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## Literature and medicine

# Why literature and medicine?

M Faith McLellan, Anne Hudson Jones

This very question—why literature and medicine?—was put to a number of physicians, writers, literary scholars, and medical humanists 15 years ago to elicit the responses that made up most of the first issue of the journal *Literature and Medicine*.<sup>1</sup> Medical humanities was then a budding enterprise, made up primarily of those with special interests in the history of medicine or in the emerging field of bioethics. Literature was just beginning to find its place at the table where these pioneers were attempting to bring the values and concerns of the humanities to bear on medical practice. Since the initial question was posed, however, literature and medicine has evolved in its own right, and this evolution has taken place in ways that few people writing in 1981 could have foreseen. In this essay, we will review developments in the field as a background for characterising some of its most important conceptual issues, especially as these relate to clinical practice.

As a result of changes in US medical education that began in the 1960s, the relationships between literature and medicine have been explored in myriad ways. Beginning with the appointment of the first full-time professor of literature and medicine at a US medical school, literature began increasingly to be recognised as an important subject of inquiry in professional training.<sup>2</sup> This early incorporation of literature into medical

education was an experiment that reflected the then somewhat tenuous connections of literature and medicine.<sup>3–6</sup> Literature was introduced to medical students in the belief that “to teach a student to read, in the fullest sense, is to help train him or her medically”.<sup>7</sup> Some outcomes of learning to read this way—a way that focuses on literary analysis of complex texts—are thought to be increased empathic understanding, development of complex interpretive skills, and a greater appreciation for the art of medicine by students and practitioners.<sup>8,9</sup> This orientation, sometimes identified with early descriptions of the field by the literary scholar Joanne Trautmann Banks, came to be known as the “aesthetic” approach and is frequently juxtaposed with the “ethical” approach to teaching literature in medical education—a method that focuses on content.<sup>10</sup> The psychiatrist Robert Coles has been a fierce proponent of the ethical approach; for him the sole purpose of using literature in medical schools is to teach ethical reflection.<sup>11</sup> The ethical approach focuses on moral quandaries and decision-making as they are represented in literature, with stylistic analysis being clearly subordinate to questions of character and action. The use of literature in this way may have reflected some discontent with traditional analytical approaches in medical ethics.<sup>12,13</sup> Interestingly, the aesthetic and ethical approaches seem to have merged in the current interest in narrative ethics.<sup>10,14,15</sup>

Bringing literature into medical education was not as odd as it might appear: the affinity between literature and medicine has long been recognised and stretches back to antiquity. Apollo, the Greek god of medicine and poetry, who has come to symbolise this “strange marriage”,<sup>1</sup> is often invoked to provide historical authority. Physicians and literary scholars alike have traditionally explored certain relationships between literature and medicine, including images of physicians<sup>16</sup> and works of physician-writers,<sup>17,18</sup> such as François Rabelais (c 1494–1553),

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Tobias George Smollett (1721-71), Oliver Goldsmith (1730-74), John Keats (1795-1821), Sir Arthur Conan Doyle (1859-1930), Anton Chekhov (1860-1904), William Somerset Maugham (1874-1965), William Carlos Williams (1883-1963), AJ Cronin (1896-1981), and Walker Percy (1916-90). Themes of disease, wounds, and illness in novels, short stories, and autobiographical writings have also been popular areas of investigation, especially in such texts as *The Magic Mountain*, *The Death of Ivan Ilyich*, and *The Yellow Wallpaper*. Literature—the reading and writing of it, especially poetry<sup>19-22</sup> and the personal journal<sup>23</sup>—has also been suggested as a mode of healing,<sup>24</sup> going back to Aristotle's observations on the power of catharsis.<sup>25</sup>

Novels that portray the history of medicine, whether sketchily or in depth, give readers a snapshot of the development of medicine and its practitioners. The works of physician-writers show the affinity of one field for the other and document, often powerfully and eloquently, how some professionals have nourished an important part of their lives outside medicine. Themes of illness in works of literature are an unusual and not entirely explained phenomenon. Why some writers, such as Camus in *The Plague*, for example, have been so drawn to illness as a foreground, background, or controlling motif to communicate other themes is an intriguing and complicated question—the answer to which may not be fully known even by the writers. The theories and tools of recent literary critical movements, including reader-response criticism, deconstructionism, and feminist criticism, have raised new questions for old texts, as well as expanded the number and type of works considered as fertile ground for exploration in the field. Owing, partly, to these developments, literature and medicine has also concerned itself with clinical hermeneutics and concepts such as the patient as text.<sup>26,27</sup>

In the past 25 years, the field has grown to the extent that literature is now taught in about one-third of all US medical schools.<sup>28</sup> Similarly, the range of literary scholars' teaching and research activities has expanded to include courses for medical and graduate students that explore, in depth, topics and themes such as the physician-patient relationship, women in medicine, AIDS, ageing, and death and dying. In these courses the skills of literary interpretation of texts are integrated with the analytical work of medicine. In some courses, for example, students are asked to write about illness from the patient's point of view.<sup>29,30</sup> Among the goals of these experiments, whether they involve reading fiction or writing it, are to deepen students' capacities for empathy and to remind them of the totality of the lives of patients they may meet only in limited, fragmented ways.

