Literary Practice as High-Stakes Action: Narrative Medicine in the School of English

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Abstract

At the heart of narrative medicine as conceived and practiced at the Columbia University Program in Narrative Medicine lies the desire to maintain contact, the move toward intersubjective encounter, reader and writer, doctor and patient, colleague and colleague. Whereas narrative medicine is most commonly described as arming medical professionals with narrative tools to develop more effective relationships in health care, the human consequences and ethical implications for literature scholars in this interdisciplinary practice are equally profound. "Ethics" can be an unfashionable word in contemporary literary circles. Today's scientific community, by contrast, regularly tackles issues of empathy and "meaning." Contact, engagement, and affiliation are at the heart of both the literary and the medical act, and by extension, the ethical act. Post-workshop reflections from the Aristotle University Thessaloniki School of English narrative medicine seminar "Understanding Illness and Trauma through Narrative" (2013) indicate that narrative medicine calls readers and writers toward conscious engagement with the complexity of the other. Around the narrative medicine table, when physicians, writers, and literary scholars alike look and look again at a text, they are called to act, to engage with the real-world implications of those texts, and so to understand literary practice as real-world endeavor.

Keywords: narrative medicine, ethics, intersubjectivity, literary criticism, medical humanities.

In a 2014 discussion at the Columbia University Narrative Medicine Rounds in New York, fiction-writer Aleksander Hemon fielded two questions, one from a novelist on the narrative side of the table, the other from a physician on the medicine side. "What is writing *for*?" asked the creative writer. Hemon responded, "To make contact, to bring about engagement." When the physician followed up with "What is healthcare *for*?" Hemon immediately shot back, "To make contact, to bring about engagement" (Charon et al., 177). The teaching of narrative medicine, medicine practiced with the narrative skills of "recognizing, absorbing, interpreting, and being moved by the stories of illness" (Charon, *Honoring* 4), occurs at a hospitable table around which questions of clinical

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bioethics are being considered alongside questions of literary ethics. To borrow a metaphor from "Embodied Narrative," by Rita Charon, co-founder and director of Columbia's Program in Narrative Medicine, narrative medicine creates a "clearing" where physicians, health care professionals, writers, artists, philosophers, political scientists, and social scientists sit together at the intersections of medicine, health care, literature, and the arts exploring the relation between narrative competence and competence in the practice of medicine, assessing the real-world concerns of both medical and literary practice.

Rita Charon, a physician who obtained her PhD in literature in a quest to better respond to the stories she encountered in her practice of medicine, asserts that the more she learned about the complex foundations of literary theory, the better doctor she became. To know what a story is, how a story works, and what happens when one person tells another that something happened is fundamental to comprehending and acting upon the stories that patients bring to the clinic ("Shock"). Along with a multidisciplinary cohort of literature, creative writing, philosophy, and political science scholars, she subsequently developed a program she has characterized as "the narrative road to effective medicine" (*Honoring* 6).

Hemon aptly proposes that contact, engagement, and affiliation are at the heart of both the literary and the medical act, and by extension, the ethical act. Reading and writing can be regarded as a "fundamentally moral undertaking" (Charon, *Honoring* 56) by which the reader and writer are called toward "ethical transcendence" (Irvine 12). By giving form to previously formless thoughts, perceptions, and sensations, the writer forges an intersubjective bond with the reader or listener, lets the reader "in on" an interior world, makes authentic contact with another, engages with another. Further, the writer's "telling exposes the moral freight of the story not only to the light of day but to the lights of others." The listener or receiver, then, is "summoned by the text to act" (Charon, *Honoring* 56).

Narrative medicine—whose signature method includes close reading, creative writing, responding to the writing of others, and co-constructing narratives—proves a most effective means by which to raise questions of ethics in the literature classroom. Literature professor Shannon Wooden, for example, implemented narrative medicine-based critical methods to lead her class through 200 pages of a novel, urging her students to listen closely to the narrator and so to walk in his shoes. When she bolsters her literary practice with narrative medicine practice, Wooden says, the narrative medicine analysis not only leads to more complex readings of the text, but also bids her and her student reader/critics "to ask what action we are called on to perform by having received the story" (291).

