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**The Limits of Humanism:
Uses of Metaphor and Narrative in Medical Texts**

By

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THESIS

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INTRODUCTION

My thesis concerns, broadly speaking, the relationship between the humanities and medicine; specifically, it explores this relationship by asking how metaphorical and narrative aspects of language use reinforce clinical practices and professional self-concepts in the medical arena. The individual textual interpretations are motivated by the interdisciplinary question of what the humanities can offer to medicine. The idea that medicine is in need of external influence by the humanities has gained currency in recent years. Perhaps medical care could become more humane, it is said, if practitioners broadened their educational horizons, honed their communicative skills, and attended more closely to the psycho-social circumstances of patients than to an abstract disease process. Recruitment of the humanities for the benefit of medicine raises two questions, a methodological and a practical one. First, what are the limits and possibilities of interdisciplinary analysis, given the divergent theoretical concerns and methodologies of medical science and the humanities? Second, what practical improvement could preoccupation with the humanities bring to patient care in a modern medical setting? I will develop these questions further in the introductory remarks that follow. In the body of my paper, I attempt to answer them, albeit indirectly, by examining a specific instance of the relationship between medicine and

the humanities. I interpret the meaning of metaphorical and narrative functions in medical discourse, and discuss the identifiable 'attitudes' that medicine has developed towards these aspects of language, transforming and limiting their use. By analyzing the ways linguistic and literary phenomena are adapted to a medical context, I also hope to show how these incorporations reflect specific ideological and professional tenets of medicine. My approach will be not only to interpret medical texts--largely medical textbooks themselves--but also to include assumptions made from scientific, medical and lay points of view about the standards of medical language. Statements about linguistic function drawn from the combined first- and second-hand texts constitute what may be called the medical discourse about language. I begin with a discussion of a 'humanistic deficit' in medicine and of the problems in both theory and practice attending efforts to make the humanities useful for medicine. In two subsequent sections on metaphor and narrative respectively, I then show how the humanistic potential of language is subordinated to the practical requirements of clinical discipline.

In recent years, medicine has increasingly yielded its secrets to consumers, gadflies and theoreticians. Medicine has become the interdisciplinary field par excellence, with a little piece of itself to distribute to everyone. The causes for this explosion are many, but one may guess that

the most important contributing factors are institutional and economic; that is, when medical care descends as conspicuously as it has in the last decades into the marketplace, it relies for its sale on broadly scaled self-promotion.¹ The public has fully participated in this development by taking a more active role in acquiring medical knowledge, but it has also begun to preoccupy itself critically with the inner workings of the medical profession. Consumer insight and critical scrutiny go hand-in-hand, as many lay health manuals emphasize.² Such intense involvement has generated everything from malpractice suits to best-selling 'inside stories.' It has also generated a vast amount of scholarly interest in medical practice by social scientists, moral philosophers and students of literature.

In consonance with the public's pugnacious attitude, the scholarly approach has been to focus on the failings within the medical profession, and to seek remedies; furthermore,

¹ Modes of dissemination include frank advertising as well as esoteric promotional tactics, such as hospitals offering patients hot tubs and large-screen television sets (William Celis, "Hospitals Compete for Affluent Patients by Offering Luxury Suites and Hot Tubs," Wall Street Journal 3 Feb, 1986). More familiar themes through which medicine is popularized include vaunted wonder drugs and technological medical miracles; publicity about the benefits of nutrition and exercise ("The U.S. Quest for Physical Fitness," The San Francisco Chronicle, 3 March, 1978: 15); the vast array of home medical literature authored by M.D.'s.

² See, for example, Lawrence Horowitz, Taking Charge of Your Medical Fate (New York: Random House, 1988); Keith Sehnert with Howard Eisenberg, How to be your own Doctor (Sometimes) (Toronto: Perigree Books, 1975).

interdisciplinary perspectives have led to critical self-appraisal within the medical community itself. Taking the cue from other disciplines, this self-criticism has raised the question, in effect, of how medicine can benefit from the study of ethics, law, anthropology and sociology. In this way, medicine has duly internalized its relevance for all kinds of academic pursuits. Medicine has become interdisciplinary, then, not only because of its appropriation by other fields via increased public scrutiny, but by its own self-scrutinizing assimilation of other disciplines.

One of the fields newly explored for promising applications is the humanities. This generic term crops up in various arguments, instead of specific reference to art, music, history or literature, for at least two reasons, both closely related to the usefulness the humanities are thought to have for medicine. First, the term evokes a loosely defined historical period, that of 'humanism,' associated with such physicians as Paracelsus, Rabelais and Sir Thomas Browne who are regarded as having practiced the art as well as the craft of medicine in an era when "medically related literature was still invariably informed by moral, religious, and social values..."³ This intermingling of disparate intellectual and aesthetic realms projects an image of a complete, integrally functioning

³ Philip Mosley, "The Healthy Text," in Literature and Medicine 6 (1987): 35.

practitioner, and echoes the contemporary call to restore medical attention to the 'whole' patient, as a psychosocial entity and not just as a disease process. Apparently, the alienation attributed to the patient in some medical settings is experienced by the physician at the level of his clinical activities as well. Renewed attention to the humanities thus fills a gap created in the physician's professional life by an imputed disruption of the humanistic heritage.

Secondly resonating in the term 'humanities' is the word 'humane,' or 'human,' and indeed, the much-touted 'changing health-care climate' is seen to have eroded this component of medical care. As Eric Cassell argues in "The Commodity View of Medicine", physicians are perceived as behaving poorly:

Patients increasingly want to be treated as persons--not just as containers of a disease. People who have been sick usually do not complain about the technical inadequacies of their care--there has been plenty of technology. They complain, rather, that their doctor did not listen to them, did not explain things, did all kinds of tests but never stopped to find out what they, the patient, thought.

This tainted image, according to Cassell, is made possible by the development of medicine as a commodity, raising demand for agreeably packaged medical care. In a more ad hominem vein, physician disrepute has been attributed to

⁴ Eric Cassell, The Wall Street Journal, 30 April, 1979.

sheer greed, as columnist Jon Carroll colloquially summarizes: "Lots of people hate doctors. I mean, really hate them; a deep and abiding dislike. Doctors are perceived to be rude, avaricious and callous. Specifically, they are considered to be more interested in dollars than in healing."⁵ It is not my purpose to ponder the veracity of these familiar imputations, although at worst we all have our personal anecdotes to lend credence to popular opinion.⁶ Suffice it to say that these physician-Beelzebubs are the precise counterpart of the deified image of the physician that preceded them historically by a decade or two, and that the humanist ethic as a prescription for medicine is conceived as an antidote to both divine and satanic proclivities.⁷

In any event, elegies to an old-fashioned, personal, and compassionate standard of care abound, many of which again draw on first-hand observation. Thus Melvin Konner, having returned to teach anthropology after his medical student experience, sums up his impression of doctors:

⁵ Jon Carroll, "Doctor Rage" The San Francisco Chronicle, 16 October, 1983.

⁶ My own story, though perhaps here gratuitously placed, entails witnessing a physician announce to a patient a fatal diagnosis. "Looks like we have a little bit of leukemia here," he announced cheerfully as he strode into the room.

⁷ "You look like a god. Oh, yes you do. Don't contradict me. Medicine may be your game, but the detection and identification of gods in modern life is mine, and I assure you that you look like a god. Your patient may not think so--not consciously. But about your head shines a divinity..." Robertson Davies, "Can Physicians be Humanists?" The Johns Hopkins Magazine, (36, 3), 1985, 29.

To them, the world consists of only doctors and nondoctors. They inevitably drift, on their sturdy boat of medicine, farther and farther away from the shore of common human experience. Even the superb body of experience to which they are exposed in their daily work is somehow largely lost to them as a source of existential growth. Despite their impressive and heavy responsibilities, they often remain eternal adolescents....

This indictment is followed by the longing "...to see them gain some greater understanding of the human situations they deal with, understanding...of the fear, the loss, the dependency, the emptiness, the pain."⁹ The humanistic disciplines, not the hospital rat-race, Konner's message reads, nurtures the kind of understanding that is lacking in medicine.

Konner's view is widely shared by advocates of the new medical 'humanities', but with an important difference. Konner's double exposure as an anthropologist and a doctor have convinced him of the incommensurability of the two realms. He feels that in the context of the modern practice of medicine, humanistic training represents an excess that trips up the smoothly oiled institutional machinery. "In dozens of situations where my fellow students seemed to act first," Konner writes in an all-too-frequently evident tone of self-congratulation, "I usually thought and then

⁸ Melvin Konner, Becoming a Doctor (New York: Viking Books, 1987), 376.

⁹ Konner, 364.

acted..."¹⁰ This value-laden distinction, together with an ambivalent sense of superiority ("I often wished for less consciousness") recalls Dostoevsky's celebrated juxtaposition of the man of thought with the man of action, relying on a powerful topos to separate the goals of science and art.¹¹ Instructively, Konner's self-analysis echoes a comment by another physician, quoted in the context of a plea for a more humanistic medicine: "'When you find yourself at the bedside, don't immediately do something: just stand there!'"¹² For indeed, the power to reflect productively is one of the exportable skills that the humanities are thought to have to offer to medicine.

Konner's pessimism is not shared by other physicians and writers preoccupied with the potential impact of the humanities on medicine. Nevertheless, the effects that the humanities are considered to have on medical professionals are vague, and that is no doubt why little effort is made to evaluate epistemologically the different contributions made by art, literature, music, and even jurisprudence and ethics, which are all lumped together by virtue of their common 'humanistic' origin. Their effect is considered to be

¹⁰ Konner, 364.

¹¹ "...facing the wall, such people--the straight-forward persons and men of action--are genuinely non-plussed. For them, the wall is not an evasion, as for example for us people who think and consequently do nothing..." Fyodor Dostoevsky, Notes from Underground, trans. Ralph E. Matlaw (New York: E.P. Dutton, 1960), 9.

¹² Robertson Davies, 30.

indirect, qualitative, and difficult to define. Overall, they are thought to create better human beings, and by extension, better, more caring doctors. Among the transmogrifications imagined to result from a humanistic education are "the cultivation of empathy for the suffering...the coming to terms with human frailty, failure and mortality," "an appreciation of complexity, of the ambiguities and ironies that characterize each life, and of the psychological and moral subtleties that illness so often sets in motion" and "to appreciate the many dimensions of human experience".¹³ However, specific clinical skills, such as making an emergency ethical decision, or communicating a prognosis, have also been adduced as beneficial results of humanistic pursuits.

Built into this medical humanism are the limits imposed by its speculativeness. Any effort to gauge the ameliorative effects of a programmatic humanism runs counter to its implication, which is to generate a certain attitude or preparedness rather than to produce a measurable behavior. Furthermore, methodological problems that arise both theoretically and practically in linking the disciplines cast a shadow over any broader speculations. To take

¹³ James Terry and Edward Gogel, "Poems and Patients: The Balance of Interpretation" in Literature and Medicine, (6) 1987, 43; Robert Coles "The Humanities in Postgraduate Training" in JAMA 9257, 12), 1987, 1644; Physicians for the Twenty-First Century, Report of the Panel on the General Professional Education of the Physician and College Preparation for Medicine (Washington: Association of American Medical Colleges, 1984), 6.

cognizance of these weaknesses is to understand better the real and potential relationship between the humanities and medicine.¹⁴

One problem with many humanistic approaches to medical science is what may be called the forced analogy. By establishing strict and sometimes strained correspondences, certain medical phenomena are shown to be 'really like' similar phenomena in another field. Linguistics and literature often supply points of analogy. For example, Roland Barthes, in an early essay "Semiology and Medicine," runs through various semiotic features, including the structure of the sign, the opposition between simultaneous and sequential features, the so-called marked and unmarked terms, and so forth, and finds for these medical equivalents.¹⁵ Thus the notion of 'fixed syntagm,' which in linguistics is a group of words that are always used

¹⁴ It goes without saying that one need not look to medicine to question the ameliorative effect of the humanities; social scientists, literary critics, philosophers and so forth are presumably not 'better' than their medical colleagues. This is the point made by Leon Eisenberg and Arthur Kleinman, prefaced by a remark with which I also agree: "Helping to make young doctors humane is more likely to be achieved by providing role models of humane internists and pediatricians than by courses in literature or philosophy. Humanism is a criterion by which all of us must be measured; we are not convinced it is more often found among Professors of Romance Languages or American History than among Professors of Physics or Molecular Biology." Eisenberg and Kleinman, "Clinical Social Science," The Relevance of Social Science for Medicine, ed. Leon Eisenberg and Arthur Kleinman (Dordrecht, Holland: D. Reidel, 1981), 15.

