ONE

Where Does Narrative Medicine Come From?

Drives, Diseases, Attention, and the Body

RITA CHARON

A FORTY-EIGHT-YEAR-OLD Dominican man visits me for the first time, having chosen my name at random from his Medicaid Managed Care plan book. He has been suffering from dizziness and chest pain and, he tells me, he fears for his heart. As his new internist, I tell him, I have to learn as much as I can about his health. "Could you tell me whatever you think I should know about your situation?" I ask him. And then I do my best to not say a word, to not write in his medical chart, but to absorb all that the patient emits about himself—about his life, his body, his fears, and his hopes. 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. After a few minutes, the patient stops talking and begins to weep. I ask him why he cries. He says, "No one has ever let me do this before."[1]

In this emerging form of medical interviewing, I am developing new skills to achieve what I think of as the diastolic position—relaxed, absorbing, accepting, oceanic, filling. Like the heart, this position alternates with and mutually requires the systolic position—vectored, muscular, propulsive. One may but need not gender these positions. The heart beats. Either function can be deranged—diastolic dysfunction, we have learned, is as severe a handicap as systolic dysfunction. Good cardiac function absolutely requires both.

THE ROOTS OF NARRATIVE MEDICINE

As an internist, I have been given specified and quite circumscribed duties toward those in my care. I attend to the patency of the blood vessels, the inflation of the lungs, the integrity of the skin. I listen for, in the inspired words of Felix Guyot (1937), the silence of health.[2] As Lewis Thomas said somewhere: If you were put in charge of your own liver, you'd be dead in a day. And so, the internal-medicine ideal of the body is that of the BMW: the barest whirr of parts well-oiled, the confident ignorance to which one can consign the workings of the insides. If something goes wrong, signals flash on the dashboard, the silence is broken by the sounds—the complaints, as we call them—of disease.

It is only when the body complains that we have something to do. Medicine is based on symptoms, and symptoms reflect derangement of function, that is to say, disease. However much some of us like to pay attention to preventing disease or, even a greater reach, being well, the tremendous armature of medicine—NIH, training, everyday practice—is vectored, systolically, toward fixing what is broken. The body is not Virginia Woolf's (1926) smudged and rosy pane of the soul; it is the messenger of molecules gone awry. With near delight do doctors rub their hands together in the presence of disease, or at least rare or unusual diseases—zebras, we call them—because we can behold the perfect in the negative image of the diseased. It is only when something breaks that it becomes visible. Genetic mistakes or acquired damage become the portal through which, in the obverse, medical scientists behold the order of the universe. Disease is the cost—paid, of course, by someone else—of medical knowledge.

But that is not the kind of hearing that my Dominican patient with dizziness and chest pain needs from me. The internist's choice ought not be between the silence of health and the utterance of disease. There are other kinds of communications to be heard. They, too, come from the body. But the body is heteroglossic, is it not? The poor internist has only been trained in one tongue—the tongue of complaint. I think narrative medicine came about in order to teach doctors the language of pleasure, the language of loss, the language of life, and to help them come to understand that these discourses, too, speak of health. What they speak of is *salient* to the work of the general internist, the pediatrician, the busy surgeon examining a belly, the obstetrician sounding a uterus.

Looking with a critical and catholic eye at the emerging field of narrative medicine reveals its disparate roots—literature and medicine, the so-called medical humanities, primary care, relation-centered care, patient-centered care, and biopsychosocial medicine. These several movements are different ways to honor the complexities of the self's relation to the body in which it lives, and they all in one way or another circle around language,

telling, relation, and the imagination. They are all roads toward correcting the undue simplemindedness of biomedicine. Biomedicine has become paltry, limited, conceptually cramped, even as it takes pride in its dazzling complexity and daring. The poverty of medicine is in the dimensions of the figural, the connotative, the meaningful. As doctors and scientists rub their hands in glee in front of their various zebras, sick people are being abandoned left and right, not because their doctors do not recognize their molecules but because they cannot apprehend their narratives.

