What's Left Unsaid: Exploring the Role of Narrative in Reconciling with Power Dynamics and Predefined Healthcare Roles via Patient and Doctor Perspectives

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"Human beings do not go hand in hand the whole stretch of the way. There is a virgin forest in each; a snowfield where even the print of birds' feet is unknown."
- *On Being Ill,* Virginia Woolf

"One day I saw a winter meadow covered with a smooth expanse of snow. Glacial, still perfect. The next day I returned to see that a line of footprints had advanced from the edge of the meadow to the middle. Peer as I might, I did not see them complete the traverse to the opposite side. Perhaps it was too far to see? But no, I walked around the circumference to see if they had come across. They had not! Nor had they returned. Perhaps…perhaps they stopped in the middle. But how *can* that be? Now is a time of exaltation, for these footprints prick the imagination as no feet ever could. They have introduced a new element, the element of narrative, history, character, plot…Were I to follow them with my own feet, stepping carefully into each depression, or, more respectfully, alongside, surely then I would pick up the trail. Something keeps me from it…To solve it would place a limitation upon these marks."
- *Letters to a Young Doctor*, Dr. Richard Selzer

The communication between patient and physician is a widely studied interaction—the vulnerability, trust, and power deficits inherent to the relationship within a healthcare experience can have deep-seated physiological and psychological ramifications for both parties. While numerous qualitative and quantitative systems have been created to study what is said between patient and provider, it is often the ineffable, the parts left out, that have the most important implications for the trajectory of the relationship and treatment course. One such way to gain insight into the patient's and provider's thoughts regarding an interaction and its subtext is through written narrative. Just as a reader gains access to the reflections that lie teeming beneath a conversation's surface in a text, so too can a writer use the process of creating a narrative to unpack their own hidden feelings and perceptions that lay unaccessed in their mind. Inherent to the writing of the narrative is the profound desire to tell one's story. It is through creating a narrative that patients gain self agency over their variant and unpredictable illness and with which doctors can reconcile with their idiosyncratic role in preserving, bettering, and elongating human life. Narratives, from both the patient and physician perspective, provide an opportunity to extend a greater sense of understanding on one's role and interactions with illness. This paper seeks to explore the use of narratives in providing insight into the subtext of the doctor-patient relationship.

The Metanarrative and Narrative Agency

The metanarrative approach, described by Hanna Meretoja as "characterized by reflection, first, on the significance of cultural narrative practices for individuals and communities, and, second, on the functions of narrative processes in our social reality" (Meretoja

et al. 394) belies critical insights into the nature of doctor/patient experiences: It is by stepping *into* the narrative and adopting the perspective of the author, then stepping *out* of it to witness the unfeigned impact of telling one's story, that the scaffold of the healthcare experience begins to emerge.

Meretoja defines the narrative itself as "an interpretative activity of cultural sense-making in which experiences are presented to someone from a certain perspective (or perspectives) as part of a meaningful, connected account" (Meretoja, 48). She adds that narrative hermeneutics see narratives as "provid[ing] interpretations of being in the world" (Meretoja et al. 390). Narratives thus allow one to critically examine their individual roles, including those that exist in the world of healthcare. What underpins this ability is the idea of narrative agency—navigating one's narrative environment by "[practicing] how we narrate our lives, relationships, and the world around us" (Meretoja et al. 391) while "[signaling] that culturally mediated narrative interpretations play an important role in constituting us as subjects capable of action, while simultaneously alerting us to the ways in which our narrative agency is socially conditioned" (Meretoja et al. 391-392).

Narrative agency consists of three dimensions: narrative awareness, narrative imagination, and narrative dialogicality. The first, narrative awareness, can be defined as the awareness of the culturally available narratives that inherently influence one's life. By examining these narratives one can become actively conscious of their impact—be it through reflecting on one's own sensemaking or through perspective awareness which entails the idea that each story can be both told and interpreted differently depending on the person (Meretoja et al.). The second, narrative imagination, can be seen as envisioning one's narrative possibilities. Professor Mark Freeman writes that it's a reflection on what governs one's actions and the actions that one

wants of their future self (Freeman; Meretoja et al.). Narrative imagination can thus be a way to cultivate different behaviors and engage in perspective taking, imagining the ways in which a narrative can be shaped or understood by others. Finally, narrative dialogicality, which we will closely use to analyze the doctor-patient relationship, is the way in which the narrative can be used as a vehicle to enter into relationships with others. Meretoja describes how "critical engagement with normative cultural narratives of relationships and communities, which often draw problematic lines of division between 'us' and 'them,' can open up new possibilities of relationality" (Meretoja et al. 388). Narratives can encourage openness to the experiences of someone else as well as create intersubjective spaces to reflect, imagine, and create new relationships, predisposing the conditions for unity and change.

It is within such a framework that this paper seeks to elucidate the nested narrative agency that underlies the experience of illness and doctor narratives. Through illness narratives and doctor narratives, readers can become *aware* of their own relationships with doctors (or patients), *imagine* what a trusting relationship can look like, and enter a *dialogic* space where they consider, empathize, and understand the role of the 'other' in the healthcare field. In the same way, the authors of illness and doctor narratives use narrative agency to grapple with their own lives, and their respective roles in the healthcare system. Whether it's becoming aware of implicit biases, imagining the ways in which their illnesses or expectations might change, or engaging in perspective taking of the patient or doctor they see or have seen, the opportunity to tell one's own story allows for understanding of the doctor/patient relationship and predicates the changes that can be made to improve it.

By examining both the narrative agency of the authors of illness narratives and doctor narratives as well as our own narrative agency in reading them, we are creating a network of

conversation, dialogue that is left ‘unsaid.’ Be it between that of the reader and the patient/doctor in the illness/doctor narrative, the doctor in one narrative speaking to the patient in another, or the doctor and herself or the patient and herself, a web of reflexivity and relationality emerges, amplifying the complex relationships and roles of individuals who exist in the healthcare realm while setting the stage for amelioration of communication between such roles.