¹⁵ Roland Barthes, in The Semiotic Challenge, trans. Richard Howard (New York: Hill and Wang, 1988), 202- 213.

together but mean just one thing, such as 'word processor,' translates for medicine into a 'syndrome', which consists of preestablished symptoms that together constitute a disease entity. More heavy-handed than Barthes in selecting their comparative terms, co-authors James Terry and Edward Gogel force patients on the Procrustean bed of poetry. Their conclusion is that "...the analogy between poetry and diagnosis makes it possible to postulate the balanced empathy necessary for effective clinical practice. Poetry's strong claims are its indirection, its ambiguity, its transcendence of parts--all of these very much like working with real patients in real time. A good poem retains its wholeness even while being analyzed."¹⁶ While Barthes' one-to-one correspondences are only pedantic, Terry and Gogel's analogy closely approximates the absurd: their anthropomorphic premise is that a poem is like a person and can therefore be understood in the same way. Barthes, by his own admission, was at least motivated by an epidemic passion for 'scientificity' to seek the underlying equivalences between disciplines; no such methodological quest organizes Terry and Gogel's work.

Yet another attempt at analogy is incorporated into a scientific paper by the celebrated immunologist Niels Jerne, who draws on transformational grammar in his heuristic review of the body's immune system. The tightness of the

¹⁶ Terry and Gogel, 52.

analogy is already suggested by the prepositional link in his title, "The Generative Grammar of the Immune System." In actuality, however, the fit between the comparative terms is poor, as a detailed analysis could readily show. What interests me here is the assumption that such analogies can be made smoothly, without acknowledgement of differences. Indeed, Jerne comes to the following astonishing conclusion: "Biologically speaking, this hypothesis of an inheritable capability to learn any language means that it must somehow be encoded in the DNA of our chromosomes. Should this hypothesis one day be verified, then linguistics would become a branch of biology, and the humanities, perhaps, some day, part of the biological sciences."¹⁷ The relationship between the immune system and generative grammar is, in the final analysis, inscribed in the human genome. Though Jerne introduces his analogy as a mere heuristic tool, he ultimately moves beyond the unreflected equivalence by subordinating the human phenomenon of language use to biological science. This almost inapparent transition from equivalence to hierarchical arrangement illustrates a second type of problem that frequently mars efforts to make the humanities relevant for medicine. More the result of structural and practical arrangements than methodological weakness, the problem can be characterized as one of 'appropriation:' when medicine incorporates lessons

¹⁷ Niels Jerne, "The Generative Grammar of the Immune System," in The Embo Journal (4,4), 1985, p. 852.

from the humanities, it subordinates these lessons to its own institutional necessity.

The subordination of humanistic inquiry to medical discourse is methodologically problematic, but it also raises questions about the practical implementation of 'humanistic ideas' in a clinical setting. Although a literary work or a Renaissance painting may indeed stimulate thought, facilitate relaxation and so on, they lose their identity, chameleon-like, the moment the medical humanist assesses them for their usefulness. In all the talk about what the humanities can do for medical practice, the work of art becomes medicine's adjunct--a therapy, an instrument of cure. Poetry, story-telling, hermeneutics, to cite examples from literary studies, are recruited for their healing potential, often magically redemptive as might be incantations and amulets in non-Western cultures. Though he writes with tongue in cheek, Robertson Davies challenges patients' 'stupidity' precisely by imagining a physician prescribing Rabelais, Mark Twain, and John Donne to his bored, self-involved and fat-headed clientele. These inspirational 'doses' will give them something else to think about.¹⁸ In other instances, advocating the study of the humanities, readings, discussions, and breaks from the workaday routine become metaphorical prescriptions to cure doctors of their disaffections and clinical maleficance.

¹⁸ Davies, 34.

Problems of scheduling and curriculum enhance this hint of regimen. Professional and curricular time constraints force humanistic preoccupations into convenient, temporally segregated slots. For example, planning committees have alternately suggested that exposure to the humanities should take place in the premedical curriculum or in post-graduate training, as a medical school class or a faculty seminar.¹⁹ If there is sometimes a sense of opprobrium that limits attendance of these sessions, it is because structurally they occupy a position identical to other medical education classes. Insofar as that is the case, the key issue is not when they are offered but the formal circumstances of their introduction.

Bruce Psaty in his article on literature and medicine mentions another, more far-reaching example of appropriation. His skeptical observation is that the multitudinous humanistic-oriented studies of the doctor-patient relationship all point to a single conclusion: that patients like their doctors to treat them politely.²⁰ Glib

¹⁹ See, for example, "Physicians for the Twenty-first Century," Report of the Panel on the General Professional Education of the Physician and College Preparation of Medicine ((Washington D.C.: Association of the American Medical Colleges, 1984) 6; and Steven M. Radwany and Bernard Adelson, "The Use of Literary Classics in Teaching Medical Ethics to Physicians," Journal of the American Medical Association 257 (1987): 1629.

²⁰ "...their [the studies'] scientific results largely document a social preference for manners." Bruce Psaty, "Literature and Medicine as a Critical Discourse" in Literature and Medicine, (6), 1987, 22.

though he may be, Psaty goes on to remark that this finding has no humane benefit because it serves only to make medicine better at what it already is: a business. Specifically, medicine has become an economic enterprise and the humanities, adopting the methods and values of science, have described ways of enhancing the doctor's marketability: "...these studies on the patient-physician communication strike me as the sort that corporate managers might commission not only in order to develop a sound advertising policy but also in order to choose, monitor, and control their hands, including physicians who practice the art of medicine."²¹ Though his conclusions are more cynical, Psaty draws from the same thematic pool as Cassell, linking the demand for improved physician attitudes to medical consumerism. Within the marketplace, distinctions between the disciplines disappear in the service of economic

²¹ Psaty, p. 25.

promotion.²²

The examples above show an inherent stumbling block of interdisciplinary work. When a field imports concepts from another field that is institutionally foreign to it, an adaptation and a reduction take place. Both methodological and practical constraints soon make the imported ideas fit the internal structures of the host discipline. My analysis of metaphor and narrative shows how these constraints exert themselves on the level of ordinary medical language. The advantage of interpreting uses of metaphor and narrative is that these are ubiquitous language functions, while at the same time they are considered to be sufficiently 'literary' to stand out in medical discourse. Their presence in medical contexts yields information about how clinical practice and doctor-patient roles are structured; it also tells us what limits we must impose on our idea of humanistic medicine.

²² Though Psaty does not cite Taussig, the latter puts forth another controversial argument criticizing medical appropriation of the social sciences and is bitterly rejected by the anthropologists Eisenberg and Kleinman. Their summary of Taussig is as follows: "In specific, Taussig criticizes a paper (Kleinman et al. 1978) in which we have put forth the view that clinical social science can lead to measurable improvement in management and compliance, patient satisfaction and treatment outcomes. He complains that our proposal to incorporate knowledge of anthropology into medical practice contains 'the danger that the experts will avail themselves of that knowledge only to make the science of human management all the more powerful and coercive.'" Their reply to Taussig insists on concrete experience: "In its obsession with power relationships, [Taussig's analysis] entirely ignores the central fact that the patient comes to the doctor in search of relief from distress, a relief which can only be obtained if effective medical measures are available and if the patient agrees to apply them." Eisenberg and Kleinman, 17-18.

I. Metaphor and Bodily Transparency

In what follows, I will be arguing that the attitude towards metaphor in medicine and science parallels medical approaches to the patient's body. By drawing this analogy, one might ask, am I not falling into the same methodological trap of creating artificial equivalences that I previously criticized? I would answer that this is not the case, for the reason that bodily expressivity is itself a metaphor deeply rooted in our cultural self-understanding. This notion warrants elaboration.

The body is a communicative site. We are forever looking for ways in which the body reveals itself to us. Our eagerness to read the body is already evident in our tendency--innate, according to some--to translate visual surfaces into bodily signs. Our orientation towards physical expression is such, argues the art historian Ernst Gombrich, that we 'see' a face in odd patterns: "To our emotion, a window can be an eye and a jug can have a mouth..."²³. Through this metaphorical act, we impose a bodily order upon the world and thereby render it intelligible. What stands out in this process is the interdependence of the physical and cultural realms. The body's fundamental biological situatedness coincides with its cultural expressions: the body, being there, simultaneously announces itself, that is,

²³ Ernst Gombrich, Art and Illusion (Princeton University Press: Princeton, New Jersey, 1972), 114.

communicates in a cultural space. Three very different examples come to mind to illustrate the contemporaneity of the biological and the paralinguistic substrata of the body. The first is from Rousseau's Confessions, in which he recalls the last words of a dying woman who has just broken wind: "Bon, dit-elle," Rousseau quotes, "femme qui pette n'est pas morte."²⁴ In this reassuringly human double articulation of corporeality and hope, the body momentarily resists being silenced. The irreducibly material body has a language (and is thereby no longer irreducibly material) through which it brings to consciousness its physical embeddedness. The physical, mortal substratum is thus paradoxically coupled with language: the body conveys meaning, but the meaning, earthily evoked by the moribund woman's flatulence, is precisely the ordinary, physical, familiar world; relating namely to bodily strength and vulnerability. Another example illustrates the equivalence of expressivity and physical human nature in a fictional context. The hero of Patrick Suskind's novel, Perfume, is born without human odor. His odorlessness effects in others an unconscious revulsion. Because of his exceptionally keen sense of smell, however, he is able to concoct a perfume--made of cat droppings, cheese, vinegar and a few other choice ingredients--that perfectly simulates human smell. When he applies a few drops of this tincture, he suddenly

²⁴ ("A woman who farts is not dead.") Jean-Jacques Rousseau, Confessions (Editions Gallimard, 1952), 83.

becomes a member of the human race: he is acknowledged on the street, people tip their hats, nod in a friendly way and even imagine that they've seen him somewhere before.²⁵ The odor, synecdochally the body's language, is the medium of human communication and of common humanity. Without this language, the subject is disembodied; in Suskind's novel, virtually invisible. Here again, the body's means of expression anchors the body in a physical, human reality. Finally, I refer to Richard Selzer's meditation on the skin, which he regards as the expressive surface of the body, the biological material upon which is inscribed the narrative of the body's experiences: "Moreover, it is not the brain nor the heart that is the organ of recollection. It is the skin! For to gaze upon the skin is to bring to life the past."²⁶ Both as a sensuous and engravable surface, the skin recapitulates a history, and not neutrally, because only the person with a past comes into his own as someone 'real,' like the velveteen rabbit of the eponymous children's story

²⁵ Patrick Suskind, Das Parfum (Diogenes: Zurich, 1985), 193ff.

²⁶ Richard Selzer, Mortal Lessons (New York, Simon and Shuster, 1976), 115.

who attains authenticity through physical handling.²⁷

In each of the three examples above, the body is a vehicle for language; but even more than that, the body comes to be itself, in its physical, human instantiation, only through a language proper to it. Bodily expression is not a layer superimposed upon the material substratum: the two levels are interdependent. It is thus possible to learn about bodies through our understanding of language just as we can learn about language through conceptions of the body. Not surprisingly, then, the physician's relationship to the sick body can be clarified by drawing on attitudes towards language. Michel Foucault, in The Birth of the Clinic, explores precisely this possibility. According to Foucault's analysis, the theme of a body made transparent in and through language contributes to the definition of what he calls 'anatomo-clinical' medicine.

