

Maria Vaccarella
King's College London

Medical Humanities: Renewing Praxis across Disciplines

Abstract

This essay investigates recent issues in the development of the medical humanities in North America and in Britain. It discusses different definitions and approaches (e.g. additive, integrated) within this interdisciplinary field of studies, and what its very interdisciplinary status entails. The second part of the essay concentrates on the encounter between literature and medicine, with a specific focus on the conceptualization of pathographies as a genre and on narrative medicine as a tangible example of how to integrate humanistic knowledge into clinical practice.

1. Medical Humanities: Timeliness and Elusiveness

In September 2012, Italian engineer and artist Salvatore Iaconesi uploaded his medical charts and scans on a webpage under the title «The Cure. A brain cancer. Some very personal Open Data. An opportunity»¹. He called for a cure, which could or could not come from health professionals: «Grab the information about my disease, if you want,» he wrote «and give me a CURE: create a video, an artwork, a map, a text, a poem, a game, or try to find a solution for my health problem. Artists, designers, hackers, scientists, doctors, photographers, video-makers, musicians, writers. Anyone can give me a CURE»². This invitation resonates with the ethos of Art is Open Source, the network of artists that Iaconesi leads: they are «pushing forward the possibilities to reinvent our reality, to promote a more positive, aware, active and col-

¹ <http://www.artisopensource.net/cure/> (last access: 22/10/2012).

² *Ibid.*

laborative planet.»³ Building upon his professional identity and resourcefulness, Iaconesi highlights how – while some professionals might help him recover from his illness – anyone can help him make sense of this all too human experience.

This is a compelling example of what humaneness and the humanities can contribute to medicine. In medical sociologist Howard Waitzkin's reflection, modern medicine is now faced with the challenge of including a critical discourse which «would recognize the limits of medicine's role and the importance of building links to other forms of praxis that seek to change the social context of medical encounters»⁴. Although «[t]he phrase 'medical humanities' has a currency that is perhaps wider than any agreement as to what it means,»⁵ its rationale could be broadly defined as an exploration of the complexities of human bodies, minds and suffering through analytical frameworks derived from humanistic disciplines, while holding a critical perspective on medical practice and education.

In this sense, within the single disciplinary grounds of philosophy, literary criticism, or art history, to name but a few, a great number of scientific contributions informed by this awareness will be easily found, even before the advent of the medical humanities era⁶. If we restrict our survey to publications that explicitly position themselves within the interdisciplinary field of the medical humanities, the first volume to pursue this scope is arguably *Personal Choices and Public Commitments: Perspectives on the Medical Humanities*, edited by William J.

³ <http://fellows.ted.com/profiles/salvatore-iaconesi> (last access: 22/10/12).

⁴ Howard Waitzkin, *A Critical Theory of Medical Discourse: Ideology, Social Control, and the Processing of Social Context in Medical Encounters* in "Journal of Health and Social Behavior", 30 (1989), p. 237.

⁵ Martyn Evans, Rolf Ahlén, Iona Heath, Jane MacNaughton (eds.), *Medical Humanities Companion*, vol. 1 "Symptom", Radcliffe, Oxford and New York, 2008, p. 2.

⁶ The opening of the Department of Humanities at Penn State College of Medicine (Hershey, Pennsylvania, USA) in 1967 can be regarded as a profitable reference point for the beginning of academic medical humanities.

Winslade and first published in 1988⁷. This is a collection of public lectures delivered in ten different Texas cities and organized by the Institute for the Medical Humanities at the University of Texas Medical Branch at Galveston. It features prominent scholars and tackles key topics – from patient empowerment to end of life issues; yet, quite surprisingly within this early phase of the discipline, there is no attempt at providing a satisfactory definition of the medical humanities. They are either taken for granted in this book or equated to a rediscovery of humaneness in medicine, this last connection being congenial to the nature of the topics discussed and the focus on ethics that still characterizes many of the medical humanistic activities in the US.

On the contrary, unpacking the phrase “medical humanities” is the eminent preoccupation in what could be regarded as the British equivalent of Winslade’s volume: *Medical Humanities*, edited by Martyn Evans and Ilora G. Finlay, first published in 2001.⁸ The book puts forth an «integrated» conception of the medical humanities, developed in its opening chapter by philosopher and practitioner David Greaves and then corroborated with insights from sociology, creative writing and history of medicine⁹. Surpassing the view of the medical humanities as a collection of non-quantitative approaches to medical issues, aimed at (further) humanizing healthcare, Greaves posits them as the core of a renewed medical praxis: a philosophical – in its broadest sense – outlook, meant to consolidate medicine’s engagement with human subjects. Far from being a utopian endeavour, neurologist Oliver Sacks’s literary career stands out as an illuminating, tangible example of how

⁷ William J. Winslade (ed.), *Personal Choices and Public Commitments: Perspectives on the Medical Humanities*, Galveston, Tex.: Institute for the Medical Humanities, 1988.

