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Literature and Medicine: Origins and Destinies

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ABSTRACT

Literature and medicine is a flourishing subdiscipline of literary studies that examines the many relations between literary acts and texts and medical acts and texts. The author examines the historical connections between these two fields and suggests that the growth and decline in medicine's attentiveness to the power of words can be used as a marker for medicine's degree of attentiveness to the individual patient's predicament. The recent explosive growth in medicine's interest in literature and narrative is taken as evidence that medicine's swing toward the reductionist and away from the narrative has ended. Patients and doctors have reason to await the return swing of the pendulum—if not the turn of the spiral—toward a medicine that is both technologically and narratively competent.

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"The future of poetry is immense," wrote poet and literary critic Matthew Arnold in 1889, "because in poetry, where it is worthy of its high destinies, our race, as time goes on, will find an ever surer and surer stay."[1] Poetry—and in that term, Arnold included fiction, drama, and poetry—has offered a surer and surer stay to medicine. Tonically over the centuries and lately with accelerating force, literary texts and literary acts have found their way into medical schools, hospitals, doctors' practices, and patients' lives.

Most medical educators today are aware of the flourishing contemporary intellectual subdiscipline of literary studies called "literature and medicine."[2,3] Since the early 1970s, North American medical schools have appointed literary scholars to their faculties and have included the study of literary texts and methods in their curricula. Literary texts have been found to be rich resources in helping medical students and doctors understand pain and suffering; literary methods of close reading have been helpful in training doctors and doctors-to-be in the fundamental skills of interpreting clinical stories; and close literary scrutiny of medical uses of language (for example, in the hospital chart or the medical interview) have been found to help physicians understand their work.[4,5]

The field's impressive growth in the past 25 years attests to the urgency and timeliness of literature's contributions to medicine, a contribution that can provide medical students and doctors with the narrative skills necessary for effective medicine and with stories resonant with the human meanings of illness.[6,7] An informal survey performed by members of the Society for Health and Human Values in 1994 revealed that literature was taught in approximately 30% of U.S. medical schools.[4] By 1998, according to the *Association of American Medical College's Curriculum Directory 1998–1999*, 74% (93/125) of U.S. medical schools taught literature and medicine, and in 39% of U.S. schools, such study was part of a required course.[8]

But this nourishing relationship between literature and medicine was not invented in 1972. Examining the deep sources of the companionship and resonance between these two rather quite dissimilar fields and searching for their relationship's historical antecedents demonstrate that the connection between literature and medicine is enduring because it is inherent. Literature is not merely a civilizing veneer for the cultured physician, and medicine is not merely the source of convenient plot twists for the novelist. Instead, the beliefs, methods, and goals of these two disciplines, when looked at in a particular light, are strikingly and generatively similar.

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SIMILARITIES BETWEEN LITERATURE AND MEDICINE

More Than the Sum of the Words

Literary studies arise from a fundamental belief that a literary text and literary language, written or oral, mean *more* than the sum of the meanings of the individual words. Through their structures, diction, imagery, and plots, literary texts and language bring both writer and reader to understand that which they can indicate as known but that which, though "known," cannot easily be articulated. Literary studies attempt to answer, in one way or another, such fundamental questions as "Why do we read?" and "Why do we write?" by suggesting that we are drawn, as humans, to that particular use of language that reveals something beyond what the words themselves say.[9–11] The serious reader of a literary work becomes a diagnostic instrument for the text, offering himself or herself as a medium for transforming the text into meaning.

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Although it is not a literary enterprise, the practice of medicine advances its work through textual, or language-based, means and therefore may, like literature, know more than it can tell. The texts of medicine—for example, the medical interview, the case presentation, the hospital chart, and the consultant's report—can also be found to reveal more than the sum of the meanings of the individual words.[12] Like literary texts, medicine's texts are instances of specialized language governed by convention and shadowed by but unbounded by intention. As such, they cannot be interpreted without considering the formal characteristics—their structure, diction, and plots—that amplify the meanings of their content. "To 'put' things," as Henry James suggests in his preface to *The Golden Bowl*, "is very exactly and responsibly and interminably to do them."[13] The writers and readers of medical texts accomplish a number of implicit *actions*, so to speak, by using the forms of medical texts. For example, doctors who write in the hospital chart imply, by the very act of writing the way a chart demands, a loyalty to medical traditions that have persisted for centuries, while enacting a positivist belief that progress continues into the present moment.[14,15] Disciplined attention to texts of medicine has the power to unearth complex understandings about medicine unavailable through other means.