The name "narrative medicine" visited me as I was working on an essay for a medical journal and could not decide between calling it the narrative hemisphere of medicine or the narrative dimensions of medicine. I realized all of a sudden that if you took the narrative out of medicine, there would be very little left. What would be left in the non-narrative hemisphere? Not research, which always starts with a story; not teaching, which relays tradition; and not clinical care, which, ideally anyway, unfolds in time, attends to the singular, seeks causality and tries to tolerate contingency, requires intersubjective connection, and raises ethical issues between teller and listener. All these features of what we call medical practice—temporality, singularity, intersubjectivity, causality and contingency, and ethicality—are bedrock narrative features. You find them in the tables of contents of the narratology textbooks of Seymour Chatman (1978), Gérard Genette (1972), Shlomith Rimmon-Kenan (2002), Percy Lubbock (1957), and E. M. Forster (1949).

These are the enduring features of how stories are built, and these are the subterranean but nonetheless enduring features of medical knowledge and practice. So the phrase *narrative medicine* came to me as a way to designate medicine practiced with the narrative competence to acknowledge the urgency of time, to value the singularity of patients and self, to seek the causality and to tolerate the savage contingency of disease, to dare to forge an intersubjective connection to sick people, and to fulfill the ethical duties incurred by hearing the stories of illness. I appreciated the grammatical kinship to such names as nuclear medicine and internal medicine. As a nominal phrase, it can say with more directness than can a phrase such as "literature and medicine" that this is a bona fide field of medicine in which you can specialize and still be a doctor.

The roads that narrative medicine have so far traveled began with its roots in humanities and medicine and in general practice. We have joined with literary scholars, novelists, poets, chaplains, oral historians, health professionals of all kinds, artists, and patients to examine the discourse of health care, to teach professionals and trainees about what patients go through, to attend to the interior of those who practice medicine, nursing, or social work, and to develop the competence to recognize, absorb, interpret, and be moved by the stories of self and other. Narrative medicine has evolved as a means to honor the stories of illness, whether told by the patient, family member, doctor, or

nurse. More sharply, it has become a way to probe the *narrativity* of disease, of health, of healing, and of the relation between the sick person and the one who tries to help. The Program in Narrative Medicine at Columbia directs research in the mechanisms and outcomes of narrative training for health professionals, oversees the teaching of medical interviewing skills in the medical school, supports Writers-in-Residence at the medical school (including, of late, Michael Ondaatje and Susan Sontag), provides required courses at the medical school in humanities disciplines, and coaches training seminars in writing and reading for faculty and staff of the medical center.

Unlike such movements as humanism in medicine and professionalism in medicine, narrative medicine provides *methods*. It is not enough to exhort doctors to be humanistic or professional. One has to show them how to achieve such complex goals. Methods developed and sharpened in English departments, creative writing workshops, and oral history projects *work* to teach close reading, reflective writing, and bearing witness to others' suffering. We are slowly coming to see that these are the skills that medicine now lacks, these abilities—I call them collectively *narrative competence*—to get the news from stories, to cohere the booming buzzing world so that it makes sense, to value the tellings themselves and the position of the witness. We are accruing evidence that narrative training is helpful for health professionals and students, but we are at the very beginnings of understanding what really happens when one offers them these methods.[3] We have convened an intensive study seminar of Columbia faculty from a variety of humanities and clinical departments, funded by the National Endowment for the Humanities, to investigate the mechanisms, the intermediates, and the consequences of narrative training for health professionals. What happens that accounts for the benefit of reading and writing in medicine? Our NEH deliberations are generating the hypotheses that narrative training increases learners' capacities to attend to the narratives of patients, to represent that which occurs in clinical practice, and—by virtue of conferring form in the act of representation—to examine these situations once they have been rescued from formlessness. Guy Allen, a psychoanalytic scholar at the University of Toronto, proposes that personal narrative writing functions as a playground, a Winnicottian transitional object, allowing True Self to emerge from False Self and enabling the teller to navigate the shoals between self and non-self. Whether as a transitional object or through another mechanism, we find that narrative writing enables health professionals and patients to join together collaboratively, to build community, to enter affiliation with one another toward the work of healing.

Narrative medicine from the start has been a very practical field, never theorizing outside a praxis, be it in patient care or medical education or doctorly reflection. We offer narrative skills to health professionals and students not as civilizing veneer—how cute, a doctor who writes poetry—but as means to increase their clinical effectiveness. Although one runs the instru-

mental risk of seeming to flatten the intrinsic value of reading and writing by virtue of focusing on the improvements in clinical performance that occur as a result of narrative training, we believe that this field has first to declare its *usefulness* within the clinical setting if it wants health professionals to make time for it and to choose it against all the other skills competing for time and effort.