In this paper we will dissect two illness narratives: *Intoxicated by My Illness,* by Anatole Broyard and *Your Hearts, Your Scars,* by Adina Talve Goodman. We will also explore two doctor narratives, *Letter to a Young Doctor* by Richard Selzer and *What Patients Say, What Doctors Here* by Danielle Ofri, which also contain a metanarrative element. These four texts were chosen based on the diversity of genre (essays produced after receiving a terminal diagnosis by a 69-year-old man; a posthumously produced collection of essays written by a woman in her twenties who, at the time of writing, had overcome heart failure; a collection of letters written in 1982 by a surgeon; and a review of medical practice filled with anecdotes and research on patient/doctor communication by an internist). In putting these diverse works in conversation with each other, seeing what emerges as ‘unsaid,’ one can glean important insights into the reflection and narratology of different healthcare experiences on different sides of the so-called table.

It can be immediately acknowledged that narratives, having transformed thoughts to paper, perhaps with some flourishes and alterations, then edited, revised, and published, don’t necessarily relay the unsaid thoughts of patients and physicians as they appear naturally. In fact, they are probably far from the exact reactions and emotions that were felt by both parties however many weeks/months/years the interaction happened before being committed to written form. However, there is something to be said for analyzing the reflections of each author’s

experience, as this altered form articulates what has stayed with them and what they feel remains important to share. Time and time again, from patient and doctor alike, there arises the feeling that one must tell their story. Each of these authors feel the need to communicate the lessons they have learned to a broader audience. By looking at one's unsaid thoughts, enhanced by the narrative structure and through layers of reflection, readers get a concentrated and retrospective look at the unsaid truths that have carried on past a particular moment as they relate to their receiving or offering of medical care. It is from these ideas that the patient/physician relationship can be further understood in order to improve critical communication between the two.

Reconciling with Roles: Doctor Narratives and Reflections

Today, collaboration, communication, understanding, and trust are emblematic of a "good" doctor-patient relationship, but that hasn't necessarily always been the case. In 1984, an article in the *Journal of the American Medical Association* found that 47% of patients wanted their doctors to make all of the decisions regarding their medical issues (Strull et al.). Indeed, in the last couple of decades, there has been a shift within the physician-patient relationship away from a paternalistic method of care and towards one which centers around the patient and mutual participation. Such an approach has been described as one in which "the physician tries to enter the patient's world, to see the illness through the patient's eyes" (McWhinney 876; Kaba and Sooriakumaran). Now, fewer and fewer patients have the desire to blindly follow the doctor authority, but figuring out the balance in shared-decision making is still a difficult process that differs from patient to patient and doctor to doctor.

Although a more contractual definition defines the doctor-patient relationship as one in which the physician agrees to respect the patient's autonomy, maintain confidentiality, explain

treatment options, obtain informed consent, provide the highest standard of care, and commit not to abandon the patient, such an objective definition fails to accurately display the immense and profound nature of this relationship, one in which patients unburden their secrets, worries, and fears to physicians and trust serves as a cornerstone to maintaining or regaining health (Chipidza et al.).

Adding to the complexity of the patient/physician relationship is the way in which the patient and physician feel about their roles. Even though recent years have seen care shift from one of telling-and-adhering towards a more collaborative conversation, deep-rooted and predefined positions and expectations still reign in a healthcare interaction and conversations remain ladened with varying degrees of power. Patients arrive to see their doctors in a state of vulnerability, and often with a deficit of knowledge and education relating to their health, yet with higher stakes in the interaction. And doctors come to this relationship with an increased sense of responsibility—this interaction after all is their profession, and with it comes their professional identity. Dr. Clare Gerada describes the doctor's professional identity as 'the medical self' where their personal (the 'I') and their group (the 'we') are merged to create a single identity (Gerada). This is further explained by German sociologist Norbert Elias, when he argued that each of us derives our 'we' identities from the groups to which we belong; and that 'we' identities are inseparable from what we might call our 'I' identities (Elias and Scotson; Gerada). Because the medical self is so ingrained into the training of doctors, doctors find it hard to switch in and out of their professional identity. Dr. Gerada adds, however, that the medical self is a "mature psychological defense mechanism" that "protects doctors from feeling disgust, fear and shame" and "ensures that doctors internalize the characteristics expected of their group: altruism, perfectionism and self-sacrifice, as dictated by the first line of the World Medical

Association Geneva Declaration 'I solemnly pledge to dedicate my life to the service of humanity'" (Gerada). With such a declaration, along with that of the Hippocratic Oath's 'Do No Harm,' it is not hard to see how the internalization of doctor expectations occurs. Nevertheless, numerous studies continue to reveal the ways in which doctors struggle with their identity. Yardley et. al., for example, describes the struggle that newly graduated medical students face in adopting an identity of doctor and assuming increased responsibility (Yardley et al.). As the doctor/patient relationship continues to change over time, and with it the identity and emotional understanding of the doctor regarding his/her work, it is imperative that we look at the ways in which roles are articulated and reflected upon in doctor narratives.

The Power of Witnessing: A Case Study on Richard Selzer's "Imelda"

In this study, we look at how doctors use narrative to reconcile with their responsibilities and sense of self. The short story "Imelda" looks at the careers of two physicians: Hugh Franciscus, a renowned plastic surgeon, and the narrator, presumed to be Selzer himself, who upon hearing that this former teacher has died, recalls what happened years before on a medical mission with Dr. Franciscus in Honduras (Selzer 21). The story spans many perspectives, times, and locations but focuses on the plight of a young girl, Imelda, who is treated for repair of a complete cleft lip but dies of malignant hyperthermia due to the anesthesia prior to surgical intervention. The two doctors break the news to Imelda's mother, who, in her grief, holds on to the notion that her daughter's lip was finally repaired and could now "go to Heaven without it" (Selzer 31). Dr. Franciscus then returns to the morgue to finish the procedure on Imelda without anyone knowing. The mother expresses her gratitude for the repair and "finish[ing] the work of God" (Selzer 31) to the narrator when she comes to pick up her daughter's body for burial, but

the narrator is shocked, and even horrified, that Dr. Franciscus altered the true nature of what happened by completing the post-mortem repair. Six weeks later, Dr. Franciscus gives a lecture on his work abroad and the narrator, controlling the slides during the presentation, removes the 'after' picture of the repaired lip (taken in the morgue) from the slide desk before the audience can see it.

