J Med Humanit (2013) 34:415–428
DOI 10.1007/s10912-013-9241-9

Why Teach Literature and Medicine? Answers from Three Decades

Anne Hudson Jones

Published online: 1 September 2013

Abstract In this essay, I look back at some of the earliest attempts by the first generation of literature-and-medicine scholars to answer the question: Why teach literature and medicine? Reviewing the development of the field in its early years, I examine statements by practitioners to see whether their answers have held up over time and to consider how the rationales they articulated have expanded or changed in the following years and why. Greater emphasis on literary criticism, narrative ethics, narrative theory, and reflective writing has influenced current work in the field in ways that could not have been foreseen in the 1970s. The extraordinary growth of interest and work in the field nationally and, especially since 1996, internationally has included practitioners in many additional areas such as disability studies, film studies, therapeutic writing, and trauma studies. Along with the emergence of narrative medicine, this diverse community of scholars and practitioners—affiliated more through their use of narrative methodologies than the teaching of literature—makes the perennial challenge of evaluation and assessment even more complicated.

Keywords Literature and medicine · Medical education · Medical ethics · Medical humanities · Moral inquiry · Narrative ethics · Narrative medicine

This *JMH* special issue on medical humanities pedagogy goes to press 40 years after Joanne Trautmann joined the Department of Humanities of the Pennsylvania State University College of Medicine at Hershey in 1972. Because she was the first professor of literature to hold a regular full-time faculty position in an American medical school, Trautmann's appointment at Hershey has often been regarded as the beginning of literature and medicine as a recognized subspecialty within medical humanities. Although the Department of Humanities was an integral part of the new Penn State College of Medicine when the doors

A. H. Jones (✉)
Institute for the Medical Humanities, The University of Texas Medical Branch, 301 University Boulevard, Galveston, TX 77555-1311, USA
e-mail: ahjones@utmb.edu

first opened in 1967, not until 5 years later was literature added to the program. This pattern of development has been repeated many times in the years since. Historically, if not still contemporaneously, the "practical immediacy" (Trautmann 1982, 7) of history of medicine, medical ethics, and medical jurisprudence has been more readily apparent than that of literature and medicine. Misperceptions that literature offers more by way of cultural refinement than practical skills for clinicians—the infamous "civilizing veneer" charge (Charon 2000; 2004; 2012)—has made literature seem to some a luxury rather than an essential component of medical education. Early practitioners of literature and medicine were often called upon to explain and justify their activities to skeptical colleagues in the humanities as well as in medicine. It is not surprising that, more often than not, their responses emphasized practical utility—what literature can do for medical education and practice. Nor is it surprising, decades later, that we are still asking questions about what we do when we teach literature in medical settings, why and how we do it, whether it matters in the lives of doctors and patients, and—if so—how we know and how we can prove it. What may be surprising in looking back is that the early practitioners got so much right.

Answers from the first decade (1972–1981)

Two foundational articles published near the end of the first decade offer distinctively different ideas about the use of literature in medical education. One comes from Trautmann (1978), the first literary scholar to teach in a medical school. The second comes from Robert Coles (1979), child psychiatrist and Pulitzer Prize-winning author, who was teaching medical students at Harvard. Trautmann focuses more on literature's instrumental and practical value for clinicians; Coles, on its essential ethical and existential value. Both are careful to disavow the idea of teaching literature to provide a "civilizing veneer" for medical students and physicians.

Reading in the fullest sense

By the time she wrote "The Wonders of Literature in Medical Education," Trautmann (1978) had been teaching literature to medical students at Hershey for 5 years and had already heard, probably many times, the most common reservations about the conjunction of two such different disciplines. She begins by tackling the objection that medicine and literature are fundamentally opposed in their methodologies, resources, and content—medicine dealing with the real world and literature dealing with fiction. She dismisses "the real versus the fictional" (32) opposition as an invalid distinction between medical and literary worlds, explores the concept of *fictionality,* and points out that "the great literature of the past and present is one of our best sources for illuminations [not just illustrations] of many medical subjects" (35). The most important part of Trautmann's essay, however, comes in response to the objection that medicine needs to be "decisive and to the point" (36), while literature is vague and indirect, filled with details, metaphors, symbols, and ambiguity. It is precisely these attributes, she claims, that make literature so valuable—so useful—in medical education:

> In short, to teach a student to read, in the fullest sense, is to help train him or her medically. To ask the medical student what is being said here—not at all an easy question when one must look at words in their personal and social contexts and when several things are being said at once—is to prepare him or her for the doctor-patient encounter. (1978, 36)

Teaching students "to read, in the fullest sense" sounds deceptively simple, but the kind of close reading Trautmann taught is a complex and demanding interpretive skill. Much

more difficult than reading for the straightforward transfer of basic information, it is reading closely and attentively enough to be able to interpret "what is being said" even when the meaning is not expressed directly. Meanings can be conveyed to astute readers through figurative language—irony, metaphor, symbol, paradox—or through patterns of juxtaposition, repetition, or even silence. Learning "to read, in the fullest sense" helps students develop "tolerance for ambiguity" (1978, 36); formulate "conclusions when the data are incomplete or capable of being interpreted variously" (36); "enlarge [their] capacity for compassion and empathy" (40); and sustain themselves through the difficult negative experiences of medical training with the "affirmation" (43) great literature offers.

