# Listening to Stories — A Poet Speaks to Physicians

*by Stephen Dunn*

*Even at its scientific best, medicine is always a social act. — A.H. James*

I address you today as a poet and a teacher of poetry and fiction — that is, as someone intimately concerned with how stories are mediated and heard — but also as a patient who has respect for doctors and doctoring, and who has often been on the receiving end of the doctor's expertise and care. With respect, therefore, I want to explore the links between teaching students and treating patients, the language we use, and the quality of attention we give. I want to make a case for the value of what we might call the "sweetly irrelevant."

## Constructive Listening to Students and Patients

I've long loved a line in an essay by the poet Wallace Stevens (1965): "The poet does not yield to the priest." Stevens thought that poetry was a blend of the imagined and the literal that puts people "in agreement with reality." He sought new "supreme fictions" to supplant the great religious stories, which he felt no longer satisfactorily informed our experience. The priest, he thought, is at most the middleman of a story not very amenable to change. The poet resees the world in his own time, and thus is one of its makers. You may be thinking with equal skepticism, "The physician should not yield to the poet," and there are many instances in which you'd be wise. Poets don't fix anything. Physicians do. Yet there are ways, I think, that we can be useful to one another.

What the patient should want first and foremost from you is your expertise and skill regarding the mysteries of the corporeal body, which our training and modern science have gone a long way to demystify, thank God. A definitive diagnosis is a blessing regardless of its content. The patient has been put in agreement with reality, and therefore can make some informed choices, whether they involve how to live or how to die. At such times, as you well know, the language you use and your tone of voice are crucial. And prior to the diagnosis and its language, the questions you ask and the quality of your listening are crucial. These are matters of tact as much as tactics, and entwined therefore with fellow-feeling and empathy. I suspect such things can be faked, but not over the long haul. The patient on a very fundamental level knows. All of us are known, finally, by the quality of our attentions.

I was pleased to learn recently that there's an area of thinking and concern called narrative-based medicine, which attempts to explore patients' specific stories within the wider narrative of their lives (e.g., see Launer 1999). One of its contentions is that through the detailed study of discourse in context, physicians can learn to listen more constructively to their patients' stories, and therefore make more thoughtful and accurate diagnoses. The implication is that there have been problems in this regard. "Sometimes," one writer states, "a diagnosis can be a tool for fending off a doctor's anxiety," and can "distract attention from parts of the patient's story that might create cognitive dissonance for the doctor." In other words, the doctor, armed with countless "illness scripts" from his education as well as his practice, may encounter a script that fits none of his models. What, then, does he or she do?

## Diagnoses and Remedies

As a teaching poet, I've experienced many parallel situations, and will address a few of them shortly. But usually, when a beginning student comes to me with a flawed poem, I know how to suggest a remedy. After all, I've seen many of its kind. The medical equivalent might be a badly cut finger. It announces itself as such, and you stitch it up. Your ability to make fine, discriminating judgments is not invoked, yet there is little danger of a misinterpretation. It's regular trench work. As professionals, we'd like to think our abilities don't become tested until the problems brought before us are complex, not easily diagnosed or solved. But in fact we face a constant test, regardless of the problem; we're ministering to people who would like us to be more than problem solvers. Yet no one should want a "nice" doctor who isn't also highly capable, just as one shouldn't want a kindly poetry writing teacher who doesn't also possess the objectivity and some of the skills of a surgeon.

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It's safe to say that all patients and most students are needy; we need to recognize this without necessarily wholly giving into it. The paradox is that in order to do our jobs we must become somewhat inured without losing our capacity for empathy. I don't, for example, hug the student who's written a poem about being abused. Neither does the psychotherapist who listens to the same story. I acknowledge the content, but must not become overwhelmed by it. At the moment, I am like a scientist cognizant of superior models to which I might refer the student. My usefulness is in my knowledge, which presumably is unavailable on the street. But in certain instances, I'm confronted by a well-made poem that doesn't easily fall within my models of what a good poem is, which I must nevertheless try to read on its own terms. To bring my preconceptions to it is to do it a disservice and perhaps to miss what it's saying. Though I know this, I confess that sometimes I've been unable to help myself.

Similarly, in an article entitled "Why Study Narrative," Greenlaugh and Hurwitz (1999) point to the dangerous tendencies of some doctors to see the expected and unconsciously dismiss the anomalous. In one instant, they cite a case in which the doctor not only doesn't listen to the patient who suspects he has diabetes, but offers advice predicated on an entirely different story from one the patient told. The patient was diabetic, but the doctor concluded that he had an upset stomach, no doubt because he did, in fact, have an upset stomach. The doctor entirely ignored the mitigating factors, which evidently he couldn't process.