⁸ Martyn Evans, Ilora G. Finlay (eds.), *Medical Humanities*, BMJ Books, London, 2011.

⁹ David Greaves, *The Nature and Role of the Medical Humanities* in *Ivi*, pp. 13-22.

health professionals can incorporate humanistic reflection into their clinical practice¹⁰.

This debate between «additive» and «integrated» medical humanities has characterised their British development, as it is clearly summed up, as well as linked to issues of academic structures and research funds, in Evans and Greaves's guest editorial for the December 2010 issue of BMJ's *Medical Humanities*, which marked the tenth anniversary of the journal¹¹. This tension was spelled out in the very first issue of the journal (a spin-off of the BMJ's *Journal of Medical Ethics*), which was explicitly aimed at promoting «all aspects of this debate»¹².

2. *Metaphors We Research By*

Evans and Macnaughton's 2004 article *Should medical humanities be a multidisciplinary or an interdisciplinary study?* provides a valuable contribution to the discussion by means of a well-sustained exploration of what interdisciplinarity entails. A particularly interesting aspect of their argument is their focus on shared disciplinary metaphors:

Indeed, perhaps the sharing of metaphors which were previously discipline specific, across or among suitably imaginative exponents of other disciplines, is a necessary formative process in the development of an interdisciplinary team, and their success in this an index of their having achieved some genuine interdisciplinary understanding¹³.

¹⁰ *Ivi*, p. 17.

¹¹ Martyn Evans, David Greaves, *Ten Years of Medical Humanities: A Decade in the Life of a Journal and a Discipline* in "J Med Ethics: Medical Humanities", 36 (2010), pp. 66-68.

¹² David Greaves, Martyn Evans, *Editorial: Medical Humanities* in "J Med Ethics: Medical Humanities", 26 (2000), p. 1.

¹³ Martyn Evans, Jane Macnaughton, *Editorial: Should Medical Humanities Be a Multidisciplinary or an Interdisciplinary Study?*, in "J Med Ethics: Medical Humanities", 30 (2004), p. 3.

The medical humanities rely on a somehow extreme version of interdisciplinarity, insofar as they aim at bridging the proverbially differentiated two cultures of sciences and humanities. Following Evans and Macnaughton's argument, it is within the medical humanities that the successful establishment of the field insists on a ground-breaking heuristic expansion of metaphorical cognitive processes.

This results in an alternative approach to the interdisciplinary dynamics within the medical humanities and their relationship with medicine, which has been adopted for the *Medical Humanities Companion*, of which two volumes have been published to date¹⁴. Scholars from a range of humanistic disciplines and medical subspecialties have been asked to respond to the issues characterising the different stages of the course of an illness (e.g. symptoms or diagnosis) in four fictional patients. As the editors of the first volume Martyn Evans, Rolf Ahlzén, Iona Heath and Jane Macnaughton explain, this arrangement is not only meant to collect a variety of perspectives, but also to question the possibility of agreeing on one single (or a series of) well-defined object(s) of enquiry from a diverse, multi-disciplinary spectrum¹⁵. The volumes, thus, probe the tenability of shared interdisciplinary metaphors, while working on and through them. For example, can pain be equally understood as a sign in symptomatology and in semiotics?¹⁶ Can Bakhtin's polyphony be of any help when doctors face the need of conveying medical diagnoses in lay language?¹⁷

It is also worth noting how the risk of yet another academic objectification of patients is addressed in the volumes: with the help of crea-

¹⁴ See Works Cited.

¹⁵ Martyn Evans, Rolf Ahlzén, Iona Heath, Jane MacNaughton (eds.), *Medical Humanities Companion* cit., p. 5.

¹⁶ Raimo Puustinen, *Another Day with a Headache: Semiotics of Everyday Symptoms in Ivi*, pp. 101-114.

¹⁷ Raimo Puustinen, *The Dialogue of the Clinical Encounter* in Rolf Ahlzén, Martyn Evans, Pekka Louhiala, Raimo Puustinen, *Medical Humanities Companion*, vol. 2 "Diagnosis", Radcliffe, Oxford and New York, 2010, pp. 47-61.

tive writing, actual clinical experiences are developed into verisimilar patients' stories. As a consequence, contributors have the possibility of incorporating one or more subjective points of view within the development of their arguments, in their attempts at balancing the need for scientific generalisation with a special attention to subjective illness experience. One could argue that, notwithstanding the resourcefulness of creative (re)writing of clinical encounters, literature offers a virtually endless collection of subjective views on health, illness and end-of-life issues. In actual fact, the two volumes do feature abundant literary references, from Virginia Woolf to W.B. Yeats, from Ovid to Leo Tolstoy: this is an all too valid point I will expand on later in this essay.