Attaining these important cognitive skills and affective capacities depends, Trautmann believes, upon using "almost exclusively first-rate material…the best that has been thought and said" (43). To help others in medical education identify such material, Trautmann and Carol Pollard (1975) had already compiled an annotated bibliography of literature and medicine with 1,000 entries organized by century and listed under key terms—such as *abortion, aging,* and *death*—that made it easy to find a literary work topically suitable for a particular course. But teaching students to read and interpret rich and complex texts such as Joyce Carol Oates's novel *Wonderland*, the example Trautmann turns to most often in her argument, requires more than identifying an appropriate text: time, willing students, and a gifted teacher must all converge, as they did at Hershey.

Historically, two other points Trautmann (1978) makes are worth mentioning here. She acknowledges in passing that while she has "assumed that literature in a medical school's curriculum will normally mean the reading of literature, there is also the writing of it to consider," and she hopes "the same increased compassion…in readers of literature might also occur in writers…"(41). Finally, she makes very clear that her overall pedagogical goal is "better patient care" and that she is "convinced that literature can contribute quite directly to achieving this goal" (43).

Important as this historic essay is as a foundational statement of purpose and goals for teaching literature and medicine, it is not well known today because the slim volume in which it was published has long been out of print. Now a collector's item, the volume—proceedings of a conference titled *The Role of the Humanities in Medical Education*—also includes presentations by other well-known first-generation medical humanists: Edmund D. Pellegrino, Chester R. Burns, K. Danner Clouser, John Cody, and Ronald A. Carson. Donnie J. Self (1978) edited the volume, which was published by the Bio-Medical Ethics Program of Eastern Virginia Medical School in Norfolk. The audience for both the conference and the proceedings probably comprised a small group of like-minded colleagues already interested or engaged in medical humanities.

Moral inquiry of a wide-ranging kind

By contrast, Coles's essay, "Medical Ethics and Living a Life" (1979), was published in the *New England Journal of Medicine,* then as now the country's most prominent and prestigious medical journal. Aimed at a large audience of physicians, his initial questions are not about literature but about medical ethics: "How broad and deep ought such a subject cut—to the bone of the doctor's life?" and "How does one live a decent and honorable life, and is it right to separate, in that regard, a person's 'private life' from his or her working life?" (1979, 444). After acknowledging that "the traditions and resources of analytic philosophy have been extremely helpful" (444) in examining ethical questions in medicine, Coles writes of doctors' need to move from "large-scale theoretical formulations" and "well learned abstractions to the individual person at hand" (445). It is the existential philosophic

tradition that directs attention to the "particulars of everyday life" and leads to the kind of moral inquiry that focuses on "how we ought to live our lives" (445).

For Coles, literature is by far the best resource for helping medical students and doctors think about the moral values of their lives as physicians. He turns especially to novels—long and complex texts such as George Eliot's *Middlemarch,* F. Scott Fitzgerald's *Tender Is the Night,* Sinclair Lewis's *Arrowsmith,* and Walker Percy's *Love in the Ruins*—to explore "a kind of medical ethics that has to do with the quality of a lived life" (1979, 445).

Although Coles (1979) is not primarily concerned in this article with providing a rationale for using literature in medical education, he dismisses curtly those who might think of literature as a luxury rather than an essential: "The point of a medical humanities course devoted to literature is ethical reflection, not a bit of culture polish here, a touch of story enjoyment there" (445). He points to literature's value in teaching the kind of medical ethics and medical humanities that focuses on "moral inquiry of a wide-ranging kind"—the "intense scrutiny of one's assumptions, one's expectations, one's values, one's life as it is being lived or as one hopes to live it" (446). There is no better way, he concludes, to engage in such moral inquiry "than through the important stories and character portrayals of novelists who have moved close to the heart of the matter—the continuing tension between idealism and so-called 'practicality' in all our lives" (446).

Despite their different backgrounds, audiences, and approaches to using literature in medical education, Trautmann and Coles agree on the importance of teaching great works, the power of those works to evoke personal reflection about moral values, and the value of literature to sustain in readers an idealism and affirmation about life. Trautmann focuses more on the utility of literature in developing interpretive skills that have practical immediacy in clinical work; Coles, more on the essential value of literature in helping physicians live a good life both in and out of the clinic. In the second decade, discussions of literature and medicine circled back to their works, as shall I.

Reflections from the second decade (1982–1991)

Toward a new discipline

The first year of literature and medicine's second decade was marked by publication of the first issue (a hard-bound annual volume) of the new journal *Literature and Medicine* (1982). Subtitled *Toward a New Discipline,* the issue opens with an essay by Trautmann (1982) that offers a historical account of the first decade of the field. Although she does not name them, Trautmann (1982) reports that there are by this time three full-time professors of literature and medicine. Only three pages of her essay are devoted to teaching, but she confirms that "excellent conditions" continue at Hershey, which "allow one new literature course to be offered in each of three terms per year…on direct themes such as aging, handicaps and chronic illness, sexuality, and women as patients and professionals," and that she also teaches "creative writing courses" (10). Having her own separate courses allowed her to use longer literary works and to focus on creative, rather than strictly medical, writing. In other American medical schools of the time, literature and writing were introduced into the curriculum as adjunct material—illustrations or illuminations—in other courses, especially courses in medical ethics (Jones 1990). Teaching writing was clearly important to Trautmann (1978; 1982), but her time and attention were primarily devoted to teaching literature.