In such cases — mine as well — it might be said that "know thyself" is as important as "pay attention." Why study narrative? There are pragmatic answers to that question, such as to help generate a new hypothesis or provide a framework for perceiving the reliable from the unreliable. But I'd also suggest, in terms of getting to know your patients, that you might have less immediate goals, or none at all. Let stories unfold. Allow them to be sweetly irrelevant, at least for a while, as we do with literature. It is from the latter that over time we learn about ourselves and about otherness. We needn't always think of links to pathology or to message.

## Patients as Amateur Storytellers

Part of my job, as it is no doubt part of yours, is to keep people alive while telling them the truth. This is a delicate art, part tactical, part psychological, always involving tone. "It's tempting to say, "your poem stinks," especially to a student you don't much like. Or to make suggestions for its repair as if I were talking about a little machine made of words not written by a human being. Though I know some creative writing teachers who say such things, I consider it a form of laziness if not

inhumanity. My job is to address the problem in the poem, without making my comments personal, knowing that everything I say — from "this comma is out of place" to "something's wrong at the center of your poem" — will be taken personally. I try to deliver critiques with precision, devoid of ad hominem indictments. The problem, I try to suggest through tone, is one for which I have sympathy; literary sympathy. I understand it as an aesthetic issue and therefore might be useful. That's me at my teacherly best. But what if the poem is far outside my capacity to be sympathetic to it. Not a bad poem, say, but one that arose out of an aesthetic persuasion that I can't abide. If I'm wise I tell the student just that, and suggest it might be better to show it to someone else. (Second opinions are as useful to writers as they are to patients.) If I'm less wise that day, I might diagnose it according to my prejudices.

An ill person is, by definition, solipsistic. One is rarely more self-involved than when ill or troubled. I suppose this circumstance is one good reason why doctors should be paid very well and are, and why creative writing teachers should be paid almost as much. When telling a story in public it is inexcusable in my judgment, not to be interesting. In private, one can think of many good reasons for not being interesting, though it's inexcusable to regularly burden the same person with just the facts. In a social situation, we can say that a bore is someone who tells us about his great sadness twice. But obviously physicians and psychotherapists must have a tolerance for, if not an interest in, the boring. A story, phlegmatically told, for example, may be a clue to something important. Boring or not, ill people are likely to continue to tell their stories until they're sure they've been heard. Teachers need to have some tolerance for the boring, but not much. Writers should have none at all.

## Interpretive Listening

If a fiction writer merely pointed to, instead of creating, a framework for a particular malady, we'd say he was an amateur. All patients are, in some sense, amateurs. They have no obligation to tell their stories well, and we can be sure that most don't. The doctor nevertheless is wholly obligated to listen well, and to keep asking the questions that narrow the possibilities. They must also be open to the unsaid, to that which the patient is either withholding or doesn't know how to say. The doctor must be a kind of detective, alert to the slightest clue. A specialist is someone who knows one or two of those crimes very well, so well — we trust —that he's likely to know who the culprit is and where, and has a reasonable record of tracking him down. Modern technology, of course, is among

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the superior detectives (MRIs, EKGs, and X-rays, to name a few, save a lot of guesswork). All the more reason why physicians must not become machines themselves. We want to believe that our physicians take us seriously in exactly the way machines cannot.

When taking patients' medical histories, physicians are inevitably social scientists in addition to the scientists they've been trained to be. So they need to have the interpretive skills of historians, and psychologists, maybe even ethnographers. But in the broadest sense they need to have the skills of good readers. What are those skills? Alertness, skepticism, and a profound attentiveness to signal, pattern, and tone. Above all, they need a long history of reading to make them comfortable with the frequency of false hints and inevitable complications, and thus permit their intuitions, their provisional analyses, to be altered or reversed or, when appropriate, sustained. The same may be said for scientific method. Follow the wrong lead, and you lose the drift of the unfolding story. Ask the wrong questions, you get useless answers. Ask the right questions, well then, you have something to go on, at least for as long as you reasonably can. Good readers hold their opinions provisionally, adjusting them to new circumstances. A lifetime's immersion in the varieties of story telling will likely permit them to recognize an important moment when it presents itself.