Similar Goals

Beyond the structural fact that medicine and literature are human activities that encode their intelligence and meaning in textual representations of particular sorts that mean more than the sum of their words, these two enterprises have similar goals. Both literature and medicine, at their most fundamental levels, are concerned with individual persons' origins and destinies. Much of literature provides tentative answers to the reader's and writer's often unspoken questions about their own sources. Creation myths, Scripture, fairy tales, family tales, national epics, generational novels, and autobiographies are especially explicit examples of answers to the question, "Where did we come from?" Simultaneously, literature can provide tentative answers to a reader's and a writer's questions about their own destinations by trying to answer, in one way or another, the implied "Where are we all heading?" or, more simply and savagely, "What is it all *for*?"

In a parallel fashion, medicine searches for answers to the patient's two questions: the demand to know about the genetic fount—"Where am I from?"—and the equally dark and uncertain brooding about the prognostic future—"Where am I going?" Not only the patient raises questions about origins and destinies; all who witness patients' suffering and dying cannot help but pose—and must find tentative answers to—profound questions about life and death and the source of human meaning.

Similar Methods

If some of the fundamental beliefs and goals of literature and medicine can be seen to coincide, so can their methods. When a doctor and a patient meet to face a clinical problem, they are engaged in the process of reading and writing the life of the patient. The enterprise of attending to the health concerns of the patient brings doctor and patient together for the mutual task of articulating, in some language or another, the events of the patient's life—bodily and otherwise—that form the context of a medical problem. Obtaining the medical history from the patient is an activity based in language.[16,17] The means the doctor uses to interpret accurately what the patient tells are not unlike the means the reader uses to understand the words of the writer.[18] To be clinically effective, the doctor has to grasp the multiple contradictory meanings of the many texts—the patient's account of symptoms, the course of the illness, the opinions of other professionals, images and tracings of the body, inspections of the patient's blood and tissue, and the contours of the body itself—that a patient offers up for interpretation. He or she also must tolerate the ambiguity and uncertainty of what is told, understand one narrative in the light of others told by the same teller, and be moved by what he or she reads and hears. Not from science but from literature might a physician learn how better to perform these actions.

Reciprocity and Confluence

Both literary traditions and medical traditions have acknowledged their reciprocity and confluence. Literature lives in the shadow of the themes and concerns of medicine, and medicine respects the diagnostic and therapeutic power of words. When such writers as Sophocles, Shakespeare, Dante, Jane Austen, Leo Tolstoy, Henry James, George Eliot, Thomas Mann, Toni Morrison, or Michael Ondaatje reach for plots and metaphors rich and complex enough to capture fundamental human predicaments, they reach not infrequently toward birth (and all that is required for it), reproductive choices (that is to say, marriages), suffering (both physical and spiritual), and death (and all that leads up to and from it). That which occurs within the gaze of every doctor, every day, is that which allows artists to articulate and to illuminate the most profound and universal truths about human life.

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If literature borrows medicine's plots, then medicine borrows literature's forms. Hippocrates understood his medical effectiveness to rest on his ability to describe, in words, what his patients seemed to have been going through.[19] The indelible contributions to medicine of such physicians as Thomas Sydenham and Hermann Boerhaave, two towering figures in the 17th-century and 18th-century history of medicine, respectively, redound, in large part, to their gifts for describing diseases and the patients who suffered from them.[20,21] Eighteenth-century clinical notions of sympathy and literary notions of sentiment converged in the belief that the patient's suffering mobilized in the physician an energizing sympathy that compelled or inspired the physician to do something about the patient's suffering, much as the purpose of a literary work was to arouse sympathy in the reader or spectator.[22,23]

Case histories written in the 19th and early 20th centuries by physicians reflect exquisite and clinically significant attention to detail and implicitly acknowledge the importance of the narrating of the events of illness. The medical case histories of Thomas Addison, Abraham Jacobi, and Richard Cabot demonstrate how early pathophysiologic thinking was inseparable from the stories of the individual patients stricken with disease.[24–26] The neurologic and proto-psychiatric case histories of Josef Breuer, Sigmund Freud, and, later, W. R. H. Rivers reveal all the more powerfully the innate relation between telling and healing.[27,28] Freud recognized that his case histories "read like short stories," and that his clinical reports revealed "an intimate connection between the story of the patient's sufferings and the symptoms of his illness."[29] If Freud's cases of the Wolf Man and Dora are the most spectacular examples of the sort of epiphanic knowledge that visits the doctor while he writes about the patient *and is found to be clinically useful*, others less well known are as salient to the care of patients.[30,31] That is to say, illness has never been unrelated to the language used to describe, understand, or banish it.