Also of interest here is Trautmann's report (1982) that "some students, notably those who majored in literature and the other humanities as undergraduates, claim they want more

'straight literature' courses, something on Shakespeare, perhaps, without regard to his immediately medical themes. But when such courses are suggested, no one signs up" (11). Although she does not elaborate, her observation brings up a question often discussed by practitioners in those days, and perhaps still. Is it necessary to teach literature that is topically about medical themes in order to accomplish the goals of using literature in medical education—whether the goals are teaching "to read, in the fullest sense" or encouraging "moral inquiry of a wide-ranging kind"? The answer was always no, but in practice the use of literature with medical themes has prevailed for the most part. A notable exception came a decade later, after Anne Hunsaker Hawkins replaced Trautmann at Hershey and began to teach works such as *The Aeneid* and *The Divine Comedy* (Hawkins 1992).

Coles (1982) has one of the short essays in this issue that responds specifically to the question: Why literature and medicine? He recounts the influence of William Carlos Williams on his decision to take premedical courses and apply for medical school, and he credits Williams with helping sustain him through the first 2 years of medical school by encouraging him to read the works of Chekhov, Camus, Kafka, Dostoevsky, Tolstoy, and Thomas Mann. In reading their works, Coles was led to the kind of ethical reflection about which he writes so movingly in his 1979 essay.

Other contributing editors to the new journal who sent short essays about "their thoughts on literature and medicine" in response to the editor's request (Rabuzzi 1982, ix) are physicians Robert W. Daly, Edmund D. Pellegrino, Lawrence J. Schneiderman, and Thomas Szasz; medical humanists Samuel A. Banks, Ronald A. Carson, Larry R. Churchill, and Ruel W. Tyson Jr; literary scholar Stanley Weintraub; and poet Elizabeth Sewell. Carson, Churchill, and Tyson were trained in theology or religious studies; Banks, in psychology.

Pellegrino's essay is of special interest here because it combines important aspects of Trautmann's and Coles's responses even as it anticipates future developments in the field. After quoting philosopher George Santayana and medical historian Owsei Temkin, Pellegrino declares that medicine and literature have a "natural affinity" because they are both "moral enterprises" (1982, 19). They are also linked because they fundamentally depend upon language: "Language is the instrument of diagnosis and therapy, the vehicle through which the patient's needs are expressed and the doctor's advice conveyed. Understanding the nuances of language, its cultural and ethnic variations and its symbolic content are as essential as any skills the clinician may possess" (22). In his emphasis here on the intrinsic importance of language to both literature and medicine, Pellegrino affirms Trautmann's stress on the importance of interpretive skills in clinical work and anticipates the work of Kathryn Montgomery Hunter (1991) a decade later.

From his vantage point as director of the Institute on Human Values in Medicine, established in 1971 by the Society for Health and Human Values and co-sponsored by the National Endowment for the Humanities, Pellegrino had a good overview of pedagogical efforts to include literature in medical education:

> In a dozen medical schools, courses in literature are serving several goals in unique ways: teaching empathy with the ill person, giving insight into the peculiarities of the medical life and the doctor's place in society and culture, underscoring the dilemmas of medical morals, and improving the use of narrative forms in history taking. These medical uses of literature offer some hope for buffering the encroachments of technology, to which today's scientifically trained clinician seems so especially vulnerable. (1982, 20–21)

He also speaks eloquently of the need not to let "these utilitarian ends … obscure the more subtle but really the most important service literature performs for all human beings—enhancement of the experience of life itself" (1982, 22). Trautmann makes that point as well (1978) but not so

forcefully as her physician colleagues do (Coles 1979; Pellegrino 1982). As a literary scholar, she may have felt more intensely than they did the need to emphasize the value of literature's "practical immediacy" in medical education (Trautmann 1982, 7).

The aesthetic and the ethical approaches

In 1989, toward the end of the second decade, I was asked to give a keynote presentation for an annual conference on comparative literature that had taken literature and medicine for its theme that year. My charge was to address both historical traditions and contemporary innovations in literature and medicine. Reflecting on the perennial question—Why and how teach literature to medical students?—I subsumed the practices and rationales that I saw throughout the field under two dominant approaches, which I called the aesthetic and the ethical (Jones 1990). Trautmann's and Coles's divergent ideas about their respective teaching practices were my exemplary models. My own statement of purpose and goal for teaching literature to medical students was unabashedly pragmatic: "to make them better doctors … who will take better care of their patients and better care of themselves" (1990, 18). Both the aesthetic and the ethical approaches lead, albeit from different starting points, to accomplishing that goal.

The aesthetic approach, exemplified by Trautmann's practice, requires teaching complex literary texts to teach reading in the fullest sense—that is, interpretation. The "excellent conditions" Trautmann (1982) enjoyed at Hershey allowed her to teach courses devoted specifically to literature rather than teach literature in the service of medical ethics. Although she used novels such as *Wonderland,* the aesthetic approach can also use shorter works, especially poetry (Terry and Gogel 1987). The primary goal is to develop and enhance skills that are transferable to the clinical work of medicine and that will improve patient care.

At that time, however, the ethical approach was in ascendancy at most medical schools because literature often entered the curriculum as a handmaiden of medical ethics. Literary works—usually short works because of the very limited time allocated even for the teaching of ethics—are useful as more fully developed cases for discussion than are the usual cases from ethics texts. Short works of physician-writers such as William Carlos Williams, Richard Selzer, and Perri Klass lend themselves wonderfully well to this pedagogical use. Although using short pieces of literature as ethics cases in the service of a more narrowly focused medical ethics does not fulfill Coles's call for "moral inquiry of a wide-ranging kind" (Coles 1979, 446), it does share with Coles's vision a focus "on a mimesis of moral dynamics, images of healers and their ethical dilemmas" (Jones 1990, 18). As it was Coles who compiled Williams's "doctor stories" (1984), thereby making them readily available for such use, presumably he would favor their being taught to medical students even if they do not have the scope of the larger moral reflection he encourages through the use of the longer and more complex novels that he favors. Lamentably, few can successfully eke out space and time in the medical curriculum for a course that requires the reading of such long works.