In Charon's words, teaching literature and creative writing in the narrative medicine mode "operates in view of the desire to achieve and maintain contact with another—be it a distant reader, a student, a classmate or colleague, or a patient. The things we do in

working with texts, we know, can lead to consequences for ourselves. … [O]ur studies are vectored toward very practical goals of improving health care" ("Ceci"). Although the practice of narrative medicine is most commonly reviewed in terms of arming medical professionals with narrative tools to develop more effective relationships in health care, the human consequences and ethical implications for literature scholars in this interdisciplinary practice are profound. Charon and philosopher Craig Irvine discuss the relation between literary studies and the clinical world, proposing that contact with one another is key:

> The idea that one person can understand what another person says or means is the deepest part of science and the deepest part of art… . In the shadow of that meta-perspective of human experience, we place our work in narrative medicine at a series of boundaries, realizing the effort is always to bridge the divides, to seek the permeability, to unlock the channels that might provide unexpected benefit to both sides… . [T]he effort is to transcend the partisan or defensive, toward contact with one's partner not in argument or agreement but in paradox, a contact that will not nail answers but will craft vessels for thought. In the process of the craft comes relation … comes the affective and emotional processes that, if nothing else can, can open the pores between the subject and the object, the seer and the seen, the person seeking care and the person offering it. (Charon et al., 176-77)

Imagining oneself in another's world by close reading, and representing that world in the act of critical analysis or creative response, the student of literature is thereby implicated in an intersubjective encounter. The work of literature, operating under its own peculiar ground rules, summons the close reader to open herself or himself to the world according to the text at hand, to enter through imagination the moral code of another.

"Moral code" and "ethics" can be unfashionable terms in contemporary literary circles. In his 1993 essay "On Relocating Ethical Criticism," Wayne C. Booth points to the rift between aesthetic and practical concerns prevalent in literary thought since mid-twentieth century. "Most practicing critics had been graduate-schooled to believe that all partial questions—ideological, ethical, political—are irrelevant to our appraisals of *artistic* worth: the surest sign that a critic had been badly educated was any hint that judgments about 'life' could intrude on aesthetic judgment" (Jost 181).

Well into the twenty-first century, despite advances in literary ethics, hesitation to pursue ethical criticism is still common in the academy. "In our field," Wooden observes, "teaching and learning how to 'be human beings' remains taboo: such work is too soft, too subjective, too spiritual, too politically problematic" (274).

In addition to being controversially out of fashion, ethics in the intersection of humanities and medicine can seem to bifurcate rather than join the fields. Lest, in the practice of narrative medicine, humanities professionals perceive themselves to be the singular bearers of enlightenment to those dehumanized "hard-science" doctors, Wooden

cautions against that "sense of smug, if silent, superiority" (274). She admonishes the literary scholar to interrogate the notion that pursuit of humanities study is in, of, and by itself humanizing:

> As professional readers of narrative, we "listen" to people, real and fictional, and strive to understand their stories as a matter of course. It's what we do. We may even see ourselves as representatives of a field that—by offering a variety of our texts and techniques to the study of medical humanities—is responsible for having given medical education some degree of humanity. But interdisciplinary practices like those incorporated into "narrative medicine," having created a model for ethical engagement between healthcare professionals and their patients, can also be used as a mirror for literary scholars to hold up to ourselves. (274)

The stereotype of the "soft" humanities scholar challenging the obdurate physician to reform is ironically out of date. Ironically, despite the literature department's study of the "most profound accounts of human existence" (Wooden 274), such as Henry James's vortex of culpability in "A Round of Visits" or Emily Dickinson's moebius strip of mortality and immortality in "Because I Could Not Stop for Death," ethical goals of literary study "yet take a back seat at best to 'critical thinking,' to historical and cultural literacy, to theoretical play with the written word" (Wooden 274-75). Today's scientist, by contrast, regularly talks in terms "paradoxically foreign to the humanists: wisdom, gratitude, empathy, and … the 'meaning' people can make by reading and creating narrative together" (Wooden 275).

