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Scientific Contribution

The doctor and the literary text – potentials and pitfalls

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Abstract. Expectations are growing that literature may contribute to clinical skills. Narrative medicine is a quickly expanding area of research. However, many people remain sceptical to the idea of literature having a capacity to "save the life of medicine". It is therefore urgent to scrutinize both the arguments in favour of and those against the potential of literature for increasing medical understanding. This article attempts to do this. It does in fact support the assertion that literature is important, but it stresses precisely its character of potential. There is no simple connection between acquaintance with literary texts and understanding of the different aspects of medical work. Much more need to be known about the conditions which allow the experiences residing in texts to be transformed into lived personal knowledge.

Key words: ambiguity, clinical encounter, experience, literary text, perception, potential, understanding

1. Introduction

> *It was Stephen's custom to listen attentively to what his patients had to say; this was unusual in his profession, as he admitted, but he found it helped his diagnosis.*
>
> *O'Brian: Desolation Island*[1]

The turn of the century and of the millennium has been accompanied by a wave of medical optimism. This optimism has taken surprisingly traditional forms, in the sense that it has been directed to supposedly imminent breakthroughs in the detection and prevention of wide-spread diseases such as atherosclerosis and cancer. One of the engines of these revived utopian forecasts is, of course, gene technology. The challenges of modern medicine are thus predominantly understood as scientific, in the sense that an ever more sophisticated mastering of the bodily processes is still the road to medical success, as it has been for one hundred and fifty years.

While no one can reasonably question the importance of progress in the area of biomedical diagnostics and therapy, there are good reasons to doubt that it will relieve all short-comings of clinical medicine. It is not only that the preoccupation with scientific progress tends to overshadow the parts of clinical medicine that is not scientific. Even more problematic is that it ignores, or is ignorant of, the fact that exactly these continuing triumphs of scientific medicine are also the source of one of the most fundamental challenges of modern medicine: that of making possible a fruitful coexistence between the objectifying "medical gaze" and the interpretative effort of approaching the life world of an ill person – or, in the words of philosopher Martyn Evans: "... viewing the embodied self of the individual patient through the prism of biomedicine's categories whilst remaining free to see the patient as (an) individual" (Evans, 2000).

This tension within medical practice has been discussed in an essay by Stephen Toulmin (Toulmin, 1993). For him, medical science represents the epistemology of universal knowledge, while the existential side of the clinical encounter basically relies on the understanding of particulars, of the uniquely personal: that is, on knowledge based on narratives. So, while a doctor in her training is learning to abstract from the person's lived body in favour of the scientifically constructed generalized, impersonal, passive and measurable body – a process which every student of medicine knows can be both complicated and even painful – there still remains the task of reaching empathetic understanding. In this way, and in the words of another philosopher, Fredrik Svenaeus, "art and science are united in the activity we call medical practice" (Svenaeus, 1999, p. 98).

While I agree with Svenaeus that to "explain" this is the primary goal of medical philosophy, I would also

contend that philosophy will probably turn out to be insufficient to the accomplishment of this end. If we take "explain" to mean understand, illuminate, grasp, highlight – in short: get a better knowledge of – we will *also* need a description of reality that gives full justice to crucial elements of clinical practice – like ambiguity, complexity, paradox, tragic choice. This description must, first and foremost, have a form that is in some way congenial to its intentions – that is: to capture human lifeworlds, especially as they may evolve in and around illness and suffering.

It is exactly at this point that art and literature become very relevant. There is no reason to support simplified dichotomies between art and science, or to ignore how extremely heterogenous these activities are. Nevertheless, it is reasonable to view them as two basically different ways of approaching reality. The one – art – may be said to have *phronesis* as its goal, whereas the other – science – is directed towards *epistemic* knowledge. Another way to express this difference may be to use Susanne Langer's distinction between the discursive as opposed to the presentational methods of approaching a phenomenon, or a set of phenomena (Langer, 1942, ch. 4). The *discursive* – i.e. scientific – way has stringency, impersonality, measurability and univocality as its ideals. Here, form is basically irrelevant and is thought to be fully subordinated to content. The *presentational*, in contrast, is intended to show, to depict, to illuminate. Form is inseparable from content. In presentational knowledge, truths are not *said* but *shown* – they emanate, sometimes enigmatically, out of the complexities and the richness of the picture and the text. They can seldom easily and sometimes not at all, be transcribed into discursive language.