Robert Frost (1984) argued that one is not safe in the world unless he has been properly educated by metaphor. We need metaphor for what can't be directly apprehended. Analogues for soul. Or cosmos. Or mind. Or, for that matter, our love lives. For whatever can't be quantified. And we need the companionship of science to chip away at these mysteries, just as science needs the companionship of art to do the same. In this century alone, think how many mysteries have been replaced by credible, inferential data. Think how much of what seems to have empirical validity has nevertheless led to further mysteries. Black holes, for example, or neutrinos. By hypothesizing that they exist and finding some evidence that they do, makes the universe that much more identifiable for us, though not more metaphysically understood. Conversely, Freud (in many ways I consider him as belonging to the ranks of artists) gave us the metaphor of id, ego, and superego — a handle on the psyche that goes only as far as metaphor can go. We need to be happy with the limitations of metaphor, that is, with brilliant approximations. In other words, we need to know that a large part of our education devolves from stories, from that which has been compellingly imagined.

## Using Literature Wisely

I will conclude with two short stories — one by Katherine Ann Porter (1990) and the other by poet and doctor William Carlos Williams (1956). I've chosen the Porter story, in particular, because it has nothing directly to do with doctoring or caring, but a great deal to do with how literature in general can sensitize us to the nuances and complexities of behavior. One of the shortcomings of current education in America, it seems to me, is its emphasis on relevance, or the fallacy of utility, the notion that there must be a direct connection between what a person is taught and that person's life or field of interest. An education based only on what is "relevant" to our disciplines narrows and straightens the paths we travel toward wisdom. And there are no straight or narrow paths toward wisdom.

### *Flowering Judas*

Porter's story is about a woman who betrays her body, in this particular case her sensuality, for the sake of a revolution. "She wears the uniform of an idea," Porter says. Conversely, the leader of the revolution is a sensualist who betrays his revolution, someone who has learned to use his power to gain small luxuries rather than further an idea. With critical incision, Porter depicts him as having "the malice, the cleverness, the wickedness, the sharpness of wit stipulated for loving the world profitably." The woman senses this, but her ideological sympathies — which we increasingly feel are a kind of body-shield — prevent her from leaving what is now a corrupt, empty shell of a political movement.

Porter's narration and tone are eminently clear for those who have experience with narration and tone and have some politics. But I have taught this story to those who have none of the above, and are therefore confounded by it. It's called "Flowering Judas." The woman has a beautiful, full body, right-minded opinions, and is soul-sick. When confronted with the possibility of sex or even romance, her refrain is "No. No. No." Porter delineates her character and situation as we might expect a surgeon to present what was at stake to his or her assistants before a necessary operation. The woman cannot help herself — in part, of course, because she's a character in a story who is deliberately given limited consciousness. The story that she tells herself is not the same story that Porter, in her artistry, allows us to understand. This is a common literary device. We, the readers (or listeners, if you will), experience an unconscious presentation of self (the woman's) and a highly conscious exploration of that self (the author's). This literary doubling is also, we might say, a paradigm for an ideal attentiveness — a mixture of intense involvement and maximum perspective. This doubling is literature's gift to us: it allows us to see in others the truth we cannot see in ourselves because, like the woman, we're involved in the welter of living it.

Porter has no interest in prescribing a "cure" for the woman's ailments. That is not literature's job. She wishes to deliver her to us, to put us in agreement with a particular reality: how the woman is her own "Judas," a betrayer of self. All the details of this story contribute to this

understanding. Porter focuses a clear, cold eye on the job at hand. Her humanity, it could be said, resides, in the precision with which she delivers human folly and frailty. Much the same could be said of Chekhov — a doctor, as you know, as well as a great writer, whose cold, precise eye also was deeply humane. "Art prepares the soul for tenderness," Chekhov said.

In the fixed structure of a story, life stands still for awhile, the better for us to examine it. The physician, on the other hand, deals with life in flux, and is inevitably presented with different challenges. You must "read" a patient without the help of a governing, omniscient intelligence such as Porter's. I said earlier that many students of mine have misread "Flowering Judas" in spite of the clarity of Porter's narration and tone. These inexperienced readers don't know how to be properly attentive. They focus too exclusively on one thing, say the moral of the story, or on character, as opposed to recognizing the simultaneity of the many factors that constitute "meaning," not the least of which is the author's arrangement of detail and pattern. The equivalent in physician-patient terms, would be a physician focusing solely on one symptom of a person with an indeterminate illness, thus perhaps learning only part of the story. One thing that literature teaches us is that there's rarely just one factor behind an action or motivation. As a teacher of literature and creative writing, it is crucial that I never forget that. I assume that healthcare providers must be equally alert to possible complexities when making a diagnosis.