The story begins with the perspective of the narrator finding out about Dr. Franciscus's death. Immediately, what comes to the narrator's mind regarding Dr. Franciscus is the power he felt encapsulating his mentor: "To us medical students he was someone heroic, someone made up of several gods, beheld at a distance, and always from a lesser height. If he had grown accustomed to his miracles, we had not" (Selzer 22). The structured hierarchy within the medical education system is potent, but perhaps no other deficit within it is larger than that which rests between a medical student and a highly accomplished attending surgeon who is chief of his discipline. From the moment these two characters are introduced there emerges the creation of reflexive identities—Dr. Franciscus as a superior and teacher, and the narrator as a student and inferior whose sole mission was "to avoid the hemorrhage and perforation of disgrace" (Selzer 22). It is thus critical to keep in mind that every action that occurred thereafter reflects these relational roles.

With the narrative format, Selzer, presumed to be the narrator, is able to reflect on Imelda's story years later, having made his own way through the medical hierarchy. Yet despite the time that has passed, Selzer's writing still displays this power dynamic, and the reader is able to see the ways in which Selzer is still engrained in it. For instance, although Selzer writes retrospectively in the past tense, his admiration, almost worship, for the image of Dr. Franciscus

remains discernible, still referring to his mentor as “tall, vigorous, muscular, as precise in his technique as he was impeccable in his dress” (Selzer 21).

With regards to the narrator's observations of Dr. Franciscus’s relationship with his patients, the readers are alerted to a power dynamic ascertained through remoteness, as the surgeon chooses to be “forthright” and rely on scientific fact and objectivity without becoming emotionally involved: “He seemed to me a man with immense strength and ability, yet without affection for the patients. He did not want to be touched by them. It was less kindness that he showed them than a reassurance that he would never give up, that he would bend every effort” (Selzer 23). Yet, a dearth of warmness doesn’t necessarily deem relationships devoid of trust and substance. While a power gap exists between patients and Dr. Franciscus, it often manifests, according to the narrator, without malice. Moreover, the narrator, through his repeated phrase, “he seemed to me” reflects the way he once perceived Dr. Franciscus. Whether these feelings are tarnished by memory between when he witnessed the event and when he wrote about it or remain true to what was actually felt in the moment, these statements reveal the narrator’s pervasive awareness of the professional attitude of a doctor. What appears “[archetypal]” of a surgeon, to the narrator, is one of remoteness, uncomplicated from emotion.

These power dynamics ensue in Honduras on the medical mission. The narrator remarks, “despite that we spent all day in each other’s company, there were no overtures of friendship from Dr. Franciscus. He knew my place, and I knew it, too” (Selzer 25). The narrator comments on the patients as well, “compared to us, they were masked, shut away” (Selzer 25). Thus, outside of the strict confines of the Albany Medical Center where the two worked, the professionalism and power dynamics followed and were on the forefront of the narrator's mind when he reflected back so many years later. It is important to note another layer of power present

throughout the story of *Imelda*, and that is one of medical translation. Dr. Franciscus relies upon the narrator to translate his words to Imelda, and in doing so he is both dependent on the narrator (he is somewhat powerless without him) and even more far removed from the patient, as he is no longer addressing her, but the translator instead. This added barrier to communication further complicates the traditional doctor-patient relationship. This can be seen when Dr. Franciscus goes to examine Imelda's face. He says to the narrator, "Tell her to take the rag away" (Selzer 26), an indirect command. He goes on, "Tell her I've got to see it. Either she behaves, or send her away" (Selzer 26), thereby ordering his inferior, all while setting up an ultimatum to his patient—allowing Dr. Franciscus to exert his power bivalently. The notion that this girl will be turned away, in a sense 'abandoned,' further alienates the doctor from the patient. The narrator, on the other hand, adopts a more kind tone with the patient: "Please give me the cloth," I said to the girl as gently as possible. She did not. She could not" (Selzer 26). Selzer seeks to highlight the juxtaposition in role and behavior between Dr. Franciscus and himself by paralleling the phrase Dr. Franciscus told him to say, and what he actually translated to the patient. The narrator goes on to observe:

> Just then, Franciscus reached up and, taking the hand that held the rag, pulled it away with a hard jerk. For an instant the girl's head followed the cloth as it left her face, one arm still upflung against showing. Against all hope, she would hide herself. A moment later, she relaxed and sat still. She seemed to me then like an animal that looks outward at the infinite, at death, without fear, with recognition only (Selzer 26).

Here, the reader can glean Selzer's empathy. Unlike the surgeon, Selzer sees Imelda as more than noncompliant, he sees her as vulnerable and recognizes her pain. It's not that she did not remove the cloth, it was that she *could* not, a nuanced understanding of the patient's emotional state. Moreover, while the surgeon resorts to physical force, the narrator watches from afar and again uses the "seemed to me" phrase, to accurately portray the girl in her fragile state. He uses the narrative tools of metaphor to effectively convey the way he sees the patient. Thus through narrative, Selzer is able to compare his attitude towards a patient directly with that of his superior—the archetype cold and haughty surgeon—perhaps as a way to prove to himself and readers that he was more empathetic and understanding than the role he was bred and trained to adopt. Nevertheless, the narrator goes on to reveal nuance in these roles. After examining Imelda, Dr. Franciscus asks, "'What is your name?' The margins of the wound melted until she herself was being sucked into it. 'Imelda'… 'Tomorrow,' said the surgeon, 'I will fix your lip. *Mañana*'" (Selzer 27). Here, Dr. Franciscus switches from speaking to the patient through the narrator, to speaking to the patient directly, and in her native tongue. Furthermore, he asks the patient for her name, a deeply personal part of the patient's identity. Though he knows her name from the documentation, he asks for it anyway purely to establish a relationship. The narrator picks up on this shift in Dr. Franciscus's attitude reflecting,

> In spite of his years of experience, in spite of all the dreadful things he had seen, he must have been awed by the sight of this girl. I could see it flit across his face for an instant. Perhaps it was her small act of concealment, that he had had to demand that she show him the lip, that he had had to force her to show it to him. Perhaps it was her resistance that intensified the disfigurement. Had she brought her mouth to him willingly, without

shame, she would have been for him neither more nor less than any other patient (Selzer 27).