Wooden's observation is not a call to discount critical thinking and the rigorous practice that critic Eve Kosofsky Sedgwick, citing Paul Ricoeur's hermeneutics of suspicion, calls "paranoid reading" (123). The "paranoid" approach to criticism that tells us we must suspect a text in order to ferret out its hidden agenda, however, has too often become "a mandatory injunction rather than a possibility among other possibilities… . [T]o theorize out of anything *but* a paranoid critical stance has come to seem naïve, pious, or complaisant" (125-26). Sedgwick suggests that critics lay beside this paranoid perspective what she calls "reparative practice," a critical approach that allows for surprise and pleasure in the text, "the position from which it is possible in turn to use one's own resources to assemble or 'repair' the murderous part-objects into something like a whole—though, I would emphasize, not necessarily like any preexisting whole" (128). Narrative medicine can teach the double duty of laying strong critical practice beside the surrender of close reading in order to enter fully and imaginatively into the text. Charon draws the analogy thus:

> Not unlike the clinician's efforts to think diagnostically about a patient and at the same time to develop a therapeutic alliance with him or her, the reader categorizes, analyses, measures up successes and failures, and deploys critical judgments of the work at hand while at the same time submitting to the world of the text. One's susceptibility to imaginative transport does not cause one's critical feet to leave the ground. (*Honoring* 112)

As Wooden observes, narrative medicine has found "a clear, promising, and rigorous method for doing ethical criticism in our English classrooms" (275). The methods and practice of narrative medicine, designed by and for "hard" scientists in collaboration with humanities scholars, "demand a systematic study of narrative" (275), a study that invites ethical inquiry alongside of and as part of employing "the intellectual tools of literary criticism we [literature scholars] have spent half a century developing" (275).

Critical encounter, then, can lead readers not only to multiple meanings in text, but also to meaning in our lives. In his article "The Other Side of Silence," philosopher and professor of narrative medicine Craig Irvine points to the work of philosopher Emmanuel Levinas who sounds the "call to respond to the suffering of the Other" (12). Irvine writes that "Western thought manifests an allergic reaction to the Other (12). He continues:

> Science, like all forms of conceptualization, *by nature* ignores what it presupposes: it ignores the ethical demand out of which it arises. As a form of conceptualization, of identification, science is naturally a totalizing enterprise. But it is a totalizing enterprise that presupposes—is called forth by—the infinite, nontotalizable, absolute alterity of the Other. For Levinas, science ought to be guided by the ethical dimension that exceeds it, by the Good that it presupposes, by the imperative that demands its creation. Levinas points science and all other human endeavors toward the ethical transcendence that inspires them. (12)

Ethical practice, then, is not at odds with literary criticism or with the scientific method. Rather, as Segdwick and Irvine argue, the ethical demand that gives rise to the rigorous conceptualizing practices of science and art is the very imperative that requires ethical transcendence. Narrative medicine, in its methods of close reading, writing, and reflection, offers participants practice in becoming better encounterers of the Other, and by doing so strengthens our sense of meaning, whether our work be medicine, which seems more obviously meaningful in everyday life, or literature which might stereotypically be relegated to the ivory tower.

Charon finds that humanities scholars in particular gain a sense of real-world participation by joining with medicine, "Literary studies and narrative theory … seek practical ways to transduce their conceptual knowledge into palpable influence in the world, and a connection with health care can do that" (*Honoring* viii). The pedagogy and practice of narrative medicine calls for reciprocity between and among its multi-disciplined practitioners:

> Whether we listen to the story of a patient in the office or we read the words of a well-wrought novel, we are taking seriously human beings' capacity to formulate, in words, what they are going through. We use the same narrative skills in both the literary and the clinical contexts. … Narrative medicine is poised to integrate the literary narrative ethics and the clinical narrative ethics, being a citizen of both worlds, so that the clinical ethics deliberations can proceed in light of the literary and rhetorical insights now available from narrative study. (Charon et al. 124-26)

Engaging at the site of this borderland of science and the humanities, practitioners in both fields stand with the ethical scholar in the experience of reading and writing as "high-stakes actions with consequences not only in books but in ordinary lives" (Charon, *Honoring* 55).

One such encounter between the medical and the literary fields took place at Aristotle University Thessaloniki (AUTh) School of English in 2013 with an undergraduate course in American Literature and Creative Writing entitled "Understanding Illness and Trauma Experience through Narrative," a course that I co-designed with Tatiani Rapatzikou, PhD, associate professor of American literature at AUTh. Responding to the latest trends in literary analysis and criticism aiming at a cross-disciplinary cutting edge narrative practice, the objective of the creative writing endeavor at Aristotle University was to arm literature students with the narrative competence to read closely, write reflectively, and respond effectively across disciplines, pairing arts and literature with health and human welfare. Using poetry, fiction, non-fiction, and dramatic texts, students were guided to analyze and write about these texts, to write creatively in the shadow of these texts, and to reflect upon and respond to each other's creative and critical work.