### *The Use of Force*

William Carlos Williams's story "The Use of Force," is written in the first person, and therefore we neither get nor expect from it the omniscience or perspective that Porter's third person narration permits. Instead we get the immediacy of a struggle told from a doctor's point of view. I haven't chosen this story because the doctor makes house calls. This paper is not an attempt to get you to give that kind of attention. (The story is set in the 1930s or 1940s.) But in fact the struggle commences at the home of a young girl who won't open her mouth so that the doctor can examine her throat — the likely source of what's wrong with her. Structurally, what we have is a girl who won't tell her story and a doctor who nevertheless must ascertain it. What is the doctor to do? Williams makes us privy to the thoughts of a passionate, angry man "in love" with "the savage brat" who won't let him save her, and furious with her over-protective parents. Finally, these thoughts lead to a kind of force, if not violence. After the girl bites down on the wooden spatula that the doctor is using to inspect her throat, reducing it to splinters, Williams's narration continues:

> Get me a smooth-handled spoon of some sort, I told the mother. We're going through with this. The child's mouth was already bleeding. Her tongue was cut and she was screaming in wild hysterical shrieks. Perhaps I should have desisted and come back in an hour or more. No doubt it would have been better. But I have seen at least two children lying dead in bed of neglect in such cases, and feeling that I must get a diagnosis now or never I went at it again. But the worst of it was that I too had got beyond reason. I could have torn the child apart in my own fury and enjoyed it. It was a pleasure to attack her. My face was burning with it.

In short, we are given a doctor we rarely see, bedside manner stripped away. That's a large part of the story's pleasure, and no doubt any doctor reading it will recognize himself in it, albeit his repressed self. To find the source of her illness the doctor literally breaks into her mouth, the diphtheria is revealed, and by the end, the doctor admits with a kind of admiration that "she had fought valiantly to keep me from knowing her secret."

It has been brought to my attention that "The Use of Force" is often taught in the humanities programs that have cropped up in American medical schools since the 1970s and 1980s. In particular, it is used in classes concerned with medical ethics, and no doubt, if the following is any indication, in ways that appropriate its content without regard for the way it is narrated. "They (the residents) can learn how ethical principles and arguments may sometimes be used to rationalize unethical behavior

that is driven by sexual attraction, anger, or pride. So says an apologist for how "The Use of Force" is taught in medical ethics classes. It does not seem to matter to the writer that her statement constitutes a total misreading of the story.

Williams does not attempt to rationalize anything. He enacts a drama with a tone that suggests he's more interested in revealing the "human," albeit flawed, side of a doctor than he is in justifying or advocating anything. Granted, "The Use of Force" can lend itself to that kind of scrutiny, and certainly any text can be appropriated for whatever agenda. Marxist and feminist criticism, for example, enlighten and annoy in the same way. But in terms of education we're left with an interesting trade-off. Students learn something about "unethical" behavior, but almost nothing about how to read well.

If we want our students to be sensitive to hints and clues that occur in the daily world as well as in narration, we need to insist that they read and listen with an alertness that does not allow them to separate content from tone. Or, if they do separate them, they need to know they are "using" the text instead of reading it closely.

Williams's story, for our purposes, does two things, both of which I think are closer to the author's intention and tone. It gives us the sensibility of a particular doctor, and it offers an emblem, however extreme, of what all patients want: the doctor cared so much about the patient that he would do anything to "hear" her story.

Varieties of behavior, degrees of ambiguity, the mysteries and struggles of being alive — that's what good literature enacts and explores. Once we've learned how to read it closely we can approach it without a program, and let its relevancy occur as it may.

Every human being is a story with subplots and perhaps even more than one personality. Patients or students, they come to us asking to be read. To do our jobs well we need to strive toward a kind of double mastery. First, of what can be known because of our training and practice. Second, of that which can be intuited or pieced together because we have taught ourselves to be, in the broadest sense, good readers. There are times of course, when we must say, "You have cancer," or "your poem is an ill-conceived poem," moments without the slightest ambiguity. That's when we must hope our education has instructed us in the delicacies of saying so.

Listening, as has been said, involves caring and empathy, and another rare commodity: time. How do you see as many patients as your managed care affiliate deems appropriate and still give each patient sufficient time? How do you transcend the sorrowful state of our litigious society, which no doubt inspires excessive caution, if not fear? How do you risk being wrong these days? In short, how can we do some soul-work with so many forces militating against it?

We can always get by with giving less. Some of us can even do a great deal of good without actually caring very much about individuals. But as stated earlier, we will be known, finally, by the quality of our attentions. To take someone's problem seriously, that is, to bring to it an amalgam of one's expertise and attentiveness, is the professional's form of love.

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