This observation reveals that Dr. Franciscus indeed changed his behavior towards the patient. But according to the narrator, this is precisely due to the power dynamic between them—Selzer speculates that Dr. Franciscus acts kind not because of his compassion but because she resisted him. Whether or not this is the case, it is clear that the narrator has adopted a more cynical view of his mentor. The narrative tone of this interaction both in his speculation ("perhaps") and in his framing of his teacher, reveals how Selzer still (at the time of writing) views his superior and the role in which Dr. Franciscus operated. Even when Dr. Franciscus shows humanity, '"Wait!' The surgeon stopped me. I lowered the camera. A strand of her hair had fallen across her face and found its way to her mouth, becoming stuck there by saliva. He removed the hair and secured it behind her ear…" (Selzer 28) Selzer makes it unclear whether or not this was truly an act of compassion, or a mere boosting of the surgeon's medical ego. Although Selzer adds in the surgeon saying "Take three more, just in case" (Selzer 28) reminding the readers of the surgeon's intentions—he is taking performative pictures to be able to show others how transformative his work really was. Thus, Selzer is constantly revealing important information about Dr. Franciscus, but in doing so he exemplifies his complicated views towards his superior.

This is especially apparent when the narrator reconciles with Imelda's death. Immediately after "it" happens, Selzer writes, "the surgeon's fingers pressed the groin where there was no pulse to be felt, only his own pulse hammering at the girl's flesh to be let in" (Selzer 29). Through narrative imagination, the narrator personifies the surgeon's pulse. But through this image of Dr. Franciscus's pulse, his heart beat traveling through his fingers found at the expense

of Imelda's, one can see the fervent, frantic, almost desperate, desire of both the surgeon, and by extension the narrator who's framing this personification, to not lose their patient. The loss of the patient sets in the devastating reality that the two doctors did more harm than good. Having traveled to another country to operate on what they perceive to be less fortunate people, gaining the trust of a mother to perform cosmetic surgery on her young daughter, and having that daughter die before they even had a chance to fix what they promised to have fixed, goes against the premise of their role of doing good. Their professional identities begin to collapse, for they have broken the sacred rule of "Do No Harm."

The roles crumble even further when Dr. Franciscus breaks the news to Imelda's mother. It is Dr. Franciscus who will do the talking, and "in whatever Spanish he could find. Only if she did not understand was I to speak for him" (Selzer 30) and with this, the medical student's role as translator starts to shift to one of witnessing. The narrator "watched him brace himself, set his shoulders. How could he tell her? I wondered. What? But I knew he would tell her everything, exactly as it had happened. As much for himself as for her, he needed to explain" (Selzer 30). The narrator imagines what Dr. Franciscus will do, but in doing so reflects his own uncertainties of how to handle the situation. He assumes that the surgeon will be clear and objective, to succumb to the need to explain, but that isn't what happens. Rather, these words seem more like a confession to the reader from Selzer himself. It is Selzer who desires to tell his story, by writing this narrative and recounting it "exactly as it had happened" (Selzer 30). Perhaps, through narrative, Selzer can reconcile with the collapse of his original identity as a young doctor whose goal was solely understood as preventing death, not causing it. He goes on, "Even in his discomfort I knew that he was teaching me. The way to do it was professionally" (Selzer 30). Though Selzer at the time of writing this story knew that what Dr. Franciscus did was, strictly

speaking, “not professional,” he still chooses to reaffirm that Dr. Franciscus was teaching him. By blurring the lines of time, through retrospective writing and including the subjective notion of what is and isn’t “professional” in ethically fraught situations, narrative has allowed us to see the ways in which this profession and its conduct can not be confined or scripted—it is variable and subject to the revision of time and hindsight. Dr. Franciscus’s speech reveals this even more:

> “Señora,” he began, “I am sorry,” All at once he seemed to me shorter than he was, scarcely taller than she. There was a place at the crown of his head where the hair had grown thin. His lips were stones he could hardly move them. The voice dry, dusty. “No one could have known. Some bad reaction to the medicine for sleeping. It poisoned her. High fever. She did not wake up.” The last, a whisper. The women studied his lips as though she were dead. He tried, but could not control a twitching at the corner of his mouth. He raised a thumb and forefinger to press something back into his eyes (Selzer 30).

Here, the hierarchy and power dynamics collapse even more. The once looming surgeon now appears shorter, older, and more vulnerable. His bellowing voice is reduced to a dry whisper. He cries. But even Selzer does not say this last truth outright, instead, Dr. Franciscus is just “[pressing] something back into his eyes” (Selzer 30). Selzer wishes to shield his superior and not reveal the surgeon’s pain, displaying the respect that still exists for his teacher. The narrator notes that when the mother touches Dr. Franciscus, “he did not withdraw” (Selzer 31), the exact opposite of the statement made from the narrator earlier observing the surgeon’s resistance to touch.

While Selzer includes direct dialogue from the surgeon, here he does not for the mother. Instead he writes,

> She spoke, the words coming slowly to make certain that he understood her…The doctor must not be sad. God has decided. And she was happy now that the harelip had been fixed so that her daughter might go to Heaven without it. Her bare feet retreating were the felted pads of a great bereft animal (Selzer 31).

By paraphrasing what the mother said, the reader is left wondering if this was exactly what was uttered. Instead readers interpret the scene through what Selzer offers—the impression left on Selzer, one that highlights God's will and her daughter's admission to heaven, as well as the metaphoric, zoomorphic description of the mother, similar to his description of Imelda in the office. Selzer compares the two women to animals perhaps to help characterize them as more than just subjects in his medical mission—the womens' emotions go beyond that of purely human description.