As is usual in narrative medicine practice, the literary texts for the class included but were not limited to illness narratives and literature directly related to health and medicine. We studied, for example, works by poet Emily Dickinson, playwright Charles Mee (*Iphigenia 2.0*), novelist Tim O'Brien (*The Things They Carried*), life-writer Audre Lorde (*Cancer Journals*). Given the multidisciplinary nature of the effort, in addition to assigning in-class and at-home reading of literary texts, we invited two physicians to present guest lectures to the class; we visited the studio of theatre director and dancer Athina Dragkou who led the group in a movement workshop titled "Disability as Performance;" and we included readings in the theory and practice of narrative medicine by Rita Charon, Arthur Kleinman, G. Thomas Couser, Sayantani DasGupta, and others. Students were guided to choose a "medical ally" from among the physicians and narrative medicine authors and to consider in a reflective essay how their creative work was informed by the work of their ally. Engaging directly with health care professionals in readings, lectures, observation, and interviews, students were encouraged to consider, by practice, how their literary studies pertain to the world around them. As Wooden says,

they learned to "connect experiences … by striving to understand them, to 'join with' those who live them" (291).

The semester culminated in a public performance and showing of the student creative work. In addition, each student produced a final reflective essay tying their creative endeavor with their newfound experience of narrative medicine. Students produced creative work in all genres, not only in poetry, fiction, non-fiction, and drama, but also in music, dance, video, and photography. Themes and subjects they chose included the trauma of war, AIDS and epidemics, ability and disability, hospitals, the wounded body, eating disorders, addiction, mental illness, illness and the family. The American literature department published the students' creative work and reflective essays in the online literary journal *Echoes* ("Issue 4: Psyche in Cycles").

While it is not possible to precisely measure the ethical impact of our use of narrative medicine in the literature seminar, we can make some observations on the students' engagement with the work, on the nature of their creative response, and on their self-reported insights and experiences in this multidisciplinary effort. The student reflections on their experiences indicate heightened awareness in meeting and responding to the suffering of others; consideration of the social and societal impact of illness and trauma, both physical and mental; understanding the effects of illness on identity; assessing duty to the self in the face of illness and trauma; consciousness that the authentically-told story has impact on others.

One of our most effective medical allies was AIDS and epidemics medicine specialist Dr. Symeon Metallidis, Assistant Professor of Internal Medicine, Infectious Diseases at the School of Medicine AUTh. Students prepared for his visit to our seminar by assembling a list of questions related to their creative writing work, questions that approached AIDS from several directions: relationships among family, caregivers, society, and persons with AIDS; technical questions on how HIV is transmitted, diagnosed, treated; psychological and physical effects of AIDS on the person with AIDS, the family and friends, the society at large; the effect on the physician treating this disease; the implications of AIDS as an epidemic; history of the epidemic; myths surrounding the disease. The simple act of inquiry moved the students into a position of awareness, opening them to dynamic interaction with the problem of AIDS, and assisting them in laying aside preconceptions. One student followed the doctor's visit by writing a fictional account of two friends, one HIV positive and the other reacting with a "fear of contamination." The student author discusses her growing understanding of the disease in its relation to social justice:

> Indeed, as Dr. Metallidis points out, the virus HIV was initially called GRIG—an acronym for "Gay Related Immune Deficiency" (22). This naming shows how closely associated the virus was with homosexuals. Arthur Kleinman also declares in "AIDS as Human Suffering," which was published in 1989, that initially a man's contagion with the virus meant discrimination and racism which "extend[ed] to hostility and even violence,

> and that has led to discrimination in housing, employment, insurance and the granting of visas" (154). These behaviors were not only towards the infected ones but towards those who were "thought to be in 'risk groups'" (154). The victims had not only to deal with their illness and an imminent death but also to fight for their survival within the community, with society posing additional problems to their already existing ones. (*Echoes*)

The information she gathered from Drs. Metallidis and Kleinman not only heightened this student's awareness of the ethical dimensions of the AIDS epidemic but also assisted her in authentic portrayal of well-rounded believable characters, addressing a real-world social problem in a work of fiction. In her desire to explore "how people have been affected by and have reacted to the contagion of the virus" (*Echoes*), this student aptly observes that presenting the situation as a work of fiction helped her "bring to life a realistic situation so as to awaken the readers' awareness that AIDS is not an illness that infects only particular social groups such as homosexuals" (*Echoes*).