Move toward Specialization and Reductionism

However, as a consequence, in part, of the 18th century's development of pathologic anatomy and the 19th century's discovery of the germ theory, disease began to be seen as separable from the patient's body. Instead of singular occurrences in individual human lives, diseases were understood to be repetitive phenomena no matter who was the host. Rather than the systemic humoral imbalances that affected the patient's entire body, diseases were conceptualized as localized in particular organs, or even in particular tissues within those organs, and treatment was hoped to arise from a more and more specialized and reductionistic view of the body of the patient.[32] The conversation with the patient was replaced by percussion and auscultation, and interpretation was replaced by inter-rater reliability.

Medical practice moved gradually from being a narrative and personal activity that took place at the bedside, where the doctor listened to and touched the patient, to a technical, impersonal activity that took place in laboratories and reading rooms remote from the patient. As doctors were freed—by their diagnostic equipment, x-ray machines, electrocardiograph machines, bacteriology cultures, and chemical laboratories—from the necessity to "attend" the patient, their medicine was transformed from a language-based intersubjective endeavor to a data-based instrumental activity.[33] Although this transformation need not spell the demise of humanism,[34] powerful economic and cultural forces could not help but push individual physicians and their profession toward valuing the latter activities over the former.

The culmination, of course, of these conceptual and practical trends began in the Gilded Age of Research in the United States in the 1950s and continues today. The enormous post-WWII research enterprise, fueled by new money available from the headily optimistic National Institutes of Health, propounded an organ-system–based reductionistic understanding of disease and encouraged such subspecialization within academic medicine. If research in the 1920s and 1930s produced insulin for diabetes, steroids for adrenal in-

sufficiency, and the first antibiotics, the 1950s effort ushered in the whole apparatus of clinical investigation, with its massive cadre of research scientists supported by an unheard-of level of financial resources from the federal government and private industry.[35] Soon, there was no disease—heart failure, arrhythmia, asthma, schizophrenia—whose cure was not at least promised. No one could argue with a frame of mind that cured horrible and previously fatal illnesses.

Perhaps success in visualizing actual organs and tissues, measuring aspects of physiologic functions, and quantitating chemical substances in the body decreased the explanatory power of words to describe human disease. With a PET scan of the brain in hand, who needs the history of aura and photophobia to diagnose migraine? The readerly skills that allow doctors to recognize that which patients tell them and the writerly skills that gain them access to that which, in the absence of writing, would remain unknown were increasingly overlooked by medicine in favor of the relentless biological positivism of the age of specialization and mechanization.

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Such movement came at a cost. For, despite the sustained technical progress made in diagnostics and therapeutics in the past half century, one set of concerns about medicine has been heard with increasing frequency and alarm: doctors do not listen to their patients; they seem unable to recognize the suffering that patients and families must endure; they fail to appreciate the meanings of that which occurs in their gaze; and they seem unmoved by what their patients experience, both in the grip of illness and at the hands of doctors. Such failings interfere with effective treatment, because medicine's disregard of the most basic human requirements for compassion and respect in the face of pain and fear can deter patients from accepting whatever scientific help for their disease is forthcoming.

TOWARD NARRATIVE COMPETENCE IN MEDICINE

The dividend of a long historical view is the ability to see patterns and trends invisible to the contemporary eye. In even so cursory a look backwards over the history of medicine's relation to language and narrative as this one, one sees the growth and the decline of medicine's realization that it is a language-using endeavor. What may be reflected in the rise, over the past two decades, of medicine's interest in literature and narrative may well be a periodic return to medicine's respect for the power of words. This phenomenon of medicine's turn toward literature and narrative might not merely reflect the work of a few zealots intent on inserting literary studies into medicine. Instead, the growth of the field of literature and medicine may well signify that medicine, now, has once again become fertile to, hungry for, and humble in the face of that which can be learned only through language.

The time has come to recuperate the practice of a narratively competent medicine, that is, a medical practice that acknowledges the textual and singular dimensions of illness by paying attention to patients' (and doctors') stories and their meanings.[36] Evidence supporting such a statement is available from the medical profession and the popular culture: it is now commonplace to hear about doctors' stories, patients' narratives, active listening, and reflection on the meaning of clinical events.[37,38] And today's narratively competent medicine is not the product of a falsely placed nostalgia for good old days that were not, in truth, so good. Rather, it relies on mastery of contemporary advances in literary studies, much as medicine's technologic competence relies on mastery of contemporary scientific studies. A medicine that is technologically competent and narratively competent is able to do for patients what was heretofore impossible to do. That is to say, to do the impossible requires *both* technologic competence and narrative competence. In view of all that has historically connected the technologic and the narrative, today's robust practice of literature and medicine can be recognized as one solution to medicine's lapses that divorce it from the individual patients that it serves. Together with medicine, literature looks forward to a future when illness calls forth, in witnesses and in helpers, recognition instead of anonymity, communion instead of isolation, and shared meanings instead of insignificance. This is indeed medicine's—and humans'—surer stay.

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