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The Writing Cure

By MELANIE THERNSTROM

Chapter 1: A Healing Encounter, or How Medicine Lost Its Way and Tried to Restore a Sense of Story

There is nothing unusual about the case with which Rita Charon, a plenary speaker at a medical conference in Gainesville, Fla., began her lecture. "A 36-year-old Dominican man with a chief symptom of back pain comes to see me for the first time," she said. "As his new internist, I tell him, I have to learn as much as I can about his health."

The familiarity, however, ended there. Charon described listening to her patients in markedly different terms than other physicians do. She did not -- as she told it -- interrupt the man with pesky questions about his pain but rather listened in an analytical way as if he were a character giving a soliloquy.

"I listen not only for the content of his narrative but for its form -- its temporal course, its images, its associated subplots, its silences, where he chooses to begin in telling of himself, how he sequences symptoms with other life events," she said. "After a few minutes, he stops talking and begins to weep. I ask him why he cries. He says, 'No one has ever let me do this before.'"

Charon paused and looked out to see whether the audience was listening to her story with the same intensity with which she listened to her patient's. She is a striking, delicately boned woman, with large blue eyes set in a narrow face, and her reading has both the ingenuous charm of a schoolgirl, looking for attention and approval, and the canny confidence of a masterful storyteller who knows she has it. She's right; the audience was rapt.

The crowd of physicians, psychologists, nurses and English professors had come to participate in a conference on what is called "narrative medicine," but in large part they had come simply to hear Rita Charon -- the leader of the burgeoning movement that seeks to situate storytelling at the center of medicine. Charon, a 54-year-old internist with a Ph.D. in literature, is the director of the pioneering Program in Narrative Medicine at Columbia University, which teaches literature, literary theory and creative writing to medical students and whose practices are rapidly being incorporated and adapted by schools across the country.

Narrative medicine imports terms from literature to describe the doctor-patient relationship. In describing his backache, Charon said, the Dominican man was actually telling an "illness narrative," which can be interpreted just like a literary text: by examining the presentation of character, the structure of the tale and the plot of the disease. Regardless of the outcome -- the diagnosis or treatment (which Charon did not relate) -- what is central is the telling and receiving of the tale. Narrative medicine appears to answer a central paradox. Unlike other fields -- like literature -- medicine really is always getting better. Yet despite its ever-increasing efficacy, nearly half of patients seek out alternative care, and both patients and physicians voice increasing dissatisfaction with the practice of mainstream medicine.

Once upon a time, until the last century or so, doctors (and their predecessors, priests and shamans) had little in their tool bags except their humanity with which to channel that mysterious thing we call a healing encounter: that charged interaction -- personal and impersonal, physical and spiritual -- upon which so much depends. Now that blood tests have replaced bloodletting, how can the interaction be more rewarding?

The answer narrative medicine provides is that in growing as a science, medicine has forgotten that it is an art, which like other arts must celebrate the creation of stories. Increasingly, the medical profession is looking to a literary cure. The past five years have seen an explosion of writing about illness by both physicians and patients who -- like the Romantic poets during the Industrial Revolution -- are trying to restore a sense of meaning and healing to counter the dehumanizing effects of technological explosion. New literary journals have sprung up at medical schools, and longstanding ones have seen a significant increase in submissions and circulation. Prominent medical journals like JAMA have begun publishing personal reflections and poetry by physicians. (Recent titles include "Rubor, Calor, Tumor, Dolor," and "The Alzheimer Sonnets.") Numerous medical schools have begun integrating courses in reading and writing into their curriculums.

Charon first coined the term "narrative medicine" in a January 2001 article in the Annals of Internal Medicine. "Narrative" is the buzzword today in many academic disciplines, from philosophy to anthropology and psychology. Charon defines narrative medicine as "medicine practiced with the narrative competence to recognize, absorb, interpret and be moved by the stories of illness."

