

Introduction: Narrative Theories and the Medical Humanities

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Ten years have passed since Rita Charon's seminal work *Narrative Medicine: Honoring the Stories of Illness* appeared. It served as a manifesto, as a provisional balance of her pioneering program at Columbia founded in 2000, and also as the theoretical articulation of a sophisticated project that is at the same time hands-on and pragmatic. Narrative Medicine as a book and as a project forged the field of the Medical Humanities as we know it and conferred to the word-association between 'narrative' and 'medicine' a distinctive meaning. This seemingly bizarre semantic marriage had been explored by scholars, in different declensions and from different angles, since the late 1980s. Almost thirty years ago, in his 1988 book *Illness Narratives: Suffering, Health, and the Human Condition* Arthur Kleinman foregrounded the distinction between 'illness' and 'disease' by shifting the focus of scholarly attention from official and necessarily generalizing definitions of syndromes to the individual experiences of those same ailments that patients articulated in his ethnographies. In 1991 Kathryn Montgomery Hunter published her *Doctors' Stories: The Narrative Structure of Medical Knowledge*, one of the very first attempts to bring together medical practice, theories of narrative, and ethnography. These three foundational studies originated within distinct disciplines and served different purposes, yet they shared a pronounced emphasis on storytelling as a working category in their attempts to map and comprehend a field as layered and complex as that of medicine and health. Not only did the authors emphasize 'narrative' in their book titles, but they also made it paramount to their approach, thus inaugurating a methodological trend in the Medical Humanities that has proved to be by far among the most fruitful ones.

In the past ten years the field of Medical Humanities has been burgeoning, a growth spurred in part by the narrative medicine movement. Research into various aspects of the nexus between narrative and medicine has channeled the evolution of the discipline in specific directions and shaped its agenda, while reaching humanists and physicians alike. As a result, Medical Schools increasingly seek collaboration with sociologists, anthropologists, historians, philosophers, literary scholars, as well as performing artists. New departmental configurations, with scholars of English, law, ethics, the social sciences, and the arts conducting their research within Medical Schools, allow for cross-disciplinary collaborative endeavors, enable the formulation of new approaches, and foster what were once unusual conversations. At the same time newly founded academic journals, along with academic association conferences and symposia in all corners of the world, provide the arena for the production and the dissemination of cutting-edge research in the field. On the front of pedagogy, Medical Humanities course offerings and curricula are multiplying, while Medical School curricula in leading institutions are being revised to ensure their students' exposure to the humanities. Top research hospitals (Massachusetts General Hospital in Boston, among others) promote artist- and writer-in-residence programs or suggest

that their first-year students engage with works of World literature and draw reading lists to this goal. Countless initiatives in universities and teaching hospitals around the world are being modeled on Columbia's Narrative Medicine, while bioethics has become an institutionalized priority in global health policies, with steering committees, consultants and think tanks bridging the gap between academic research and political agendas. The two major and quite distinct facets of the Medical Humanities—the scholarly and the pragmatic—are connected by the cushioning field of medical education. In this sense Charon's pioneering program at the Columbia Medical School encompasses all these three dimensions by virtue of its research program, its Master of Science, and the practice with patients.

Why Narrative?

The narrative turn, which in the past decade has interested purviews as distant as law and engineering, evolutionary biology and architecture, information technology and media theory—one of the latest meetings of the International Society for the Study of Narrative significantly took place at MIT—has yielded an august epoch of innovative and cutting-edge approaches within the field of the Medical Humanities as well. The journal *Literature and Medicine* proposes work that engages medicine stylistically and structurally rather than merely thematically; the yearly Narrative Conference constantly features multiple panels on topics related to health and healing across media (literature, film, comic books, videogames), genres and national traditions; Rita Charon's program at Columbia attracts humanists and healthcare professionals alike; and the latest iteration of the Project Narrative Summer Institute at Ohio State (2016) was devoted to narrative and medicine.

Medicine as a system of representation and a set of practices, both of which are steeped in the time and culture that produces them, is particularly prone to be mapped and comprehended with the rich apparatus of tools and definitions that narrative theory has developed in a hundred years—(Viktor Shklovskii formulated his famous concept of 'ostranenie', commonly translated as 'estrangement' or 'defamiliarization', in a Petrograd futurist café in 1916). Questions of authorship, agency, emplotment, perspective, time and space illuminate a field that features delocalized epistemologies and a vast plurality of actors who claim authorship and authority over matters of health and illness. In sum, narrative in medicine is a frequently contested phenomenon, but that contestation makes narrative theory all the more important for understanding its role and significance.