PSYCHOANALYSIS AND NARRATIVE MEDICINE?

What, though, is the relation between narrative medicine and psychoanalysis? They are both forms of talking cure; they rest on shared beliefs about the nature of health or well-being; they include interior aspects of patient and professional in the work of healing; and they respect the intersubjective dimensions of healing relationships. But what are the dividends of putting them side by side?

A young psychoanalyst paid me a visit in my writing studio. He had read something about narrative medicine on our Web site or in *The New York Times*, and he wanted to learn more about it. We started off on a rocky course because when he looked at my bookshelves—the Henry James criticism section—he said, "I read James in high school." A little on my guard, I then listened as he explained that all I said about narrative medicine was already known in psychoanalysis and in fact was entirely derivative. "Well, but," I countered, still smarting from his diminishment of my author, "narrative medicine has the body."

He disagreed, saying that analysis, too, has the body. The body of the analysand can often give clues to the analyst that words cannot—in gestures, position, expressions, and the like. He said that the analyst will as a matter of course attend to the patient's physical presence while trying to understand his or her experience and conscious or unconscious material. Although his answer was all too meager and foreclosed the disagreement, I admired and chose to sustain the argument. A few weeks later, at a conference at Bellagio on "Narrative, Pain, and Suffering" hosted by David Morris, I related this conversation and wondered aloud to the gathered pain medicine specialists and narratologists whether my visitor was right that narrative medicine was just a synonym for psychoanalysis. Internist Eric Cassell bellowed, "RITA, WE HAVE THE BODY." And he proceeded rather scathingly to dismiss the similarities between the two fields because of the overriding engagement by narrative medicine with corporeal experiences of pain and suffering. The bodily illness, Cassell seemed to be saying, alters the talk and the relation between the two parties, and, I think more to the point, alters the *point* of the encounter. Now, happy in an odd and irrational way that the slight to James had been paid back, I could contemplate with my medical colleagues what it might mean to put these two fields together.

I think both Cassell and I were wrong, not that narrative medicine does not have the body because indeed it does, but that psychoanalysis does not. And my young visitor was far too limited in his conception of what the body does in treatment. Maybe he did not read enough James. Here is Milly Theale in *The Wings of the Dove* after her first visit to Sir Luke Strett, the physician in the novel:

> So crystal clean the great empty cup of attention that he set between them on the table. . . . His large, settled face, though firm, was not, as she had thought at first, hard; he looked, in the oddest manner, to her fancy, half like a general and half like a bishop. . . . She had established, in other words, in this time-saving way, a relation with it; and the relation was the special trophy that, for the hour, she bore off. It was like an absolute possession, a new resource altogether, something done up in the softest silk and tucked away under the arm of memory. (1902, 231)

James figures Milly's transferential relationship with the doctor's body, his face, as a physical object with sensual dimensions, and he realizes that *memory has arms*. The body is right in there, from the start, as transference develops. Known to many as a cerebral and virginal writer, James undergoes the most hazardous passion, the wildest ecstasy, the most daring offering of body and surrender of self. If he couches or hedges his scenes of desire, it is only as a testament to their absolute peril.

He called it "the great empty cup of attention." How did he know about that emptiness? How did he know that, to perform healing by one of the other, one has to empty oneself of thought, distraction, and goals? One has to donate oneself as the amphora, the clay vessel that resonates with the sound of the breath, the sound of the self. In a remarkable early essay, Roy Schafer writes, "Generative empathy may be defined as the inner experience of sharing in and comprehending the momentary psychological state of another person, . . . experiencing in some fashion the feelings of another person" (1959, 345). He cites Christine Olden's statement that "the subject temporarily gives up his own ego for that of the object" (344). Do we not feel exhilarated when we can achieve this empty attention, when we can place ourselves at the disposal of the other, letting the other talk *through* us, ventriloquizing, finding the words in which to say that which cannot be said? This attention has profound implications for narrative medicine, for it is the method through which we enact our professional duty.[4] Developing the capacity for attention may be the main reason that serious close reading is good for health professionals—we allow ourselves as readers to be taken up by the author or the text, in the fashion of Georges Poulet (1969) and congener reader-response theorists. We donate ourselves to the demands of form and of plot. And as Norman Holland (1968; 1975) has discovered, this process simultaneously clarifies and reveals the self—its char-

acteristic modes of coping with tension, its dispositions toward meaning making. Attention may be the pivotal value in all our work—to attend gravely, silently, absorbing oceanically that which the other says, connotes, displays, performs, and means.