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.<sup>31,32</sup> In future essays we will be exploring in greater depth significant markers of this evolution. We will survey the traditional relationships between literature and medicine: how the portrayal of physicians has evolved in literature, from comic portrayals to the heroic tradition; medical *Bildungsromans*, or apprenticeship novels;<sup>33</sup> major canonical works (primarily novels); smaller canonical works—generally short stories useful for teaching medical ethics; the work, both fiction and poetry, of physician-

writers; narratives<sup>34,35</sup> (in traditional print and innovative non-print forms) of both physical<sup>36</sup> and mental<sup>37</sup> illnesses; and narrative ethics. Finally, we will speculate about the future directions of this interdisciplinary undertaking.

A recent review of the contributions of literature to clinical practice<sup>38</sup> made a compelling case for the future of literature and medicine. While continuing to value the depiction of patients' and physicians' lives found in literature, the field is further strengthening its concern with narrative ways of knowing and their applicability to ethical problems. These emphases help practitioners develop important skills in communication and moral reasoning. Likewise, literary and narrative analyses help attune readers to the richness of context and the nuances of everyday clinical, personal, and professional encounters.

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. As an art form that enriches many facets of human experience, literature cannot be reduced to a tool of analysis; rather, the written word has an inherent and often inexplicable power. The continuing engagement of two exciting, enriching, ennobling professions bodes well for our hope of celebrating with a wide audience many anniversaries of the strange marriage of literature and medicine.

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## Essay

## Marketing clinical trials

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The science of marketing has many definitions but one is ". . . getting the right product in the right place at the right time at the right price". Central to the concepts of marketing is the idea of exchange: that at the heart of business is an exchange process between the provider and the customer. The product is exchanged for something of value to the provider. How does this apply to clinical trials? It can be argued that the trial organisation is the provider of the product and the clinicians the customers. The better the product and the closer it accords with their customer values, the more likely clinicians are to participate. The key features that make a trial attractive to clinicians are: 1) it addresses an important and interesting question; 2) entry (registration, eligibility, randomisation, and informed consent) to the trial is easy; and 3) data collection is simple and undemanding. The failure of some trials can reasonably be attributed to shortcomings in one or more of these areas and over recent years trial organisations have worked hard to make trials more attractive. But the demand for more quality of life and health economic data, both of which increase the effort of data collection, may well be making trials better scientifically but worse as products.

However, there are trials that seem less good but still succeed. To understand why we need to look at the central exchange process of trials—the obtaining and transfer of patient data. In this exchange the clinician is the provider and the trial organisation the customer. The process usually involves considerable time and effort either by the clinicians themselves or by someone they

employ. There may also be an expenditure of increased resources as a result of the patients being in the trial. What reward can and do clinicians get in exchange for this effort and expenditure? First, there is a tangible reward, either financial (so much per patient entered to cover costs) or in resources (free drugs for instance). This is the commercial basis of most trials sponsored by drug companies and is clearly a successful and, for some people, profitable exchange. Participation in drug company trials may also be rewarded by travel to meetings and other indirect benefits. Second, there is the reward of academic and professional esteem and it accrues mainly to those who write the papers and present the data. This esteem may be local, national, or international and, for some people, is clearly a powerful motivation and reward. But it is only likely to be a reward for the key players in any trial—the organisers and main contributors. Third, there is the reward of group membership: being part of the organisation and getting, if not one's name at the top of the paper, at least an acknowledgment at the end. The benefits from this may not be so obvious and direct but may be important. For instance it gives the possibility of having one's own trial ideas taken forward and run by the group. Finally, there is the much more intangible reward of what one might call satisfying intellectual curiosity. The desire to know the answer to a clinical question appears to be a motivation at the initial stages of any trial but may be very easily dampened by the efforts of participation. This may be why so many people agree to participate initially but then fail to enter many patients. Until recently, intellectual curiosity might have been one of the stronger motivators but increasing demands on time and resources have probably changed things. For most doctors the scale of value for these rewards now probably runs: money>resources>esteem>group membership>intellectual curiosity; although publicly they may still insist that it is the reverse.

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