Mary Midgeley has, in her *Science and poetry*, convincingly argued that "cognitive sucess depends on moral attitude". She continues: "This means that there are facts which we cannot know unless we first get the values right" (Midgeley, 2001, p. 145 f). Midgeley hits hard on the fact/value distinction, and she lets seventeenth century poet John Davies give an example of the cognitive significance of poetry:

> I know my soul has power to do all things,
> Yet she is blind and ignorant in all:
> I know I'm one of nature's little kings
> Yet to the least and vilest things am thrall.
>
> I know my life is a pain and but a span;
> I know my sense is mocked in everything;
> And to conclude, I know myself a man –
> Which is a proud and yet a wretched thing.

There is certainly no lack of enthusiastic advocates for literature in relation to medicine. What is often called narrative medicine has risen to the status of a privileged field of enquiry in only a few years time. Expectations are often high. After a comprehensive overview of the field, Rita Charon concludes:

> As doctors become more and more skilled in narrative capacities, they will improve their ability to develop accurate and comprehensive knowledge about patients, to reach patients, to become their trusted advocates, to navigate ethical uncertainty, and to be moved by all that they are priviliged to as doctors (Charon, 2000).

Similar claims abound in the anthology *Narrative Based Medicine*, edited by Trisha Greenhalg and Brian Hurwitz. Despite these gifted efforts to offer good arguments for the almost miraculous potentials of literature – or narrative knowledge, as it is now often called – to "save the life of medicine", it may well be that the sceptics remain fairly unconvinced. If this is so, one reason is, I believe, that the advocates do not take time to face a number of very common and also very plausible counterarguments against "the literature thesis".

Hence, after presenting three areas where literature may contribute to medical practice, I will attempt to deal with some of the problems involved in such claims.

2. Potentials of literature

The encounter with literary texts has a potential to contribute to medical practice in *at least* the three following ways: (1) by increasing the openness to and knowledge of the multitude of human experiences, far beyond what can be aquired by "real life" encounters; (2) by stimulating ethical responsiveness and refining moral perception, through showing – emotionally and cognitively – the presence of incommensurable values in our lives and the conflicts between these values; (3) by paving the way for the acknowledgement of human ambiguity and fallibility, of paradoxical truths and of the inevitability of tragic choices.

An expanded experience

The Swedish author Olof Lagercrantz, known for his sensitive and widely read introductions to a number of important authorships, once wrote a little book called "On the art of reading and writing". In this very personal and modest report of a life's experience in this field he tells the reader about his friend the fisherman, who, as far as Lagercrantz knows, has never read a book but is still one of the wiser men he has come to know (Lagercrantz, 1985, p. 15 f). Apart

from the somewhat embarrassing fact that Lagercrantz finds it necessary to tell us this, the passage points to an important question: Why should not life itself be good enough, why turn to "second order reality", why fiction?

There are several possible answers to this. Firstly, it is peculiar *not* to think of reading as "life itself". The inner and outer dialogue on and with experiences from fiction, and the reflection on real events, do not have different epistemological status, the former being less real than the latter. Rather they are intimately intertwined, both in need of each other, both essential for human growth.

The second answer concerns the scope of experience, and to some extent also the quality and complexity of it. Joanne Trautman has pointed out the imperfections of our daily experience; how we are often unable to arrange things in meaningful patterns, how events pass too quickly to give us a chance to reflect on them, how little of the richness of the world we are really able to discover. She continues:

> In contrast, the first rate fictional world is a fully considered one. In it, lights are cast upon shadowy corners, or veils are stripped from dailiness .... Fictions are not bound, as medical studies are, by the actual patients who present themselves, the occasionally unreliable laboratory data, the regulations about human experimentation; ...They can see the diseased person simultaneously from the outside of the body, the inside of the mind and the experience of the doctor watching the diseased (Trautman, 1982).