A construct of the late eighteenth century, the anatomo-clinical model centralizes the role of empirical observation and pathological anatomy, making the physician's 'gaze' the

27 "'It doesn't happen all at once,' said the Skin Horse. 'You become. It takes a long time. That's why it doesn't often happen to people who break easily, or who have sharp edges, or who have to be carefully kept. Generally, by the time you are Real, most of your hair has been loved off, and your eyes drop out and you get loose in the joints and very shabby. But these things don't matter at all, because once you are real you can't be ugly...' Margery Williams, The Velveteen Rabbit, (Running Press, Philadelphia, 1984).

single most important component of medical investigation.²⁸ This emphasis on seeing made possible a linguistic understanding of the body; that is, the clinical observer approached the body as a 'reading' of its surface organization. Language and disease came to be structured analogously. Prior to this transformation, symptoms collectively pointed to some pathological essence outside of the body; now they were coextensive with the body.

To the exhaustive presence of the disease in its symptoms corresponds the unobstructed transparency of the pathological being with the syntax of a descriptive language: a fundamental isomorphism of the structure of the disease and of the verbal form that circumscribes it.²⁹

Foucault describes the strict correspondence between symptoms and disease as one between signifier and signified, or, to emphasize the combinatorial relation of several symptoms, between the letters of the alphabet and words. Now 'the armature of the real [was] designed on the model of language,'³⁰ based on the perception that disease phenomena

²⁸ "Alone, the gaze dominates the entire field of possible knowledge; the intervention of techniques presenting problems of measurement, substance, or composition at the level of invisible structures is rejected. Analysis is not carried out in the sense of an indefinite descent towards the finest configurations, ultimately to those of the inorganic; in that direction, it soon comes up against the absolute limit laid down for it by the gaze, and from there, taking the perpendicular, it slides sideways towards the differentiation of individual qualities." The Birth of the Clinic, trans. A.M. Sheridan Smith (New York: Random House, 1975) 147.

²⁹ Foucault, 95.

³⁰ Foucault, 96.

could be immediately apprehended, just as is the case with the spoken word. The physician's observation conjoined with what he observed; his gaze was hooked into self-evidence:

The disease...dissipated itself in the visible multiplicity of symptoms that signified its meaning without remainder. The medical field... was to open on to something which always speaks a language that is at one in its existence and its meaning with the gaze that decipheres it--a language inseparably read and reading.³¹

With the increasing number of dissections occurring at the end of the 18th century, the relationship of the physician to the body was modified somewhat, insofar as the key to the patient's disease no longer rested on the body's surface but had receded into its interior. Instead of just looking, the physician added palpation and auscultation to his physical exam. Discovery replaced self-evidence: the physical exam and the post-mortem dissection penetrated the layers which kept hidden pathological events and revealed them for all to see. The consequence of this foray into the body's interior was an alteration in the relationship between language and disease. Foucault argues that the interpretation of surface symptoms slotted them into generalities that took statistical form: with dissection, however, the body displayed itself as a texture, richly and irreducibly individual, forcing the gaze to the very limits of language:

To discover, therefore, will no longer be to read an essential coherence beneath a state of disorder, but

³¹ Foucault, 96.

To discover, therefore, will no longer be to read an essential coherence beneath a state of disorder, but to push a little farther back the foamy line of language, to make it encroach upon that sandy region that is still open to the clarity of perception but is already no longer so to everyday speech--to introduce language into that penumbra where the gaze is bereft of words.³²

Foucault first identifies a historical moment in which language appears to furnish disease with a ready-made structure. In this isomorphism lies the clarity of medical perception. To this model, however, is added the unique, sensory texture of the opened body. The clarity is still preserved, but it now acquires a three-dimensionality that recruits the stethoscope and other means of examination than merely the observing eye. Furthermore, diagnosis is anchored in the observation of the individual tissues. Language itself, it seems, is altered in the process, coming to reflect in its descriptions the delicate minutiae of the cadaver's internal terrain.

In articulating a specific historical configuration which permitted this close correspondence between linguistic structures and physiological interpretation, Foucault does not draw on any arbitrary notion of language: he looks for models of language theory contemporary to the medical developments of the late eighteenth century, such as in the influential linguistic treatises of Condillac. He thus not only shows how the body functions as language within that

³² Foucault, 167.

segment of culture called medicine, but also shows the cultural rootedness of the linguistic models themselves.

Having legitimated the notion of bodily expressivity, I now turn to the question of the place metaphor occupies within medical language and what significance this has for clinical approaches to the body. One need not be well-versed in science to know that the conventional notions about scientific and medical language preclude the use of metaphor, which is considered a distracting and unnecessary embellishment. On the contrary, scientific language is, ideally, invisible, unencumbered by its own materiality: it does not call attention to itself with ornate flourishes, but disappears modestly and miraculously in the referential act.³³ This view of language crops up explicitly in 'how-to' manuals dedicated to the publication of scientific research. Expert advice whips language into an acceptable standard. Dicta include using short, ordinary words; avoiding all figurative language; avoiding circumlocutions; maintaining a neutral, impersonal style.³⁴ These

³³ "Literary tricks, metaphors and the like, divert attention from the message to the style. They should be used rarely, if at all, in scientific writing." Robert Day, How to Write and Publish a Scientific Paper (Philadelphia: ISI Press, 1979) 5.

³⁴ The MLA Handbook for Writers of Research Papers, a how-to manual for the humanities, includes very few stylistic directives. It briefly admonishes to clarity and coherence, but unlike the handbooks for scientists, includes advice to write paragraphs in such a way so as to be "interesting to others." Joseph Gibaldi and Walter Achtert (New York: The Modern Language Association of America, 1988) 34.

constraints minimize the medium's obtrusiveness; optimally, however, language achieves transparency by virtue of its formal characteristics:

A scientific paper is, or should be, highly stylized, with distinctive and clearly evident component parts. In short, I take the position that the preparation of a scientific paper has almost nothing to do with writing, per se. It is a question of organization. A scientific paper is not 'literature.' The preparer of a scientific paper is not really an 'author' in the literary sense. In fact, I go so far as to say that, if the ingredients are properly organized, the paper will virtually write itself.³⁵

The ideal expressed in this summary is one of automatic writing, eliminating the intrusion of authorial subjectivity. This is achieved by means of a pre-arranged structure, the format of the scientific paper. The high degree of stylization, the pre-established organization eliminate the need for a language that creates meaning in the process of its articulation. The meaning is already encoded in the form and requires not an idiosyncratic authorial voice to bring it to life but rather the impersonal intervention of a preparing scribe.

A long-favored way of distinguishing scientific and literary discourse is to emphasize the object-orientedness of the former and the self-referentiality of the latter. Already one hundred years ago, thematic content provided the basis for this distinction, varying according to whether it concerned something real or imagined: "...all our mental

³⁵ Robert Day, How to Write and Publish a Scientific Paper (Philadelphia: ISI Press, 1979) 4.

furniture," argued Thomas Huxley with a conviction that only recently has lost some of its resonance, "may be classified under one of two heads--as either within the province of the intellect, something that can be put into propositions and affirmed or denied; or as within the province of feeling, or that which, before the name was defiled, was called the aesthetic side of our nature."³⁶ The former object-oriented, transparent language obliterates itself in the service of the empirical truths to which it refers. According to the scientific ideal, metaphorical language, ensnared in its own distractions, cannot attain to the objective truths of concrete reality. One may argue conversely that an objective reality is supported, and even created by a mimetically objective, rational and unadorned language.³⁷

'Ordinary language' is one of a number of terms used to designate a kind of language that 'merely' presents or mirrors facts independently of any consideration of value, interest, perspective, purpose and so on. Other such terms are 'literal language,' 'scientific language,' 'propositional language,' 'logical language,' 'denotative language,' 'neutral language,'... 'non-metaphorical language'....Whatever the term, the claim is always the same: it is possible to specify a level at which language correlates with the objective world and from which one can build up to contexts, situations, emotions, biases, and finally, at the outermost and dangerous limits, to literature. The claim is a far-reaching one, because to make it is at the same

³⁶ T. H. Huxley, Science and Education, quoted in Wendell Harris, Interpretive Acts (Oxford: Clarendon Press, 1988) 73.

³⁷ The profound impact of the medium on credibility is illustrated by the following example. We are all familiar with the transformation our handwritten work undergoes when it is translated into word-processed form. A subjective pastiche becomes a professional product.

How claims about reality derive from claims about language becomes apparent in Susan Sontag's seminal essay on illness as metaphor. Sontag convincingly exposes the metaphorical networks associated with particular diseases within given cultural settings. However, she also indulges in a logical sleight-of-hand as she unwittingly reveals her own values. In a two-pronged approach, she endeavors first to strip language about disease of its metaphors, fictional shapes which promote ignorance and instill fear. Second, she argues that beneath this misleading web of metaphors lies the truth of the disease, waiting to be uncovered: "...all the diseases for which the issue of causation has been settled, and which can be prevented and cured, have turned out to have a simple physical cause...and it is far from unlikely that something comparable will eventually be isolated for cancer."³⁹ Sontag implies a model of language entirely concordant with the scientific ideal outlined above. She undertakes a purification of language, and she hints that once this cleansing has been achieved, the truth of the disease--its true origin, that is--will be revealed.

Revealing objects as they 'really' unambiguously are is a powerful value attached to transparent language, and

³⁹ Sontag, Illness as Metaphor (New York: Random House, 1979) 60.

enhances the indisputability of medical findings.⁴⁰ In Sontag's account, the disease ideally originates in a single cause, it is spatially localized and does not, like cancer's metaphors or like cancer itself, proliferate. Transparent language holds meanings in check; it makes itself invisible only to make visible a concrete, unambiguous empirical reality. Not surprisingly, then, control over linguistic expression imitates the control that language exerts over the 'real' world. One form of control, as I will show, is to restrict the metaphoricity of medical language.

One suspects that the direct, unflappably homely style of medical literature is a construct because it is nothing like the 'natural' language of daily experience. An important theoretical advance in the humanities in the last decade has been to show that 'literariness' and 'fiction' permeate language in a wide variety of contexts and therefore do not

⁴⁰ The impossibility of absolutely avoiding ambiguity is humorously explored by Stanley Fish, who offers several interpretations of a posted sign, PRIVATE MEMBERS ONLY, one of the meanings of which might be "Only genitalia may enter." Fish attributes the finding of truth precisely in the flexibility inherent in the ambiguity of all statements: "Thus we can see how it is neither the case that meanings are objectively fixed nor that the meanings one construes are arbitrary. To many these have seemed the only alternatives, and that is why the claims for objectivity and subjectivity have been continually debated. It is because the position elaborated here is neither subjective nor objective (nor a combining of the two) that it can reconcile the two facts cited again and again by the respective combatants: 1) that there are no inherent constraints on the meanings a sentence may have, and 2) that, nevertheless, agreement is not only possible but commonplace." Stanley Fish, "Normal Circumstances and Other Special Cases," Is there a Text in this Class? (Cambridge, Mass: Harvard University Press, 1980) 292.

in themselves specify types of discourse. Figures of speech and narrative forms abound in ordinary conversation.⁴¹ Clearly, such literary devices as metaphor do enter into medical language. However, their use tends to be well-controlled. A number of techniques signal the appropriateness of simile and metaphor in given contexts. The primary context for similes is a heuristic one. Elucidation of mechanical bodily processes such as likening vertebrate physiology to urban organization help the student 'understand' microscopic events. The biology textbook that introduces this analogy makes the parallels explicit beyond question: "Like a city, [the vertebrate body] contains many individuals that carry out specialized functions. It has its own police (macrophages), its own construction workers (fibroblasts), and its own telephone company (the nervous system.)"⁴² The authors leave nothing in this simile to subjectivity: each component's place is designated parenthetically and recapitulates the heuristic schema established by the primary parallel. This use of figuration as an aid to reason recalls an eighteenth-century definition of metaphorical function. Classically articulated by Johann Georg Sulzer, Enlightenment theory holds that metaphor

⁴¹ One of the most important analyses challenging the distinctions between poetic and non-poetic language include Mary Pratt's Towards a Speech Act Theory of Literary Discourse (Bloomington: Indiana University Press, 1977).

⁴² Peter Raven and George Johnson, Biology (St. Louis: Mosby College Publishing, 1986) 919.

progressively illuminates reality. More bluntly summarized, use of metaphors clarifies obscure concepts for dull wits. By uncovering the resemblance that exists between two concepts metaphor transforms the more obscure, inaccessible one into a clear one that is more easily understood. Sulzer describes this operation as follows:

Therein arise the metaphorical expressions, by means of which obscure ideas become clear to persons of lesser capabilities. For, as soon as someone tells us that one thing, which we can't conceptualize well, resembles another thing with which we are more readily familiar, then we work to discover the similiarity; and we do discover it by and by, and that is how our obscure

concept is transformed into a clear one.⁴³

Sulzer's explanation points to the possibility of systematically increasing the clarity of ideas through metaphor, and indeed, he recommends compiling metaphors as a means of documenting the progress of reason towards ever greater articulateness.