3. Between Education and Governance

Shifting our attention back to the USA, an interesting volume that seeks to take stock of the development of the medical humanities in North-American academia and hospitals is *Practicing the Medical Humanities: Engaging Physicians and Patients*, edited by Ronald A. Carson, Chester R. Burns and Thomas R. Cole, first published in 2003. The title clearly announces an operational take on the subject, which is nonetheless, maybe unsurprisingly, in line with the British "metaphorical turn:"

But whether the impetus was the machine at the bedside that threatened to disrupt a personal relationship between doctor and patient, a search for new knowledge that threatened to short-circuit respect for human subjects of research, or a modern medical education that attended hardly at all to the human dimensions of patient care, thoughtful physicians and humanists of a reformist bent began to compare notes. They discovered a common concern for the way medical students of the rising generation were being trained and, in particular, for what was lacking in

their education. And they shared misgivings about medicine's ability to deal with the increasing number of moral problems confronting the profession¹⁸.

Health professionals and humanists share here ethical and educational concerns, rather than metaphors, but in any case they push the boundaries of their disciplines, while tackling the same issues from different perspectives¹⁹.

Because of the addition of humanities curricula in US medical schools as early as the 1970s, the debate on the educational application of the medical humanities has always been particularly vivid: an extensive survey is to be found in Jakob Ousager and Helle Johannessen's *Humanities in Undergraduate Medical Education: A Literature Review* (2010), which, while retrieving abundant instances of humanistic curricular initiatives, underlines the shortage of articles reporting on the actual benefits that humanistic training has on future doctors in the long run²⁰.

Another American publication, "The Journal of Medical Humanities" Special Issue: *The Medical Humanities Today: Humane Health Care or Tool of Governance?* hosted a lively debate – with contributions from both sides of the Atlantic – aimed at problematizing and investigating the alleged connection between humanistic knowledge provision and humanization of care, to the point of suggesting clinical govern-

¹⁸ Ronald A. Carson, Chester R. Burns, Thomas R. Cole (eds.), *Practicing the Medical Humanities: Engaging Physicians and Patients*, University Publishing Group, Hagerstown, MD, 2003.

¹⁹ A discussion of the interaction between medical humanities and medical ethics is beyond the scope of this essay. For further reference, please see Ronald A. Carson, *Teaching Ethics in the Context of the Medical Humanities* in "Journal of Medical Ethics", 4(1994), 20, pp. 235-238; Robert Veatch, *Disrupted Dialogue: Medical Ethics and the Collapse of Physician-Humanist Communication (1770-1980)*, Oxford University Press, Oxford and New York, 2005; Frederick Adolf Paola, Robert Walker, Lois LaCivita Nixon, *Medical Ethics and Humanities*, Jones and Bartlett, Sudbury, MA, 2010.

²⁰ Jakob Ousager, Helle Johannessen, *Humanities in Undergraduate Medical Education: A Literature Review* in "Academic Medicine", 6 (2010), 85, pp. 988-998.

ance as a possible alternative venue for the medical humanistic enterprise²¹.

These considerations raise questions on the nature of the medical humanities, as well, more specifically their uncertain location between the humanities and medicine or quite often their justification vis-à-vis medicine. Christina M. Gillis in her article *Medicine and Humanities: Voicing Connections* highlights the impossibility of fitting the humanistic educational offer into the medical model of the measurable outcome:

The humanities as generally defined and practiced in higher education are not evidence-based in a positivist sense. They tend to emphasize process over product; hence any argument for a «product,» defined for example as the «development of humanity,» must rest upon the hermeneutic enterprise. [...]The development of humanity in a given group of practitioners is hardly a measurable product²².

As a consequence, the successful incorporation of the humanities into medical educational rests on the challenging search for a common language that bridges the divide between process-oriented and product-oriented disciplines.

In addition, Jeffrey P. Bishop in his article *Rejecting Medical Humanism: Medical Humanities and the Metaphysics of Medicine* warns against the simplistic assumption that more applied forms of medical humanistic knowledge (e.g. narrative medicine) will finally provide the long awaited pragmatic and measurable clinical outcomes (e.g. in terms of doctors' narrative competence and enhanced history taking skills). Through the lens of Heidegger's philosophy, Bishop sketches the goal of humanizing medicine as a radical rethinking of the doctor-patient relationship:

²¹ Alan Petersen, Alan Bleakley, Rainer Brömer, Rob Marshall, Special Issue: *The Medical Humanities Today: Humane Health Care or Tool of Governance?* in "The Journal of Medical Humanities", 1 (2008), 29.