Patients tell their stories to physicians, nurses, paramedics in hopes to have them retold by these specialists in versions that are more plausible and better informed. Differential diagnoses entail competing emplotment solutions that are superimposed over one and the same set of symptoms and phenomena. Patients, doctors, caregivers, insurance companies, pharmaceutical groups, legislators, religious authorities compete for authorship and authority over matters of illness and healing. The ordering of scattered events and phenomena into causal-temporal chains constitutes a cognitive necessity not only for the physician but also for a patient who wishes to make sense of what she is experiencing by authoring a story, let alone the liberating effect of the peculiar splitting of subjectivity that the author/hero dichotomy introduces. The slippery notion of 'patient empowerment' itself suggests these 'emplotment wars' but also the postcolonial gesture on the part of the patient to repossess a body that has been colonized by medicine and its language. Patients Google their diagnoses as soon as they receive them, they learn to speak in technical language in order to be taken seriously and sound reliable, they write blogs and autobiographies. A diffused and segmented agency ensues, which is at times displaced on non-

human actors, as in the concepts of ‘chemical imbalance’ or ‘sugar blues’ that are now widely employed by laymen and health professionals alike.

While diagnostic labeling, medical tools, and active molecules leave traces on a patient, that patient, in turn, as she moves from a hospital room to the next, from registration to the nurse’s cabinet, from the ER to the surgery room, leaves inscriptions that take disparate forms—notes about the chief complaint typed in a form by the registration desk staff, checked boxes in self-assessment pain scale forms, lab data that diagnostic tests yield, insurance bills. Hospitals have been investing considerable amounts of time and resources to streamline this information and create order within these monstrous hypertexts composed of paratactic, cacophonous, heterogeneous bits and clusters of data and fragmentary prose, often contradictory and redundant. Looking at these phenomena through the lenses of narrative theory helps both patients and caregivers get a better purchase on them.

However, if on the one hand healthcare may become more effective when patients are considered with their stories instead as mere carriers of symptoms, and narrative competence may increase medical competence, it is just as remarkable, on the other hand, that the introduction of medical materials into the inquiry of narrative theorists prompts the latter to reassess their established definitions and categories. Narrative reliability takes on new overtones when we consider mental health patients or when we simply take into account the power dynamics at play in the medical institutions. We may also observe what becomes of the ‘virtual plot’ within the ever-shifting time horizon that consecutive, possibly conflicting, prognoses determine. Moreover, how does a plot get complicated and refracted when patients try to obtain prescriptions from reluctant physicians by telling their stories in ways that are suggested and designed by informational and educational websites of pharmaceutical companies with the goal of having patients out-plot physicians—or should we define this narratological battle as ‘counter-employment’?

At the same time, it is of utmost importance not to fall prey to the old Foucauldian temptation to treat everything as discourse. Medical practice lends itself to be analyzed by the rules that apply to the production, transmission, and reception of literary texts, yet people get sick and die for real. Narrative theories provide invaluable tools to navigate this delicate territory, and the essays in this journal issue offer a myriad of perspective on medicine and storytelling and show how a focus on narrative proves effective in bridging the gap between the ‘two cultures’ in both directions.

While addressing this exciting moment in the Medical Humanities and celebrating the narrative turn in the field, this essay collection sets for itself a goal that is two-fold: it draws a balance and provides a state-of-the-field assessment through the voices of some of its protagonists, and it also aims to shape future scholarship by pointing to avenues of inquiry and articulating the theoretical and empirical challenges that lie ahead.

In her opening essay, Rita Charon retraces the development of Narrative Medicine as both a scholarly discipline and a clinical practice, since its foundation at Columbia University in the year 2000 through its development into an international field of research and a worldwide practice. By fostering the confluence of primary care medicine, narratology, literary theory, and phenomenology, Charon makes the case for “narratively-informed” health-care practice and points to emerging avenues at the borders of medicine and narratology that the field is taking.

Charon's claim that narrative competence increases medical competence is explored by James Phelan in his analysis of Roz Chast's graphic novel *Why Can't We Talk about Something More Pleasant?*, an autobiographic memoir about end-of-life and caregiving. Basing his analysis on the rhetorical theory of narrative of which he has been a major proponent and theorist, Phelan shows how Chast's story handles the tensions between the visual and the verbal components of the texts as well as those between modes of fictionality and non-fictionality, and he also reveals how those two axes interact.

