# Narrative and Healing, or Probing the Well-Dressed Wound

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Before healing, there are wounds. I begin with two metaphorical wounds. The first is described by a pregnant physician. "I cried there right in the middle of the hall with my white coat split down the middle and my belly sticking out... The surgeon came up to me,... and he ignored the tears and the belly and the baby kicking, so unprofessional...."

The second wound is described by a metaphorical physician, a Danish prince and a would-be avenger. He has diagnosed, and is trying to treat, his mother's hypocrisy. Her wound has closed prematurely: "Lay not that flattering unction to your soul," says Hamlet. "It will but skin and film the ulcerous place / Whilst rank corruption, mining all within / Infects unseen."

In each case, I'll show how the wound—and its narrative treatment—concerns the identity of a would-be healer. I want us to think about what it means to heal wounds, especially metaphorical ones, and to ask whether it should be the work of the humanities scholar to be a metaphorical doctor, offering therapeutic narratives to heal patients and doctors—and modern medicine. Or, if not, then what is it that we can offer?

My topic raises two challenges concerning the work of humanities scholars in medicine. First, the assumption that narrative *per se* is what we do, and that narrative is intrinsically a good thing, making better doctors, healing patients, and so on. And second: the meaning of the word "humanities" in the context of medicine has come to be linked, imprecisely, with a whole cluster of cognates—in particular, words like humanism, humaneness, and humanitarianism—and these words have been used as synonyms for metaphorical (and sometimes literal) healing.

Let's look at some words. Let's look "at" them, rather than using them to look at something else, which is what tends to be done—quite sensibly and usefully—in most other disciplines. I was given three words for my title: Narrative; And; and Healing.

Narrative. The term as it's used in the medical humanities, or in narrative medicine, is often not very clearly defined. One of the problems with the so-called "narrative turn" that has dominated a great deal of interdisciplinary thinking of late is that we have come to see narrative everywhere, forgetting perhaps that while "narrative" is a way of knowing, it does not describe all that is known. Not all language is narrative. Not all stories are narrated. A person's life is not a narrative. The narrative happens when the life is represented, its events recounted. Narrative is text (spoken or written) and always a construct, with some things chosen for inclusion and the vast majority—of possible words, events, impressions, and so on—left out. A narrative is an artifact.

As a way of knowing, "narrative" is also specific and usually individualistic. A narrator recounts particular events happening to particular characters in a particular setting. Narrative resists generalization, and it resists reduction to principles or precepts or probabilities. So how is it useful to medicine? As Kathryn Montgomery, director of the Medical Humanities & Bioethics program at Northwestern, has shown, medical knowledge is inherently narrative in structure. In the individual clinical interchange, the patient recounts a story, which the physician interprets, translates, and retells to the patient. Patients often describe their illness—to themselves as well as to others—in narrative terms, and, hence, experience both the illness and its treatment as subject to the rules of narrative.

Illness may mean that something has gone wrong with the plot. The ill person may think, “In this story I am the hero.” Or, “My character isn't meant to be the one in a hospital bed.” Or, “My story doesn't end before my children are grown up.” Or simply, “This part doesn't make sense.”

To this extent, “healing” (the next word in my title) may be understood as restoring integrity—wholeness. The doctor's role can be to collaborate in this process of integration. This is valuable in that it reminds the doctor that patients are imaginative beings as well as bodies, and that meaning imbues all illness or injury.

But beyond this framework for understanding the patient as a whole person, is there more that medical humanities—particularly literary studies—can contribute? This leads to the smallest word in my title, “and.” Can it do more than suture the idea of stories to that of whole persons (which characters in narratives by definition are not)?

I worry about our imposing a benevolent but premature closure on the rather jagged edges where narrative and healing—or literature and medicine—touch. I want to suggest that the role of the humanities is to provide incisive, pointed and, sometimes, aggressive reading of narrative (and other representational texts that have come to be included under the term). The sharp and prickly adjectives are deliberate. It seems that medical humanities should work by deferring premature closure, by probing wounds, or by lancing boils. Our procedures may be painful, are always aesthetic rather than anesthetic, and may cause messy results. Critical procedures are invasive. Can they also promote healing?

