto ignored, or suffered from in private. They begin to perceive events fruitfully from other's points of view (by writing in the voice of the patient for example). This can lead to vital and fundamental evaluation,

and development of their practice. They can become more thoughtful, observant and reflexive practitioners. They can begin effectively to learn not only from their own and others mistakes, but also successes. They can begin to accept and work with the essential uncertainty and ambiguity at the heart of medical practice.

These practitioners have often said: 'this is the first time I have been asked what I FEEL'.

Writing and critical evaluation of professional stories in a carefully facilitated confidential forum with trusted colleagues can draw out professional issues and ethical values, and enable the development of reflective understanding. Such stories 'oblige us to think concretely about questions that cannot be approached adequately by discursive reason alone (Shattuck 2001). Issues of concern to the profession broadly can be referred further, to effect higher level change.

'By talking and writing honestly about errors and, most importantly, discussing the lessons that might be drawn from them' Horton (1999); doctors can examine and develop their own practice effectively and do something to reverse the growing sense that medicine needs to, and can be, faultless (Horton 2001).

As educators we can help clinicians use literature and the literary arts of critical appreciation, and creative writing to 'educate their imaginations, their sensibilities as well as their intellects, with the powerful means at our disposal' (Carson 2003). I have run professional development courses, focused around the writing of vital stories of experience (clinical and management), for many years (Bolton 1999, 2001a,b). The processes of writing can enable deep, close and direct connection with issues which most need exploring and expressing (Anderson 2000). The accounts often take only 20 minutes to write. The writers then read them to each other, and are facilitated in confidential in-depth discussions about issues raised. Because these experiences are rendered as stories (sometimes poems), they succinctly communicate intensity and reflection.

Stories have communicating power because they offer selected slices of experience in a comprehensible form. The incident, its purport both to the individual clinician and to medicine in general, and its

dynamic connection to other areas of experience, can be grasped coherently and developmentally.

The very process of storying experiences in writing can engender insight and greater understanding. The reading of these stories can be cathartic if the incident has not been previously discussed. Keeping such a memory unreflected upon can be harmful, as it may inhibit effective practice in the broad area of the original incident.

The writing acts as an acute focus to the ensuing confidential discussion with colleagues which is usually deep, intense and to the point, enabling a tackling of some of the ambiguities and muddles inherent in medical situations. The careful facilitation of writing, reading and discussion enables trust, confidence, confidentiality, and an ability to deal with uncertainties which arise from viewing the events from different perspectives or points of view (such as that of patient, relative, nurse).

Sessions are conducted in camera; consent is not required from individuals described. Patients and colleagues are never named, and unnecessary identifying details avoided. Publication for wider discussion is accompanied either by patient permission, or careful fictionalization.

An example: *Hats*

Why should doctors write about their experiences? Why think about them at all, and why write rather than talk or just think about them?

Medicine is a profession under pressure. Not only are doctors and health care staff working with people at their personal margins: beginning and end of life, trauma, anguish, agony, but they need to get things right, usually in a short amount of time. They also metaphorically wear many different *hats* – bringer of wonderful or terrible news, comforter, healer, curer, fount of wisdom, holder of secrets, teacher. A doctor juggles a myriad of such *hats* every day (including of course: daughter, spouse, parent).

Awareness of these different roles, and examination of their impact, alongside all the issues related to vital decision-making with people at their most vulnerable, can enable greater clarity of function and purpose, and development of skill. Talking about them is time consuming and can fail to reach the

point; thinking privately is developmentally ineffective.

Writing is a speedy and deeply effective way of realizing which issues need further thought, and gaining contact with strategies for learning and understanding from that particular situation. Areas focused upon might not just be errors of judgement or action, but perhaps relationships with colleagues, the tricky interface between home and work, political and social issues.

The type of writing used makes direct contact with experience, knowledge, skills. In a process borrowed from novel or poetry writing, the practitioner writes stories or impressions of experience, rather than reasoned accounts. The incident, its purport both to the individual clinician and to medicine in general, and its dynamic connection to other areas of experience, can be grasped coherently and developmentally.

Certainty of privacy is central to the process: the writer needs to feel as little exposed as possible. Reading and discussing accounts with peers within a carefully facilitated confidential small forum is a vital element. Colleagues who struggle similarly bring sympathetic experienced critical faculties to bear upon the issues within each account. Exposing issues of concern, in such an equal way, is not only a relief, but can also be dramatically eye-opening.

Hats – real and metaphorical – were the starting point at a recent weekend for 24 family practitioners, working throughout in small groups of six, developing trust and confidentiality. Each doctor selected from a pile of headwear – policeman's helmet, school beret, hangman's mask. As in the Venetian *Commedia del Arte*, donning a non-habitual hat can open thinking to the different roles we inhabit. They wrote tellingly of attitudes and understandings.