In 1989, it seemed to me that these two approaches shared more than their practitioners knew, and I predicted that they would come together in the future under a rubric such as narrative ethics. It is not possible to use literature for moral inquiry of the kind that Coles proposes without having mastered the skills of reading and interpretation that Trautmann urges. Nor is it possible to read closely and interpret a literary work in its fullest sense without recognizing and attending to the moral dimensions of the text. Thus, the aesthetic and ethical approaches are inevitably interdependent. Some might say, in 2012, that indeed these two approaches have come together under the rubric narrative medicine, but I am not persuaded that this is what has occurred.

The narrative structure of medical knowledge

In the last year of the second decade of literature and medicine, a pivotal and influential work appeared. Kathryn Montgomery Hunter's book, *Doctors' Stories: The Narrative Structure of Medical Knowledge* (1991), focuses not on the teaching of literature and medicine but on medical epistemology. Its overarching and highly persuasive theme is that the deep substrate and structure of medical knowledge and practice are narrative, not scientific. The case she makes simultaneously undermines and reinforces Trautmann's understanding of what she was doing. Hunter's argument, which has carried the day, aligns the epistemologies and methods of medicine and literature. No longer fundamentally opposed, as even Trautmann believed in 1978 when she wrote her landmark article, literature and medicine share a narrative epistemology, methodology, and practice. Pellegrino already understood that in 1982, and it seems obvious once it has been pointed out, well argued, and demonstrated. One of the results of Hunter's book (1991) has been a gradual shift in medical education and practice from an emphasis on literature to an emphasis on narrative—that is, from literature and medicine to narrative medicine, which emerges as a full-blown movement a decade later.

The narrative turn of the third decade (1992–2001)

Near the middle of literature and medicine's third decade, three articles taking stock of the field's progress were published within 18 months of each other in major medical journals (Charon et al. 1995; Hunter, Charon, and Coulehan 1995; McLellan and Jones 1996). Explicitly directed toward clinical audiences, these articles fueled a new wave of interest and growth in the field, both nationally and internationally. Published first, in April 1995, was an introductory overview aimed at practicing physicians. Titled "Literature and Medicine: Contributions to Clinical Practice" (Charon et al. 1995), this article was coauthored by the eight members of the Kaiser Narrative-in-Medicine Circle. Charon, whose grant from the Henry J. Kaiser Family Foundation provided funding for the group, was the leader. Trautmann (by then, Trautmann Banks) was a member, as were Hunter and I. The other four members were Julia E. Connelly, Anne Hunsaker Hawkins, Martha Montello, and Suzanne Poirier. In retrospect, the tension between the title of the article ("Literature and Medicine") and the name of the group (Narrative-in-Medicine Circle) seems to reflect well the changing emphasis then underway within the field.

More than 20 years after the teaching of literature to medical students had begun at Hershey, some of the claims in this article for the clinical utility of literature and medicine echo closely the aesthetic approach of Trautmann (1978):

> Using literary methods and texts, literary scholars have been teaching medical students and physicians how to listen more fully to patients' narratives of illness and how to better comprehend illness and treatment from patients' points of view. These skills help physicians to interview patients, to establish therapeutic alliances with patients and their families, to arrive at accurate diagnoses, and to choose and work toward appropriate clinical goals. (599)
> …
> Reading medical narratives, finally, can suggest to physicians and medical students that acts of healing encompass acts of interpretation and contemplation alongside the technical and scientific aspects of medicine. (601)
> …
> Evaluating patients requires the skills that are exercised by the careful reader: to respect language, to adopt alien points of view, to integrate isolated phenomena (be they physical

> findings or metaphors) so that they suggest meaning, to organize events into a narrative that leads toward their conclusion, and to understand one story in the context of other stories by the same teller. (601)
> …
> Reading fiction or poetry exercises the pattern-finding and meaning-making operations that lead to apt clinical evaluation. Reading puts into play the mental and creative acts of imagination and interpretation, reinforcing subtle competencies of empathy and respect. (602)

Other claims echo the ethical approach of Coles:

> Literary accounts about medicine … give rich and accurate "case histories" of the physician's life that can stimulate important personal introspection about and examination of all that the physician is called on to do. (601)
> …
> Analytic forms cannot contain the ambiguities and subtleties of meaning that arise in the moral life; literature is better able to capture the complex resonance of human choice and human desire … As clinicians seek sustained and sensible means of arriving at fitting outcomes to the dilemmas of care, literary texts and methods can illuminate the nature of moral reasoning and can serve as valuable guides for individual and collective ethical behavior. (603)

What is new in this article is, first, the focus on narrative knowledge, narrative ethics, and literary theory and medicine, each of which is extensively discussed in a section of its own. Second, there is much greater emphasis on writing—medical students and physicians writing about their patients and themselves. Writing is put forward as a way of knowing the self and of reclaiming the affective dimension of medical practice (Charon et al. 1995, 602). These two changes in emphasis reflect the narrative turn of the humanities and social sciences in general in the preceding decades as well as the influence of Hunter's persuasive argument (1991) about the essential narrative structure of medical knowledge. Finally, a third new emphasis is the focus on "outcome studies of literature and medicine courses" (603) and a call for "longitudinal outcome research" while acknowledging the limitations of quantitative measures to assess the "effects of teaching literature in medical schools" (604).