⁴³ Johann Georg Sulzer, "Anmerkungen über den gegenseitigen Einfluss der Vernunft in die Sprache und der Sprache in die Vernunft," in Philosophische Schriften (Leipzig: Weidmann, 1773) 188. Another more dynamic, idiosyncratic conception of metaphor was introduced by Johann Gottfried Herder at the end of the eighteenth century. Herder holds the view that linguistic expression itself communicates truths, though these truths are psychological not empirical. This approach to metaphor thus produces precisely the theoretical converse of the values implied by 'scientific language.' Herder develops a complex, dynamic model of language: his contribution in this area is not, as is often thought, his emphasis on sensate, imagistic formulations as the source of communicative forcefulness, but his development of a wholly new principle in terms of which metaphorical and other figurative expressions are to be interpreted. Like Sulzer, Herder invests idealizingly in metaphor, but even where he agrees with the Enlightenment viewpoint, he transforms the linguistic model it provides by drawing it into the psychological subject. Language for Herder, then, is what he calls the 'inner word,' 'the medium of our sense of self and spiritual self-consciousness.' Unlike in the case of the classical model, language is rooted in individual experience and it is for this reason that Herder stresses the ontogenesis of language: language grows out of the experience of childhood and the maternally centered family sphere. The subjective anchoring of language has an important consequence for the understanding of metaphor, since it renders every statement a metaphorical designation of the subjective identity of the speaker: "...the sensitive human being feels himself in everything, feels that everything emanates from himself; he imprints upon it his image, his configuration." Metaphor, in other words, is the expression of a unique individuality imprinted upon speech. Johann Gottfried Herder, "Vom Erkennen und Empfinden der menschlichen Seele. Bemerkungen und Traume." Samtliche Werke, ed. Bernard Suphan, Vol. VIII (Berlin: Weidmannsche Buchhandlung, 1887), 197.

According to Sulzer's model, metaphor presumably makes itself obsolete, once a certain level of clarity has been achieved. In contemporary medical education, the more advanced the textbook--in keeping with Sulzer's notion of progressively achieved Enlightenment--the less often figuration occurs as a teaching device.⁴⁴

Metaphors, when they appear in textbooks and journals, often belong to a special category. They comprise the genre of conventional figurative expressions which are part of a familiar jargon. Thus ATP is conventionally acknowledged as the body's 'energy currency;' the genome is 'read' as a 'code' which is 'transcribed' and 'translated;' patients with chronic lung disease are described as 'pink puffers' or 'blue bloaters;' specific pathology is suggested by 'coffee-ground emesis,' and so forth. These conventions, even cliches, no doubt have a didactic origin, but also not unlike the epitheton ornans of oral literature, they are mnemonic devices as well as familiar signals to the

⁴⁴ Interestingly, the first draft of the Raven and Johnson textbook cited above, and which I had the opportunity to help evaluate, streamlined its similes for the final version. Thus, what began as a fairly lengthy description of muscle function in terms of rowers alternating oars, in the published version is reduced to a single metaphorical term isolated by quotation marks: "...the myosin [uses] the cross-links provided by its S-1 heads to 'walk' along the actin." Raven and Johnson, 132.

initiated.⁴⁵

For the host of expressions that have not entered the conventional repertoire, there are ways of indicating that these figurations are used self-consciously and therefore do not trouble the smooth concatenation of descriptions and phenomena, of neutral terminology and objective meanings. One marker frequently used to separate out figurative expressions is punctuation. We have already seen in one example how a parenthetical gloss anchors the meaning of a simile. In a further example, the metaphorical element is enclosed in quotation marks. The author of a physiology text, W.F. Ganong, refers to "'menstruation [as] the uterus crying for lack of a baby'", a statement that as one writer points out is anomalous given the cold scientific prose of the rest of Ganong's text, but that also is placed in quotation marks; in other words, its truth value is suspended and marked off from the rest of the text.⁴⁶ Also

⁴⁵ See Eric Cassell's account of such communicative conventions in medicine, which he rightly admires as extensive and detailed. He goes on to add: "This richness of language is in sharp contrast to the poverty of words doctors use to portray persons." The Place of the Humanities in Medicine (Hastings-on-Hudson: The Hastings Center Institute of Society, 1984) 35.

⁴⁶ There is also a slight change in the way this quotation is introduced from the 1977 to the 1985 edition. The 1977 version says, "Thus, to quote an old saying..." while the 1985 text holds "This is why it used to be taught..." The author thus distances himself further from the rhetorical statement in the later text. W.f. Ganong, Review of Medical Physiology, 12th ed., (Los Altos, California: Lange Medical Publications, 1985) 363. Thomas Laqueur, "Orgasm, Generation, and the Politics of Reproductive Biology," Representations 14 (1986): 35.

functioning as quotation marks are prefatory statements; one clinician introduced the statement, "The tip of the spleen is like the nose of a salmon," with an apologetic reference to poetry; he then elicited laughter by pretending to feel for the nose of a salmon, demonstrating the discrepancy between poetic imagination and the surgeon's imperative for tangible reality.

These examples show that whenever possible in controlled settings consecrated to medical education, such as the lecture hall and the textbook, metaphorical language takes up a well-defined and limited space. That is not to say that one cannot study medical metaphors and their ideological matrix, as Emily Martin in her work on the rhetoric of reproductive biology and Susan Sontag, in writing about AIDS metaphors have done.⁴⁷ But it is important to realize that in medical literature, metaphorical language is discernibly parenthesized and its potential contribution to the knowledge of individual development and psychological issues is, in theory at least, suppressed. In this sense, it contrasts markedly both with Herder's definition of metaphor as a means of understanding the individual psyche (see note 43) and with Foucault's rhapsodic evocation of a finely

⁴⁷ See Emily Martin, The Woman in the Body (Boston: Beacon Press, 1987), and Susan Sontag, "AIDS and its Metaphors" The New York Review of Books (October 27, 1988). It should be noted that Martin frequently uses older editions to support her claims and that most of Sontag's examples are not taken from medical and scientific literature.

honed language--in effect, Foucault's own soaring prose approximates the language he purports to describe--which also strains towards knowledge of the individual.⁴⁸

Although presumably the individual patient is of paramount concern to medicine, the ideal of linguistic transparency does not serve to know the person. Textured nuances of speech, subjectivity, figuration, and idiosyncratic expression have a well-circumscribed place, if they have a place at all, in the communication of medical knowledge.

The notion of 'transparency' in medical language has practical relevance as well. It can be extended to apply to the 'language' that the clinician draws on to interpret disease phenomena. An important aspect of the clinical approach to the patient and the investigation of disease is inscribed in the attitude towards language that I have just outlined. As Foucault has suggested, the clinician 'reads' the body according to certain culturally defined notions of language. The concept of a body transparent to the physician's investigative actions, like that of a transparent language, is central to the object-oriented 'science' of medicine.

For the body's language to become a window which allows the clinician the insight necessary for diagnosis, it must

⁴⁸ "Language and death have operated at every level of this experience...only to offer at last to scientific perception what, for it, had remained for so long the visible invisible--the forbidden, imminent secret: the knowledge of the individual." Foucault, 170.

correspond as closely as possible to the object it designates. The degree of approximation is determined not by resemblance but by the exclusion of diagnostic categories. "Biomedicine's goal has long been to reduce the possibilities for interpretation," writes Kathryn Staiano in her article applying semiotic theory to her cross-cultural medical work, "that is, to link a single interpretant to a sign or series of signs. In the medical model of illness, signs are always regarded as empirically classifiable given sufficient information and the necessary technology to generate and evaluate that information."⁴⁹ A standard textbook of internal medicine underscores the reduction of diagnostic complexity as one of the essential components of clinical practice. This occurs, according to the authors, through the definition of the syndrome, "a group of symptoms and signs of disordered function, related to one another by means of some anatomic, physiologic, or biochemical peculiarity." They go on to say:

A syndrome usually does not identify the precise cause of an illness, but it greatly narrows the number of possibilities....The diagnosis is simplified greatly if a clinical problem conforms neatly to a well-defined syndrome, because only a few diseases need to be considered in the differential diagnosis. In contrast, the search for the cause of an illness that does not conform to a syndrome is more difficult because a much greater

⁴⁹ Kathryn V. Staiano, "Alternative Therapeutic Systems in Belize: A Semiotic Framework," Medicine and Sociology, Vol 15B No. 3, 1981, 317-329.

number of diseases have to be sought.⁵⁰

The authors give several examples of syndromes. Shortness of breath, engorged neck veins and enlarged liver, for instance, suggest congestive heart failure. What is at issue here is not the obvious goal of medical knowledge to figure out what is wrong with a patient, but the elaboration of a method of reading. This method trains the student to eliminate ambiguity by linking, as sensitively, but also as rigorously as possible, the visible manifestations to hidden phenomena. Nowhere is this method more clearly evident than in a textbook teaching the conduct of the physical exam, which divides a page into two parts; the body of the text contains instructions concerning appropriate questions, physical manoevers, and general findings; the right margin, in red print, glosses these findings, coupling pathological manifestations with given disease entities. For illustration, I quote just one typical entry: "Identify the highest point at which pulsations of the internal jugular vein can be seen," the author instructs, while adding in the margin the observation that "Increased pressure suggests right-sided heart failure or, less commonly, constrictive pericarditis, tricuspid stenosis or superior vena cava

⁵⁰ Braunwald, Isselbacher et al., Harrison's Principles of Internal Medicine 11th edition (New York: McGraw-Hill, 1987), 3.

obstruction."⁵¹ In optimal circumstances, correspondences hold not just between syndromes and symptoms but between individual signs and their cause. Technical instrumentalization tightens this unity. Thus in an obstetrics textbook, discussion of fetal distress reveals a close link between the technological sign and its physiological counterpart. Electronic fetal monitoring showing early heartbeat deceleration, for example, indicates an increase in intracranial pressure, while a late deceleration pattern suggests uteroplacental insufficiency. Variable deceleration, in turn, 'is likely to be the consequence of compression of the umbilical cord;' mild bradycardia is not necessarily abnormal but more severe bradycardia 'may be the consequence of congenital heart lesions or severe hypoxia.'⁵² The authors interject the caveat that 'these deceleration patterns just described do not always reflect the causes ascribed to them.'⁵³ The ideal remains, nevertheless, that each sign traced out on the moving-strip recorder corresponds to an internal process that it brings to light.

This method of reading--and in effect with such technological manipulations as described above, we are dealing with graphic representations--in minimizing the

⁵¹ Barbara Bates, A Guide to Physical Examination (Philadelphia: Lippencott, 1983) 277.

⁵² William's Obstetrics, 16th edition, 356-357.

⁵³ Ibid., 356.

distance between the sign and its interpretation maximizes the transparency of the language to be interpreted. The spatial reduction, which is also a reduction of clinical ambiguity, renders accessible the body's inner recesses.

The human senses no less than machines are technical instruments mobilized in the quest for bodily transparency. Robertson Davies, in his witty essay on medical humanism, conjures up a vision of the physician's antics in the interpretive process. He describes Georg Groddeck, who practised medicine prior to the explosion of medical technology, quite literally applying himself to his patients:

...he placed his ear on the patient's abdomen, and there he listened for sometimes three hours, without speaking a word. He listened to joints. He sniffed the patient's breath and sometimes, dismayingly to the sensitive, he sniffed their privy parts....at last, when all the sniffing and listening and prodding with the fingers and thumbs was over, he began to talk to the patient and to ask questions....He had found a diagnosis, frequently an unexpected and astonishing one.⁵⁴

Relentlessly closing in on the body's interior, the physician brackets through his behavior several familiar conventions. He does not allow time pressures to interfere with his findings; he begins in silence and ends with the history, a reversal of the standard procedure; finally, he disregards the patient's 'dismay,' the sense of shame which subjectively clothes the patient and hence hinders the physician. How is this body made transparent? Like

⁵⁴ Davies, 31.

scientific language that is stripped of its extraneous, distracting figures, the body's language that Groddeck interprets has mundane and subjective elements, such as the patient's feelings about the exam, removed from it. The objective reality to which this purified language refers is the underlying disease, spectacularly diagnosed. Groddeck's irreverence for conventional behavior emphasizes that his access to the body is immediate; it is not troubled by social niceties. His diagnostic skill enables him to connect the body's surface with the interior to which it refers.