To this might be added that our relations to fictional caracters, in contrast to those in daily life, are not filled with personal bonds, resentment, guilt, prestige or love. The degree of freedom the reader has in relation to the characters of, for example, a novel – which surely does not exclude strong emotional involvement – may facilitate learning from hard and painful experience. The narrative evokes feelings which I may reflect on, inviting me to an ongoing intepretation of myself and my character (Elam, 2001, p. 138 f).

And, of course, however we may live our lives, however rich experience of life we may aquire, we will only see small patches of an enormous continent. Literature will only partly relieve that shortcoming. It certainly will not help us to see more than a few more patches of the huge landscape, but it has the potential of making us understand exactly this: how limited our understanding is, how puzzling human experience is, how many "ways of world-making" there actually are and how strangely unique individual responses to the human condition may be. And, in contrast to our daily experience, we can come back to them time and time again, find new things and make new judgements – a continuous process of evaluation and revaluation that William Booth in his *The Company we keep: An Ethics of Fiction* has termed coduction – literally meaning "bringing something out together" (Booth, 1988, p. 70).

The experience of literary texts carries the potential of facilitating the interpretative effort of the doctor in the clinical encounter. It can do so by expanding the aquaintance with different human experiences and by stimulating a continuous self-reflection, at the same time as it provides the reader with words and concepts for this reflection. The obvious fact must, however, be kept in mind that the patient is not a text and that there is a fundamental difference between a face-to-face encounter in a surgery or a hospital ward and the reading situation, where the reader "meets" characters in a novel.[2] It seems obvious that there are ways of reading that totally by-passes this potential for expanded experience, enriched language and continuous self-reflection. And this threatens to confront us with a catch 22 logic: in order to learn from fiction, you must first learn to learn from fiction, but this is exactly what fiction should have taught you in the first place. The capacities we hope may result from reading literature may be exactly what is needed for the fruitful outcome of the encounter with texts. Hence, we are once again forced to ask ourselves, whether we can learn more about the conditions under which the potential of literary texts may be actualized. Can circumstances be identified that increase the chances that even the "unresponsive" reader learns?

Perception and judgement

Literary texts are characteristically directed towards the concrete and the particular. They are like small or large fragments of life pulled out of an overwhelmingly big whole, stories rich in complexity and perspective but still preoccupied with unique persons and situations. To the extent that they carry any generality, it is the reader that will bring this into her interpretation of the text.

This does not mean that the act of reading has its only focus on particularities. As Anne Scott reminds us:

> Literature also includes some image of the general, some often strong image of that which we share as human beings; some insight into the human condition as such – otherwise one would have difficulty relating to much literature and works of art (Scott, 2000).

The text also has the God-like capacity of moving inside and outside of people's minds, showing them

as acting subjects and as objects acted upon by others. The literary imagination is an imagination about concretely striving, fallible human beings trying to find a way in their life and seeking more or less precarious forms of meaning.

How might the aquaintance with this then help the doctor in his practical work of curing and consoling the ill? A central point here is the role of moral perception in clinical work. By moral perception I mean the kind of attentiveness that makes it possible for a person to discover the moral dimension of a particular situation ("Something of great importance is at stake here!") and in doing so, in the words of the author Henry James, to be "finely aware and richly responsible" (James, 1907, p. 62). It seems clear that this is an activity which is neither strictly emotional, nor cognitive, nor intuitive – it is rather a well balanced combination of these faculties. Moral perception is intentional – that is, directed *towards* someone or something. It is not a distanced understanding, not a step backwards, but rather a step towards the situation and towards the persons involved.[3] Moral perception involves feelings, which may be looked upon as a mode of understanding the situation. The process of judgement that follows the perception may, however, very well require a number of steps both towards and backwards from the situation – in order to reflect on the very feelings that stirred your attention to the situation.