But it is Sir Luke's face that forms the link with Milly. Is it the body that functions as the amphora? The body is at the same time the vehicle through which we experience sameness with the other human being and the separateness of the integument. As we sit together, we sit apart. The merging of empathy is tempered by the discreteness conferred by the delimiting skin. The body, that is to say, is *required*. We all know that the experience of analysis is a *highly* corporeal one. Like the reader who silently mouths the words on the page or the little girl who learns to dance by standing on her father's dancing feet, the analysand takes in *nothing* if not through his or her body. We perform our drives. We enact our instincts. It is not enough to think them or imagine them. They require the presence of matter—our bodily matter, James's softest silk—to become visible, graspable, treatable.

The work of treatment takes place within the playground of transference, the bodily experiences of passion and drives toward the analyst, experienced directly in the body of the patient. The analyst too would be *absent* were it not for his or her body. Freud kept reminding us that his work began with drives. "The ego is first and foremost a bodily ego," he writes in *The Ego and the Id* (1923, 26). The goals of treatment are anterior to any emotional or existential ones. The goals of treatment start with freeing the patient's libidinal energy. The emotions and life choices will follow from the release of instinctual energy for personal use.

And yet the metaphorical dimensions of the thought that followed in Freud's wake obscured the fundamentally *bodily* realm in which he found—or placed—symptom, diagnosis, and treatment. The theoretical writings of contemporary psychoanalytic scholars in literary studies and cultural studies seem sometimes to suggest that psychoanalysis is an abstract venture, grounded, if in anything, in discursive notions of the imagination. Whether Freudian or Lacanian, the formulations that have accrued currency in present-day postmodern scholarship—and I am thinking here decidedly of the nonclinical theorizing—treat power and discourse, identity and difference, and whether or not the unconscious is structured like a language and not the elemental drives and physical instincts revealed in successful clinical treatment. Even the work of such scholars as Judith Butler and Eve Kosofsky Sedgewick treats the body as a conceptual category. Only when transference becomes alive in the analysand's body can it dwell in the self and lead to change. Transference happens between the body of the patient and the body of the analyst. Anything symbolic that might precede the physical stage of transference is foreplay.

THE BODY AND THE SELF

If psychoanalysis reminds us of the corporeal dimensions of insight, narrative medicine reminds us of the metaphorical dimensions of illness. The body is *not* transparent, however good the MRI may get. The body—and by metonymic shift, the patient—is not seeable as an object. It is as opaque and explosive a body that sits in the internist's office as is the one that sits or reclines in the treatment session. That the internist *thinks* it is transparent is the problem. That he or she has not been trained to appreciate its opacity is the *real* problem.

I had a patient, a fifty-one-year-old man, who developed terrible headaches and was convinced that he had a fatal brain tumor. He discovered—to his great astonishment and sadness—that he felt ready and even eager to die. He found the prospect of an early death to be a release, a wished-for escape from life. It was through this physical symptom and his response to it that he uncovered a serious depression. He is now in treatment and no longer suicidal.

He comes to mind here because his body *told* him something his self did not know. Illness occasions the telling of two tales at once, one told by the "person" and the other told by the body of the self. How the body communicates its tale is very mysterious. Sometimes its signals are very clear—my left knee hurts since I ran thirteen miles or a sore throat tells me I'm getting the flu. Sometimes its signals are obscure, like the paralysis suffered by Freud's hysterical patients. Even though the body is material, its communications are always representations, mediating the sensations and the meanings ascribed to them. It is sometimes as if the body speaks a foreign language, relying on bilingual others to translate or interpret or in some way make transparent what it means to say.