This 'scientific' body language, mastered through repetition and meticulous effort, by no means is neutral. As the example cited above indicates, command of the diagnostic idiom stakes out a professional claim. Groddeck's diagnosis is often 'unexpected' and 'astonishing.' These modifiers, as well as such epithets as 'really great doctor' and 'magician,' which are attributed to Groddeck a paragraph later, refer to the doctor's privileged status. The body's

language, as I will show, confers professional validity.⁵⁵

I offer as an example of how body language 'embodies' the hierarchical relationship between physician and patient the interpretation of a passage from the textbook of physical examination cited earlier, widely used by students in the health sciences.⁵⁶ In an introductory segment, the text advises the student on how to conduct a physical examination. The examiner is portrayed above all as a reader of bodies: "By listening, looking, touch, or smell, the

⁵⁵ This is an old and important fact related to notions of pure, transparent, self-evident language. In the eighteenth century, for example, interpretation of gestures and facial features enjoyed enormous popularity. Physiognomists, such as the celebrated Johann Kaspar Lavater, devoted themselves to reading facial features for clues to the inner workings of the soul. Lavater stressed the importance of 'reading' the face when it was at rest (i.e. in a natural state) and not distorted by the deliberate control which intercourse in the world prescribed. His methods were praised as a way of cutting through the veneer of civilized hypocrisy. In William Cowper's words: "I am very much of Lavater's opinion, and persuaded that faces are as legible as books, with only these circumstances to recommend them to our perusal, that they are read in less time, and are less likely to deceive us..." Quoted in Kay Flavell, "Draft for Meeting of History of Medicine Seminar" unpubl. ms. May 3, 1988. The political and moral agenda inherent in this 'return to nature' is often only thinly disguised. Expressive language served as the self-congratulatory validation of personal values. Nowhere is this more evident than in the popular literature of the day, which churned out a well-digested mixture of moral and bodily poses. The validating power of body language rests on the synonymy of nature and truth, an equivalence that is achieved by the ingenuousness of the sign. As William Cowper in his reference to Lavater suggests, natural language escapes the body involuntarily, untouched by hypocrisy. Though in contemporary medicine the body's signs are anything but ingenuous, they still reveal a truth whose discovery ensures the physician's professional worth.

⁵⁶ Barbara Bates, A Guide to Physical Examination, (Philadelphia: Lippencott, 1983).

skillful clinician examines each body part and at the same time senses the whole patient, notes the wince or worried glance, and calms, explains, and reassures."⁵⁷ The body's entire expressive surface is disclosed for interpretation. It is divided into 'parts,' yielding the signs that will be interpreted as manifestations of disease, and into a 'whole,' which allows for the proximate, unmediated access to the body. At the same time, the clinician also has the task of dividing the body up into units that are as small as necessary to yield physical or psychological intelligence. The discerning examiner does not miss even the most subtle communication, but pays attention to every wince or worried glance. And not least, he makes use of the information he is gathering to guide his patient, to steer him through the appropriate emotional straits by calming, explaining and reassuring. He is training, in short, to render the patient's body completely transparent to his gaze, and to secure his role in the process. The examiner's position, initially hesitant, stabilizes with time: "With study, repetitive practice, and time, however, both competence and confidence grow." The examiner grows into his role not only by learning to read the patient's body; he must also be concerned with his own body's legibility: "...you should take command of your own demeanor and affect. Try to look calm, organized and competent, even when you do not exactly

⁵⁷ Bates, p. 118.

feel that way....Avoid expressions of disgust, alarm, distaste or other negative reactions. They have no place at the bedside..." While the clinician's gaze interprets and evaluates the patient's body, leaving no part invisible, the clinician's own body occupies the neutral space of uninterpretability. The patient's body is rendered absolutely transparent, the clinician's absolutely opaque.

As the clinician acquires use of the idealized idiom through which he learns to 'read' the body, he steps into a privileged domain. The language I have described is one which, though ideally transparent, is so only within a professional sphere, whose definition is determined precisely by the initiated, conversant in the common idiom. Thus transparency in no way denotes easy legibility; it denotes instead masterful ease. Both the non-metaphorical language of science and medicine, and the purified language of the body are products of a certain conception of objective reality. They at once constrain and are constrained by the objects they designate, and carve out a professional identity for those who rely on these idioms. 'Transparency' is thus an important linguistic category that contributes towards an understanding of medical practice. I will now go on to analyze a very different aspect of language use and show how this language function also is shaped by and reinforces--though differently than metaphor--institutional constraints.

II. Narrative

A vast literature as well as innumerable circulating anecdotes attest to the institutional changes that have altered the character and quality of medical care.⁵⁸ Disaffected patients have complained about depersonalized treatment, which describes a wide range of behaviors such as the proverbial wallet biopsy, long waits, curtailed office time, juggling of multiple patients and lack of continuity. If language truly promotes and incorporates cultural situations, as this analysis presumes, then it should reveal some of the effects of these institutional constraints. I have shown how the ideals of a scientific and transparent language eliminate subjective and idiosyncratic landmarks that help to individualize patients. Narration--story-telling by and about patients and their illness--also contributes in a complex way to the construction and restriction of patient individuality. Even Howard Brody, who in his recent book, Stories of Sickness, emphasizes the powerful role that narrative plays in the healing process as well as in sorting out ethical issues, concedes that narrative reflects conflicting interpretive demands. In

⁵⁸ To quote just one familiar opinion: "Health-maintenance organizations...are bringing about a largely unacknowledged change in the basic doctor-patient relationship in the U.S. An increasing number of doctors are labelling it the substitution of the Veterinarian Ethic for the Hippocratic Oath. The veterinarian owes his primary obligation not to the animal he is treating, but to the animal's owner who is paying the bill." Harry Schwartz, "Sad Symptoms of Changing American Medicine," The Wall Street Journal 9 July, 1986.

writing about the parable, which 'is treated not as a unique story but as a maxim,' he states: "Many medical stories partake of this dimension, as the physician is always caught in the tension between the uniqueness of the individual patient and the need to explain the patient's illness by means of generally applicable laws."⁵⁹ In the following, I will explore this tension between individual claims and professional demands by examining some aspects of narrative in a medical context; I will focus especially on the ways in which narrative, like other language functions, is stylized and thereby restricts individual expression. Narrative emerges among other things as an institutional instrument, a finding which contrasts with Brody's notion that narrative serves as a device for generating meaning and enriching a patient's individuality.

Much attention has been directed in recent years to medical narratives; that is, to patient talk, case histories and doctors' anecdotes.⁶⁰ The discovery of the individual that Foucault locates in the empirical density of descriptive observation is currently being sought in narratives by and about patients. Howard Brody in his

⁵⁹ Brody, Stories of Sickness (New Haven: Yale University Press, 1987) 17.

⁶⁰ See Arthur Kleinman, The Illness Narratives (New York: basic Books, 1988); Larry Churchill and Sandra Churchill, "Story-Telling in Medical Arenas: The Art of Self-Determination" Literature and Medicine 1 (1982): 73-79. Also of interest is the development of a clinical project utilizing patient narratives for education and improvement of compliance (Lotte Marcus; unpublished work).

definition of narrative disallows any descriptions or statements that 'do not take into account the particularity of the patient.'⁶¹ Individualizing details invariably make up the fabric of autobiographical narrative. One cannot exist without the other:

Therefore any person, man and woman alike, will be interested both in explaining and in justifying their present conduct by referring to their personal history. Historical explanation, as a mode of understanding, comes naturally to everyone, because all normal men and women are interested in their own origins and their own history and the history of their family. They are not able to think of themselves, as utilitarians and Kantians demand, as unclothed citizens of the universe, merely rational and 'sentient' beings, deposited in no particular place at no particular time.⁶²

We have already encountered in the previous section the 'unclothed' universal man with whom the patient cannot identify: he is precisely the transparent object constituted by the unencumbered physician's examination. The self-constituting subject, by contrast, makes use of a form of expression that does justice to his individuality. In narrating his life, he espouses a different notion of truth than the one posited in scientific language. Brody asserts that narrative generally tends to make sense of a chaotic substratum; by imposing order on disordered events, narrative simultaneously creates meaning: "The concepts of narrative probability and narrative fidelity suggest that a

⁶¹ Brody, 18.

⁶² S. Hampshire, Morality and Conflict (Cambridge: Harvard University Press, 1983), quoted in Brody, 14.

coherence, rather than a correspondence, theory of truth is at work in the judging of a narrative's adequacy."⁶³ Rather than depending on a closely honed match between external signs and their meanings, narration emphasizes psychological organization, and in doing so, should allow something like an individual element to shimmer through. A similar definition of narrative structure and function is given by Arthur Kleinman in The Illness Narratives:

Thus, patients order their experience of illness--what it means to them and to significant others--as personal narratives. The illness narrative is a story the patient tells, and significant others retell, to give coherence to the distinctive events and long-term course of suffering. The plot lines, core metaphors, and rhetorical devices that structure the illness narrative are drawn from cultural and personal models for arranging experiences in meaningful ways and for communicating those meanings.⁶⁴

All narratives are ordered in varying degrees. Narrative theory of the last decades has analyzed some of the rules that govern story-making. These rules generate highly sophisticated novelistic plots as well as spontaneous stories that are part of popular culture or that arise in ordinary conversation. Vladimir Propp, in his seminal work on the folk tale, has enumerated specific functions that regularly and predictably propagate the story's action.⁶⁵ More recently, William Labov has analyzed ordinary speech

⁶³ Brody, 15.

⁶⁴ Kleinman, 49.

⁶⁵ Propp, Morphology of the Folktale. (Bloomington: Indiana Research Center in Anthropology, 1958).

(Black English Vernacular) and has identified the specific organization of so-called natural narratives produced in response to questions about salient events in a person's life.⁵⁶ Narratological theory has elucidated narrative according to a generative model, whereby specific rules, a 'grammar,' in other words, produces narrative utterances.

Contemporary poetic theory distinguishes three components of narratives, two of which are especially helpful in the analysis of stories told in a medical context. Narrative is currently defined as 'a succession of events,' an event being "something that happens, something that can be summed up by a verb or a name of action"⁶⁷ to which may be added 'that when something happens, the situation usually changes. An event, then, may be said to be a change from one state of affairs to another.'⁶⁸ The chronological organization of events, regardless of the order in which they are presented in the telling, constitutes the story level of a narrative. The text level is that which is actually heard or spoken; it consists of the actual words used to render the events. The last level is that of narration, the dynamic or productive act through which the speaker is recognizable as the author

⁶⁶ William Labov and J. Valetzky, "Narrative Analysis: Oral Version of Personal Experience," Essays on the Verbal and Visual Arts, ed. J. Helm (Seattle: American Ethnological Society).

⁶⁷ Shlomith Rimmon-Kenan, Narrative Fiction: Contemporary Poetics (New York: Methuen, 1988), 2.