The interest in moral perception, that is in the genealogy of moral awareness, is connected to the idea of the primacy of the particular over the general. If moral perception means to *take in* the peculiarities of a particular situation, to appreciate all its complexities and oddities, in short its uniqueness – then it seems that this would rule out the use of general principles in moral reasoning. But this is, as Martha Nussbaum often points out, not the case. She concludes that: "... rules and categories still have enormous action-guiding significance in the morality of perception (...). It is all a question of *what* significance they are taken to have, and how the agent's imagination uses them" (Nussbaum, 1990, p. 37). Hence, there seems to be no good reason to talk of either the primacy of the particular or of the general – but rather to see them as deeply interdependent and complementary modes of understanding.

The encounter with literary texts involves emotions.[4] Characteristically, when reading a good text, we find ourselves absorbed into the text, highly involved, strongly influenced in our mood (sometimes even for a long time after the reading has stopped). As emotions *are* relevant to moral judgement this capacity of the literary text to involve the reader should be seen as an advantage. The capacity of the good novel, poem or drama to bring emotions into dialogue with reflection is then what makes these texts morally significant. It is important that these emotions do not carry guilt or responsibility or shame and hate with them towards concrete persons in our lives – except perhaps secondarily by the associations they create, when emotional involvement in fictious characters reminds us of our relations to existing persons around us.

Imagination is crucial to moral judgement through its role in hermeneutic understanding. According to Hans-Georg Gadamer "it is imagination that is the decisive function of the scholar. Imagination naturally has a hermeneutical function and serves the sense for what is questionable. It serves the ability to expose real, productive questions ..." (Gadamer, 1989, p. 28). We may tentatively substitute "doctor" for scholar and "morally problematic" for questionable and we get an assertion for which good arguments need to, and I believe can be, given.

Ambiguity and paradox

Certain truths about life seem to demand another form and another language than the language of the sciences or, for that matter, of academic philosophy. Literary language can of course not replace scientific language, and has no inherent superiority over it. But its capacity is of a complementary kind, and it invites us to a richer and fuller and more truthful understanding of important aspects of the world. Martha Nussbaum states that "with respect to certain elements of life, the terms of the novelist's art are alert winged creature, perceiving where the blunt terms of ordinary speech, or of abstract theoretical discourse, are blind, acute where they are obtuse, winged where they are dull and heavy" (op cit, p. 5).

It seems that among the most difficult aspects of life to capture in "ordinary" language is its inherent ambiguity. Neither the language of the humanistic sciences helps us here. Ambiguity is a kind of truth about the world that is rather shown than stated flatly. Let's say, for example, that we wish to convey to doctors that their patients can be expected to be ambiguous in certain clinically important ways – in their relation to their own bodies, to their doctor, to their relatives. The chances that the doctors fully *understand* this, in the action – guiding sense of the word, would seem greater if this fundamental insight is somehow emerging out of the encounter with a story or a poem that has grabbed them, shaken them, opened their eyes to a new aspect of their clinical reality. We are again reminded of Langer's distinction between discursive knowledge and presentational. Presentationally aquired knowledge of ambiguity in general and as part of the illness experience in particular may,

I believe, facilitate doctors' recognition of it when they encounter it in the clinic.

How "unclean", complex and precisely ambiguous some decisionmaking situations in clinical practice are is well illustrated in literature. In Czechov's short stories we may find many examples of this, as in those of Richard Selzer.[5] Or take these concluding lines from the swedish poet Tomas Tranströmer's long poem *The Gallery* (in my own attempted translation):

It happens, but seldom
that one of us actually sees the other:

for a moment a human being is shown
as on a photo but sharper
and in the background
something that is greater than his shadow.

He is standing full-figure facing a mountain.
It is more of a snail-shell than a mountain.
It is more of a house than a snail-shell.
It is not a house but it has many rooms.
It is diffuse but overwhelming.
He grows out of it, and it out of him.
It is his life, it is his labyrinth.

What would be the point of this poem if we attempted to eradicate its ambiguity and its opacity in order to make it univocal and permeable?