Part of a special theme issue on medical humanities, the second influential article about literature and medicine published that year (Hunter, Charon, and Coulehan 1995) appeared in October in *Academic Medicine*, the official journal of the Association of American Medical Colleges, which reaches a very important and powerful group of deans, department chairs, and educators in all American medical schools. After giving a short history of literature and medicine, the authors move into a section subtitled "Goals," in which they largely disavow the ethical approach promulgated by Coles in favor of the aesthetic approach associated with Trautmann:

> Certainly, literature has been regarded as a moral teacher…Yet, moral influences of literature—to help readers become better human beings—are the bonuses of literary study in medicine. Embracing more modest goals, teachers of literature provide the means of conveying some of the skills and attitudes that prepare students to meet patients with openness, curiosity, and empathy and to understand the life situations that illness creates and complicates.
>
> More specifically, literature has been included in the medical curriculum to develop students' narrative competencies, for example, the capacity to adopt others' perspectives, to follow the narrative thread of complex and chaotic stories, to tolerate ambiguity, and to

> recognize the multiple, often contradictory meanings of events that befall human beings. The study of literature can provide a vocabulary for the affective and interpersonal dimensions of patient care. Reading literary texts and writing in narrative genres about patients help students to develop the clinical imagination, the moral imagination, and an empathic perception of other people and their life situations. (788)

Perhaps because of the increasing diversity of American and medical culture, at John Coulehan's suggestion the authors add to the aesthetic and ethical approaches I had previously described a third approach (or goal) for the teaching of literature and medicine: the empathic approach, "which aims to enhance the student's ability to understand the experiences, feelings, and values of other persons" (789) and focuses on the cultivation of empathy. Breaking out this third approach highlights the importance of literature in teaching cultural competence—or cultural humility. The authors correctly point out that "although overlap is common among these three approaches," they "lead to characteristic types of seminars or courses" (789), and they give examples of the different kinds of texts that might be favored by each of the three approaches. Interestingly, they observe that "because [the aesthetic] approach need not teach texts related to medicine or doctoring, faculty choose works of great literature from a wide variety of genres and periods for their power to convey the human search for meaning," including the works of Dante, Henry James, and James Joyce (789).

Notably, Hunter, Charon, and Coulehan (1995) insist on recognizing the importance of students' writing as well as reading; on expanding the texts for literature and medicine courses beyond great literary works to "the texts of medicine—patients' histories, physicians' medical narratives, the hospital record, students' case presentations" (788); and on exploring "the readers' own associations and emotional responses called forth by the text" rather than employing "the theoretical apparatus of literary criticism" (790). It may seem at first puzzling that Charon and Hunter, among the coauthors on the April article published in *Annals of Internal Medicine* that points to the important insights and concomitant skills that literary theory offers clinicians, would publish another major piece only 6 months later in which they caution against the use of too much theory or literary criticism. This apparent contradiction is, I think, a result of the journals' different audiences. Practicing physicians, especially academic physicians, might well benefit from theoretical work that would only frustrate students in the early stages of their training.

In July of the next year, Faith McLellan and I published the first article in a yearlong feature series that we wrote about literature and medicine for the *Lancet* (McLellan and Jones 1996). Our subtitle for the opening essay—yet again, "Why literature and medicine?"—signals our need to introduce the field and its rationale to an international clinical audience that was largely unaware of its emergence and development during the previous quarter century in the United States. Balancing historical overview with future projection, we point to the changing emphases as the field has matured: "Thus, the evolution of the field of literature and medicine has been marked by a shift from descriptive work to analysis, with scholars less interested in how literature reflects medicine than in how it can be used to dissect, critique, and strengthen medical epistemology and practice" (110). But, we conclude, this shift was more in the research interests of scholars than in the use of literature in medical education: "Just as medicine and medical education have been moving towards more humanistic concerns, scholarship in literature and medicine has been incorporating more analytical methods. Paradoxically, though, as the techniques of literary criticism become increasingly important, making literature more 'useful' to clinical practice, the joys and intangible pleasures of reading remain" (110). Perhaps the most important thing about this article is that the series it introduced provided encouragement in the

United Kingdom and several other countries for creating courses or programs in literature and medicine and medical humanities. The trajectories and fortunes of those international efforts deserve an article of their own, which might provide a fascinating comparative analysis of the differences in rationale and implementation from country to country.

The most significant development in literature and medicine's third decade, however, came near its close, as Charon began to shift the focus of her work from literature and medicine to narrative competence and then to narrative medicine. In January 2000, she published an article in *Academic Medicine* titled "Literature and Medicine: Origins and Destinies," in which she explores "historical antecedents" to "demonstrate that the connection between literature and medicine is enduring because it is inherent" (2000, 23). She insists that "literature is not merely a civilizing veneer for the cultured physician" (23) and concludes, in a section titled "Toward Narrative Competence in Medicine," that "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" (26).