Another narrative tool that Selzer employs is that of time changes in his retelling of this story: "I had been drawn to this scene as one is drawn, inexplicable, to certain scenes of desolation—executions, battlefields" (Selzer 31). Though Selzer is referring to the physical place where he goes to meet the mother, it appears that Selzer is referring to recalling this scene in his memory many years later and it is this interaction that sticks with him. He quotes the mother directly this time, "the doctor is one of the angels. He has finished the work of God. My daughter is beautiful…" (Selzer 31), the mother says. Though this moment causes pain for Selzer, both in the moment as the narrator and as he writes it as the author ("[he regrets] having come to this

place" (Selzer 32)) he gives voice to the mother who calls this act divine, thereby referencing the parallels (and perhaps pressure) sometimes created between doctors and God. This is critical to how Selzer sees his professional role. Selzer then zooms out in time, writing explicitly from the future, "There are events in a doctor's life that seem to mark the boundary between youth and age, seeing and perceiving. Like certain dreams, they illuminate a whole lifetime of past behavior. After such an event, a doctor is not the same as he was before" (Selzer 32). Selzer refers to this moment with the mother as shaping the boundary between seeing and perceiving but generalizes it to the events of all doctors, not just him. Though this moment is personal only to Selzer, the narrative reveals how moments like this—where doctors must grapple with a role that is morally complex—happen frequently, as if it is a rite of passage. No longer can medicine be seen as strictly black and white, purely healing and saving—rather it is ripe with the pain of loss, futility, and the notion that doctors are not perfect. Their roles are not that of God, for they are fighting the ever powerful force of disease and tragedy. Selzer learns, through writing and reflecting, that his role as a doctor is not as straightforward as the Hippocratic Oath or the Geneva Convention decrees, and it is this realization that is essential to becoming a doctor. Here, narrative helps acctuate this epiphany. Because this story appears in *Letters to a Young Doctor,* Selzer uses the medium of letter to transmit this learning to a future generation.

Nowhere can this be seen more than in Selzer's shift in sentiments towards Dr. Franciscus's surgery on the now-dead girl. At first, when Selzer reflects back on what he thought of Dr. Franciscus's repairs at the time of learning about it, we see the thoughts of someone who has not yet processed this realization, "It had seemed to me then to have been an act of someone demented, or at least insanely arrogant. An attempt to reorder events. Her death had come to him out of order" (Selzer 32). Selzer immediately makes the distinction that these are what "seemed

to [him]" then. He writes about his guilt in being implicit in the "Act of omission" (Selzer 32) and how, at the time, he thinks he will live to regret it. As the narrator goes on to speculate the feelings of Dr. Franciscus ("The words of the mother had not consoled him; they had hunted him down. He had not done it for her. The dire necessity was his" (Selzer 32)) and imagines his superior going into the morgue and performing the operation under candlelight, he again uses narrative imagination. But it is this imagination that reveals to the reader the current state of the narrator, one who still sees the situation through the lens of a doctor practicing with a clear sense of right and wrong. To the reader, it seems as though the narrator is being unreasonably harsh when in reality it can be recognized that what Dr. Franciscus did was complicated, even if Selzer, at the time, could not condone his actions.

Yet, with time, the reader can see how Selzer's attitude towards his professional role has shifted. He writes, from a retrospective perspective, "Now and then, in the years that have passed, I see…his face bent over in the morgue" (Selzer 36). Selzer is revisiting a scene in his mind that never happened, he never witnessed Franciscus in the morgue, but his narrative imagination allows him to engage in this perspective taking and empathy for his superior. He goes on, "I would like to have told him what I now know" (Selzer 36) initiating narrative dialogue, "that his unrealistic act was one of goodness, one of those small, preserving acts done, perhaps, to ward off madness…But of course, it's too late now" (Selzer 36). With distance, both in time and through the vehicle of narrative, Selzer reflects a new found understanding of his role as a doctor. Unlike before, where Franciscus' act was "demented," Selzer can see now that this act was "one of goodness" (Selzer 36). He sees that he operates in a world in which healing is not defined verbatim by a book, and what is or is not professional, can take on a variety of different meanings in different contexts.

Though the reader sees this event through Selzer's eyes, they are still given the opportunity to see Dr. Franciscus's attempt to grapple with his own professional identity. By performing the operation on Imelda, Dr. Franciscus attempts to rewrite the story, and by putting it on display for the medical students to see upon return, he chooses to share this altered story. The slide show was Franciscus' 'narrative,' his way of reconciling with his role as a doctor and the thickening of his identity. The narrator shares that Franciscus was never the same after this medical mission, suggesting that Franciscus was not able to come to terms with this more complex role that revels in the 'gray area.' It's explicitly noted that Franciscus was not able to get out the words when presenting Imelda's case, "it was not that the man would not speak as that he could not" (Selzer 34). Selzer's use of repetition with the would not/could not distinction highlights the notion that Franciscus is unable to tell this narrative, "[diminishing his ferocity]" (Selzer 36).

It is a narrative that allows us to see the passing of time and what happens when the definition and role of the doctor crumble, when the trust that is intertwined with power is on the line. The reader bears witness to the ways in which power dynamics within the medical hierarchy shift and how power, be it through taking care of someone's life or rewriting a story, can change and shape during tragedy. From a metanarrative perspective, the reader can observe within the narrative the ways in which a traditional power dynamic manifests in a medical mission setting, while also observing how narrative is used by the narrator to reflect back on the incongruencies of an interaction and reconcile with the role of being a medical student who is both inferior within a medical education hierarchy while still holding power over his patient. When tragedy strikes, these roles drop, and the reader can watch how two doctors must struggle with holding two opposing truths: To work to better human lives, and to realize that bettering lives doesn't

have a strict definition. While Selzer is able to tell this story through narrative and realize this more expanded definition of a doctor's role, Franciscus is not. Thus, the telling of one's story is a critical way of dealing with the challenges of being a doctor.

Metanarratives, from the Doctor's Perspective

Selzer's *Letters to a Young Doctor* exemplifies the way narrative can be used in healthcare settings while teaching readers important insights into the way medical power dynamics operate. Elsewhere in the collection, in true metanarrative fashion, Selzer makes direct mention of the use of the narrative. In the infamous "Brute," in which Selzer ties down the ears of a misbehaving patient in the emergency room, he writes that "Even now, so many years later, this ancient rage of mine returns to peck among my dreams, I have only to close my eyes to see him again wielding his head and his jaws, to hear once more those words at which the whole of his trussed body came hurtling towards me" (Selzer 63). By writing "Brute," Selzer gives voice to this guilt and the immoral use of his power over a vulnerable patient. He ends "Brute" with an apology, if not to the audience (a warning for how power can corrupt a young doctor), to his patient, and even to himself, "How sorry I will always be. Not being able to make it up to him for that grin" (Selzer 63). Selzer might not be able to go back and apologize for this abusive act to the patient directly, but by giving voice to his actions, by being honest about his mistakes, he is able to, even a little, rectify the situation for the posterity of doctors. Throughout *Letters,* Selzer often writes about power dynamics and his role as a doctor through explicit metaphor: "In an operation where the patient dies on the table, the surgeon, although he is rescued from the whale and the sea of blood, is not fully healed, but will bear the scars of his sojourn in the belly of the patient for the rest of his life" (Selzer 54). Through the analogy of Jonah and the Whale, Selzer displays to readers the intertwined nature of the patient-surgeon relationship, revealing an