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Let's return to the first of my wounded healers. Dr. Martin is the protagonist and narrator of a short story called “Laundry” by Susan Mates,[1] who is also a physician. We know the character is called “Dr. Martin” because she points to the name tag on her white coat that says so. She doesn't tell us the rest of her name.

In this passage, Dr. Martin has just refused—or failed, depending on your point of view—to persuade Mr. Dantio, a terminally ill cancer patient, to consent to a lung biopsy. First she tells him that “some studies show” that the procedure might enable them to lengthen his life a little. He asks her to “Tell me what you would do,” and after a struggle she gives in: “Don't let them do it to you,” she says and then bursts into tears.

“. . . I couldn't stop the tears,” she says. “I kissed you [she addresses her narration to her now-dead patient] and waddled out of the room and stood around the corner so your wife couldn't see me and I cried there right in the middle of the hall with my white coat split down the middle and my belly sticking out, the baby writhing like a snake making ripples in my navy-blue maternity dress with the little red bow on top.”

Her white coat dressing cannot contain the leakage Mr. Dantio has provoked by calling forth her personal self, with its red bow. She continues:

“The surgeon came up to me, a young man, younger than me, so energetic and clean-shaven and he said did you talk him into it? and he ignored the tears and the belly and the baby kicking so unprofessional and I said no.

“No! he shouted at me and I said I know as a doctor I should have said do it but as a person I felt no no no and he looked at me and stared at me and finally said there is no difference between how I feel as a doctor and as a person . . .”

We have two doctors here. The surgeon, as he presents himself, is fully integrated. He is directed, sure of himself, unambivalent . . . and he is clean-shaven. Not hairy. His body is under control, just as his personal life maps neatly onto his professional one. As she observes a little later, “His clean white coat [is] buttoned down his flat front.”

Our narrator is not buttoned down. Her body is not under control, and her identity as a person is in clear and explicit conflict with her identity as a physician. So clear that we can actually see the one bursting out of the confines of the other: the tears leak out of her face, and her white coat is “split down the middle.” She has a significant wound in the fabric of her being as a doctor. Does she need to be healed? Why is it that the story seems to suggest instead that the surgeon needs to be wounded?

I believe this story is not just about women doctors, although it can obviously be read as such. There's more. Mates presents the doctor's body—or rather her person—a complete, materially present, psychosomatic entity—as overflowing the limits set by her professional role. To read the story as only about gender diminishes its meaning.

It is also about professionalism. Professionalism has recently become a significant focus in medical education, often as a catchall phrase for efforts to restore to medicine something that seems to be missing. Oddly, this seems to have led to shifts in the meaning of the word itself. The professional used to mean the opposite of the personal—as it does in Mates' story, where the doctor and the person are split apart. Yet current efforts seem to be trying to make professionalism do the work of restoring the personal to a profession that has become overly focused on surviving the impact of mega corporations, bottom lines, and a healthcare delivery system that seems at times designed to breed cynicism in practitioners. A “professional behavior” curricular competency includes the expectation that students learn to “deliver appropriate care regardless of patients' personal characteristics.” To be professional is to submerge the personal. To be professional is to be fair, neutral, equitable—disinterested. That's why doctors don't treat their own families. Yet what if we ask what “appropriate care” means? What is dictated by the studies or what the doctor's interested, imaginative, personal engagement with the individual patient as a person leads her, sometimes in tears, to recommend? What kind of education can help doctors resolve this ambiguity?

The term “narrative professionalism” was coined by Coulehan in *Academic Medicine* to describe the use of stories about good doctors to inoculate medical students against the dehumanizing effects of their training.[2]

How would we choose stories for narrative professionalism? Does Mates' story offer this inoculation? She presents the biopsy option to her patient in two voices. As a doctor, Dr. Martin offers calculations based on statistics: the studies. The knowledge she offers is formalized and generalized. Science knowledge. As it should be.

But then, as a person, she finds herself imagining what it'll be like for him, a specific person: "I thought of you lying in the ICU with tubes in your mouth and arms . . . nurses ripping the sheet off . . . your eyes are like mirrors . . . your heart keeps going" and so on. She says what she thinks will lead to a happier ending: "Don't let them do it."