Yet, by the very next year, Charon had moved beyond literature and medicine to what some have called her manifesto of narrative medicine (e.g., Charon 2001a; Charon 2001b). These first two manifesto articles (Charon 2001a; Charon 2001b) were published in high-profile medical journals, *Annals of Internal Medicine* (2001a) and *JAMA* (2001b). Much of what she says sounds familiar from her previous articles about literature and medicine (Charon et al. 1995; Hunter, Charon, and Coulehan 1995; Charon 2000), but the name of the endeavor has changed and the opening question has become, "What is narrative medicine?" (Charon 2001a, 83). She answers: "Physicians are reaching to practice what I have come to call *narrative medicine*—that is, medicine practiced with the narrative competence to recognize, interpret, and be moved to action by the predicaments of others" (83).

In the second version of her manifesto published just a few months later, Charon (2001b) again offers an answer to that question:

> Medicine practiced with narrative competence, called *narrative medicine*, is proposed as a model for humane and effective medical practice. Adopting methods such as close reading of literature and reflective writing allows narrative medicine to examine and illuminate 4 of medicine's central narrative situations: physician and patient, physician and self, physician and colleagues, and physicians and society. (1897)

Narrative medicine, she continues, is "not so much a new specialty as a new frame for clinical work," one that "provides access to a large body of theory and practice that examines and illuminates narrative acts" (1898). Much of this theory and practice resides in literary texts and studies, as Charon acknowledges, and those texts continued to be taught under the name of literature and medicine as the third decade closed. What the relationship between literature and medicine and narrative medicine was or would become was not yet clear, but at this point it looked as if nothing had changed except the name—that is, Charon was continuing her previous work but calling it narrative medicine instead of literature and medicine.

The paradox of narrative medicine and the problem of assessment

For the next 3 years, it seemed as if the congruent practices of literature and medicine and narrative medicine were continuing alongside each other, albeit under two different names.

But in April 2004, when the *New York Times Magazine* published an article featuring Charon's work, their relationship was redefined, as Melanie Thernstrom reports:

> Charon is not the first to relate literature to medicine: most medical schools offer optional literature courses, under programs known as "literature and medicine" or "medical humanities," that have been instituted in the past three decades. However, these programs have typically been institutionally marginalized because they are perceived as offering mere enrichment rather than vital skill. "Medical humanities programs are not at heart as practical a set of clinical skills as narrative medicine," Charon told me. Narrative medicine, she said, is not intended to create "a civilizing veneer—how cute, a doctor who writes poetry—but is a very practical field. Skills are offered that will allow for more efficacy." (2004)

Thernstrom also quotes David Morris, himself then a scholar of literature and medicine and medical humanities, who agrees with Charon: "We've seen medical schools vote with their feet and their money that medical humanities are not central to their mission. Narrative medicine, on the other hand, is new, clinically relevant and has great potential" (2004).

In February 2004, just 2 months before Thernstrom's article was published, Charon had published another article on narrative medicine, this time in the *New England Journal of Medicine,* in which she maintains that "reading literature, studying humanities, writing in literary ways about practice" to acquire a "civilizing veneer" (2004, 863) was the practice of an older generation of "gentlemen" physicians. In Thernstrom's article, however, the implication is that the contemporary practice of literature and medicine creates only a "civilizing veneer" (2004), in contrast with the more efficacious practical skills offered by narrative medicine. Charon may have been misquoted or her words taken out of context, but the general attitude represented in Thernstrom's article is one of praise for narrative medicine at the expense of literature and medicine and medical humanities.

In her recent plenary presentation at the 2012 spring conference of the Project to Rebalance and Integrate Medical Education (PRIME) initiative (Doukas, McCullough, and Wear 2012), Charon again emphasizes her move beyond literature and medicine and beyond medical humanities: "I stopped calling my program humanities in medicine a long, long time ago, because I felt it was restrictive" (Charon 2012). Whereas medical humanities excludes those who come from non-humanities disciplines, she says, narrative medicine comprises all "those scholars and practitioners who examine and interpret singular accounts of lived experience" (Charon 2012). Her list includes literary scholars, historians, philosophers, creative artists and writers, plus clinicians, medical educators, social scientists, behavioral scientists, qualitative researchers, and policymakers. Yet her designation of narrative medicine's domain as that of "singular accounts of lived experience" seems at odds with her focus on the "large, large goals" of transforming institutions and effecting systemic change in American health care. It is "the institution, not the individual, who's the unit of analysis" that she is interested in now, and she urges her audience to "get beyond the itsy-bitsy outcomes" (Charon 2012). The large outcomes that she names include clinical outcomes, cost effectiveness, decrease in error, patient safety, and quality improvement, and culminate in "access, justice, and equity" (Charon 2012). She closes her presentation by looking back at how far we have come: "Let's be grateful that what *might* have started years ago with 'civilizing veneer' … maybe it started with our simple love of literature … and yet … it's now to be put into the service of justice, equity, and health" (Charon, 2012).

A powerful and passionate speaker, Charon is a strong and charismatic advocate for narrative medicine. She has been remarkably successful in developing and funding the work of narrative medicine—receiving major grants, establishing research and educational agendas, developing a Master of Science program in narrative medicine at Columbia University, and

focusing the spotlight of national and international media attention on narrative medicine's rationale, methods, and goals. Given such success and the resonance felt by so many who hear her call for a just and equitable society with access to health care for all, one might well wonder why we still need literature and medicine and medical humanities programs.