important finding in which patients can find solace in trusting their surgeon and healthcare workers can further understand the ways in which losing a patient impacts a doctor's psyche. In the midst of writing a letter to a young surgeon, Selzer talks about why he writes: "Where before he had felt only the rhythm of his work, now he has become conscious of himself. Perhaps he has lost his childlike innocence. Perhaps he has begun the process of dying" (Selzer 172). It is at this point that the surgeon can turn to narrative to reconcile with this shift, to realize what before felt natural is now more complicated. Selzer writes about the ineffable—his inability to euthanize a hospice patient in "Mercy," the devastation of a severely disabled child in "Witness," the humiliation of the medical hierarchy system in "Grand Rounds." As shown through the case study on "Imelda," analyzing these narrative representations of doctors' struggles with their roles can help better understand the healthcare system as a whole, and improve the relationship with doctor and patient, as only through excavating both roles can the relationships between the two be improved.

Danielle Ofri's collection of narratives and studies entitled *What Patients Say, What Doctors Hear,* further elucidates this notion. As someone who is at the forefront of narrative medicine, Ofri has devoted her career to giving voice to stories from doctors and patients alike. Through this particular metanarrative, however, readers are able to glimpse Ofri's own experiences intertwined with scientific studies. Ofri's inclusion of her own experiences displays the necessity of storytelling, of experiencing and sharing the lived reality of practicing medicine. Rather than creating a book written in the third person, while analyzing statistics and methods of how to improve the doctor-patient relationship, Ofri infuses her own first-person experiences to illustrate how these studies operate in real life. In doing so, she is able to grapple with her own role as a doctor and improve the care that she offers.

Ofri describes the premise of her writing,

> In this book I trace the paths of several patients and doctors, examine how a story travels from one human being to another. By exploring the challenges and pitfalls as well as the collaborations and the successes, I hope to illuminate the role of this most potent diagnostic—and therapeutic—tool in medicine. The more technologically advanced medicine becomes, the more we are reminded of the crucial role of the story (Ofri 6–7).

Ofri is writing a story about storytelling, leaning into the narrative to make her point while showcasing her use of narrative agency, most specifically narrative dialogicality, to create conversations between herself and the subjects of her study, as well as between author and reader. She starts her book with the real story of Mr. Amadou, a patient who was desperate for an appointment. Ofri, upset by his seeming entitlement for an immediate appointment with her, his refusal to go to an urgent-care clinic, and his showing up unannounced, finally agrees to see him, but upon entering the room for the appointment, Mr. Amadou collapses to the floor secondary to a cardiac episode. Ofri reflects back, "There is always that dreadful moment of silence—probably less than a second, but it feels like an hour—when you realize something terrible has occurred…I was swamped with a horrific wave of guilt" (Ofri 4). Ofri reflects back on this pivotal moment as one of reckoning—an eye opener that she needed to improve her listening skills with her patients. Like Imelda's tragedy that made Selzer realize the complexity of his role as a doctor, so too did Mr. Amadou's cardiac event make Ofri rethink her responsibilities as a doctor. Through narrative, compiling the resources to improve doctor-patient relationships and analyzing this interaction ("In Mr. Amadou's case, there were mutual missteps

that served to worsen his medical condition" (Ofri 6)) Ofri is able to expand her definition of physician. She employs narrative awareness when she writes,

> For all of his annoying mannerisms and pushiness, Mr. Amadou was fundamentally trying to say, 'Help me.' Deep down, no doubt, he was terrified that his heart could give out at any moment. This fear informed all of his actions. Seen in this light, his relentlessness was understandable—his life hung in the balance—so he could never take no for an answer (Ofri 5).

In taking Mr. Amadou's perspective, Ofri is able to tease out what went wrong in her communication. The doctor-patient relationship only functions properly when both sides lean into listening—and predefined roles play a large part in that. Ofri realizes that her role as a doctor is one of listening. Later she writes, "Gone is the standard idea of the listener merely slitting open the verbal bundle into which the speaker has dutifully packed his or her story…the listener helps draw out the story, helps illustrate the story, and even helps shape that story into its best possible form" (Ofri 112). Ofri uses the language of narrative to better her care, then documents how she tries to become a better listener. Through narrative she realizes how she can improve her role as a doctor, citing a patient, Mr. Leonard, who was struggling with an undiagnosed illness and was constantly frustrated at every appointment. Ofri, committed to the notion that she and the patient "could be co-narrators" realized that in her previous visits with Mr. Leonard, she "was desperately trying to shape Mr. Leonard's story" (Ofri 114). By writing this narrative, Ofri became aware of her role as a doctor as a co-narrator and was able to make a concerted effort to improve with future encounters.

Ofri also demonstrates the way narrative can be used by a doctor to reconcile with medical error and to improve communication. She reflects back on a misstep she made earlier on her career, “My body felt like it was turning to stone as all my metabolic processes ground to a halt. An intracranial bleed? A hemorrhage into the brain? You couldn’t get much worse than missing an intracranial bleed” (Ofri 139). Her hyperbolic statement helps exemplify just how much this moment impacted her and she uses the conditional tense, “ If I could have willed myself to melt away on the spot, to melt myself out of existence—I would have” to further paint the picture of distress. Just like Dr. Franciscus and Selzer in “Imelda,” Ofri feels these fervent emotions because mistakes made by a doctor, someone to whom a life is entrusted, have drastic ramifications and run contrary to the sacred rule of causing no harm. Though many would argue that mistakes are inherent to any human profession, including medicine, letting these mistakes blister, to expand into a lie that destroys confidence and potentially one’s sense of self can be pernicious. Ofri exemplifies what happens when one keeps this shame to oneself, “I was so ashamed that I didn’t tell anyone about my lapse—not that day and not ever after. I didn’t tell my intern. I didn’t tell my attending....” (Ofri 140) yet through time, and via narrative she comes to realize that, “had I felt comfortable enough to tell my attending on that morning, she could have helped me understand how the error occurred and how to prevent it in the future. Even more powerfully, she could have taken our team to the bedside and modeled how a doctor might speak to a patient about an error” (Ofri 144). Thus Ofri links the telling of one’s mistakes to an invaluable opportunity to learn more about the role of a doctor and how to move on from mistakes because that is part of the job. If one cannot accept this fact they are susceptible to “the devastating effect on the person who made the error” (Ofri 144). Again going from generalizations about the field to the personal, Ofri looks back in time once more,