⁶⁸ Rimmon-Kenan, 15.

of his speech. In most texts, whether situational or fictional, all these three levels are conjoined to form a unity. What is unique about narratives predominating in medicine is that the story and text levels are performatively separated. That is to say, the patient typically renders his complaint in his own words; the physician then reformulates the patient's story in a fashion appropriate to medical interpretation. This method is described as follows:

Several approaches can be employed successfully in obtaining a medical history. I believe that patients should first be given the opportunity to relate their experiences and complaints in their own way. Although time-consuming and likely to include much seemingly irrelevant information, this technique has the advantage of providing considerable information concerning the patient's intelligence and emotional make-up, as well as providing the patient with the satisfaction that he or she has been 'heard out' by the physician, rather than merely having been exposed to a series of laboratory examinations based on 'high technology.' After the patient has given an account of the illness, the physician should obtain information concerning the onset and chronology of symptoms, their location, quality and intensity; the precipitating, aggravating, and relieving factors; and the details of response to therapy.⁶⁹

The well-intentioned approach outlined here distinguishes two narratives, one of which corresponds roughly to the 'text' level of narrative poetics, and the other to the 'story' level. The patient is allowed to convey his tale in his own words--there is a hint of indulgence in the author's prescription, since the patient's account will be time-

⁶⁹ Eugene Braunwald, A Textbook of Cardiovascular Medicine (Philadelphia: W.B. Saunders, 1988), 2.

consuming and irrelevant, and much of its purpose is to give the patient 'satisfaction.' The physician then extracts the essential information from the patient's version and reformulates it into 'story,' in the technical sense of the word, ordering it chronologically and according to specified medical criteria. Even though the patient's narrative could be analyzed satisfactorily on its own, the fact remains that a significant transformation has taken place between the patient's and the physician's rendering of the 'same' content. The stumbling nature of the patient's text is nothing like the physician's finished version. The latter is a highly stylized, formulaic product, organized precisely according to the criteria indicated--chronology, location, quality, intensity of symptoms and so forth--and containing stock phrases such as, notoriously, "The patient was in his usual excellent state of health until two weeks ago when...".

The formal history controls and limits the patient's self-expression, to be sure, and this method of gathering and reshaping a patient's story is inculcated very early in a medical student's career. But do more informal situations generate different narratives? I would argue that the structure of the medical encounter is such that the patient's story is always reformulated to the detriment of his self-expression. By attributing this transformation to a structural situation rather than to the personalities of the participants, I hope to avoid the pitfalls of a moralizing,

ad hominem argument. In the following pages, I analyze at length a specific encounter of the informal type I have just mentioned. This detailed interpretation shows how the patient's story is remodeled into the clinician's story. The patient's 'narrative' is the hypothetical account a mother gives to explain her baby's constant crying. The health care provider, a nurse practitioner, constructs a new narrative in the course of the interview.⁷⁰ Both typify 'medical narratives,' in Brody's sense, their primary function being to give meaning to an illness experience.

On arriving at the clinic, a mother expresses her concern to a nurse practitioner about her baby's frequent crying. She wonders if the crying is caused by 'teething'. In the course of the exchange over 20-25 minutes, the nurse practitioner attempts to account otherwise for the baby's crying. She uses two methods to engineer a new hypothesis. The first is a technique I call detouring by means of which she both cuts short the mother's narrative and conceals its replacement with her own; the second is introducing the components of her own narrative in a process I call scenario building.

The detour is a device that draws attention away from the mother's stated topic. The nurse practitioner introduces the technique almost immediately in response to the mother's

⁷⁰ Interview. Clinic Visit: Mother and young Baby with Nurse Practitioner--San Francisco. n.d. A partial transcript is provided in the appendix.

opener on teething. Although she appears to respond directly to the mother's concern ("about teething...l. 12) she subsequently directs attention to the more subjective topic of 'crankiness' and finally to the mother's psychological response ("and his crying and things upset you a lot?" l. 21). On a number of occasions throughout the interview, the mother reopens her narrative ("maybe he's sick, too, I thought" l. 105; "I wanted to make sure he isn't sick" l. 167) but it is not until the nurse practitioner has--more or less successfully--lobbied for her own hypothesis that she herself addresses the mother's worry about teething ("is there anything else that you...wanted to talk about besides his teething and crying? [my emphasis] l. 164 and "We'll check him over and see how he's doing" l. 170). Detouring--and hence avoiding appearing as though one is railroading an opinion--may well be a technique taught to professionals involved in health and psychological counseling, but what is relevant here is its structural function in framing the interaction. It thus leads from the initial statement of the mother's concern through new topical territory about the mother's home life to the final rebuttal of the mother's first hypothesis. ("Well, Mrs. C., how do you feel now that we've finished and your little boy is really doing well...." l. 173). Moreover, the detour serves an important structural function in the actual moments in which the nurse practitioner formulates the alternate, opposing hypothesis. By deflecting attention in various ways from her own

narrative version, the nurse practitioner attenuates the brashness inherent in contrariness, since her opinion conflicts with the mother's assessment.

The entire sequence of communicating her hypothesis takes the nurse practitioner from l. 67 through l. 151. My choice of a point to begin analysis is thus arbitrary. In one instance the practitioner begins: "I think maybe-" (l. 107) and interrupts herself by addressing the baby with innocuous baby talk. She then returns to her discourse, not by finishing her sentence, but by what we may construe as a second interruption, in which she asks the mother a question about how she has handled the situation. The question may have two functions: first, it gives the impression that the practitioner is still gathering information rather than expressing an opinion and second, it offers the mother another opportunity to reiterate her frustration about her child's crying, thereby supporting the need to come up with a satisfactory story, as the practitioner handily is in the process of doing. Next, the nurse practitioner again addresses the baby. She then appears to tackle the issue head on. This is one of two occasions in the conversation (other than during the formalities of introduction) that she uses the mother's name: both occasions announce statements of narrative summary or recapitulation. But again, the nurse practitioner interrupts herself, wanting to "get it straight in her own mind." (l. 119). Only then, by conflating "getting it straight" with the analysis, does she articulate

her hypothesis. She does this consistent with the mode of narrative 'scenario building' discussed below, in which she produces the story of the mother's home life. In doing so, she depicts a reality which appears to be independent of her personal or professional opinion, although this reality is rendered interpretively. However even after she has summarized her view in ll. 121-134 and recapitulates her position (ll. 145-149) in response to the mother's providing additional background information to support the hypothesis, the practitioner resorts to further detouring by adding another, supplementary narrative construct. The primary hypothesis is that the baby cries because the mother's household is busy. However, once she has the mother's preliminary assent, the practitioner also suggests, secondarily, that the baby cries because he is at a certain developmental stage. As in the case of the other examples of detouring, the utterance of this supplementary hypothesis deflects from the primary hypothesis. The practitioner can thus be said at every point to be insinuating her own story while supplanting the mother's.

Integral also to venturing an opinion is the technique I call 'scenario building.' The nurse practitioner asks the mother to portray the circumstances surrounding the baby's crying at home. She makes every effort to elicit narrative detail. ("Can you tell me a little more about that?" l. 50; "Exactly what does he do? How much does he cry?" ll. 82-83) In the course of doing so, she allows the mother to

introduce the theme that forms the mainstay of the proffered hypothesis, namely, that of business. It is the mother who first introduces the theme with reference to her husband, who is "awful busy" (l. 37) and reinforces it some lines later: "Well, it's pretty busy around the house in the morning." (l. 58). The practitioner then, in proffering her hypothesis, couches her opinion in a mini-narrative:

Perhaps it might have something to do with how busy you are getting your little boy to school? do you think that might be a kind of tension and everybody's feeling in a hurry and..you might feel..that he's not getting as much attention as he..did even last summer you know when he..didn't *have to go to school this is a big change..everybody's getting ready and your little boy has to have--your *other little boy has to have some attention *too/ (ll. 120-138)

This 'narrative recreation' of the pertinent domestic dynamics is the result of her "getting it straight" in her own mind, but is also presented as a joint venture: "Uhh, you said, in the morning, when we explored perhaps it might have something to do with...how busy you are..." [ll. 119-121 (my emphasis)]. Thus scenario building has two functions, the first of which is to establish a complicity between the nurse practitioner and the mother. The second may be construed as a kind of detour, by drawing attention away from the subjective opinion of the nurse practitioner and projecting instead a 'visible reality'--the practitioner evokes such domestic details as making the coffee and shaving as props in her portraiture--which has its own validity independently of the opinions of the participants.

The foregoing analysis reveals the subtle and complex nature of a medical interaction and illustrates precisely what Brody identifies as the tension between 'the uniqueness of the individual patient' and 'the need to explain the patient's illness by means of generally applicable laws,' the knowledge of which is the clinician's province. It also shows that even in a very personal and humane interaction, the patient's story is as it were dubbed; the practitioner steers the mother--subtly, understandingly, to be sure--into jointly formulating a story that conforms to the nurse practitioner's fund of pediatric knowledge.

We have seen patients' stories become the clinicians' stories. As I have suggested, this relationship is structurally inherent in the medical encounter. The patient's narrative, especially its textual surface, is tentative; it is translated by the health professional into a stable, medically useful format. Whether the physician's retelling occurs in the formal setting of a written medical history or in the context of an anecdote, it is he who has the final say. Brody mentions the existence of two story versions but gives their separate authorship another sense:

Overworked and harried physicians display little tolerance for any information from patients that is not already formulated as, or at least translatable into the standard "medical history"....If we assume that storytelling does indeed play an important role in the day-to-day subconscious world of the physician, it is small wonder that such physicians should end their activities feeling vaguely frustrated and unfulfilled. They might indeed succumb to temptations to tell their stories about patients in social settings removed from their practice, where they need not fear being derided for being "anecdotal," but where instead their

compulsion to tell their stories to someone may produce important weakenings in ⁷¹the traditional respect for medical confidentiality.

According to Brody, patient and physician story versions arise not from a structural necessity, but from the physician's irritation with his patient's stories. In a more congenial environment, he compensates for his alienation. His own retelling restores his personal integrity by letting him speak for himself. One could argue, and I do so here with the reserve appropriate for conjecture, that narrative serves not primarily the patient in the process of healing and therapy, as Kleinman, Brody, Marcus and others interested in the function of narrative claim, but more fundamentally supports the physician psychologically and professionally. The physician's anecdotal urges--which probably don't wait for a non-professional milieu to find relief--act as a foil to the institutional and formal restrictions of the workaday milieu. More important, however, may be the pivotal function of the physician's stories in consolidating professional identity. Nowhere is this tendency more evident than in the presentation of the case history, around which physicians gather for ritual collaboration. The celebrated case studies presented weekly in the New England Journal of Medicine provide a convenient example. That these Journal case studies serve professional

⁷¹ Brody, 3. Churchill and Churchill also contrast patient narratives with the formal medical history. "Story-telling in Medical Arenas," 75.

vested interests may not be surprising, given their presence in medicine's most prestigious professional publication. How this occurs is nonetheless interesting and warrants commentary.

In each case study, a patient with specific symptoms, leading to hospital admission, is presented. The relevant features of the patient's history are reviewed, as are previous hospitalizations and current physical and diagnostic findings. When all the information is 'in,' the doctor to whom the case is presented guesses what further diagnostic procedures were implemented and makes a diagnosis. He substantiates his conclusion with a lengthy analysis, and then his diagnosis is compared with the clinical diagnosis. Subsequent discussion among experts reveals further aspects of the case, including the results of the procedure performed, pathological analysis, and additional remarks about the clinical course of the illness. In all of this, the patient acquires very little individual identity. The case typically presents a few key features describing the history of the patient's illness; the laboratory values, which can hardly be said to confer individual character, occupy the same position, from an informational point of view, as other details about the patient. In narrative terms, the case indeed traces the evolution of the patient's illness, focussing extensively on radiographic findings, test results, pathological analysis, etc., but I would argue that the definition of narrative as

'a sequence of events entailing a change of state' describes not so much the course of disease as the passage from ignorance to knowledge: the sequence of events coincides with the unveiling of the patient's condition. Earlier, I spoke of the narratological convention that analyzes a narrative in terms of its story, text and narration aspects. 'Narration' refers to the actual generation of the narrative. In the Journal case studies, this level takes on particular prominence. Much of the suspense of the case rests on what the participants--the procession of medical experts--will say. Everyone watches for their slips, and more often by far, admires their diagnostic acumen. The physicians, then, are the main characters in their patient's story. That a professional territory is staked out in these discussions is underscored by the ritual coda, in which the medical students are asked for their conclusions, invariably with the formulaic: "Dr. Pomerantz, may we have the medical students' diagnoses?" Their tell-tale presence foregrounds momentarily the hierarchical-professional space in which the case unfolds.⁷²

I have thus far analyzed two features of medical narratives. The first entails a restriction of the patient's

⁷² This is not to say that the medical students don't sometimes make the right diagnosis where the performing physician himself misses the mark. In one instance, the physician actually praises the medical students for their accuracy. New England Journal of Medicine 319 (1988) 1008. Rather than undermining their superior, their competence reinforces the reader's faith in the future of the profession.

personal expressivity. This restriction has as its underlying condition the unique separation of the narrative's story and text. It takes shape as a formal characteristic which relegates to the physician the task of producing definitive narratives, involving him in an ordering activity that at the same time structures his relationship to the patient and helps position him professionally. The second feature is precisely this construction of a professional identity through narrative: by virtue of an emphasis on the story's narrational aspect, the patient and physician are fixed respectively as object and subject of the narrative. These are psychological and structural elements that enter into the practice of medicine, where narrative plays a central organizing role. However, in the theory of medicine, narrative is excluded from the center. We can define this 'center' as a space occupied by the ideal of a healthy, normal person. Narrative concerns only the passage to and from the norm. It traces the pathology exhibited by the 'individual patient.' Contrarily, the 'general laws' of medicine originate and end in the static norms of health. Preventive and therapeutic aims of medicine are, as it were, counter-narrational. To claim for narrative a central role in the healing process, as Brody does, is to overlook this constitutive contradiction between the individualizing and generalizing tendencies of medicine.