Selzer's stories, as Chechov's and many others, also make plausible that medical practice is inevitably filled with tragic choices and that there exists no magic formula, no theoretical construction, that can save us from the painful realization that there may be a moral loss – even if the choice was the best one possible.[6]

3. The pitfalls

To be interpreted as to some degree naive and vaguely idealistic seems to be a risk that any one who speaks for the importance of literature exposes herself to. Paradoxically, parallel to the enthusiastic claims on behalf of literature in medicine, strong and almost self-denying reservations are sometimes attached to pleas for the introduction of literature in different educational programs. We must, it is then said, not fool ourselves into thinking that any one will become a better person by reading, and by no means make literary courses compulsory. We are reminded that "moralistic reading" is a catastrophy, and that looking for moral education in novels will kill the whole idea of literature.

People obviously do not become good in proportion to the number of dramas they have seen or novels and poems they have read. Familiarity with the "great" tradition in literature is, thus, neither a sufficient nor a necessary condition for developing empathy, refined moral perception or broad experience of human reactions. From this does, however, not follow, that all arguments against the role of literature in clinical medicine are to the point, and certainly not that they can be taken to falsify the assumptions that I just made. In short, we need to examine the counterarguments closely and see what there may be in them.

I will shortly deal with some of the arguments that might count against literature's claim to help develop clinical skills. It need hardly be reminded that there may be several more interesting arguments that are not dealt with here.

The multitude of texts and readers

An interesting and important practical objection to the thesis on the importance of literature for the clinician concerns the multitude of different texts and readers. Among the enormous amount of different stories, told in innumerable styles – which texts should then be chosen? Is any special "genre" to be preferred? Is a short poem of maybe eight or ten lines really equal to, say, *The Karamazov Brothers?* Is it defensible to break out fragments of larger works, like novels, and collect them into anthologies? What is lost in this process? Is it, in short, possible to say anything *general* about the extremely personal encounter of a reader with a text?

I will leave most of these questions open. However, the question about what is "good literature" must shortly be adressed. Martha Nussbaum flatly states that we find, in contrast to much philosophical discourse, that "good fiction" can play the reflective role it does in our lives because of "the particularity, the emotive appeal, the absorbing plottedness, the variety and indeterminacy" of the text and also because of its capacity for "making the reader a participant and friend". If we agree here, noting that the two parts of this pledge might not always fit together, we might continue by asking what a good text is for a doctor or for a doctor-to-be?

What question might a clinician pose to the text? Well, if the general question following Nussbaum is "How should one live one's life?" (op cit, p. 23), the particularly clinically oriented form of this question is "How should I live my life as a clinician?". What text could answer this question? Any, one might be tempted to answer. Any text that has anything to say about what it is to be a human being, however peculiar this segment of reality might be, is of value for a doctor. The opposite answer is, of course, to say that only texts will do, which to some substantial degree deal with human illness and suffering due to illness, and doctors' ways of meeting and dealing with this.

We must, I think, admit the degree of our ignorance at this point. As the interest of medical professionals in the potentials of literary texts has been so diminutive during at least the last century, few persons have taken time and energy to deal with this complex question. Let's say, as in our earlier example, that we have a general wish to stimulate the capacity of clinicians to notice, acknowledge, interpret, harbour and act upon their patients' ambiguity – could anyone reasonably say that this or that book, or drama, or poem, is exactly what is needed? And furthermore, because clinicians are just as different in taste, in experience and in sensitivity as people in general – wouldn't it be preposterous to declare to *one* of these doctors that "you will get exactly what you need to be a better doctor out of this literary text?"

But while nobody can exactly foresee what happens when a person meets a text, we can surely say *something* about the potentials of the text under certain circumstances. Wouldn't it be far too solipsistic to assume that there is *no* common ground for our reading experiences? And wouldn't it be a huge underestimation of our capacity to communicate even very private experiences to each other, if we say that we cannot reach out towards a common understanding, or at least a common understanding of our partly different understandings, in a dialogue about a certain text?

The meaning of a text appears in the meeting with a reader. Different meanings will arise out of the same text in different readers, and different texts might generate rather similar meanings in different readers. These meanings are communicable, albeit that they have inevitable differences. This fact, that our interpretations will vary widely or perhaps just marginally, expands the text, makes it grow out of its own limitations.