Another student focused her creative work on the change in her relationship with her own body after having undergone surgery for an ovarian tumor. In narrating her experiences both in memoir and in poetry, she moved from a totalized view of herself as possessing unchanging control over her own body to a position of openness, uncertainty, and wonder. She reports:

> To borrow Charon's words once again, "[a]s we tell of ourselves…, we seek out the clarity available only from putting into language that which we sense about ourselves" ([*Honoring*] 70). While seeking this clarity, we also discover our stance towards past experiences and health issues. My life-writing piece starts as a statement of control and power, only to result in wonder and questions and a final reconciliation with uncertainty. The poem is, from beginning to end, an expression of the amazement we can feel toward our own body and its processes and an acceptance that we will never be able to know everything. In both cases, there is a journey from health to illness and back, from the outside of the body to the inside and back. Such journeys might not result in clarity but with a question mark. Even this is a kind of answer. If anything, the stories have been told. (*Echoes*)

This student's journey toward accepting uncertainty echoes the Levinasian mandate discussed above by Irvine; no longer engaged in the "totalizing enterprise" (Irvine 11) of controlling and managing her illness, she records her submission to a self-and-other encounter with her changed and changing body.

Similarly, a student memoirist and videographer illuminates the complexity of her relationships with time, with herself, and with the other, a complexity she confronted in the process of writing her own story. For her creative project, she chose to expand a piece she wrote during the narrative medicine workshop in response to the prompt "relate a precious memory." Her expanded piece begins with a simple memory of a childhood incident when she and her friend Nikos spent a day "surfing" on boards they improvised

from pieces of plastic found on the beach. That night, back at home, the pleasurable day takes a turn for the worse as the ten-year-old girl finds herself covered with itchy welts:

> The very boards that had filled us with such joy only hours ago, were indeed so terribly weathered that tiny particles of plastic had come off their surface sticking all over our skin. And thus, as I lay on my bed, a terrible itching started to gradually take control, second by second and inch by inch, until my whole body was so itchy that I had to wake up my mom. So she took me to the shower, grabbed a sponge and almost rubbed my skin off, so as to make sure all the plastic particles were washed away. My whole body was aching from the scratching and the rubbing. And still, when the morning came and Nikos and I met again, all we could do was run to each other giggling and exchanging all the details of each one's tormenting night that now seemed hilarious. (*Echoes*)

The student could have left the story here in its "happily ever after" incarnation and its tone of light nostalgia, but in reflecting upon Charon's "Narratives of Illness" (*Honoring* 65-83), this young writer came to understand that a story closely read may reveal much more beneath the surface. In her post-creative-workshop essay, the student says that reading Charon influenced her to look again at her childhood tale. She writes:

> As Charon points out, the actual significance of a story is not always straightforward at first glance… . [T]he patients' stories contain crucial yet often "encoded" information and details which both the health professionals and the patients themselves are called to "decode" for the healing process to initiate... . The next step for me is to put this "why" into words and make it itself part of the initial story. (*Echoes*)

Understanding that patients and—by analogy here—writers encode their stories, this student re-evaluated the significance of her childhood story and considered her deeper reasons for having written it. In closely reading herself, she looked more closely at the aspects of corporality in the childhood memory. "Step by step, the deeper significance of this memory becomes clear to me as the process of self-writing itself eventually leads me to the climax of the story, the confession of my very own deepest fear that has been haunting my adult life but also my very own ultimate wish" (*Echoes*). Face to face, through the writing process, with a previously unnamed fear, the student expanded her memoir to consider the wounded adult body and the impact of violence on both body and soul. Additionally, in the process of delving deeper into the theme of corporality in her story, the author describes how she was driven to retell the story in a visual medium.