The concept of health as a tightly maintained balance between extremes has a long history, significant traces of which resonate in modern medical physiology as well as in medical therapy. Towards the end of the eighteenth century, preventive medicine turned upon the notion of moderation, a common-sense balance of personal habits. Medicine relied predominantly on allopathic theories; for example, by treating a 'softening' of the brain with 'hard' substances or by countering lethargy with force. Moderation was defined as a sense of proportion aimed at modifying the excesses of culture, of controlling the increasingly widespread use of intoxicants and personal luxuries. By general consensus, this kind of superfluity produced an epidemic 'slackening,' 'softening,' and 'lethargy.' Vocal repudiations aimed at overindulgence in both corporeal pleasure and uncontrolled bursts of passion:

Immoderate eating and drinking and other sensual pursuits gradually weaken the body and place the soul into a kind of stupor that renders it wholly incapable of any kind of sharp thinking. Moderation on the contrary firms up the body and furthers the strength of the soul's energies. For that reason does Horace⁷³ require of aspiring poets a meticulous restraint...

The author here makes the standard reference to food and drink as part of a cycle of vices, to an encroaching weakness affecting both body and soul, and to moderation as

⁷³ Carl-Friedrich Flogel, Geschichte des menschlichen Verstandes (Frankfurt und Leipzig: in der neuen Buchhandlung, 1778) par. 155, quoted in Caroline Wellbery, "Sensibility and Socialization: The German Sentimental Novel of the 1170's," diss., Stanford University, 1981, 32.

an effective remedy. His mention of Horace also names the conventional model for many eighteenth-century advocates of abstemiousness. To cite another example, the body was deemed to have a built-in mechanism enforcing moderation: the need for sleep. How is it, the poet and philosopher Friedrich Schiller asked while still unsuccessfully pursuing a medical career, that hardly has the mind hit upon an idea, 'just as we are moving along a clear, straight path to Truth,' when we are overcome with fatigue and have to put everything aside to rest? The answer, he suggests, is that sleep serves as a protective mechanism which, by restraining the mind, prevents the body from being destroyed in a paroxysm of intellectual zeal. "Precisely this lassitude and slackening of the organs to which thinkers object so much," Schiller writes, "prevents our own strength from wearing us out in no time, and ensures that our emotions do not continue to grow in intensity until we ourselves are destroyed."⁷⁴

The sometimes precarious maintenance of health thus depended on the negotiation of simultaneous possibilities; too little or too much, too strong or too weak, too hot or too cold--all these vicissitudes threatened the stability of the organism. Moderation in effect ensured stasis. In describing the lethal effects of excessive pleasure, Schiller wrote: "We can only term health that good condition

⁷⁴ Kenneth Dewhurst and Nigel Reeves, eds., Friedrich Schiller: Medicine, Psychology, Literature (Berkeley: University of California Press, 1978) 273-274.

of our natural processes which will produce similar natural processes in the future, i.e. which will ensure the perfect functioning of subsequent processes. Thus an essential element in the concept of health is that there should be a tendency to permanency."⁷⁵ [Schiller's emphasis].

Maintenance of the status quo through time is a principle familiar to contemporary students of biology and physiology as the basis of the homeostatic mechanism. The concept of a stable, self-perpetuating 'internal environment,' a phrase coined by the nineteenth-century physiologist Claude Bernard, has made its way directly into the introductory pages of modern physiology texts:

Each functional structure provides its share in the maintenance of homeostatic conditions in the extracellular fluid, which is called the internal environment. As long as normal conditions are maintained in the internal environment, the cells of the body will continue to live and function properly. Thus, each cell benefits from homeostasis, and in turn each cell contributes its share toward the maintenance of homeostasis. The reciprocal interplay provides continuous automaticity of the body until one or more functional systems lose their ability to contribute their share of function. When this happens, all the cells of the body suffer. Extreme dysfunction leads to death,⁷⁶ while moderate dysfunction leads to sickness.

A general law of medicine is thus to manage the occurrence of events by approximating normal physiology in its uneventful automaticity. This law is ever more firmly articulated in medical practice, as two relatively recent

⁷⁵ Dewhurst and Reeves, 277.

⁷⁶ Arthur C. Guyton, Textbook of Medical Physiology, (Philadelphia: W.B. Saunders, 1986) 7.

innovations in diagnosis and therapy illustrate. The first example illustrates the application of meticulous monitoring in neonatology. Technological advances permit measurement of a premature infant's bilirubin levels in the neonate's breath, whereas these had previously been derived from hemotological analysis. Blood levels reflect a past status, fixed at the instant phlebotomy occurred, while breath measurements make possible moment-to-moment monitoring of the patient's condition and early, preventive intervention.⁷⁷ Monitoring to achieve the salubrious effects of homeostasis also has important therapeutic applications. Increasingly, it is thought that some of the late complications of diabetes, such as diabetic nephropathy, can be limited by what is called 'tight control' of bodily glucose levels.⁷⁸ Home monitors and temporally staggered actions of insulin have contributed to the feasibility of tight control.

The notion of a well-managed health status through homeostasis permeates the lay literature and alternative medical practices as well. The Revici method of cancer management holds that "controlling a disease is a matter of detecting the nature of a biological 'off-balance' and

⁷⁷ Stevenson, David K. Personal Interview. 14 Dec. 1987.

⁷⁸ "It has not yet been definitively proved in prospective trials in humans that correction of hyperglycemia will prevent [the specific microvascular complications of diabetes]. But the philosophy of tight control, when achievable, is becoming more universally accepted." George Cahill and Roald Arky, Scientific American, 9 (1983) 20.

administering a substance that corrects it. Revici first determines whether a patient's condition is 'anabolic' or 'catabolic'....He then prescribes substances of his own formulation, to be taken orally or by injection, that he believes will correct the off-balance."⁷⁹ In a more orthodox vein, a home health manual explains homeostasis to its readers:

The natural state of the body is health, its natural tendency to restore this condition after any disturbance. It is as if every part of this human village has an 'ideal' of wholeness and performance to work to, and instantly gives the alert when this model is challenged. The greater the threat, the more extreme the response; as the threat is reduced, the response too diminishes. Through this homeostasis, we live in a dynamic balance with our inner and outer worlds--the body ever ready to rise to an emergency, yet seeking wholeness, harmony and equilibrium, and to return the vital functions...to within the 'ideal' norms of health.⁸⁰

Medicine's bodily ideal is achieved by the body's dynamic integrity. The body holds in check any disturbance as it strains towards recovery. Unlike pathology which leads through a sequence of events, health clings sturdily to its place of origin. The former conforms to narrative structure, the latter resists it: medicine realizes itself fully only in the story's absence. That medical stories abound by no means lessens the force of this observation. Rather, their presence underscores the opposition in medicine between

⁷⁹ "Unproven Methods of Cancer Management: Revici Method," Ca-A Cancer Journal for Clinicians 39 March/April 1989, 119.

⁸⁰ Andrew Stanway, Natural Family Doctor, (New York: Simon and Schuster, 1987) 33.

science and art, between technical achievement and human interest. Furthermore, institutionally, the conflict is smoothed over in the narratives themselves by means of their formal control. For by managing through numerous constraints the way narratives are solicited and revised, the medical collective reasserts the homeostatic ideal: the ever-reiterated highly stylized form limits the degree to which unpredictable elements can disrupt the institutional status quo. This interpretation merely takes one step further the commonplace notion that by imposing a formal structure narrative gives meaning to illness. Control of this structure itself, I submit, reaffirms the institutional identity of medicine. It recreates the pathological event as a routine occurrence and thus subordinates it to the belief that medicine can restore and preserve homeostatic processes.

CONCLUSION

In the previous pages, I have shown how language use in medicine reveals the limits of humanism. Though it is the privileged instrument of the humanities, especially of literature, language does not export to medicine a humanitarian content so much as it reinforces the native structures of the medical institution. In particular, language which in literature purportedly gives voice to 'individuals' and life to their feelings, thoughts, growth and suffering, in a medical context standardizes

relationships and facilitates their integration into hierarchical arrangements. This depersonalization necessarily affects not only those on the receiving end of medical care, but also those who administer it and who are locked no less than patients into the prescribed rituals of their myriad interactions.⁸¹

Having said this much, I do not wish to convey the impression that of all society's institutions, medicine alone exerts its constraining influence on language, and that everywhere else, individuals speak freely and unconditionally. All social circumstances, but especially highly ritualized professional situations, reveal aspects of their organization through language. This assumption underlies work of recent decades on the performative role of speech. Rather than regarding language as an object which passively allows manipulations to be performed on it, speech act theory, conversational analysis, discourse analysis and other related linguistic approaches treat language uses as

⁸¹ Yet another example of this dual effect on patients and physicians respectively is the juxtaposed presence of two articles under the common title "Sad Symptoms of Changing American Medicine." The first article, "The Veterinarian Ethic," concerns institutional effects on patient care; the second, "The Disaffected Doctor," addresses the physician's frustration with new medical care delivery systems and the erosion of a medical 'art.' The Wall Street Journal 20 July 1986.

events.⁸² Because language accomplishes actions both individually and institutionally, it is implicated in the formation of personal and cultural patterns.

Why the analysis of narrative and metaphor should reveal the negative cast of these patterns--by defining, for example, the limits of medical humanism--cannot be explained solely in terms of medicine's deficits. Within the humanities themselves, literary scholars have called attention to the constraints on individual expression which language in various forms echoes and reproduces. Modern narrative provides just one frequently adduced example of this depersonalization. In his essay on storytelling, Walter Benjamin describes the disappearance of an oral art rooted in experience.

...experience has fallen in value. And it looks as though it is falling further into a bottomless abyss. Every glance at a newspaper proves that it has reached a new nadir, that not only the image of the external, but also of the cultural world has suffered overnight a previously unimaginable transformation. The World War inaugurated a process which has not since come to a halt. Didn't one notice that soldiers returned mute from the⁸³ front? not richer--poorer in shared experience.

For a storytelling tradition to survive, Benjamin argues, experiential wisdom is necessary, and the story-teller's

⁸² See, for example, J. L. Austin, How to do Things with Words (Oxford University Press, 1962; M. H. Goodwin, "'Instigating': Storytelling as Social Process," American Ethnologist (1982b) 9: 799-819; J. Maxwell Atkinson and John Heritage, Structures of Social Action (Cambridge University Press: Cambridge: 1984).

⁸³ Walter Benjamin, Illuminationen (Frankfurt: Suhrkamp, 1977), 385-6. [My translation]

'having been around' is linked intimately with the authority he commands as a spinner of tales. Not an abstract teller, but a real person embodies this authority, and his medium is not so much language as the slow passage of time in which he paces his story. The temporal component (whose medium is boredom, or Langeweile) of storytelling locates the narration in the physical present, which at the same time anchors the storyteller in a living reality. This reality is important because it binds the teller to the concrete, immediate world for which he is, as it were, a kind of spokesman. According to Benjamin, both storyteller and the unique relationship he entertained with the surrounding environment have disappeared. He cites two examples of modern narratives--the novel and news items--that deprive storytelling of its rootedness in a community and of its physical embodiment respectively. First, the novel, Benjamin argues, is produced and consumed in solitude, not in a community; further, it lacks the experiential component of the oral tale. Second, the news proffers a form of narrative that relies not on an individual presence; as 'information,' it derives its authority through its verifiability. With the advent of these two narrative forms, stories have lost their original meaning-making capacity.