The goals of narrative medicine are similar to those of other medical movements that have focused on communication and treating "the whole person" instead of the disease alone, like biopsychosocial medicine, patient-centered care, relationship-centered care, the primary care movement and others. But while other movements have used psychological and spiritual terms, narrative medicine uses literary ones.

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."

By describing communication skills as "narrative competence," Charon is trying to move literature from the margin to the center of medical education. Vital skills are termed "competencies" in medical schools. Narrative competence holds that listening is a skill that can be taught through the study of narrative (in the jargon, "narratology"), just as anatomy can be taught through an anatomy textbook. "I think we're going to see a lot more narrative medicine in the next 20 years and less medical humanities," says Professor David Morris, a writer who is a co-director of the annual Taos Writing Retreat for Health Professionals, a weeklong creative-writing seminar -- imitations of which are popping up. "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."

At Columbia, all second-year medical students are required to take a seminar in narrative medicine; other students may take additional classes like figure-drawing classes at the Met and poetry and fiction-writing workshops -- practices Charon says she believes will create more imaginative, empathetic doctors. It is clear from the institutional support she has won from the National Endowment for the Humanities, the Guggenheim and numerous private foundations and corporate donors and from her busy lecture circuit and attention in the media that Charon's ideas are rapidly gaining acceptance.

"Everyone wants a doctor who's a mensch," says Dr. Jerome Groopman, author most recently of the best-selling "Anatomy of Hope." "Medical schools are searching for structures to produce more empathetic physicians." Disturbingly, psychological testing of medical students shows levels of empathy consistently decline during medical school and residency. Yet empathy is crucial. As a hematologist-oncologist, Groopman says, the last thing he wants is his patients "going to alternative practitioners for healing and me for chemotherapy."

Groopman and the physician-writer Abraham Verghese are both preoccupied with the same issues

that narrative medicine purports to address: ways that medical schools can, through reading and writing, develop in young physicians "the ability to bear their patient's suffering," as Groopman puts it. Groopman is an adviser in a pilot program at Harvard Medical School in which first-year students write a "book" about a patient and his disease over the course of a year. Yet both he and Verghese, who uses literature in his teaching at the University of Texas Medical School, question many of the tenets of narrative medicine, and their programs operate under very different assumptions.

Charon retells the story of the Dominican man in an article in a February New England Journal of Medicine. Groopman notes that he was particularly struck by a revealing detail at the end of it. The Dominican man with back pain, whose story lends itself so perfectly to literary analysis, is actually a composite character based on several patients -- a fact Charon didn't mention in Gainesville.

What, skeptics wonder, does that say about the verisimilitude of narrative medicine? Is this exchange with a composite character a useful model for doctors treating noncomposite patients? Does narrative medicine actually work or is it merely a fiction in love with fiction?

Chapter 2: The Invention of the Parallel Chart, or What Doctors Really Think of Us

"If you asked any of the residents whether they could write poetry, they'd say no," Dr. Bertie Bregman told me. "Yet give them 10 minutes with an assignment and look what they came up with."

Bregman, the energetic and popular chief of hospital services for family medicine at the Columbia University Medical Center, is in charge of shepherding a half-dozen interns and residents through an intensive monthlong rotation in internal medicine. Every other Friday morning, instead of the usual case conference, Bregman and another colleague of Charon's, Craig Irvine, who has a Ph.D. in philosophy, gather with the students over Greek deli coffee and oatmeal to read literature or poetry and write. The Friday I visited, they read a Sharon Olds poem, "The Death of Marilyn Monroe," written from the point of view of the ambulance drivers who removed her corpse. Then they took 10 minutes to write a poem about an incident in the hospital that broke through their own professional veneers.

The poems themselves said little. They tend to resemble song lyrics (Mariah Carey, not Bob Dylan) more than poetry. They consisted of lines like "She knew. . . . /She cried/I cried" (about telling a young married woman she is H.I.V. positive) or "I sweat and scream and laugh and cry with her inside" (about struggling to thread an IV line into the vein of a little girl).