> As a barely-out-of-the-gates doctor, my missing the intracranial bleed was cataclysmic. Until that moment I'd thought I was a reasonably good doctor—no worse or no better than my colleagues—but in a split second that entire persona came shattering down. It wasn't just that I had made an error; it was that my being a doctor was an error. I felt like such a crashing disappointment to my profession that the only prudent course would be to take down my shingle, such as it was, and barricade myself at a desk job alphabetizing insurance forms, selflessly sparing future innocents my shabby medical ministering (Ofri 144).

At the time, Ofri linked her mistake to her professional identity of being a doctor: With the occurrence of the former comes the crashing of the latter, as though they are dominoes and not inextricably linked. But through narrative she comes to see the usefulness in admitting and forgiving herself for errors—practicing medicine can never be perfect, and coming forward with transparency and acceptance allows the doctor to be able to operate in their role once more and regain their sense of self. Because unlike with hospitals, where "after the money is forked over and the publicity dies down, hospitals continue on as they always have," for "the individual physician or the nurse; the emotional ravage tunnels deep into the soul" (Ofri 146). Moreover, one sees the way hierarchy again dictates a doctor's ability to recover after a setback. Without power dynamics within the hospital system, Ofri might have been more inclined to speak out about her mistake, instead of letting it fester and torment her from the inside. Thus, there can be severe impacts on the doctor (in addition to the patients and families) when a mistake occurs. For instance, in addition to the emotional elements, not speaking about one's mistakes can lead to a

cascade of mistakes in performance, “I’m certain there was a trail of errors in the wake of my missing that intracranial bleed—many of which could have been avoided if I’d been able to speak openly about what had happened. The shame burrowed so deep and with such tenacity that it took me a full twenty years to finally be able to speak of that moment” (Ofri 146). The hierarchy is the very reason a young doctor might not want to tell their supervisors. Ofri therefore uses narrative, in part to reflect on her experiences and to truly reconcile with the way medical errors and mistakes in communication can happen. Though *What Patients Say, What Doctors Hear* is primarily a reference to the ways in which both parties can improve communication, ladened with studies and anecdotes from other physicians and patients, the snippets that Ofri offers from her own experiences and the way she uses sources to reflect and improve her own care, displays one of the many ways narratives can be used to better understand roles, power dynamics, and relational care in the healthcare system.

Illness as an Identity: Patient Pathographies

While doctors are constantly seeking to better understand their unique identity within the healthcare system, so too do patients as they oscillate in and out of their identity from wellness to illness. Whether they have always been sick or are experiencing an acute event for the first time, patients must adopt a new role when they enter an appointment, one that is different from their professional identity but that permeates all aspects of life. According to articles that have been published in the *European Journal of Cardiovascular Nursing*, “illness perceptions are associated with: quality of life, performance of self-care, adherence, treatment-seeking behavior, [and] general healthcare use” (Van Bulck et al.). Expanding the idea of illness perception to illness identity, which Van Bulck et al. defines as “the degree to which a chronic health

condition, such as a heart disease, is integrated into someone's identity" (Van Bulck et al.) it is important to acknowledge the bidirectional nature of illness, examining not only the ways that patients perceive a certain disease but how that particular disease impacts the way they perceive themselves. Oris et. al., gives structure to illness identity dividing it into four major dimensions: engulfment, rejection, acceptance, and enrichment. The first, engulfment, refers to the way that patients describe disease as dominating their sense of self. The second, rejection, consists of othering the disease as separate from the patient's identity, or seeing it as a threat. The third, acceptance, is where patients come to terms with the disease as part of their life, without letting it overwhelm them. The fourth, enrichment, entails patients who feel their disease has allowed them to grow as a person (Oris et al.). These identities are critical to ameliorating the healthcare experience. They dictate the emotional state of the patient, impact disease management and adherence, and play a large role within patient-doctor communication.

Patients use illness narratives to explore this complex identity and the way it impacts their lives. Likewise, readers can learn about the emotional difficulties that underlie illness identity, looking beyond a patient's physical health after diagnosis toward the way illness can undermine one's very sense of self. Through understanding on both sides, the relationship between doctor and patient can be improved—since empathy and perspective taking are the cornerstone to partnership.

Your Hearts, Your Scars is one such illness narrative that explores illness identity, specifically identity as the recipient of a heart transplant. This paper will again utilize the metanarrative and narrative agency lens to explore the ways this young woman dealt with the redefining of her sense of self, post-transplant. According to Mauthner et. al., "of heart transplant recipients, 30 percent report ongoing or episodic emotional issues post-transplant, which are not

attributable to medications or pathophysiological changes" (Mauthner et al.). Unsurprisingly, receiving an organ from someone else, benefiting in some way from someone else's death, and dealing with the repercussions of living with someone else's body part have far-reaching implications on one's own identity. Transplant recipients may feel pressure to live a certain way, imagine behaviors of their organ, or feel separate from "it" (Haddow). The novel idea of transplanting a body part from one individual to the next is perhaps one of medicine's greatest accomplishments, but with transformative advancements comes psychological impacts that must be addressed.

The author, Adina Talve-Goodman, wrote these essays after she received a transplant at the age of nineteen and before she died of post-transplant lymphoproliferative disorder (PTLD) (although this book is about her experience with her heart transplant, not lymphoma). Her sister helped publish these papers posthumously honoring Talve-Goodman's wishes to share her writings and narratives she had been working on. Through narrative, the author was able to elucidate the ineffable details of transitioning from a lifetime of illness—Talve-Goodman was born with a single ventricle heart and pulmonary atresia, requiring many surgeries until she went into heart failure at the age of twelve—to a life of wellness, post heart-transplant.