We then moved on to writing accounts of experience. I asked them to write about an occasion which surprised them, which did not go as anticipated, in which they were wearing a different metaphorical hat from the one they expected. They had only 20 minutes: no time to sit and think, to create reasoned statement. The only sound in the large light room for those 20 minutes was of pens, papers rustling, the occasional in-drawn breath.

Writing about childhood experiences of illness was the project for Sunday – wearing a childhood hat.

This opened up diverse areas of understandings of medicine, and the kinds of reasons these clinicians chose medicine for their careers. It also facilitated a remarkable quality of writing. Somehow going back to listen the voice of themselves as children, opened a door to lucid, heartfelt and straightforward deeply communicative writing styles.

In a different writing group, one doctor wrote about missing the diagnosis of subdural empyema. His account was long, impassioned, full of expletives, and strong expression of guilt, anger, fear, horror. He expressed his immense relief and gratefulness that the patient's parents offered absolution and consolation when he was brave enough to speak to them. Eventually, humbly and reluctantly, he accepted that it was not his fault: that most doctors would have failed to diagnose, given the symptoms. The group's range of supportive enquiry was deep, wide and very fruitful.

Clinical error and managerial misjudgement are only some of the areas opened out by the reflective writing process. The careful handling of a lad from a fundamentalist Christian family, veering towards mental instability because of exploration of potential homosexuality, is an example. Another understood her ageing widower patient wanted no treatment for his cancer, and persuaded the oncologist not to pursue treatment, but allow him to die in peace (Bolton 2001b).

A thoughtful, constructive, developmental, and above all open and honest approach to muddles and mistakes, as well as successes and joys, can strengthen the profession. Medicine rests on story and narrative, poetry and metaphor, as well as science. Writing such stories, and reflecting critically and constructively upon them, has unique power.

One of the foci of medical humanities is to reintegrate thought and feeling, called the 'dissociation of sensibility' by Eliot 1953. This is a healing of the Cartesian divide.

Medical humanities: a general background

Medical humanities is concerned with the fostering and development of essential human principles and values such as understanding, trust, respect, collegiality, and teamwork. Ethics is a complex area needing intellectual and moral application in order to develop

principles and practices which will protect individual patients and clinicians, and avoid litigation.

Medical disasters have recently been prominent in the media. These have taken place within a context of increased political, social and economic pressure. Most of these disasters involved a lack of effective communication and mutual understanding between colleagues, clinicians and patients, regulating authorities and individual clinicians, and between employers and employed. They have also been partly caused by a lack of a solid base of personal and interpersonal values and ethical principles.

There is a wide range of courses on offer in medical humanities, from the MA at Swansea, and MPhil/PhD supervision at Durham, to the short courses at University College London. The Association of Medical Humanities holds conferences (Evans 2003b; Gelipter 2003), and the database held at University College London includes details of many undergraduate courses (<http://www.mhrd.ucl.ac.uk/> and <http://www.pcps.ucl.ac.uk/cmh/>). There are useful publications (Greenhalgh & Hurwitz 1998; Evans & Finlay 2001; Kirklin & Richardson 2001; Hurwitz, *et al.* 2004) as well as the *Journal of Medical Humanities* (BMJ Publishers). The extent to which patients benefit is still being researched (Meakin 2002; Lewis 2003).

The interdisciplinary nature of medical humanities

Medical humanities is interdisciplinary. Its role is to develop and support medicine in a reconfiguring process, in order not only to meet the demands of third millennium culture, but be ahead and shape issues (Greaves 2002, 2004). Literature, philosophy, history and so on are used to enable a rethinking of the aims and functions of medicine and health care. This is far more than multidisciplinary, which is when a range of disciplines are brought in to support the main one, such as a literature course only to give doctors insights into a range of human experiences. So medical humanities is not an add-on, a multidisciplinary bit extra to make better doctors (Greaves 2002). The perspectives and tropes of the arts and humanities are to be central to medicine alongside the scientific.

'Interdisciplinarity' or 'critical interdisciplinarity'

(Barnet 1997) places the emphasis upon the ways in which insights from one discipline may challenge the assumptions and practices of another.

A recent UK government directive 2002 states that: 'The greatest challenges for society... are all ones in which the arts and humanities, and science and technology need each other... [Medical] education is about understanding and imagination, as well as training and skills'.

There might be a future *transdisciplinary* stage when the focus is upon problem solving (Gibbons *et al.* 1994). This is a dynamic situation in which health questions, for example, would be tackled with no reference to disciplinary boundaries, but in a pragmatic reflexive process with a practical focus.

What medical humanities are NOT

There are several things the medical humanities are not. First: they need to retain an intrinsic value and not become merely 'instrumental' (Pattison 2003). Doctors read *Middlemarch* for the value of reading one of the most powerful texts we have in English literature, not just to find out about Victorian medicine, or what Lydgate might have done better, or to help them empathize better with the complexity of human nature, as I have discussed above.

Secondly: they are far more than enjoyable Wednesday afternoon diversions to make clinicians or students feel better, happier, more relaxed, more culturally developed, better at communicating, or understand themselves and their motives better.