²² Christina M. Gillis, *Medicine and Humanities: Voicing Connections* in *Ivi*, p. 6.

The humanities might save medicine but not by making it more effective at manipulating its biological objects—namely, patients. Doctors just might find themselves called into being, calling into being there with (Mitdasein) the other. Doctors might find that, instead of constituting their objects by placing them into the theoretical categories of medical science, they themselves are constituted by the other that calls them out of their objectifying and categorizing stupor. It is perhaps in being there with the other that human being appears for the first time, and perhaps even more so when being there with the other is both inefficient and ineffective, when the metaphysics of efficiency collapses²³.

4. Focus on Literature

Following this thought-provoking argument, I would like to proceed with a review of the encounter of literary studies and medicine, which I deem will be of special interest to the readership of this journal. Also in this case, we can retrieve an additive and an integrated arrangement of this interdisciplinary blending: on the one hand, literature and medicine studies, and narrative medicine, on the other. It is my contention that these two categories are not as self-contained as they might appear at first glance.

4.1 Literature and Medicine

Literature and medicine studies started as an educational project in 1972, when Joanna Trautmann was appointed to teach literature to medical students at the Penn State University College of Medicine. It has, since then, evolved into a substantial sub-discipline of literary studies: it now also taught in schools of humanities (e.g. the MA in Lit-

²³ Jeffrey P. Bishop, *Rejecting Medical Humanism: Medical Humanities and the Metaphysics of Medicine* in Alan Petersen, Alan Bleakley, Rainer Brömer, Rob Marshall, *The Medical Humanities Today* cit., p. 24.

erature and Medicine is a distinctive pathway within the MSc in Medical Humanities at King's College London) and its research agenda has been consolidated through a number of publications and the creation of the journal *Literature and Medicine* in 1982²⁴.

In her editor's column for the inaugural issue of this journal, Kathryn Allen Rabuzzi describes the pairing of the two disciplines as a «strange marriage»²⁵, only to open the floor to a number of interesting articles on the similarities, rather than on the all too patent differences, between literature and medicine. To give just but one example, in Edmund D. Pellegrino's words: «Medicine and literature are united in an unremitting paradox: the need simultaneously to stand back from, and yet to share in, the struggle of human life»²⁶.

The critical richness of the thirty volumes of the journal to date testifies to the validity of this approach, which extends far beyond the occasional indulging in retrospective diagnoses of characters or authors. By way of an example, in his article "*You Can Kill, but You Cannot Bring to Life*": *Aesthetic Education and the Instrumentalization of Pain in Schiller and Hölderlin*, John B. Lyon analyzes the aesthetic use of pain in German Classicism and how these two authors appropriate this discourse in their works²⁷. Another illuminating study worth mentioning is Rita Charon's examination of diagnosis as a form of doctor-

²⁴ Anne Hunsaker Hawkins, Marilyn Chandler McEntyre, *Introduction: Teaching Literature and Medicine: A Retrospective and a Rationale*, in Anne Hunsaker Hawkins, Marilyn Chandler McEntyre (eds.), *Teaching Literature and Medicine*, The Modern Language Association, New York, 2000, p. 4.

²⁵ Kathryn Allen Rabuzzi, *Editor's Column* in "Literature and Medicine", 1 (1982), p. IX.

²⁶ Edmund D. Pellegrino, *To Look Feelingly – The Affinities of Medicine and Literature* in "Literature and Medicine", 1 (1982), p. 19.

²⁷ John B. Lyon, "*You Can Kill, but You Cannot Bring to Life*": *Aesthetic Education and the Instrumentalization of Pain in Schiller and Hölderlin* in "Literature and Medicine", 1 (2005), 24, pp. 31-50.

patient negotiation, which sheds new light on Henry James's construction of Milly in *The Wings of the Dove*²⁸.

While browsing these encouraging results, we should likewise be aware of a number of epistemological issues raised by this cross-pollination of systems of knowledge. A pioneering figure in literature and medicine studies, George Rousseau, has written extensively on the creation of this field of enquiry, complicating, for example, the naive assumption of the originary unidirectional information flow from medicine to literature, given the writers' participation to or embedding into the medical culture of their time²⁹. This approach runs the risk of overshadowing an equally fascinating trajectory of cultural influence, i.e. how literature has contributed metaphors, concepts and general insights to medicine. It is indeed equally true that «medical authors and patients adopt the values of imaginative writers of their own period»³⁰. At the same time, literary influence often acquires transhistorical and transnational validity, as in the case of French neurologist Henri Gastaut, who revised his theory of cognitive deterioration in primary generalised epilepsy after reading Fyodor Dostoyevsky's novels, which incorporated echoes of the latter's firsthand experience of the disease³¹.