The self depends on the body for its presence, its location. Without the body, the self cannot be uttered. Without the body, the self cannot enter relation with others. Without the body, the self is an abstraction. Religious scholar John Hull, who became blind in midlife, says that without vision, "I often feel I am a mere spirit, a ghost, a memory" (1990, 25). "This is such a profound lostness" (145). Anthropologist Robert Murphy experienced fleeting neurological symptoms of muscle spasms and numbness of his feet. Eventually, he learned that a tumor had grown around his spinal cord from the level of his neck to mid-chest, compressing the cord and eventually causing quadriplegia. Murphy bends all his skills and conceptual powers as an anthropologist to write a "participant-observer" report on himself, called *The Body Silent* (1990). He understands this dual nature of the body:

> People in good health take their lot, and their bodies, for granted; they can see, hear, eat, make love, and breathe because they have working organs that can do all those things. These organs, and the body itself, are among

> the foundations upon which we build our sense of who and what we are, and they are the instruments through which we grapple with and create reality. (12)

Poised between world and self, the body simultaneously undergoes the world while emanating to that world its self. Or again, the body is simultaneously a receiver with which the self collects all sensate and cognate information about what lies exterior to it and a projector with which the body declares the self who lives in it. The body is the copulative term that bridges self to world.

We are beginning to realize the metaphorical generativity of the body. Ed Cohen (2003) has written about the complex healing metaphors of the body, including the pluripotence of the word *immunity*. The body is probably equaled only by Shakespeare or the Bible in its allusive powers. One need not exceed the body to utter almost anything of value about life. For example, I am currently working on an essay entitled "The Clitoral Brain." What I mean to point to by that phrase is the fact that the body, in all its fecundity, can represent almost anything one cares to represent. It is the master mediator of our passions, the sacred fount of trope. Both merging and keeping separate, this body combines its diastole and systole, ever not explaining but *living* our human situation.

But it is also the harbinger of dread. In a routine medical interview tape-recorded and transcribed in linguistic research, an internist meets a patient for the first time.[5] The patient is a sixty-five-year-old former truck driver who has had to take early retirement for a variety of symptoms. (In what follows, D = doctor, P = patient, tabulated utterances represent interruptions, and square brackets represent inaudible utterances.)

D: You wake up at night short of breath?

P: Right.

D: You do. How long has that been going on?

P: I think about a year. I be sleeping . . .

D: Uh-hunh . . .

P: Where for [. . .] pretty much out of nowhere, and all of a sudden I wake up and I can't get my breath back and I sit up.

D: And how often has that happened in the last year? Is it, you know, once a month, every week, every night?

P: Not every night, not every night. I figure maybe once a week, sometime every two weeks, it all depends, you know it varies.

D: Un-hunh, so and then you, and then what happens?

P: I set up. I'm in pretty good shape.

D: Un-hunh.

P: I be alright, you know.

D: How long does it take before you, your, your breathing calms down?

P: Maybe about five minutes.

D: Five minutes. Anything else when that happens, do you sweat a lot, or . . . ?

P: Once in a while I might break into a sweat, if it be real warm, but that don't happen too often.

D: Most of the time, what about chest pain when that happens, do you have chest pain or not?

P: No, no, no.

D: You're not . . .

P: Not . . .

D: Okay. And, um, uh, uh, do you sleep with one pillow, more than one pillow?

P: Three pillows I sleep on.

D: Three pillows. How long you been doing that?

P: Past two or three years.

D: Past two or three years.

P: Since I quit work.

D: Is that because your breathing is easier on two or three pillows?

P: In a way, yes. It helps.

D: It does.

P: Un-hunh.

The patient seems to be trying to tell a story of himself as a strong working man who drove a produce truck until retirement age, leaving his job only when his leg gave way but who continues to be "in pretty good shape." The doctor interferes with this story, eliciting instead a shadow story of severe congestive heart failure told unwittingly by the patient. Although the patient does not know the significance of his nighttime breathlessness and his reliance on three pillows for comfortable sleep, the doctor does. In effect, the patient's body tells the doctor—over the patient's shoulder, as it were, whispering out of his hearing—about his heart disease. The patient's statement of health—"I be alright, you know"—is overpowered by the voice of his own body. In effect, the body colludes with the doctor to negate what the patient says.