Yet the experience of hearing the poems read aloud was powerful, as the cliches turned into opportunities for discussing the kind of disturbing undercurrents of experiences that usually go unvoiced in the course of medical training. The young married woman who turned out to be H.I.V. positive was one of Jill Groves's first real patients, Groves told the group; she had ordered the test routinely, along with many others, when the woman had a minor gynecological problem and was shocked by the result. Before the follow-up visit, several days passed during which Groves harbored the terrible information within herself. As she was brushing her teeth at night, she felt the burden of knowing something that would irreversibly alter someone else's life. When the time came, she held the woman, and they both cried for a long time.

"I didn't do much," she said.

"It sounds like you did a great deal," Craig Irvine responded.

Bregman nodded encouragingly. Although Bregman clearly has a good rapport with his students, he hadn't known that Jill Groves spent time crying with the patient; his focus is necessarily on making sure she knows how to treat H.I.V. A class like this provides the only scheduled opportunity to deal solely with empathy.

Currently, psychiatry is the only field in medicine in which doctors are routinely encouraged to write about and examine the personal feelings they have about patients as part of their professional work. Yet medical students are so flooded by feelings that they have no time to examine or process that a significant proportion are thought to be suffering, literally, from post-traumatic stress disorder.

It was in response to the lack of structures for reflection that Charon, in 1993, came up with a writing exercise she called "keeping a parallel chart." A parallel chart is a personal notebook in which the doctor writes his or her own feelings about the patient -- the ghost, as it were, of the patient's actual medical chart. For example, a doctor might write in the official hospital chart that the patient is a 57-year-old man with congenital heart disease, adding that he is "pleasant" (the common medical euphemism that signals to other health care staff members that the patient is compliant). In the doctor's parallel chart, however, she could write that the patient reminds her of her dominating ex-boyfriend and that she finds herself becoming infuriated at the way he peers at her through his horn-rimmed glasses.

Ordinarily, you would think such reflections belong in a diary and -- if shared at all -- would be confided only to a friend or a therapist. But by giving these reflective writings the term "parallel charts" and asking students to read them aloud, Charon puts the charts in a clinical context.

"This isn't for troubled students -- it's part of professional training," she says. Charon's vision of the value of a parallel chart differs from Bregman's. Charon feels that to describe this work as therapeutic is to "pathologize," or trivialize, it, as if students were engaging in a support group rather than writing literary prose. "Parallel charts are not for students' emotional benefit but to help them take better care of the patient," she says crisply, as if the latter did not stem from the former.

Charon analyzes the parallel charts using the principles of a formalist literary theory known as narratology, which focuses on the structural elements of stories. Charon teaches students to analyze the elements of contingency (chance), intersubjectivity (the relationship of writer to subject and reader), genre and diction in their parallel charts. It is easy to see why narratology would appeal to physicians; it offers a set of defined and specialized-sounding terms to decode the opaque body of the text. Students came in with bits of writing that Charon helped them realize were actually obituaries, poems, dramas or epistolaries. "Students may be used to writing, but they have yet to experience the marvelous discovery that you can write more than you know," she told me. "We're hoping to let them get the news from what they write -- to gain access to that exquisite knowledge that is only accessible through writing." Students said things to her like, "How interesting -- I didn't know I thought of my patient as a crocus."

In 1999, Charon tried to prove the efficacy of parallel-chart writing. She obtained a foundation grant for a project she titled "The Parallel Chart: Developing Empathy, Reflection and Courage in Physicians." The project was designed, she says, to show how the parallel chart can help students "summon up the courage and insight to interact effectively with sick and dying patients." She took 100 third-year medical students (two-thirds of that year's class at Columbia) and randomly assigned half to keep parallel charts and discuss their writing one day a week for an hour, over the course of five weeks. The study is still being analyzed and has not yet been accepted for publication, but some intriguing initial results have emerged.