Ideally, an exchange of reading experiences has the potential of evoking feelings like: "Oh, how amazing, did you really see *that* in this book!", or "I did not think of her ways of acting at all, the same way as you, but it is fascinating to hear how you read the passage!" And as noticed above, it is because we usually have not invested prestige or felt guilt or have commitments in relation to the characters of the text, that we are more free to open ourselves to the multiplicity of interpretations arising out of it, and to involve ourselves in discussion with ourselves and others about how to understand it.

This is not to say, for example, that basic differences of literary taste cannot constitute a considerable challenge in this exchange of experience, and in the reader's own meeting with the text. If the reader is really going to feel like the "participant and friend" that Nussbaum talks about in connection with the good text, there certainly has to be some sort of *fit* between text and reader. It is not very hard to imagine a reader who has his first try with *The Magic Mountain* and exclaims: "I can very well see that Thomas Mann tries to say some important things here which seem reasonable enough – but this doesn't really *bother* me. I get no relation to this mass of text. It is just reflected back from me, like a ball on a hard wall."

Literary form carries with it an enormous potential for just the qualities that Nussbaum points to – but the other side of the coin is that exactly this potential for attraction of the reader can also work for repulsion. Whatever a writer tries to tell me, it might just be impossible for me to take it in because the style of the book, its literary form, is alien to me. I might just not *stand* Henry James, and however much of Nussbaum's wise commentaries I read, he is still just unbearable. Form is of importance in all texts, scientific also, but may be said to be even more crucial in the novel or the poem. The invitation of the literary text to involvement and expanded experience can also be an invitation to disgust, or boredom, or alienation.

Given these considerations, some practical responses may be: more reflection on the nature of doctor-patient interaction, more knowledge of how literary texts work in relation to different readers and different goals and better knowledge of dialogue about texts as a means to expanding the "room of interpretation".

The vicious text

Reading Nussbaum and other advocates of the role of literature, one might find oneself with the question of whether the influence of literature is not perhaps occasionally idealized. Perhaps some literature is written in a way and deals with things that make some readers more, not less, prone to prejudice, contempt and careless viciousness. In short, some texts may be dangerous, at least for some readers and under some circumstances?

It seems to me that the only reasonable answer to this is: yes, of course they can. The task of identifying these texts has, of course, not very much to do with whether they deal with evil or viciousness or cruelty, but *how* they do this. Neither can we judge from the author: not very admirable characters, like perhaps Céline and Pound and Junger and many more, have produced texts that seem very unlikely to work in this way – while one can at least wonder whether or not some highly decent authors have written things with dangerous potentials. One may exemplify with the discussions on German author Botho Strauss' dramas, or in Sweden on the female author Carina Rydberg's

alleged lack of respect for existing persons' integrity, or the anthropology implicit in Swedish academy member Per-Olof Sundman's books.

Is it possible to say anything general about this risk? Any text might perhaps carry it? We face the huge question of individual reception, of how a text works on a reader. A somewhat pessimistic conjecture is that a person who is already reasonably open-minded, compassionate and not-so-prejudiced will become even more so by reading and perhaps discussing good texts – but that the narrow-minded, heavily prejudiced reader can always use the text as a reinforcement of his world view. But why should we expect from literary texts what we cannot realistically expect of any single aspect of life: the capacity to save the person who has "decided" to look upon the world in a fixed and rigid way, and to lead her into a more open interplay with life? On the other hand, do we not have good reasons to expect that most of our doctors and medical students actually belong to the former category, that they *do* have a potential for personal change and an inherent openness to new experiences that ought to be taken care of and stimulated in the best possible way?

The trap of particularism

A keen eye for particularity, or the unique, has so far been mentioned as something of importance for the doctor. Literary texts might, was the guess, be of value in breeding this capacity. But what if particularity is a trap? What if the frequent plunging into literary worlds with their almost endless array of faces, life histories, events of peculiar and strange sorts constitutes an obstacle to the kind of generalizations that doctors have to do? If a balance has to be found between the two epistemologies that Toulmin writes about, the universal and the existential, then maybe literature tips this balance over and lets the doctor drown in an ocean of human conditions. Doctors must act, sometimes quickly and briskly and a too sophisticated attention to unique individual experience may threaten this capacity. Overwhelmed by her literary aquaintances the doctor keeps associating to fictious persons and their fates and is overwhelmed by a mass of fragmented knowledge, incapable of a bold synthesis.