> Having established that the pivotal element of the story is the body, itself the epitome of physicality and materiality, I realize that this physicality and materiality would be more effectively presented and communicated through a more "concrete" medium … the visual image, offering a more "tangible," "concrete" and generally realistic representation, and being perceived in a more direct way through the senses than the images convey through language … allowing the viewers to get more attached or engaged to what is presented. (*Echoes*)

Not only did this writer experience a deeper engagement with herself by closely reading and attentively re-writing her own story, but here she comes to consciousness of the importance of direct engagement with the other, the reader of her story and the viewer of her video. Through authentic representation, she approaches the profound sense of connection with other humans that Charon describes, "We have gradually come to recognize that the *having* of a human body gives us a rare ground of unity. … Our bodies may be the only thing left that we truly, globally share" (*Principles* 176). Further, as she became more aware of the responsibilities of her engagement with her readers and viewers, this writer/videographer was drawn to examine transformations through time of the self and body, the boundaries of self and other, and the fragility of human life. This process of re-evaluating the significance of the story is also closely related to what Charon points out about the "time" of the story, which transcends the actual time of the events narrated transforming into a revelation about the "now" of the narrator.

> Eventually I realize that this is not simply a story about my past, but most importantly, a story about my present. It is a story about the relationship between my self, my body and its fragility but at the same time about the relationship between my self, body, and its fragility on the one hand, and another human being's self, body and its own fragility on the other. Most importantly, it is a story about the way that these complex and multi-leveled interrelations have transformed through the years, and how this transformation has affected my present self. (*Echoes*)

The story that began as a simple childhood romp becomes a site of the author's engagement with the Other, not only with the other young body wounded on the plastic surfboard, but with adult bodies affected by violence, with the physically examined bodies landscaped in the video, with the potential readers and viewers who meet her at the site of her creative work. In Levinasian terms, we might say that the student, in the process of writing and video-making, came to conscience: "If we call a situation where my freedom is called in question conscience, association or the welcoming of the Other is conscience" (Levinas qtd. in Irvine 10). Levinas says that the Other calls me into question, and that calling into question is "brought about by the other" (qtd. in Irvine 10). In that Other, Irvine says, I encounter "what I can never possess," what "always eludes my grasp," is "always more than my power over [it] … more than an object of self reflection" (10). The act of writing draws the writer out of herself, opens her to the call of the other whom she will never dominate, never take complete possession of, never reduce to her own self image; the writer then opens a space where authentic encounter occurs.

This engagement of creative writing students with the health care community in a literary rather than a clinical fashion and the close reading of and reflective writing on literary texts exploring themes of illness and trauma offered students a foundation not only for better understanding stories, but for *knowing what to do* with stories. The broad range of genres, voices, narrative strategies, and techniques explored provided diverse models from which to develop their own creative work. A student playwright who wrote

and performed a humorous monologue about dyslexia credits the narrative medicine experience with a transformation in his *use* of story:

> The creation of the monologue has been a unique experience for me, despite my previous writing experience. In the past, when I wrote something, it had no specific purpose other than my personal satisfaction. In this case, writing a monologue that advocates a specific view about people with special abilities (or disabilities as most people call them) and at the same time attempts to be funny and provocative but not irritating and insulting, has made me more attentive to detail and careful language use. (*Echoes*)

Newly aware of the power and responsibility of story, the student describes how he used the authority of texts by G. Thomas Couser and Arthur Kleinman to convey the message to his audience that what we call "disability" is neither sinful nor disturbing:

> It is this notion that I have tried to incorporate in my monologue, relating to how society has been trained to think that anyone different from the majority should undergo some medical treatment to become "normal" again. I have tried to implicitly criticize the fact that just because some people have, for example, a different way of perceiving the world, it is necessary for them to be subjected to a medical treatment. I question the "overzealous" attempt by the world of medicine, or "business" as Kleinman calls it to "normalize" (609). (*Echoes*)

While no journalist will be surprised by the notion that stories persuade, the salient point here is that a student, previously unaware that his creative work could have real-world impact, arrived at this insight through narrative medicine practice.

These student reflections point back to Charon's core belief that at the heart of narrative medicine lies the desire for contact, the move toward engagement, toward the intersubjective encounter which "incurs in us both responsibilities toward the other and transformations within the self" (*Honoring* 135). Shannon Wooden eloquently asserts that when literary scholars endeavor to read "comprehensively and empathetically" attentive to the ethical nature of our practice, we produce "not just better readings, but better readers, better people who read" (292). Literary practice and ethical practice are not competing practices, but rather reciprocal practices. The signature method of narrative medicine—joining medicine, literature and ethics—calls readers and writers toward conscious engagement with the complexity of the other, whether that other be a text, a person, society at large, or another aspect of the self, and by doing so encourages the literary scholar toward a heightened awareness of literary practice as real-world endeavor.

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