The claim that it is narrative medicine that has now put literature "into the service of justice, equity, and health" (Charon 2012) merits scrutiny in light of the history I have recounted here. From the beginning of their work—that is, the beginning of literature and medicine in contemporary American medical education—Trautmann and Coles also spoke against the misperception that the purpose of teaching literature to medical students was to provide that "civilizing veneer" to which Charon alludes (2000; 2004; 2012). Their goals were also focused on "better patient care" (Trautmann 1978) and just and equitable care of the sick. Coles (1979) opens his article with an African-American woman's story of reprimanding her white doctor, in Mississippi in 1969, for his dismissive attitudes and behavior toward "the poor people and us colored people" (444). Her challenge to that physician to "take a hard look at himself and see if he's living the best life he can—the kind of life a doctor should live" (444) was part of Coles's inspiration for challenging medical students to undertake a similar kind of ethical reflection with the help of "the best of our novelists" (446). The goals of these two endeavors—literature and medicine and narrative medicine—are not so different as they sound in Charon's presentation (2012). Neither are their methods.

The most striking paradox of narrative medicine is that it proclaims to have left literature and medicine in the dust, even as it remains fundamentally dependent on literature and medicine. The primary method—the process—of narrative medicine that Charon uses to transform clinicians and administrators into the agents of institutional culture change is the close reading of texts. In her recent presentation (Charon 2012), she talks of the importance of close reading in teaching narrative medicine and names some of the texts she has recently used with faculty colleagues and graduate students—John Berger's *A Fortunate Man,* Ari Folman's film *Waltz with Bashir,* and Tony Morrison's novel *Beloved.* These same texts could be—and probably have been—used in courses of literature and medicine. Charon's methods are those Trautmann (1978) described 35 years ago. Narrative medicine still uses the methods of literature and medicine, as Charon has acknowledged: "By concentrating on specific missions that began within the universe of literature and medicine—the teaching of close reading, reflective writing, narrative *seeing* in clinical training—we hoped to fortify clinical practice with the peculiarly narrative capacities to make contact and to affiliate with patients, colleagues, students, and the people" (Charon and DasGupta 2011, viii).

If the methods and goals of literature and medicine and narrative medicine are basically the same, what is the difference between them? Is it only the name that has changed? And is it the name that has given narrative medicine so much more "cash and cachet," as Thernstrom (2004) puts it? Not entirely. That Charon is herself a physician, as well as a well-trained and skillful literary scholar, is clearly important. She has insider knowledge, access to, and influence on her clinical colleagues. But her choice of name for the work was deliberate and brilliant. In her 2009 plenary presentation for the joint annual symposium of the New York Academy of Medicine and the Royal Society of Medicine, Charon explained that she wanted a term that places narrative at the very center of medicine and clinical practice, a term that sounds like a subspecialty of medicine, like, for example, *nuclear medicine* (Charon 2009). Physicians practice nuclear medicine; physicians can practice narrative medicine. Yet the term she has chosen to place narrative at the core of medical work, echoing the argument of Hunter (1991), is itself restrictive in a way that Charon perhaps did not originally realize or intend. Her first definitions of the term (Charon 2001a; 2001b) make very clear that narrative medicine is a medical practice of physicians. As a physician herself, Charon is understandably interested

most of all in the practice of medicine and is "not so much committed to literary studies or even to the humanities" (Charon and DasGupta 2011, viii). It is harder to understand why non-clinicians have been so quick to jump aboard and call what they do—whether it be teaching literature, writing about illness, looking at art, taking photographs, making films—narrative medicine rather than literature and medicine or medical humanities.

Matters get more complicated when the pesky question of outcomes and their assessment comes up, as it has repeatedly over the years, especially since 1995 (Charon et al. 1995; Charon 2004; Thernstrom 2004; Kuper 2006; Ousager and Johannessen 2010; Belling 2010; Doukas, McCullough, and Wear 2012). The relatively more modest goals of teaching reading in the fullest sense (interpretive skills) and encouraging moral inquiry (ethical reflection) are notoriously resistant to quantitative measurement (Charon et al. 1995; Kuper 2006; Ousager and Johannessen 2010; Belling 2010). In her PRIME presentation, Charon (2012) suggests that she would assess her work's contribution to the large outcomes of "access, justice, equity" and "health" by looking for positive changes in population health in the zip code where she practices. Statisticians know how to gather and evaluate such data. But even if there were demonstrable improvements in, say, infant mortality as a marker of the larger outcomes, how could it be demonstrated that the improvements occurred because of narrative medicine? With so many large forces—politics, economics, demographic changes, and so forth—in the mix, attributing health-care outcomes to any one force seems unlikely, if not impossible.

I appreciate Charon's dedication and commitment to the improvement of patient care and health care writ large. But even while she calls us to focus on the admirable large goals of access, justice, equity, and health to be brought about through systemic change (Charon 2012), those of us in literature and medicine need to keep our focus on the individual students before us and on what we do best—teaching reading in the fullest sense and encouraging moral inquiry of a wide-ranging kind. Almost always represented in our conversations with medical educators over the years as skills with instrumental value and practical immediacy for clinical work, interpretation and ethical reflection retain their intrinsic value and their transformative potential to change the way people think and live their lives. These are changes that cannot be measured by statisticians looking at health outcomes zip code by zip code. They occur in individual lives, one person at a time, on no predictable schedule or protocol, sometimes subtly, sometimes dramatically.