Is the personal better? She's honest, but she may be wrong. What evidence leads to the particular scenario she imagines for Mr. Dantio? What is the reader to make of this? Remember, it's a narrative, and a fiction—a made up thing. The author could have given Mr. Dantio a peaceful, dignified death, had she wanted to.

How does the story end? Endings are the most powerful way that stories impose order on the endless chaos of reality. The ending ties things up, provides closure. Is closure the same as healing? We want the story's ending to be happy, I think. Yet we're also pleased that it's not a simple, too-neat ending because that would be less plausible. Mr Dantio dies, and not well. The physician is still dubious about her role. The ending is messy. She is still folding newly laundered diapers. The baby cries, she picks him up to breastfeed. Milk leaks. "We're drenched, he and I, in a fecund shower." This messiness is positive, surely? It's a fertile mess: breast milk meaning love, nurturing, the kind of things we dream our doctors will do. Mother us, make it all better.

And maybe we also see a kind of closure that is often offered as comfort in the face of death: the neatly seamless and infinite circle of life. Dead Mr. Dantio, new baby, doctor-mother joining them both in a tear-stained milky embrace. We can do this.

Perhaps the story is itself doing the laundry, washing out the dirty diapers, folding them neatly, dressing the wound (with a small red bow?), trying to make us feel we have some kind of control? The sense of an ending is what makes a story make meaning—and making meaning is finally what stories are for. The ending needn't be happy, but it should create the temporary illusion that the world is orderly and meaningful. Stories should provide the illusion of healing.

Because oddly enough, a "whole story"—made whole, all loose ends neatly knotted up—is by definition never the whole story.

A trained reader must begin by seeing the illusion for what it is. A splendid creation, an image of life and the world that is better than life and the world. The trained reader, suspicious of the seamless, then asks how it's done. And then we ask what it does outside of the story, or we might apply some of the same splendid creating in life, in the clinic, if we can do so without simply leaning on comfortable self-delusion.

There's a third identity in "Laundry." Dr. Martin also wishes she could simply cure her patient. She says: "I want to be the hero." Not healer, but curer. All doctors want superpowers. But the word "hero" also works in a more complex literary form than Marvel comic books, and I want to shift to an altogether different kind of professionalism, in a fiction text less literally relevant to medical training.

Now on to *Hamlet.* Here the identity of healer is both figurative and yet absolute, a kind of ideal of professionalism, where personal identity and vocation, task, or purpose in life are inseparable. This is in the always-fictional, always-constructed, role of tragic hero. The King of Denmark is dead and his brother has taken both his throne and his queen. The prince has to figure out his own role in the play. Called on to avenge his father's murder, Hamlet struggles with the role of revenger, the role of tragic hero, and, importantly to us here, the role of metaphorical physician (or to be more historically precise, of surgeon and anatomist).

Something is rotten in the state of Denmark and Hamlet has been called on to treat the infection. The time is out of joint, and Hamlet is chosen—was born, in fact—to set it right, to rearticulate the dislocated bones of his family and his government. This can't be done by making nice. Hamlet's therapeutic role requires him to be a killer, but before he can do that he must be diagnostician. He must, above all, be critical. Incisive, even violent, in his investigations, he enacts a kind of "radical hermeneutics" on his family and his society. I want to focus on one piece of therapeutic violence: Hamlet's figurative vivisection of his mother, Queen Gertrude. This is where he demonstrates the danger of the neatly sutured wound, of premature closure.

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He has confronted his mother in her private rooms and accused her of complicity in his father's death. More important, he needs her to acknowledge her part in Denmark's disease, and this requires inward attention. "You go not," he says, "till I set you up a glass [a mirror] / Where you may see the inmost part of you." She is terrified, for she takes him literally. But rather than pay serious attention to his objections, to the content of his speech, she tries to make him into the patient. She says he is mad—he is sick. We've heard some of his reply: "Mother, for love of grace, / Lay not that flattering unction to your soul / That not your trespass but my madness speaks." Her denial is a "flattering unction"—a soothing ointment that glosses over the flaw. It is bad medicine, for "It will but skin and film the ulcerous place" —make a clear surface over the wound, closing it off—"Whilst rank corruption, mining all

within, / Infects unseen." Beneath the healed exterior, the wound is festering.