The psychological testing revealed no differences between the control and the trial groups. So-called "levels of empathy" declined in both groups, and skill in "coping with death" improved -- characteristic results for medical students. However, the students in the trial group rated themselves higher in several important areas: their abilities to break bad news and to support critically ill and dying patients. Sixty percent of students said that the parallel chart helped them to improve their relationships with, and understand their feelings toward, their patients. Half volunteered that it had helped them to recognize or deepen their empathy. Most impressive, more than 80 percent of students said the sessions were therapeutic, cathartic or beneficial to their training -- a finding that seems to contradict Charon's belief that the parallel chart is not intended to be "therapeutic" or for "students' emotional benefit."

Chapter 3: The Uses of Literature, or Medical Students Treat Ivan Ilyich

The program in narrative medicine on the ninth floor of the old Columbia Presbyterian Hospital building is known as the cool, fun place to visit (a cause of some small resentment among much-less-fun places like radiation and pain management). Charon's welcoming exuberance draws students, reporters and visiting faculty members from other medical schools looking to import her methods -- or just to talk to her.

A remarkable number of distinguished speakers also come and go. Students are privileged to hear Susan Sontag -- last fall's annual writer-in-residence -- critique the pernicious use of metaphor in illness and to hear the writer Richard McCann use metaphor to extraordinary effect in his essay "The Resurrectionist," about his own liver transplant. A parallel-chart-writing lunchtime group for the oncology ward provides an opportunity for staff members to write about their struggles in treating critically ill patients, demonstrating that parallel chart writing can be valuable for staff members as well as for medical students.

When narrative medicine strays too far from medicine, however, it seems to lose its footing. In January, Charon experimented with a new elective called "Narrative Medicine Immersion Month" for fourth-year students, which involves reading canonical literature that is not focused on medicine and writing poetry and fiction about anything that inspires them -- little of which has to do with doctoring.

Charon says she finds it "boring" and "limiting" to teach solely the medically related literature that medical humanities programs do. And since she says she believes studying narrative teaches skills and "increases empathy and imagination" *generally*, medical content is irrelevant.

But are empathy and imagination general things? Watching a sleepy class of students stumble through "The Death of Ivan Ilyich" before a disappointed teacher did not, for me, so much call into question their competence at caring for the dying as function as a reminder that the interior monologue of the stylized Christian allegory is a world away from the I.C.U. (When Charon left the class, I asked for a show of hands: 3 of the 15 students liked the book "O.K," but none of them liked it "a lot." "What do you like about it?" they asked me curiously.)

Jerome Groopman -- who is involved in a pilot writing program at Harvard that requires no reading of literature -- says that it is "unclear how much impact reading narratives has on teaching medical students. It's not a given that the skill set to write or analyze a literary piece is the same skill set as being an effective physician."

Groopman says that he knows "tremendous doctors who speak to both the minds and hearts of their patients based on the language they learned through hard lessons at the bedside, yet do not have a literary sensibility and may not read literature at all. They may watch ESPN sports. Narrative medicine presents it as a truism that because a character's emotions are revealed in literature, reading literature would make one sensitive to patients. Yet this may not occur."

Of course, reading or writing literature is an exercise in empathy and the imagination empathy requires: the ability to inhabit another's perspective. But that kind of empathy may not be so easily extracted from literature. It is one thing to mourn the death of a fictional soldier in Algiers -- especially when the death is wrapped in touching tropes and stitched up in rhyme. It is another matter to care for an actual patient, who -- bereft of an author's linguistic brilliance to render his story beautiful and fascinating -- instead presents himself as a lump of flesh on a table: inarticulate, smelly and carping of a cramp. You have only to think of the stories of Nazi commandants humming Wagner and weeping over Goethe in the death camps to realize that studying the humanities does not necessarily make you any more humane than studying finance makes you care about the poor.

