

Writing for Our Lives: Physician Narratives and Medical Practice

THE CONTINUOUS THREAD OF REVELATION

Having grown up with 11 siblings, I learned at an early age that there often existed multiple, contradictory versions of what I thought should stand as a singular truth (my own). We 12 lived a pluripotent family history in the very moments of its making, trendsetters, perhaps, for the later emergence of the deconstruction movement. And as the decades passed, even the “hard facts” tethering our disparate recollections frequently dissolved in the fog of collective memory: “No, it was Uncle *Bill* who dropped the meatloaf,” or, “You’re wrong! It was on *Christmas* day that you ruined my life forever.”

The passionate certitude with which each of us recounted diverse memories of our childhood always amazed me. Official accounts of family history frequently were formed and re-formed by a reigning consensus, dependent upon the particular sibling mix gathered on a particular holiday. Years would pass before I finally understood—and, more notably, trusted—the legitimacy of each differently narrated experience. By all accounts, mealtimes spent around the table were dreary and fun, rancorous and dull, harmonious and adversarial. The youngest, no, the eldest, no, the middle siblings had the easiest time.

From these beginnings, in a dozen different ways, I learned that the construction of personal narratives is, indeed, *personal*. That it is fueled by highly individualized needs and desires to make sense of one’s unique life. Our family provided the context in which 12 separate experiences would hatch—a potential space, particular and relevant, but without a singular or fixed meaning. Personal narratives would evolve into shapes made apparent by each sibling’s life rubbing up against the others’ within the larger framework of family. These shapes would also shift over time as each member’s sensibilities ripened and as definitions of “family” evolved to expand or contract the context in which we related. As Eudora Welty wrote, “The events in our lives happen in a sequence of time, but in their significance to ourselves, they find their own order . . . the continuous thread of revelation” (1).

This dependence of personal narrative on shifts in time and context, and the derivation of meaning through relationship with others, heightened the possibilities for creative expansions of experiences connected to something larger. But always the delicate challenge persisted: to discover the authority of my own experience, legitimize it equally with 11 disparate others, and all the while remain somehow unified as a family. Still, I do wish we could all agree that I peeled most of the potatoes.

My entrenched skepticism about the ability of a single view to function as collective truth has proven to be both bane and bounty for me. In my youth, it stoked mistrust of

monolithic teachings about religion and social sciences, and it urged me toward various developmental versions of nihilism. Yet it also fostered in me a driving curiosity about other peoples’ experiences and a ready desire to hear them—elements that have enlivened my life as a physician and writer.

STORY HAPPENS

In the first of this *Annals* series about physicians and their writing, Abraham Verghese reminds readers about the importance of narrative in medical practice and the role we physicians play as both story and storyteller (2). Extending these points, I would add that, regardless of any dissention about the importance of narrative in medicine, still, “story happens.” It happens automatically during clinical encounters because our patients intentionally insert us into their lives, creating circumstances that directly implicate us. Within health care as context, patients draw us into commenting on, investigating, or altering some fundamental aspect of their lives, explicitly relating us to them. How (but not if) patients make meaning of these encounters is the stuff of their narratives, determining how (but not whether) we physicians are perceived.

Trying to understand how patients perceive us serves more than a curious or aesthetic enterprise. From a practical consideration alone, the therapeutic outcomes following clinical encounters may depend critically on whether we are recognized as caring or uncaring, brilliant or incompetent, involved or disinterested characters responding to their illness as they move along its trajectory.

While patients compose written, thought, or spoken narratives of illness implicating us in various relational ways, we physicians construct parallel narratives incorporating our patients. We assemble them in their most skeletal forms with the bare-boned facts we excavate from patients’ histories and link them to their present lives in hopes of structuring meaning for their problems.

Moving further up the narrative spectrum, we progressively flesh out those bare-boned facts with reflections about our work with patients. We may muscle them with the strength of our personal convictions and interpretations. We may embody them with more holistic considerations of the multidimensional experiences implicit in the life and death transactions of our work.

Here we find writings by physician-authors such as Oliver Sacks, Rita Charon, Abraham Verghese, Susan Mates, Alice Jones, and Richard Seltzer. Their works so fully expand and engage the personal and professional dimensions of doctoring that they expressly remind us of the vast range of human and transcendental experiences avail-

able to us. And, simultaneously, they make us aware of the compromises we've made—agreeably or not—to delimit them.

POTENTIAL SPACE

The distance between the parallel narratives authored by patients and doctors can be as wide as the Arctic flats or as narrow as a sun's lone ray. Yet it always marks a third space, one that belongs to neither but is shaped by both. The pediatrician and psychoanalyst D.W. Winnicott developed the concept of a third space existing between two people in a relationship (3). When each subject asserts himself or herself as an independent being while simultaneously acknowledging the unique independence of the other, the space between them can be filled with shared meaning.

This dialectical process of mutual assertion and recognition fosters opportunities for seeing each other more clearly, for better identifying the shapes and surfaces of each other's life and the genuine differences between them. In relating to each other across this third space, in trying to illuminate it with words, experience is newly mined and generated, making new thoughts and fresh perspectives possible.

Winnicott described this third space as "potential space" to convey its inherent creativity. Within physician-patient relationships, the third space holds the potential for myriad ways of relating to each other within the context of medical practice. And like the elastic notion of family, this context expands and contracts according to shifting definitions of health care over time.

Throughout the twenty-plus years that I've practiced medicine, this potential space has tended toward greater degrees of collapse. It has been compressed by rigid time constraints wrapping around ever-expanding expectations of patients and doctors who must negotiate increasingly complex and multifactorial illnesses using increasingly complicated diagnostic and therapeutic tools. Within a progressively corporate framework narrowing the context of health care, physicians and patients have been made to relate to each other in mechanical or expedient ways, limiting opportunities for mutual recognition and assertion, diminishing chances for genuine contact. As a result, they have drifted unwittingly toward corporate identities as "service provider and consumer" couples.