Thirdly: there is no aim to turn clinicians or medical students into philosophers, historians or artists. Doctors do not need to learn how to discourse learnedly using the intricacies of literary theory, for example; but enough of a grasp will enable them to relate to literature with depth and insight.

Fourthly: the medical humanities cannot make doctors more humane (Downie 2003). If this were possible, English and philosophy departments would be full of saints.

Evidence required by medicine

The potential evidence base for medicine is broad and eclectic. I recently heard the editor of a Royal College Journal say that he wished he could only

accept papers which were reports of randomised control trials (RCTs). His opinion is that these are all his readership need to read and learn about. A wider and deeper range of evidence is required than this.

A palliative care consultant colleague told me about his research into the *art of dying*. His work draws insight from historical sources and currently written pathographies into how to support people in the dying process. The editor of the journal in which the research was published referred to the work as *tabloid*; the doctor took this to heart and described it himself as *anorak* (likening it to train spotting). I think the editor was threatened by the possibility of medicine breaking bounds from the safe environs of technology, and like any playground bully when threatened, belittled the author, and his humanities based approach. I am mindful here of this psychological philosophy:

‘Rabbit’s clever’ said Pooh thoughtfully.

‘Yes’, said Piglet, ‘Rabbit’s clever’.

‘And he has brain’.

‘Yes’, said Piglet, ‘Rabbit has brain’.

There was a long silence.

‘I suppose’, said Pooh, ‘that’s why he never understands anything’ [Milne 1958 (1928)].

A spirit of intellectual enquiry and wonder is the basis of science, and is essential to avoid unscientifically narrow perspectives and purely technological understandings of the human being, and its care. As (Banville 2003) pointed out: ‘what we today think of as science is for the most part not science at all, but *applied* science, that is, technology’. Technology is, of course, essential. But a confusion as to what is science and what is technology is not useful. Science makes leaps of understanding using metaphor and insight from dreams (such as Loewi’s Nobel prize winning discoveries about the function of acetylcholine in the central nervous system). There is a call coming now (Greenhalgh 2002) for a sensible balance between a mature view of the evidence-based *science* (Sackett *et al.* 2000), and the *art* of medicine (Evans & Sweeney 1998).

Conclusions

Medical humanities fosters a sustained reflective and reflexive exploration, examination of practice theory, and the foundations of medicine and health care,

both personal and general; it can enable practitioners to express their experience and perceptions more clearly, concisely and critically. They communicate in this way to other people – peers for example; they also use it to communicate reflexively with themselves in order to understand their practice better, and therefore improve it. At the same time practitioners or students are encouraged, and enabled, to take a positive and constructive attitude to the inherent uncertainty in medicine and health care, rather than attempt to deny this inevitable lack of certainty and control, or do away with it. Abilities in interpreting, understanding, and communicating the human experience of illness, disability and suffering, and the connections between areas of experience or knowledge are thus developed.

Reflexivity is essentially synthetic as well as analytic, encouraging the development of abilities in linking and making connections, as well as interpreting, understanding, and communicating the human experience of illness, disability and suffering. This approach complements the analytic.

This paper focuses particularly upon literature and medicine – both reading and writing. Practitioners and students can be encouraged to explore and express their experience and perceptions clearly, concisely and critically. This can be a process of attempting to understand what health, disease, sickness, sanity, caring, curing, peace of mind, quality of life, medicine, health care – means to them. They ask themselves in depth: ‘what is medicine?’, ‘what is it for?’, ‘why do I do it (or want to do it?)’, ‘how is it best practised?’ ‘for whom?’, ‘who are my patients (who are they as individuals?)’, ‘what is this patient saying to me and why?’, ‘when am I really helping (and not just being a doctor/nurse)?’, ‘where is an appropriate/effective locus of healing?’. They can reflect upon their relationship with themselves, their own feelings, thoughts, ideas, and spirituality, as well as those of the patient. This dynamic attitude of educational enquiry is vital to a doctor or nurse.

Medical humanities is about charging medicine with the power to see the human body, mind and spirit as ‘a many splendoured thing’ rather than a complex to be tackled with spanner and oil can. It is about developing the model of what medicine is: to include understandings only to be gained from the

arts and humanities; to include the aesthetic; and to include the whole person of the patient, and the whole person of the doctor.

In medicine and health care there is an increasing gulf between what gets measured and what matters. Medical humanities is concerned with what matters, measured or not. The evidence base for medicine must include that offered by the eyes, ears, noses, feelings, experienced intuition, and deep human and cultural knowledge enhanced by the arts and humanities. This way medicine can avoid hearing the story but missing the plot.

Medicine and health care need to harness the arts and humanities in tackling the joyous but utterly messy and uncertain complexity of their discipline. There is the distinct possibility this will verge on areas which could be considered to be dangerously *tabloid*, but certainly never *anorak*.

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