As critic and diagnostician, as vengeful healer, as hero, Hamlet works as a lancet. He opens wounds. He lets blood (which was at the time therapeutic for a great many illnesses). Hamlet's methods prove effective. His incisiveness is educational. Gertrude acknowledges her guilt in his medical terms: "Thou turnest mine eyes into my very soul, / And there I see such black and grained spots / As will not leave their tinct," and later, "O Hamlet, thou hast cleft my heart in twain." What follows, this being a tragedy, is a very complex kind of healing: in assisting Hamlet and trying to protect him, she is of course herself killed.

To be more critical is, for the medical humanities scholar, also to be more ethical.

It's important that the kind of wound-draining presented here is not identified with airing of grievances, unreflective emotional disburdening. Claudius is denied the relief of confession, and Gertrude doesn't feel better now that she has apprehended her inner lesions. She dies by taking into her body the poison intended for Hamlet. So is there healing in the play? Or, does Hamlet heal? Tragedy, as a fiction, as life remade as artifact, is, like narrative, always more tolerable than suffering in a meaningless abyss. In response to a question Howard Brody asked in his 1994 article on fixing broken stories,[3] a tragic story is no less healing than a comic one. But much may depend on one's rules for genre and one's expectations of healing.

To be more critical is, I believe, for the medical humanities scholar, also to be more ethical. But the name of our disciplinary field continues to place on us the expectation that we will join torn edges together. The "human" has come to be the word used most to bridge the gap between profession and person. A published definition of the medical humanities captures the burden this conflation of terms can place on our work. Stephen Pattison, professor of religious studies and a leader in medical humanities in Britain, gives a fairly representative—and representatively imprecise—account of what many in medical education expect of the field: "a humane contribution to the humanization of health and health care in the broadest possible way. It would affirm common, if diverse, humanity. It would aim to enhance and affirm human existence and to remain relevant and accountable to humanity understood in the broadest sense."[4] Pattison does not define what he means by "humane," "humanization," or "humanity."

The difficult circularity of these terms makes me suspicious. If we turn to *The Oxford English Dictionary,* to humanize means, most simply, "to give human characteristics or qualities." But we, being human ourselves, pick the admirable characteristics. The second meaning is given as: "to make humane; to civilize, soften, refine; to imbue with gentleness or tenderness."

Stephen Pattison goes on to say what, in his opinion, medical humanities should not be—and I confess that here I feel a little wounded myself. He says that medical humanities "must avoid becoming exclusive and elitist, disaffirming of what people are already doing, dismissive of non intellectuals and nonprofessionals [those who are not professors], or indeed dismissive of professionals [those who are doctors]. It must avoid both becoming 'expert' dominated, narrowly academic, burdensome in its expectations and demands, and imposing an extra compulsory part on an already overcrowded healthcare syllabus. It must not be selfserving or selfperpetuating to justify the existence of some academic groups" and must not be led by "professors of medical humanities who communicate in esoteric jargon." We must personalize and humanize. We dare not professionalize.

But what about the ending of *Hamlet*? Just before the final scene—the one where just about everybody dies—Hamlet finally decides that he will take on the identity of avenger, and dress himself in whatever passes in such tragedies for the white coat—figuratively, at least, the bloodstained garb of the surgeon—but he does so in full acknowledgment of his uncertainty. In fact, the value of his role lies in the uncertainty itself and in his willingness to articulate it. In terms that directly contrast with the hypocrisy he had to cure in his mother, he says to his best friend, Horatio: "Thou wouldn't not think how ill all's here about my heart."

He even likens his forebodings to an infirmity that might affect a doctor, one with a body like Dr. Martin's: "It is such a kind of gainsaying as would perhaps trouble . . . a woman." But despite his uncertainty he proceeds, saying, "the readiness is all."

In the bloodbath that follows, it is Hamlet's apprehension of the complexity and contingency of all action—a perspective unusually self-reflexive in the Renaissance tragic hero—that makes possible the play's final and very conditional optimism about a future, less corrupt, and a healthier world.

And perhaps in that stubborn struggle to find—or make—meaning lies the value of medical humanities. Perhaps it's in acknowledging the way in which well-read texts resist closure—and narratives, even when they end well, are never quite the whole story—that the humanities in medicine can approach a more realistic kind of healing.


## REFERENCES

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