Though there might be a real problem here, one immediately wonders why this should not, then, be just as much or more of a challenge when it comes to all the real life persons the clinician has met. These are certainly particular enough, and furthermore they have not so easily allowed – as fictious characters do – the kind of distanced reflection that would contribute to the fruitful interplay between particular and general (except in the few lucky cases where a practitioner has the help of a group to reflect on his clinical encounters[7]).

Once again, the question of reception comes into focus. Reflected reading means reading that lifts itself over the particulars while still acknowledging the weight of and relevance of them. As soon as reflection and dialogue start, associations are made, similarities and differences explored, inferences tried. The particular is brought into dialogue with the general in a way that resembles how the physician must make empathetic knowledge about the patient interact with scientific evidence.

The unpredictability argument

In a recent article, Neil Pickering has offered an interesting argument against the use of poetry in health care education (Pickering, 2000). Though he surrounds it with reservations, it may be interpreted as a counterargument against the clinical importance of literary texts.

Pickering's argument runs like this: As we can never know what kind of interpretation a poem will give rise to, it is pointless to think it can be used for any external end. The outcome of the meeting between reader and text is wholly unpredictable, and hence the only thing we may expect from the text is enjoyment – what he enigmatically calls its "internal" use.

This argument has already been partly dealt with above. There are at least two things to be said against Pickering. The first is that texts are surely not as "open" as he assumes. We may have sound reasons to expect them to be interpreted in a certain direction. The exact interpretation may be impossible to foresee, but that does not mean that the understanding of even a poem is wholly unpredictable.

Secondly, and perhaps more important, if we can expect the text to be interpreted in different ways, then this fact seems to carry an important potential of clinical interest. By reading and discussing literary texts – with ourselves and with others - we are reminded that words carry an amazing number of possible meanings. We learn, furthermore, that we, to some degree, can exchange interpretations when we engage in dialogue on texts. We are given a chance to notice both the possibilities and the limits of such an effort to reach out for common understanding. And is this attempt to make meaning match each other not also characteristic of the clinical encounter? (Ahlzén and Stolt, 2001).

Doctor overload

The last of the objections that I will deal with concerns the possibility that the receptivity of doctors is overestimated, and that by introducing ever new elements

in their training we will, sooner or later, be counterproductive. It is not only that physicians must inevitably be well informed about basic scientific facts concerning the functions of the body, and about new diagnostic and therapeutic options. During the last decades, the increasing awareness of the patient as a person has lead to the introduction of new disciplines in the medical curricula: psychology, sociology, anthropology, philosophy, ethics, history. The advocates of these new areas often have convincing reasons for presenting them to the medical students or practitioners. A doctor who relies exclusively on her biomedical knowledge would no doubt be a dangerous doctor.

However, it is not difficult to see that there is a huge challenge involved in this. No person, however receptive, has even the smallest chance of being well aquainted with more than fragments of all the knowledge in the sciences and in the humanities that may seem relevant for clinical practice. If doctors are told that to be a good doctor you must have a superhuman capacity of covering huge areas of knowledge – that is: be both a scientific expert, a humanist of the classically well read sort and continuously in contact with different works of art – then doctors may well abdicate from even the most modest attempt to cross the borders from biomedicine to art and humanities.

Someone might imagine the opposite risk here. If doctors become so fascinated by humanistic knowledge, and if their orientation so much becomes that of Toulmin's "existential epistemology", will they not perhaps then be unable to understand the secrets of the body, to make diagnosis and to treat the patient? This argument is reminiscent of the well known Question: would one prefer a "clever" (read: biomedically shrewd) or a "kind" (read: empathetic) doctor. Not surprisingly, the former is preferred – who would not trade all to be poorly understood in her thoughts and feelings but diagnosed and treated for a serious ailment, than met with the deepest respect and genuine empathy, but without the curative diagnosis?