The more you think about the differences between literature and life, or an encounter with a real patient versus an encounter with a fictional one, the greater they become. As Joanne Alonso Byars, a second-year medical student at the University of Florida at Gainesville, who is active in its narrative-medicine program, points out, "The author gives you all the necessary details so the character doesn't, you know, have a kidney condition or whatever that might not come out if you don't ask the right question."

The reason that a literary text lends itself to analysis is that it is a frozen, finished form. A patient encounter, on the other hand, is evolving: the narrative changes with the conversation. Moreover, there is no objectively true reading of a literary text; their truths reside only in the slippery world of words. Clinical narratives, on the other hand, can be either accurate or inaccurate (and subject to malpractice!).

None of these theoretical problems appear, in fact, to be problems for Charon in her own practice. Observing her for several days in a clinic in the hospital that serves the local low-income, mostly minority population, I was struck by the dynamic nature of the interaction. Far from sitting silently and absorbing patients' stories, as she described herself in the anecdote of the Dominican man, Charon was an active questioner. The patients volunteered little -- they were shy and sick -- but Charon led them to tell her what she needed to know by giving positive verbal and nonverbal feedback when they did. She did not dwell on anything, but elicited and responded to personal sorrows one minute and asked about smoking habits the next -- with no sense of disjuncture. The patients -- who, after all, had trekked to the hospital not to have their narratives analyzed, but to get better -- seemed to leave the brief 10- and 15-minute appointments with good care.

Chapter 4: The Fate of Narrative Medicine

At the University of Texas at San Antonio, Abraham Verghese (an occasional contributor to this magazine), heads a program in which he teaches his students what he describes as "literature at the bedside," without "the theoretical gloss." He says that he sees the value of his course as providing informal opportunities for conversation and emotional exchange. "It probably could be a knitting circle and accomplish the same thing," he says cheerfully. "But I'm glad that it's literature."

Speaking at a conference on narrative medicine in Gainesville, in February, Verghese ruffled the feathers of the narrative-medicine community by asserting that the focus of such programs should be works of literature that examine the doctor-patient experience. In contrast to Charon, Verghese says he believes that medical content is crucial and that the value of reading other literature in groups is not to teach narrative competence but simply to provide a "much needed support group" for isolated, overwhelmed medical students. Verghese teaches works like W. Somerset Maugham's "Of Human Bondage," which was part of his own inspiration for going into medicine. He says that he conceives of his own books ("My Own Country" and "The Tennis Partner") as an attempt at writing that "will call others to medicine."

After he spoke, Charon and others stood up and made critical comments and everyone agreed that his ideas were "dated," "old-fashioned" and "passe."

"Seems like I said the emperor has no clothes," he told me ruefully.

Verghese has been surprised at how successful Charon has been at copywriting, so to speak, the idea of storytelling in medicine, "as if this is a new invention." When Verghese submitted an essay to the Annals of Internal Medicine exploring some of his own ideas about the relationship between doctoring and storytelling, the anonymous readers commented that he had failed to cite the narrative-medicine movement. Even though Verghese said he had not, in fact, been influenced by Charon and her followers but was drawing upon his experience as a physician and writer, he duly added citations.

There are also ways to use creative writing in medical schools in which the value of the prose is simply utilitarian -- a tool to learn medicine, without literary aspirations. The pilot program that was begun at Harvard Medical School this fall, which Groopman advises, does not call itself narrative medicine, though it may represent a direction toward which narrative medicine evolves.

Nancy E. Oriol, the associate dean for student affairs at Harvard Medical School, and other faculty members decided to experiment with a no-credit elective in which first-year students were assigned to faculty mentors, who would then match them with one of the mentor's patients, whom the students would follow for a year. In the course of the year, the students would produce "a case book" in which they would write a chapter about every aspect of the patient's disease. One chapter might be devoted to the genetics of the disease (which the student would research by contacting experts), another to its treatment options, another to the patient's familial situation and so forth.