From an educational point of view, the provision of modules in literature and medicine has spurred a number of interesting discussions, a good selection of which can be found in Anne Hunsaker Hawkins and Marilyn Chandler McEntyre's collection *Teaching Literature and Medicine* (2000). As they point out in their introduction, the field can now rely on a solid theoretical framework that makes the most of the similarities and differences of its two parent disciplines. Echoing cau-

²⁸ Rita Charon, *The Great Empty Cup of Attention: The Doctor and the Illness in The Wings of the Dove* in "Literature and Medicine", 9 (1990), pp. 105-124.

²⁹ George Sebastian Rousseau, *Enlightenment Borders: pre- and Post-Modern Discourses: Medical, Scientific*, Manchester University Press, Manchester, 1991, p. 4.

³⁰ *Ivi*, p. 9.

³¹ Henri Gastaut, *Fyodor Mikhailovitch Dostoevsky's Involuntary Contribution to the Symptomatology and Prognosis of Epilepsy* in "Epilepsia", 19 (1978), p. 198.

tionary tales developed in the research environment, teaching literature and medicine should not depend on a hasty, simplistic synthesis of knowledges:

While recognizing the connections between literature and medicine, it is important not to ignore the deep-lying differences and resultant tensions between them. Humanists especially are tempted by what one might term the rhetoric of reconciliation [...]. An interdisciplinary course is more challenging in every sense if it acknowledges tensions, points out contrasts, and encourages controversy than if it tries to establish a harmonious complementarity or subordinates one discipline to the other³².

Implicit in these reflections is a call for a thorough targeting of literature and medicine modules to specific student populations (either within medical or humanities schools), but also, I believe, for an enhanced awareness of how both literature and medicine respond to broader socio-cultural factors according to their own peculiar traditions.

4.1.2 Pathographies: A New Genre?

Another crucial debate within literature and medicine revolves around what looks like its most original contribution to literary theory, namely the definition (if not, in some cases, promotion) of the (contested) genre of pathographies. Anne Hunsaker Hawkins coined the term «pathography» to designate «a form of auto-biography or biography that describes personal experience of illness, treatment, and sometime death. ‘What it is like to have cancer’ or ‘how I survived my heart at-

³² Anne Hunsaker Hawkins, Marilyn Chandler McEntyre, *Introduction: Teaching Literature and Medicine* cit., p. 3.

tack' or 'what it means to have AIDS'»³³. While true and fictional illnesses have been variedly depicted in literature throughout the centuries, *pace* Virginia Woolf, pathographies consciously emerged as a genre in the 1950s: to quote but two recent, highly popular examples, Hilary Mantel's *Giving Up the Ghost* (2003) – which retraces her difficult search for a diagnosis of endometriosis in the 1970s – and Jean-Dominique Bauby's *Le Scaphandre et le Papillon* (1997) about living with locked-in syndrome, which was adapted into a film by Julian Schnabel in 2007.

Hawkins compares pathographies to adventure (often in the sense of survival) stories first, and myths later. She counterbalances Susan Sontag's famous statement about the inherent disempowering use of metaphorical thinking about illness, by highlighting to what extent myths about illness can also help patients make sense of their suffering³⁴:

What is striking about pathography is the extent to which these very personal accounts of illness, though highly individualized, tend to be confined to certain repeated themes – themes of an archetypal, mythic nature. [...] Why should the same paradigms recur with such frequency in pathography? [...] If pathography is an imaginative reformulation of experience that reconnects the isolated individual sufferer with his or her own world, the connecting "formula" needs to be both culture-specific and transcultural, for the patient's world includes both a particular society at a certain moment in history and the larger and more timeless human community that underlies it³⁵.

Thus, Hawkins proceeds to identify four recurring myths in pathographies: battle, journey, rebirth and healthy-mindedness – each one the object of scrupulous scrutiny in the different chapters of her book, with canonical literary works (e.g. Augustine's *Confessions* and John

³³ Anne Hunsaker Hawkins, *Reconstructing Illness: Studies in Pathography*, Purdue University Press, West Lafayette, Ind., 1993, p. 1.

³⁴ *Ivi*, pp. 23-24.

³⁵ *Ivi*, p. 27.

Donne's *Devotions Upon Emergent Occasions*) often functioning as blueprints for the different nuances of this new (auto)biographic sub-genre.

Even scholars working on illness narratives have been nonetheless unwelcoming of the category "pathography." Medical sociologist Arthur W. Frank – to a certain extent a pathographer himself, who in his seminal *The Wounded Storyteller* (1995) has provided us with a profitable, even if somewhat rigid, classification of illness narratives – writes:

I am unwilling to adopt Hawkins' preferred term for illness stories, "pathographies," because no ill person has ever called her story a "pathography." Medical language differentiates itself by attaching Greek prefixes of "patho." To call people's stories pathographies places them under the authority of the medical gaze: medical interest in these stories is legitimated and medical interpretations are privileged³⁶.