In the analyst's office, the body of the patient takes center stage. It is not the body of symptoms that signify disease, but the body of drives and instincts signifying libidinal health, or a potential return to health. In the internist's office, the patient's body that presents itself is one of hidden frailty, bad news

to be delivered. "I'm sorry to have to tell you this, but you have end-stage congestive heart failure. You have a 20 percent chance of being alive in five years." The double vision that internists develop is one of impending death. All we see when we look into the distance is defeat—not pleasure, not freedom, but death. This is true.

Another important feature of medical practice is illuminated by placing it beside psychiatric or psychoanalytic treatment. It is the case that I can touch the bodies of my patients. I must. I must inevitably inflict pain on them. I do things to them that no one else is allowed to do. I handle my patients' bodies, I fondle them, I stroke them. I percuss them, I palpate them, I inject them. Surgeons do worse. We have *not at all* thought about the implications of this corporeal contact in our work, and I simply bracket that thought for future work.

What the analytic situation makes clear to the narrative medicine situation is the centrality of relation. "Non-narrative medicine," whatever that might be, dispenses with the transference. It overlooks it. It pretends to universality, that is, the belief that any doctor would do the same thing as any other doctor. It dismisses the personal investment in and love of the patient. When we introduce narrative methods to medicine, we are encouraging health professionals to examine their deep attachments to patients. Here is a short poem written by a social worker in Narrative Oncology, where doctors, nurses, and social workers on the inpatient oncology unit gather to read to one another what they have written about their clinical work:

I look at you in the bed, a child
    you think you are a man.
You are fading away,
    now only your eyes seem to enlarge.
You ask when you can go home,
    go back to your life.
This is your life now.
Your family members stand mute
    awaiting answers that are not there.

I will stay the course with you.

We find it is helpful for health professionals and students to reconcile themselves to their tremendously powerful feelings of love and attachment to their patients. The casual use of the word "countertransference" that has sprung up in medicine is usually reserved for feelings of hatred or distaste that we all occasionally experience toward patients, especially those with revolting diseases. And yet the positive countertransference of medicine is tremendously magnetic. Here is a third-year medical student's entry in the Parallel Chart,

a place where students are encouraged to write those aspects of their care of patients that do *not* belong in the hospital chart, in which she has merged, in imaginative identity, with a woman dying of AIDS:

> The day you started to bleed out I ran to the lab with a tube of your blood to find out how many platelets you had left. I told the lab lady that it had to be STAT, STAT, STAT because you were bleeding. She STAT, STAT, STAT-ed her way to the automated blood count machine and promptly put your tube in line behind eight others. I said No!—My blood—I meant your blood—goes in first—and I managed to get us six tubes ahead on the conveyor belt. As the row of purple tops advanced, I watched the tubes ahead of ours be picked up and stirred by the science-fictiony robotic arm. Then it disappeared into the machine and the computer screen told us that someone named Melissa Brand had 110,000 platelets. I never thought there was such a thing as "platelet envy"—but when your count came back as 2,000, I found that I was very resentful of Melissa Brand.[6]

I think that one of the most urgent goals of narrative medicine is to reveal to health care professionals the extent of their positive regard for patients under their care. The corollary goal is to let them understand the power of this transferential relation to improve health. This is vital. The time I spend with a patient, over decades, equals what an analyst might spend with an analysand over years. If I see a patient every two or three months for a half hour at a time and a couple of times a day when she is hospitalized, and this goes on for twenty-five years, and all those phone calls in between and letters to housing, to the disability board, to Medicaid, to get her off jury duty, I have amassed the equivalent of the analytic hours of a couple of years, at least.

We ordinary doctors, I am trying to suggest, can reformulate the goals of everyday medicine in view of psychoanalytic lessons about attention, drives, and relationships. Complicating our notions of the body helps us to do so. Acknowledging the medical transference that develops between us and our patients likewise aids us in this effort. We can all try to achieve the oceanic absorptive position, intercalating and giving *lift* and singularity to our vectored actions on the patient's behalf. We can recognize the human meaning and consequences of disease along with its mechanisms and molecular implications, and we can accept that recognizing them is a necessary ingredient to our care. We can bear witness to patients' suffering as we try to diagnose and treat their diseases.