It seems urgent to reject this dichotomy. We are, as stated earlier, not dealing with two different and unconnected areas that are somehow added together to a crude sum of "knowledge". If we want to avoid a parodic picture of medical practice we must realize that there is no fruitful, efficient use of medical technology and of basic biomedical knowledge without genuine knowledge of human beings in all their complexities. A doctor cannot be good at *either* the human side of medicine *or* the scientific. These are so closely interconnected as to be two sides of the same coin.

If, therefore, doctors feel overloaded by the oceans of knowledge in all possible areas that they are assumed to be able to take in, the answer cannot be to state that "biomedical knowledge is primary and the small amount of time left over may be devoted to humanities or social sciences". Neither can it be the opposite. The challenge is to strike a reasonable balance between these ways of understanding and explaining the world, in particular ill persons. There is only one overriding guiding principle here: what is relevant for the clinician is what contributes to her efforts to prevent and to treat diseases and to alleviate suffering caused by illness. And this "mixture" of knowledge, practical and theoretical, will necessarily emanate out of aquaintance with many different areas of human activity.

4. Conclusions

There is an interesting and important difference between the narrative of a clinical encounter and the narrative of a reading situation. In the former case, concrete mutuality is the crucial shaping factor, a mutuality that is ideally dialogical, which means that the narrative unfolds under constant exchange of perspectives. The narrative is actually shaped by this reciprocity, albeit to very different degrees in different encounters.

When reading, on the other hand, the narrative does not develop under constant shifts of perpective. Even if the reader in a sense has a dialogue with the text, it is important to realize the difference between this dialogue and that of the living encounter. The reader is sovereign. She makes her interpretations, experiences her emotions without the text being able either to object or support.[8] On the other hand, while engaging in a discussion about a text, the interpretations of one reader may be challenged and her perspective accordingly modified.

The intention of this article has been to show that there are no self-evident conclusions regarding medicine and literature. The stress has been on the notion of potential. A reader may or may not add experiences from the meeting with a text to her understanding and handling of clinical situations. The dialogue with others has been suggested as one of the circumstances that may increase the chances for learning from texts. But it is neither a necessary nor a sufficient condition for it. I may come out of the reading of *The Memories of Hadrian* without one single clinically relevant insight, even though I have discussed it over and over again with others – or I may bring with me crucial knowledge even though my dialogue has been exclusively of the inner kind.

Research on how texts are received and how they interact with clinical experience is urgently needed.

Still, final proof of the importance of literature will not be given. This should not discourage us from acting on the evidence of good arguments, and on the relative weakness of the counterarguments, and hence give full credit to literature as one of several roads to clinical understanding.

Notes

1. O'Brian, p. 306.
2. The dialogic aspect of the patient-doctor encounter, and the mutuality that this ideally contains, is of course not present in the meeting with a literary text, even if many readers seem to experience a kind of "dialogue" with the caracters of a novel. See also Svenaeus, op cit, p. 218 f.
3. The connection with empathy is obvious, but the act – or rather acts – of perception should not be identified with this concept. A capacity for empathy may be a necessary but not a sufficient condition for identifying a situation as morally important.
4. I have been reminded that the notion of emotions brings together a number of states of mind – "feelings" – which may be rather or very different, and that ought not to be lumped together the way usually done.
5. Raimo Puustinen has dealt with Chechov's *A case history* but not quite captured its ambiguity, see Puustinen (2000). A good example of Seltzer's art is *Taking the world in for repairs*. New York: W. Morris, 1986.
6. The word tragic is not used here to imply that there could be a morally ideal world or a morally ideal character. The point is to remind us that no magic bullet, no "ethical model" or "ethical theory", helps us make choices where nothing of moral value is lost - even if we make the best possible, or least bad, choice.
7. It seems to me that this is exactly what happens in Balint groups, where general practitioners "tell stories" about their clinical encounters and are then helped by the dialogue to reflect on these cases in a way that they would not do otherwise. The similarity to a discussion about fictious stories strikes me as considerable, though of course one of the persons around the table is here concretely involved with the patient.
8. One may of course object to this and say that the text itself introduces these shifts in perspective, forcing the reader to do exactly the kinds of interpretative efforts that we do in a "real" dialogue.

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