Along similar lines, John Wiltshire perceives an inherent, contradictory medicalization of (self-)expression in the use of "pathography" as a genre:

ugly in itself, the word makes illness narrative sound like a branch of medicine, thus subverting one of the genre's distinctive aims. More importantly it tends by implication to replicate one of the characteristic epistemological aspects of medicine itself, its focus on a single diseased organism³⁷.

Wiltshire insists on the "pathographical" element as being often only a thread in contemporary narratives, which does not justify Hawkins's crystallization of it into a whole new genre:

³⁶ Arthur W. Frank, *The Wounded Storyteller: Body, Illness, and Ethics*, University of Chicago Press, Chicago and London, 1995, pp. 190-191.

³⁷ John Wiltshire, *Biography, Pathography and the Recovery of Meaning* in "The Cambridge Quarterly", 4(2000), XXIX, p. 409.

The pathography is then certainly a critical patient narrative – a critique of medicine – but it has a broader agenda than simply, like the postcolonial subject, to ‘write back’ to the conquering imperialism of biomedicine, and other issues are involved than those which, in a post-Foucauldian milieu, are likely to be formulated solely in terms of inequities and modalities of power³⁸.

In sum, the fortune of this budding genre seems dependent on the articulation of these epistemological discussions. A closer collaboration with recent life-writing theory, as well as a possible involvement of pathographers themselves in the debate, should yield fruitful results and put to the test the future development of a major avenue in literature and medicine studies.

4.2 Narrative Medicine

Narrative medicine (sometimes called narrative-based medicine, on the model of evidence-based medicine) has embarked upon the most ambitious medical humanistic project of integrating a specific humanistic knowledge (namely, literary studies) to medicine, in order to generate a new modality of clinical practice. It starts from the assumption that patients present themselves and their symptoms to doctors in an eminently narrative form (the patient as text), which is subsequently translated into another narrative during the history-taking phase of the clinical encounter. The dynamics of this rewriting are indeed fascinating from a critical discourse analytical point of view; as Katherine Montgomery Hunter explains in her pioneering *Doctors' Stories. The Narrative Structure of Medical Knowledge* (1991):

The account of illness that the physician is putting together is not the patient's story, although it depends upon it and in part reconstructs it. Instead, it is the beginning of the medical story, a narrative that will be tested against the physical find-

³⁸ *Ivi*, p. 412.

ings and amplified and refined by the physician's physical examination and the results of tests. [...] the physician's concern is to translate the subjective experience of illness into the recognizable discourse of medicine and to record its details, codelike, in the patient's medical record. The case presentation, if it follows, will be the physician's performative telling of this medical story³⁹.

Hunter also identifies a number of issues revolving around this form of representation within the unbalanced power relation between doctor and patient and lucidly singles out the risk of epistemic violence in what she terms «metonymic imperialism:» «a hazard of the act of representing another person in a narrative of one's own construction, and it contributes to the professional shortsightedness that sees maladies rather than people as the objects of medical attention»⁴⁰. It is interesting to note that if, according to Wiltshire, creative rewritings of illness experiences can only partially be explained with reference to the post-colonial agenda⁴¹, the semantic framework of (anti)imperialism provides a valid critical approach, when it comes to the all too factual representation of patients in clinical encounters.

Narrative medicine responds to this status quo, by advocating a new, better informed and more mindful way of attending to patients' stories. So much so, since doctors have to return a narrative to their patients, in the form of diagnosis and treatment plan, as Hunter clarifies:

Just as therapeutic potential is wasted when the medical interpretation of the patient's story is incomplete, inattentive, or dismissive, so when that story is not returned to the patient, the physician-patient encounter is incompletely healing⁴².

³⁹ Katherine Montgomery Hunter, *Doctors' Stories. The Narrative Structure of Medical Knowledge*, Princeton University Press, Princeton, N.J., 1991, p. 53.

⁴⁰ *Ivi*, p. 61.

⁴¹ See John Wiltshire, *Biography, Pathography and the Recovery of Meaning* cit., p. 412.

⁴² See Katherine Montgomery Hunter, *Doctors' Stories* cit., p. 125.

Accordingly, Howard Brody links clinicians' burnout syndrome to sporadic opportunities to re-narrate patients' stories and thus make sense of them⁴³.