WHAT IS FOUND THERE

I recently spoke with a group of medical students, and, after explaining my observations about this third-space collapse, one fourth-year student replied, "Well, what's so bad about that?"

I noticed that she held a shiny personal digital assistant device, presumably filled with most of the answers she would ever need. Her short white coat was neatly pressed. And registering the earnest expression on her bright, young

face, I realized that she could be right. That perhaps, in her lifetime, the new corporate paradigm of health care already had supplanted the old one and normalized business-like arrangements with patients. That perhaps it was impractical, irrational even, to deliberate about alternative relationships if now they were solidly conceived as service provider-consumer pacts. Admittedly, whatever is happening in health care settings, many of us are living longer and healthier lives.

And yet, for me, imagining a life of doctoring under the new business paradigm causes Peggy Lee's blunt plaintive refrain to echo hauntingly in my head: "Is *that* all there is?" (4). The new paradigm unsettles me because its shallow purview fails to accommodate all operative elements of the healing interactions that occur between physicians and patients. In the end, I worry about those elements of experience that must be amputated to oblige the new paradigm. I imagine them piling up, forming ominous heaps of unarticulated experience accumulating inside dark warehouses made of thin walls, with doors that do not reliably close.

Voluntarily entering that warehouse is, of course, optional. And choosing to do so will not help you to finish clinic on time, improve quality-utilization scores, or favorably nudge even one Kaplan-Meier survival curve. But entering it will allow you to begin searching through what William Carlos Williams called "what is found there" (5). It will offer you opportunities to reclaim what you might have lost along the way—discarded parts of your inconvenient self, momentary erasures of your misfit perceptions, sharp detachments of your strong feelings and awkward imaginings. It may simply allow you to possess more of yourself.

You can enter that warehouse in many ways. You can step in blindly and stumble onto truths or bump into edges of various perceptions. You can bring a lantern and illuminate each corner, one at a time. Or you can enter with a fistful of words and use them like keys, finding which ones fit to open you to greater expanses of your personal experience.

Authoring this exploration through writing, speech, or thought offers a way of keeping conscious the process of examining personal experience. It encourages an internal dialectic within the physician-author, and so allows the creative, potential space between those two roles to grow.

RESURRECTING NARRATIVES

Writing and speaking about doctoring can save your life. By this I do not mean that they can prolong life, but, rather, that they can prove deeply enlivening. As doctors, we are uniquely positioned to bear witness to birth, death, pain, suffering, and healing. We come up against these conditions repeatedly, encountering them as mirrors, or windows, or both—all reflections that are consciously formulated with language.

Giving language to what we witness lifts into personal

and, sometimes, public consciousness the otherwise unarticulated existential dimensions of experience that permeate our work—whether we name them or not. Consciously narrating these accounts illuminates more of our collective lives as patients and physicians, expanding our felt understanding of human frailty, compassion, strength, love, fear, hatred, and ill will.

I first discovered the urgency to write during my clinical work with AIDS patients in the early epidemic years. During that time, I looked to traditional narratives about physicians' lives but found little that resonated with my personal and professional experience of working with young patients who would all die. Writing my memoir about that time became an exercise in staying alive—to my patients' stories, to their felt experiences of life near death, to my evolving identity as a doctor, to the changing cultural norms contextualizing medical practice (6). I wrote privately and publicly, desperately trying to name "what was found there." Occasionally, I co-narrated stories with patients, and this often transcended the interpersonal. Like two voices blending to create a unique third sound depending on both but belonging to neither alone, our co-creations filled the potential space between us and invoked the broader dimensions of the transpersonal or spiritual.

In these modern times of practicing medicine to the fast-paced ticking of corporate clocks, we may think it luxurious to spend time exploring our personal depths, our private experiences of wonder, and our innermost responses to our patients and our work. As the shape of the physician–patient relationship increasingly resembles depersonalized models of provider–consumer couples, it may seem frivolous or self-indulgent to pay attention to who we are and how we practice medicine. As technological imperatives expand our work within shrinking time constraints, it may seem irrelevant to consider the interior worlds of our patients and ourselves, let alone to speak or write about them.

And yet, paradoxically, these very hesitations reveal why we need to think and speak and write about our work. During "clinical hours" compressed into minutes by the exigencies of health care economics that drearily objectify us as "service providers," to articulate subjective experience—if even privately, if only momentarily—constitutes a radical act that defies this depersonalization.

While writing my memoir, I was encouraged by Muriel Rukeyser's question: "Who will be the throat of these hours . . . Who will speak these days?" (7). In responding,

I claimed my own, unique experience of being a doctor—no more or less important than a dozen disparate others', but one belonging to the whole. As each of us narrates the experiential dimensions of doctoring that only we can know, each of us uniquely becomes "the throat of the hours," speaking and writing to articulate our very lives, finding our own "continuous thread of revelation." As individuals, when we say, "This, but not that, is what I think and feel," or, "This, but not that, is who I am," we widen the truth about who we are as a group.

Finally, when we reflect back on how we live in relation to our work, we will probably consider the choices we made as healers that rendered our patients and ourselves more or less open to the radiant possibilities of being alive. Rather than measuring our professional lives by clocks and corporate yardsticks, we might find ourselves weighing our engagement with the vast potential realm of experience that is made uniquely available to us as doctors. Like Mary Oliver, each of us may hope to claim that "I was a bride married to amazement," that "I did not end up simply having visited this world" (8).

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