What Benjamin perceives on a cultural level to be the erosion of the individual voice recrudesces formally in narrative theory as the death of a story's author or its characters. Drawing on a tradition inaugurated by the 'new

novelists' earlier this century, recent theory has emphasized the creation of these personae through narrative conventions:

Stress on the interpersonal and conventional systems which traverse the individual, which makes him a space in which forces and events meet rather than an individuated essence, leads to a rejection of a prevalent conception of character in the novel: that the most successful and 'living' characters are richly delineated autonomous wholes, clearly distinguished from others by physical and psychological characteristics.⁸⁴

It is hardly much of a leap from this view of characters and individuals to the type of analysis I have performed, which asserts that individuals are the products of a set of professional and disciplinary conventions embodied in medical language. However, I do not mention these discussions of depersonalization in order to identify the methodological indebtedness of my argument. Rather, I wish to locate the point of contact between medicine and the humanities in the common awareness of the limits imposed on individual expression and on the expression of individuality. What is at issue in both medicine and the humanities is the phenomenology of the individual. In his critique of structuralist theory's 'scientistic fallacy,' Wolfgang Holdheim argues that it is precisely this phenomenology that contemporary linguistic analysis ignores: "Language is much more than signification: it is existential

⁸⁴ Jonathan Culler, quoted in Shlomith Rimmon-Kenan, Narrative Fiction: Contemporary Poetics (New York: Methuen, 1987), p. 30-31.

projection, imbued with experiential intensities, unfolding within the context of an inner horizon (the living history of language) and an outer one (a changing world or reality)."⁸⁵ Holdheim seeks to revitalize the use of language for theory by emphasizing its empirical rootedness in a richly changing present. Revitalization of this sort can come from many sources. In a curious reversal of a popular assumption, David Smith argues that the humanities generally may benefit from medicine by an infusion of the 'real': "A large contribution that involvement with medicine can make to the humanities is helping to make scholars aware that people are more important than words, that words matter as tools for the interpretation of selves. Not only medicine, but criticism should be limited by respect for embodied selves."⁸⁶ Elision of individual reality haunts the humanities no less than medicine.

To 'humanize' medicine through theoretical or practical interdisciplinary work, two realizations must be conjoined. First, one must recognize the coercive force of the internal structures of the medical institution, of which language use is one important component. It will not do merely to have the student write empathetic fictional accounts of their patients, as internist Rita Charon does in her practical

⁸⁵ W. Wolfgang Holdheim, "Idola Fori Academici," Stanford Literature Review (1987): 9.

⁸⁶ David H. Smith, "The Limits of Narrative," Literature and Medicine 5 (1986): 57.

teaching, to alter these structures. Her approach provides a model which in her own words "has no stake in the current structure of medical education or in adapting students to its rigors."⁸⁷ The well-intentioned implication in this claim is that her approach leads the student to the heart of what is human and thus facilitates an 'authentic' doctor-patient encounter despite institutional constraints. But if what I have said about language use is true, then one cannot simply declare one's private innovations exempt from institutional rule. Secondly, one must understand that what is happening in medicine is but one, albeit complex, manifestation of the evolution of our technocratic, overcrowded and inegalitarian society. The deficits suffered by the individual are reflected--and sometimes rationalized or aestheticized--in medicine and the humanities alike. To expect the humanities to inject a dose of humanism into the practice of medicine is to ignore this common ground. That is not to say that nothing can be learned from a combined approach to the humanities and medicine. But these disciplines touch each other most closely where they call for a remedy that neither can supply.

⁸⁷ Rita Charon, "To Render the Lives of Patients," Literature and Medicine 5 (1986): 72.

APPENDIX

Nurse Practitioner and Mother: A Clinical Encounter

- 1 NP: Since this is your first *visit..do you have any
2 special concerns or problems that have come up?..
3 that you'd like to=..talk about today//
- 4 M: ^{=mm=} Yeah i i *did have a question ([p]) and that
5 was about teething/=
- 6 NP: =uh huh=
- 7 M: just that..i i *heard that teething can..make the
8 babies very cranky and..i wondered if uh if you
9 think thth- =
- 10 NP: =mm hmm=
- 11 M: =that's true/
- 12 NP: about teething <[clears throat]>::umm::how- does
13 he have any teeth? =()
- 14 M: = Well= not...not real
15 recently, no//
- 16 NP: uhuh/ was there some special reason that you are
17 asking..about his being cranky?
- 18 M: yeah, he *has been kind of cranky=
- 19 NP: =[uh huh]
- 20 M: and i i wondered if it was maybe his teething/
- 21 NP: uhhuh..and..his crying and things upset you a lot?
- 22 M: ==*mmhm/
- 23 NP: ==uhhuh
- 24 M: ==yeah ()
- 25 NP: how does it bother you?
- 26 M: hmm?
- 27 NP: how does it bother you?
- 28 M: wel- it makes me feel *bad//
- 29 NP: that you're..that you d- that you can't comfort
him because he seems to be crying a lot?

- 31 M: y:eah/
- 32 NP: uhhuh..how's your *husband feel about it?
- 33 M: well..s'kinda hard on him too//
- 34 NP: uhhuh: he's trying..is he..uh helping you with the
35 baby..that's picking him up or..is he =just kinda=
- 36 M: =well 'cause
37 he's awful busy/
- 38 NP: =uhhuh/
- 39 M: =so,
- 40 NP: what do you mean *busy: works late at night or
41 something?
- 42 M: yea:h/
- 43 NP: [hi] what are his hours: working?
- 44 M: uh oh he he he starts works around..um..guess he
45 leaves home around 8 8:30/
- 46 NP: uhhuh/
- 47 M: doesn't get home..til pretty late at night/
- 48 NP: uhhuh/ o.k. you mentioned that he cries a lot/
- 49 M: ==mhm/
- 50 NP: ==can you tell me a little more a*bout that?
- 51 M: wh- what d'you mean?
- 52 NP: a*bout his crying does- is he crying all the time?
- 53 M: [hi] we:ll..pretty much throughout the day..but
54 uh..especially bad in the morning//
- 55 NP: mhm/ what's going on in the morning,..that you
think he's crying more?
- 57 M: well it's *pretty *busy around the house in the
58 morning/
- 59 NP: do you have any other children?
- 60 M: mhm/

- 61 NP: how many?
- 62 M: uh: one//
- 63 NP: one and how old is that one?
- 64 M: he's five//
- 65 NP: five and is he going to school?
- 66 M: yeah he just started//
- 67 NP: uhuh/ so you are ~busy,
- 68 M: mhm/
- 69 NP: getting ready for s- you have to take him to
70 school/
- 71 M: uhuh/
- 72 NP: <2> and do you think that maybe.. you're really
73 busy getting everything..ready for your first son
74 and maybe-..maybe he feels a little out of uh..
75 out of sorts and maybe he's not getting enough
76 attention or..
- 77 M: well::could be/
- 78 NP: ::i'd like- i would be kind of important since it
79 is..that you you- you know..say that you're really
80 concerned about it,
- 81 M: mhm/
- 82 NP: unmm:..exactly w-what does he do/ how much does he
83 cry..when does he cry/
- 84 M: well..it seems that it's uh [ac] especially bad
85 in the morning when he first wakes up and
- 86 NP: ==mhmm
- 87 M: he-he wants me to hold him all the time/
- 88 NP: ==mhmm
- 89 M: ..and uh..very clingy/
- 90 NP: ==mhmm
- 91 M: and crying a lot/
- 92 NP: ==mhmm

- 93 M: = (x) =
- 94 NP: =what= time does *he wake up?
- 95 M: oh he wakes up at about 7?
- 96 NP: mmhuh and what time does he- are you getting up
97 and getting breakfast for=
- 98 M: ==just about the same
99 time//
- 100 NP: uhuh/ do you think that might be..one of the
101 reasons why he night be crying a lot and fussy?
- 102 M: [hi] yeah-
- 103 NP: because you're *busy and..
- 104 M: [lo] maybe but then i i felt..well..y'know..he
105 never did this be*fore:..m-maybe he's *sick *too
106 i thought..y- you know//
- 107 NP: mhmm/ i think maybe..<[lilting talk, evidently to
108 baby]> hi/ how are you?..uh..you've tried to
109 comfort him? by [lo] holding him..bringing him
110 *out/ to where you're getting breakfast,
- 111 M: y:eah:/
- 112 NP: that hasn't helped?
- 113 M: well a *little bit but..n-not for *too long//
114 y'know/
- 115 NP: mhmm/ <[baby makes noise. NP resumes high,
116 lilting voice, evidently addressing baby]>
117 [hi] he*llo/ how *are ya'? umm [lo]..well, Mrs.
118 C. i..*i feel::wait now..so..let me just kinda
119 get it straight ..in my own mind/ uh you said
120 um..in the morning..when we explored..perhaps..it
121 might have something to do with how busy *you are
122 getting =your=
- 123 M: =[p]yeah=
- 124 NP: your little boy
- 125 M: ==mhm
- 126 NP: to school/ do you think that might be a:
- 127 M: ==yeah/

- 128 NP: kind of tension and everybody's feeling in a
 129 hurry and..you might feel..that he's not getting
 130 as much attention as he..did even last summer
 131 [ac] you know when he..
- 132 M: ==mm
- 133 NP: didn't *have to go to school this is a big
 134 change..
- 135 M: yeah/
- 136 NP: everybody's getting ready and..your little boy
 137 has to have- your *other little boy has to have
 138 some attention * too/
- 139 M: mhm..yeah..and then..[ac]you know my husband has
 140 to get out 'n'..[lo] i have to get off too//
- 141 NP: mhmm ri- are you *working?
- 142 M: yeah//
- 143 NP: o::h..so you *are a busy lady//
- 144 M: mhmm/
- 145 NP: i- do you suppose that he might be feeling all
 146 this:: *busyness..kind of..he's reacting to all
 147 the- everybody running around and he seems to
 148 be getting ig*nored? do =you think that might
 149 have= s-
- 150 M: =maybe he *does feel that=..
 151 maybe he *does feel that/..<f>he's been *so happy
 152 up until now/ y'know?
- 153 NP: mhmm/..well..*also about this age they *do
 154 get..they do get kind of clingy..kind of *to
 155 their mothers/ they very close and they get what
 156 you call a separation anx*iety/ it's part of
 157 their growth and development//
- 158 M: yeah/
- []
- 159 NP: it- i think he's feeling..anxiety/
- 160 M: ==mhmm
- 161 NP: ==a little tension everybody getting- <[baby gets
 162 louder, NP addresses baby]> well *yea:h: what do

163 *you think? is there anything *else that you had
 164 ::uh..i- wanted to talk about/..besides his
 165 teething and crying/

166 M: well that- that was the main thing and i- i
 167 wanted to make sure he isn't *sick/

168 NP: ==uhhuh

169 M: ==you know/

170 NP: we'll check him over and..see how uh..see- see
 171 how he's doing

[physical examination by NP]

172 NP: Well Mrs C. how do you feel now that we've
 173 finished and your little boy is really (in exc-)
 174 he's really doing well/ his *teeth..and his ear-
 175 his *teeth are coming in but they don't seem to
 176 be uh:: he doesn't have any coming in right
 177 a*way//

178 M: no/ mm*mm/

179 NP: uh..his ears are fine and his throat- and
 180 everything checks out fine, uh,

181 M: so y- y-you don't think he's crying because
 182 of *illness or because of his =teeth=

183 NP: =no=/
 184 ==no..*i i think tha- that you (xx) you feel
 185 you *are a little worried about..his- your (his)
 186 leaving him/ umm,

187 M: [to baby] (xx) [hi] *baby,

188 NP: [to baby] well *yeah..i think that might be
 189 the um..reason- one of the reasons why he
 might be crying/

190 M: mhm..so y-you don't think i'd have to..*quit
 191 the job?

[NP proceeds to give extended advice]

192 NP: well how do you feel about that? do you think
 193 that-

194 M: well i'll try that and see if that helps you
 195 know? i i hope it *does 'cause it's- it's
 196 real hard/

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