I am grateful for those who have taken on the challenges of trying to find ways to assess the value of including literature in medical education (Kuper 2006) and of seeking sharper instruments to replace the "blunt tools of outcomes measurement" (Belling 2010). I am also grateful for those physicians—for example, Pellegrino (1982) and, more recently, David Watts (2012)—who remind us that "scientific assessments of humanistic values are little more than reflections in a parallel universe and will never tell the full story" (Watts 2012, 1185). And I am grateful for the testimony of all those students and clinicians whose lives and practices have been transformed by the poems, stories, and novels they have read—and have sometimes written. Why not say what we know to be true? Literature and humanities have enduring value and power in medical education no less than in all our lives.

References

Belling, Catherine. 2010. "Commentary: Sharper Instruments: On Defending the Humanities in Undergraduate Medical Education." *Academic Medicine* 85: 938-940.

Charon, Rita. 2000. "Literature and Medicine: Origins and Destinies." *Academic Medicine* 75: 23–27.

———. 2001a. "Narrative Medicine: Form, Function, and Ethics." *Annals of Internal Medicine* 134: 83–87.

———. 2001b. "Narrative Medicine: A Model for Empathy, Reflection, Profession, and Trust." *JAMA* 286: 1897–1902.
———. 2004." Perspective: Narrative and Medicine." *New England Journal of Medicine* 350: 862–864.
———. 2009. "What is it all for? The Fundamental Goals of Medical Humanities." Plenary presentation at the Annual Joint Symposium: New York Academy of Medicine and Royal Society of Medicine: The Humanities in Medicine and Medical Education. New York.
———. 2012. "Deep Structures, or How Our Work Improves the Care of the Sick." Plenary presentation at the PRIME 2012 National Conference: Project to Rebalance and Integrate Medical Education. Louisville. iTunes U.
Charon, Rita, Joanne Trautmann Banks, Julia E. Connelly, Anne Hunsaker Hawkins, Kathryn Montgomery Hunter, Anne Hudson Jones, Martha Montello, and Suzanne Poirier. 1995. "Literature and Medicine: Contributions to Clinical Practice." *Annals of Internal Medicine* 122: 599–606.
Charon, Rita, and Sayantani DasGupta. 2011. "Editors' Preface: Narrative Medicine, or a Sense of Story." *Literature and Medicine* 29: vii-xiii.
Coles, Robert. 1979. "Medical Ethics and Living a Life." *New England Journal of Medicine* 301: 444–445.
———. 1982. "Why Novels and Poems in Our Medical Schools?" *Literature and Medicine* 1: 32–34. Rpt. 1989. *JAMA* 261: 670.
———, comp. 1984. *William Carlos Williams: The Doctor Stories.* New York: New Directions.
Doukas, David J., Laurence B. McCullough, and Stephen Wear. 2012. "Perspective: Medical Education in Medical Ethics and Humanities as the Foundation for Developing Medical Professionalism." *Academic Medicine* 87: 334–341.
Hawkins, Anne Hunsaker. 1992. "Charting Dante: The *Inferno* and Medical Education." *Literature and Medicine* 11: 200–215.
Hunter, Kathryn Montgomery. 1991. *Doctors' Stories: The Narrative Structure of Medical Knowledge*. Princeton, NJ: Princeton University Press.
Hunter, Kathryn Montgomery, Rita Charon, and John L. Coulehan. 1995. "The Study of Literature in Medical Education." *Academic Medicine* 70: 786–794.
Jones, Anne Hudson. 1990. "Literature and Medicine: Traditions and Innovations." In *The Body and the Text: Comparative Essays in Literature and Medicine,* edited by Bruce Clarke and Wendell Aycock, 11–24. Lubbock: Texas Tech University Press.
Kuper, Ayelet. 2006. "Literature and Medicine: A Problem of Assessment." *Academic Medicine* 81: S128-S137.
Literature and Medicine: Toward a New Discipline. 1982. 1: 1–111.
McLellan, Faith, and Anne Hudson Jones. 1996. "Why Literature and Medicine?" *Lancet* 348: 109–111.
Ousager, Jakob, and Hellle Johannessen. 2010. "Humanities in Undergraduate Medical Education: A Literature Review." *Academic Medicine* 85: 988–998.
Pellegrino, Edmund D. 1982. "To Look Feelingly—the Affinities of Medicine and Literature." *Literature and Medicine* 1: 19–23.
Rabuzzi, Kathryn Allen. Editor's column. *Literature and Medicine* 1: ix-x.
Self, Donnie J., ed. *The Role of the Humanities in Medical Education*. Norfolk: Bio-Medical Ethics Program, Eastern Virginia Medical School.
Terry, James S., and Edward L. Gogel. 1987. "Poems and Patients: The Balance of Interpretation." *Literature and Medicine* 6: 43–53.
Thernstrom, Melanie. 2004. "The Writing Cure." *New York Times Magazine*. http://www.nytimes.com/2004/04/18/magazine/the-writing-cure.html?pagewanted=all&src=pm
Trautmann, Joanne. 1978. "The Wonders of Literature in Medical Education." In *The Role of the Humanities in Medical Education*, edited by Donnie J. Self, 32–44. Norfolk: Bio-Medical Ethics Program, Eastern Virginia Medical School.
———. 1982. "Can We Resurrect Apollo?" *Literature and Medicine* 1: 1–18.
Trautmann, Joanne, and Carol Pollard. 1975. *Literature and Medicine: An Annotated Bibliography.* Philadelphia: Society for Health and Human Values; 1982 revised edition, Pittsburgh: University of Pittsburg Press.
Watts, David. 2012." Cure for the Common Cold." *New England Journal of Medicine* 367: 1184–1185.