In Rita Charon's definition, narrative medicine is «medicine practised with these narrative skills of recognizing, absorbing, interpreting, and being moved by the stories of illness»⁴⁴. Skills of narrative analysis may thus enhance clinical expertise and offer doctors essential evidence they should not ignore, e.g. «existential qualities such as the inner hurt, despair, hope, grief, and moral pain that frequently accompany, and often indeed constitute, the illnesses from which people suffer»⁴⁵. Within this framework, professionals' emotional involvement is not perceived anymore as an impediment to their accurateness and reliability. On the contrary, it is now encouraged as a way of improving clinical performance. The introduction of subjectivity into both sides of the doctor-patient encounter reconfigures a once aloof or paternalistic relationship in terms of mutual involvement and the empathic sharing of narratives⁴⁶.

The Parallel Chart, invented by Rita Charon at Columbia University in 1993, is a good example of how narrative medicine might be actualized in clinical practice. In her own words:

We were very effectively teaching students about biological disease processes, and we were systematically training them to do lumbar puncture and to present cases at attending rounds, but we were not being conscientious in helping them to develop their interior lives as doctors. Nor we were modelling methods of recognizing what

⁴³ Howard Brody, *Stories of Sickness*, Yale University Press, New Haven, CT., 1987, p. 11.

⁴⁴ Rita Charon, *Narrative Medicine: Honoring the Stories of Illness*, Oxford University Press, 2006, p. 4.

⁴⁵ Trisha Greenhalgh, Brian Hurwitz, *Narrative Based Medicine: Why Study Narrative?* in "BMJ", 318(1999), p. 48.

⁴⁶ See Brian Hurwitz, Trisha Greenhalgh, Vieda Skultans, *Narrative Research in Health and Illness*, Blackwell Publishing, Oxford, 2004.

patients and families go through at the hands of illness and, indeed, at our own hands in the hospital⁴⁷.

The Parallel Chart addresses this need: it is a personal narrative, drafted by health professionals in response to the experience of caring for a specific patient, to be later shared with colleagues in training sessions. It is about how that professional situation affects them personally, it collects aspects of the doctor-patient encounter that find no space in a hospital chart. It is not a diary, nor a preparation for group therapy: it is an insightful narrative (re)construction of their professional identity⁴⁸.

The training of health professionals in narrative competence will inevitably rely on the tools of literary criticism, e.g. close reading, narratology, socio-linguistic approaches to narrative analysis. At the same time, literature offers an immense repository of texts for practice. In this sense, with reference to what I announced above, I do not perceive a neat difference between the work of an “additive” literature and medicine scholar, investigating the depiction of a specific condition in one or more literary texts, and the “integrated” work of a clinical communication instructor, who invites medical students to retrieve the rhetorical work embedded in a fictional or genuine account of an illness experience.

On a different note, as narrative medicine develops and gains momentum worldwide, its core tenets and limits have recently been interrogated. Criticism of the contemporary pervasive narrativity thesis has come from different disciplinary perspectives. Angela Woods’ recent article *The Limits of Narrative* provides an illuminating review and thought-provoking discussion of this counter-argument in relation to narrative medicine, and to the medical humanities more in general.

⁴⁷ Rita Charon, *Narrative Medicine* cit., p. 155.

⁴⁸ *Ivi*, pp. 156-157.

Starting from philosopher Galen Strawson's rejection of the supposedly natural human narrativity, she moves on to suggest that:

scholars in the medical humanities can do more to denaturalise narrative, to acknowledge not only that different cultures (including familial, institutional and professional cultures) will tell and find meaningful different kinds of stories, but also, more fundamentally, that the attachment to and valorisation of narrativity is not universally shared⁴⁹.

This invitation is meant to have profound implications on the future development of the medical humanities. Opening up even more to non-narrative representations is likely to counterbalance the current dominance of literature and philosophy within the medical humanities – both heavily relying on narrative forms of representation and argumentation.

In conclusion, I hope I have illustrated the critical liveliness that has animated the evolution of the medical humanities so far. Along with digital humanities and ecocriticism, for instance, they offer an unparalleled opportunity for a profitable regeneration of humanistic knowledge in the academia and beyond. The emergence of these “new humanities” calls for a new form of stimulating and engagé intellectual life that young generations of humanistic scholars might not want to miss out on.

⁴⁹ Angela Woods, *The Limits of Narrative: Provocations for the Medical Humanities* (2011) in “J Med Ethics; Medical Humanities”, doi:10.1136/medhum-2011-010045, p. 4.

WORKS CITED

ALLEN RABUZZI, K. (1982), *Editor's Column* in "Literature and Medicine", 1, pp. IX-X.

AHLZÉN, R., EVANS, M., LOUHIALA, P., PUUSTINEN, R. *Medical Humanities Companion*, vol. 2 "Diagnosis", Radcliffe, Oxford and New York.

CARSON, R. A., BURNS, C. R., COLE, T. R. (eds.) (2003) *Practicing the Medical Humanities: Engaging Physicians and Patients*, University Publishing Group, Hagerstown, MD.