Since the project was not offered for credit, Oriol expected that few first-year students would volunteer for the extra work. So she was overwhelmed when 126 students -- 85 percent of the incoming class -- showed up for the first meeting. Even more startling was the response from faculty members: almost 300 of them were eager to become mentors.

"It's not only students but also physicians who find the structure of contemporary hospital life unsatisfying," Groopman told me after addressing the opening meeting of the project. "They're all looking for more meaningful relationships." Although Groopman himself is a distinguished writer, he said that "we're not looking to produce doctors who can write a sonnet instead of reading a cardiogram -- can you imagine?" He shook his head at the thought. "We're using writing as a technique to learn medicine. It doesn't matter whether the final product has any literary merit whatsoever."

Oriol told me, "I'll be equally thrilled if the student writes a 200-page, dry, clear encyclopedic book or if he writes a beautiful piece."

Like many well-intentioned humanistic trends, narrative medicine may eventually fizzle out. At the moment, though, replete with cash and cachet, it represents a bright hope for restoring ancient virtues to medicine that everyone agrees are in scarce supply. The invention of the parallel chart seems most likely to be an enduring, valuable contribution. A number of medical schools have narrative medicine programs they explicitly model after Charon's, while others have incorporated some form of reflective writing in their practices or are adapting narrative-medicine practices in their own way. At some schools, for instance, students write pieces in which they try to imagine the life of the cadaver they dissect.

At Vanderbilt University, Dr. A. Scott Pearson, a surgeon who directs the new narrative-medicine program, asks medical students on rounds to interview patients and find out some personal information that is relevant to their medical treatment and add it to their charts -- like the desire for prayer in the operating room or a personal reason such makes them unwilling to undergo surgery. Pearson's program also teaches literature, but he seems far less confident of the purpose of that study. When I asked him what he thought the relationship between listening to a patient and examining a literary character really is, he looked at me as if it were a trick question. "What does Rita think?" he asked uneasily. When I demurred, he said, "Well, what do you think?"

Arthur Frank, a sociologist at the University of Calgary, has one of the broadest and most persuasive visions of narrative medicine. He says that he would like to see its focus shifted away from literature and toward nonfiction writing about medicine, like anthropology, ethnography and sociology. "Literary narratology represents the particular interests of the person running the program at Columbia," he says tactfully. "Not that I'm criticizing it." However, in England, he points out, narrative medicine -- including a recently published guide for primary care physicians -- typically does not include the study of literature at all.

As a patient who suffered from a couple of critical illnesses (which he writes about in his classic "At the Will of the Body"), Frank says that narrative medicine should encourage not only physicians' but also patients' narratives -- known as pathographies. "What would it be like for ill people to tell their stories and for doctors to read them?" he asks.

He says he is interested not simply in a parallel chart but in a three-part chart in which the patients as well as the physicians get to write about themselves and report on their sense of the process. "For me, that would be the beginning of a narrative-medicine program," he says.

Frank's vision of how a lost sense of story could be restored to medicine is both lucid and profound. "At the simplest level, narrative medicine means I take seriously that life really is a story," he says. "When a doctor tells you, 'You are sick,' he's not just diagnosing; he is initiating a new chapter in the story of your life." Thus, he says, a physician practicing narrative-based medicine must be conscious of being a character in the story of the patient's life and taking responsibility for the part he or she chooses to play.

In Frank's new book, "The Renewal of Generosity," he examines clinical situations in which health care workers who do bring a sense of narrative to bear have transformative effects. "The physician has a unique role," Frank says. "She is invested with a particular potential for witnessing suffering -- a charismatic authority."

Is charismatic authority the central component of a healing encounter? What, precisely, is its relation to narrative?

He sighs. "I've been trying to define the medical encounter and its relationship to healing for the past 15 years or so. If you or I could define it, I think there's a Nobel Prize in there."

Melanie Thernstrom is a contributing writer for the magazine and the author of "Halfway Heaven: Diary of a Harvard Murder."

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