The place of young adult fiction, specifically the genre of sick-lit, within Narrative Medicine is the subject of Alison Monaghan's analysis. In the case-study she presents, Stephen Chbosky's epistolary novel *The Perks of Being a Wallflower*, Monaghan highlights Narrative Medicine markers in the text, and argues that young adult fiction offers teenagers, parents, and medical professional invaluable insights into illness from a young adult's unique perspective, thus proving a fertile area of study for Narrative Medicine practitioners.

Conditions, symptoms, and medical treatment can be fruitfully examined in their aesthetic and structural meanings, in their heuristic and epistemological potentials, and such is the approach of the two following essays. By raising questions of narratability, ethics, and trauma, Catherine Belling characterizes anesthesia as an agent that challenges the continuity of first-person narrative by creating an appalling blank space and a disquieting caesura within the stories that patients build about themselves and their experience by relying on memory. If anesthetics cause a tear in the tapestry of narrative that we create to make sense of ourselves and our trajectory, in Svevo's early short story "Doctor Menghi's Drug" narrative agency shifts away from the subject, too—this time to his hormonal secretions. As I aim to show in my essay, in the heyday of experimental endocrinology Svevo's fictional hormone Annina regulates the time of the story, the pace of the narration, the foregrounding of characters, and the development of the plot.

With the examination of the Hippocratic treatise *On Ancient Medicine* through a lens that is at once historical and narratological, Marco Romani Mistretta takes our discussion back to the early days of Western medicine. The author-narrator of the treatise characterizes the history of his discipline as a gradual and continuous unfolding of knowledge about the body and its diseases. The sense of progress, teleology, and time horizon is conveyed through a masterful emplotment of the past, present and future of the field.

Medical practice and the doctor-patient relationship in Gottfried Benn's *Gehirne*, along with the style of his narrative, constitute the focus of Tommaso Meozzi's essay. The peculiar "absoluteness" of Benn's prose, in which traditional causal-temporal links and sequences are discarded, allows for the dismissal of all hierarchies and challenges the usual modes of self-representation.

The following two contributions are presented by scholars who teach and conduct their research within the institutional frames of Medical Schools and Health Science departments, and who draw upon narrative concepts in their pedagogic efforts and theories. Lindsay Holmgren resorts to postclassical narratology (Fludernik, Adler, Phelan), cognitive science (Zunshine), psychology, and Narrative Medicine in order to teach empathy to her students. In a medical education setting that is pronouncedly diverse from the standpoints of culture, ethnicity, class, and gender, professional identity, and specifically empathy within the clinical encounter, is strongly dependent on narrative empathy, which is developed by reading and engaging with works of fiction and their story-worlds. Again, empathy, alongside Theory of Mind and the concept of "narrative transportation," lies at the center of Ron Schleifer and Casey Hester, who relate these three categories of cognitive psychology to character recognition, vicarious experience, and the experience of fellow

feeling in narrative theories. The effectiveness of teaching such non-traditionally medical skills to healthcare workers along with more obvious ones, such as reading X-rays or diagnosing symptoms, emerges vividly from the authors' case study on teaching Dorothy Allison's *Bastard Out of Carolina*. I must confess that as a Slavacist, I particularly enjoyed Schleifer and Hester's employment of Viktor Shklovskii's defamiliarization (*ostranenie*), as it reveals how fertile that concept still proves exactly a hundred years after its formulation.

As part of his ongoing project on 'companion stories', inaugurated with the book *Letting Stories Breathe*, Arthur Frank offers an original reading of Philoctetes's suffering in Sophocles's tragedy, which—we should note incidentally—constitutes one of the earliest literary examples of onomatopoeia employed to express pain. The potential of this and other stories to produce healing is anchored in the ethnography of a critically ill child who engages with a character from a Disney/Pixar film and his vicissitudes as a good companion story.

As I hope is already visible from these summaries of an essay collection that is by no means exhaustive of the field, current research at the confluence of medical practice and narrative theories addresses diverse subject matters with multiple methodologies, even as it remains committed to the goal improving the experience of patients, physicians, and caregivers by illuminating its narrative components, and to enriching traditional narratological categories by employing them to map an unusual territory, the medical field. Like the practice of medicine itself, the field is growing constantly and the contributions to this journal issue indicate that the pace of that growth is itself salutary.