CARSON, R. A. (1994), *Teaching Ethics in the Context of the Medical Humanities* in "Journal of Medical Ethics", 4, 20, pp. 235-238.

CHARON, R. (1990), *The Great Empty Cup of Attention: The Doctor and the Illness in The Wings of the Dove* in "Literature and Medicine", 9, pp. 105-124.

CHARON, R. (2006), *Narrative Medicine: Honoring the Stories of Illness*, Oxford University Press.

EVANS, M., AHLZÉN, R., HEATH, I., MACNAUGHTON, J. (eds.) (2008), *Medical Humanities Companion*, vol. 1 "Symptom", Radcliffe, Oxford and New York.

EVANS, M., FINLAY, I. G. (eds.) (2001), *Medical Humanities*, BMJ Books, London.

EVANS, M., GREAVES, D. (2010), *Ten Years of Medical Humanities: A Decade in the Life of a Journal and a Discipline* in "J Med Ethics: Medical Humanities", 36, pp. 66-68.

EVANS, M., MACNAUGHTON, J. (2004), *Editorial: Should Medical Humanities Be a Multidisciplinary or an Interdisciplinary Study?* in "J Med Ethics: Medical Humanities", 30, pp. 1-4.

FRANK, A. W. (1995), *The Wounded Storyteller: Body, Illness, and Ethics*, University of Chicago Press, Chicago and London.

- GASTAUT, H. (1978), *Fyodor Mikhailovitch Dostoevsky's Involuntary Contribution to the Symptomatology and Prognosis of Epilepsy* in *Epilepsia*, 19, 78, p. 198.
- GREAVES, D., EVANS, M. (2000), *Editorial: Medical Humanities* in "J Med Ethics: Medical Humanities", 26, pp. 1-2.
- GREENHALGH, T., HURWITZ, B. (1999), *Narrative Based Medicine. Why Study Narrative?* in "BMJ", 7175, 318, pp. 48–50.
- HAWKINS, A. H. (1993) *Reconstructing Illness: Studies in Pathography*, Purdue University Press, West Lafayette, Ind.
- HAWKINS, A. H., MCENTYRE, M. C. (eds.) (2000), *Teaching Literature and Medicine*, The Modern Language Association, New York .
- HUNTER, K. M. (1991), *Doctors' Stories. The Narrative Structure of Medical Knowledge*, Princeton University Press, Princeton, N.J.
- HURWITZ, B., GREENHALGH, T., SKULTANS, V. (2004), *Narrative Research in Health and Illness*, Blackwell Publishing, Oxford.
- LYON, J. B. (2005), "You Can Kill, but You Cannot Bring to Life": *Aesthetic Education and the Instrumentalization of Pain in Schiller and Hölderlin* in "Literature and Medicine", 1, 24, pp. 31-50.
- OUSAGER, J., JOHANNESSEN, H. (2010), *Humanities in Undergraduate Medical Education: A Literature Review* in "Academic Medicine", 6, 85, pp. 988-998.
- PAOLA, F. A., WALKER, R., LACIVITA NIXON, L. (2010) *Medical Ethics and Humanities*, Jones and Bartlett, Sudbury, MA.
- PELLEGRINO, E. D. (1982), *To Look Feelingly – The Affinities of Medicine and Literature* in "Literature and Medicine", 1, pp. 19-23.
- PETERSEN, A., BLEAKLEY, A., BRÖMER, R., MARSHALL, R. (2008), *Special Issue: The Medical Humanities Today: Humane Health Care or Tool of Governance?* in "The Journal of Medical Humanities", 1, 29.
- ROUSSEAU, G. S. (1991), *Enlightenment Borders: pre- and Post-Modern Discourses: Medical, Scientific*, Manchester, Manchester University Press.

VEATCH, R. M. (2005), *Disrupted Dialogue: Medical Ethics and the Collapse of Physician-Humanist Communication (1770-1980)*, Oxford University Press, Oxford and New York.

WAITZKIN, H. (1989), *A Critical Theory of Medical Discourse: Ideology, Social Control, and the Processing of Social Context in Medical Encounters* in "Journal of Health and Social Behavior", 30, pp. 220-239.

WILTSHIRE, J. (2000), *Biography, Pathography and the Recovery of Meaning* in "The Cambridge Quarterly", 4, XXIX, pp. 409-422.

WINSLADE, W. J. (ED.) (1988), *Personal Choices and Public Commitments: Perspectives on the Medical Humanities*, Galveston, Tex.: Institute for the Medical Humanities.

WOODS, A. (2011), *The Limits of Narrative: Provocations for the Medical Humanities* in "J Med Ethics; Medical Humanities", doi:10.1136/medhum-2011-010045, pp. 1-6.