What will my Dominican man and I do together? My pact is that I will husband his health while I offer an absorptive space and reflective surface to try to *represent* him for his view. His stress test revealed ischemic heart disease, and so we will embark together on treatment, on improving his health, on living within the limitations imposed by his circulatory anatomy. I prepare

for a long life with him—I will get to know his unit number by heart, the names of all his kids and grandkids, his chest x-ray, his LDL, his ejection fraction, his fears, his hopes. Knowing more or less what is in store for him (for I have seen it before), I can illuminate the future of his body while we *find* together a future of attachment and investment. What we generate together in our relation is something of substance, a "special trophy," an "absolute possession" for both of us that matters, that counts, that contributes to his health and well-being and, as a dividend, to mine. Through the attention I donate and the authenticity he displays, we grow together in knowledge, in action, and in grace, hoping for the best, making it out together.

NOTES

1. This description has been published in my "Narrative and Medicine" (2004, 862–64).

2. When I gave this lecture at the Psychoanalysis and Narrative Medicine conference, I wrongly attributed the phrase "the silence of health" to René Dubos. In a marvelous and telling collaborative act, Norman Holland came up with the actual source.

3. See DasGupta and Charon (2004) for a report of some outcomes of narrative writing for medical students.

4. The literature on attention is a vast and most varied one, including philosophers Iris Murdoch, Simone Weil, Gabriel Marcel, and Martin Buber; psychologists of mindfulness; religious scholars who write on contemplative states in Zen practice, mystical Christianity, and the Jewish Kaballah; literary scholars Roland Barthes and Sharon Cameron; aesthetic theorists John Berger and Susan Sontag; and such novelists as Marcel Proust and James.

5. This transcript is derived from a linguistic research project in Ageism and the Clinical Encounter completed at Columbia University, funded by the Andrus Foundation and AARP, with Columbia University Institutional Review Board approval as well as signed informed consent from patients and providers giving permission to the researchers to cite anonymously from the transcripts for educational purposes.

6. Permission has been granted by the author to publish this excerpt of the Parallel Chart. The name Melissa Brand is an alias.

REFERENCES

Allen, Guy. 2002. The "good-enough" teacher and the authentic student. In *A pedagogy of becoming*, ed. Jon Mills, 141–76. Amsterdam: Rodopi.

Charon, Rita. 2004. Narrative and medicine. *New England Journal of Medicine* 350:862–64.

Chatman, Seymour. 1978. *Story and discourse: Narrative structure in fiction and film*. Ithaca: Cornell University Press.

Cohen, Ed. 2003. Metaphorical immunity: A case of biomedical fiction. *Literature and Medicine* 22:140–63.

DasGupta, Sayantani, and Rita Charon. 2004. Personal illness narratives: Using reflective writing to teach empathy. *Academic Medicine* 79:351–56.

Forster, E. M. 1949. *Aspects of the novel*. London: E. Arnold.

Freud, Sigmund. 1923. *The ego and the id*. In *Standard edition of the complete psychological works*, ed. and trans. James Strachey et al., 19, 3–66. London: Hogarth Press, 1953–1974.

Genette, Gérard. 1972. *Narrative discourse: An essay in method*. Trans. Jane Lewin. Ithaca: Cornell University Press, 1980.

Guyot, Felix. 1937. *Yoga: The silence of health*. New York: Schocken Books.

Holland, Norman. 1968. *The dynamics of literary response*. New York: Columbia University Press, 1989.

———. 1975. *5 readers reading*. New Haven: Yale University Press.

Hull, John. 1990. *Touching the rock: An experience of blindness*. New York: Vintage Books.

James, Henry. 1902. *The wings of the dove*. In *The New York edition: The novels and tales of Henry James*. Vol. 19. New York: Charles Scribner's Sons, 1909.

Lubbock, Percy. 1957. *The craft of fiction*. New York: Viking Books.

Murphy, Robert. 1990. *The body silent: The different world of the disabled*. New York: Norton.

Poulet, Georges. 1969. Phenomenology of reading. *New Literary History* 1:53–67.

Rimmon-Kenan, Shlomith. 2002. *Narrative fiction: Contemporary poetics*. Second ed. London: Routledge.

Schafer, Roy. 1959. Generative empathy in the treatment situation. *Psychoanalytic Quarterly* 28:343–73.

Woolf, Virginia. 1926. On being ill. In *The moment, and other essays*, 9–23. New York: Random House, 1974.