One common theme that Talve-Goodman often touches upon is the relationship she felt or didn't want to feel with her donor. Early on she writes, "I tried not to think about the donor much. I'd spent close to two years waiting, always wondering what the donor might mean, what might change in me. I'd seen kids lose themselves to their donors" (Talve-Goodman 28). Talve-Goodman remarks on observing 'engulfment,' separating herself from the other kids' experiences. Yet despite her efforts to avoid losing herself in her donor, her writing suggests that she experiences "rejection." In her essay, "I Must Have Been That Man," she writes, "...at almost

a year, I stood in front of the mirror in a boy's shirt, wondering how long it was going to keep me up at night, How long I would have to live with this new heart before it would feel like mine…to prove to myself, and the new heart, that this body was still my house" (Talve-Goodman 29). The pressure Talve-Goodman feels to have a complete, non-fragmented identity rings clear, she feels as though she *should* feel as though the heart is hers. Yet at that point in time, she didn't. She separates herself and the new heart as though they are completely separate entities. Such phrasing gives insight into the othering of this organ. In this essay, Talve-Goodman employs narrative recognition and relationality to a man she sees on the street, who has fallen out of his wheelchair. By telling the story of someone differently-abled from the perspective of being newly 'able-bodied,' she realizes the value of telling stories through one another. She is able to use narrative imagination and take the man on the street's perspective, realizing her very own vitality while simultaneously mourning her lost sense of identity. In "San Diego, 2001" Talve-Goodman recounts a trip she took with a bunch of transplant recipient-kids to help normalize the experience of organ transplant. In one conversation she remembers a boy choosing to go to a restaurant because, "My donor, though, he liked Greek food, so I try to eat it sometimes" (Talve-Goodman 54) perhaps an example of someone losing themselves in the transplant process. She writes in response that "I did not know what it felt like to carry the weight of dead donors. I did not yet have a living altar inside my body" (Talve-Goodman 55). Her use of the word "yet" implies the way her identity shifted post-transplant to one of struggling with the expectations and pressure of living up to her donor. Although she is writing having undergone this transplant, using the narrative to transport back in time to this trip helps display the trepidations of someone on a transplant list with regards to their identity and the reality of what it is like having gone through it.

Talve-Goodman also uses narrative to cope with the guilt of her transplant. When reflecting on the Thanksgiving after her transplant she writes,

> My family's gratitude, our joy, comes in large part from another family's grief. It's not a direct correlation, nor a direct result. I did not cause that death, but I did wait for it to come for a long time, and when it did, I was grateful. But what would that make the condition of my transplanted heart—not quite grieving, not quite gratitude? What can I call the crawl space in between? (Talve-Goodman 59).

By asking questions, through her writing, she creates an intersubjective space between herself and the reader asking us all to consider the delineation of her complex situation. Talve-Goodman also references feeling as though she had to be deserving of the heart "you aren't just given a heart, you have to earn it" (Talve-Goodman 60) and by the end, she comes to the conclusion that "maybe that is the condition of my transplanted heart, one of remembering" (Talve-Goodman 64). Using contractual language like earn and condition makes the transplant seem like a life-long commitment to make one's life "'worth it." While this doesn't fit directly into illness identity characteristics, one can see how, as Talve-Goodman puts it, a biological gift can shape one's identity. Studying the language of the recipients gives insight into the emotional state—here the theme of guilt and reward—of these patients which may impact their mental health or even the success rate of a transplant.

Finally, through her collection of essays, Talve-Goodman comes to better understand her relationship with her illness identity, especially that of enrichment. In several earlier essays, she writes a phrase often identical to this: "Sometimes, kids lose themselves in their transplants and

donors. They miss their illness because it made them special" (Talve-Goodman 62). She writes in the third person, to generalize the transplant experience for others. But in the last essay, Talve-Goodman writes, "I liked the person I was and I didn't want to risk losing myself to an organ" (Talve-Goodman 123). Switching to first person, she acknowledges how these statements repeated earlier were actually fears of her own from before the transplant. The switching in subject and acknowledgment of these fears through narratives were most likely healing for her—she was able to come to terms with exactly what she worried about pre-transplant and also realize the notion that she did value some aspects of her life with illness, her suffering was "dear to [her]" (Talve-Goodman 43). In meta narrative form she addresses the entity of the illness narrative directly:

> What, then, for an illness narrative? Perhaps that I am what you make of me—I live this way, a different body, a body of hybridity, to mean something to you, to your experiences, to practice your empathy, to fetishize, even to "inspire." But perhaps keeping my heart complicates this. Perhaps the horror of keeping a useless heart in a box on one's nightstand can be read as a feminist act: at once a declaration of ownership and a way of denying possession or being possessed. A part of the body horrifically claimed. I am not empty but twofold, abundant (Talve-Goodman 89).

Here, Talve-Goodman defines her identity through the reader, she is the work that is being interpreted. She dares, even, for the reader to find benevolence in her story, to use the narrative form for practice or as inspiration but thinks that her keeping the heart can be "read" in a way

that is fighting against her fears of losing herself to the donor. She desperately wants, both before and after the transplant, to sustain her unique sense of self, even if that sense of self is tied to her illness. By describing how the reader might interpret her story, she reveals that this is how she wants to be interpreted, as "twofold" and "abundant." She is leaning away from the narrative of empathy and inspiration to something more complex; that she might miss her illness and hold on to her diseased heart physically is not a black and white perspective on illness and well-being that some people might possess. Instead, she revels in this gray area, through the meta narrative portrayal of herself as a character waiting to be read and analyzed. It is through these tools that she gains a better understanding of her identity and sentiments towards illness—not unlike Ofri and Selzer and the doctor narratives realizing their roles as doctors are complex and changing as well.

Finally, Anatole Broyard's *Intoxicated by My Illness* is a cardinal illness narrative in which both the author and the reader can wrestle with illness identity and doctor-patient relationships. Broyard, a devoted and celebrated literary critic, describes the epiphanic nature of his terminal cancer diagnosis, using the narrative to reframe his illness from tragedy to fortuity. He writes, "I'm isolated from them by the grandiose conviction that I am the healthy person and they are the sick ones…Now at last I understand the conditional nature of the human condition" (Broyard 6). An archetype of illness identity's enrichment, Broyard describes the clarity he has on life now that it isn't guaranteed. He uses literary devices to describe this revelation: "I see now why the Romantics were so fond of illness–the sick man sees everything as a metaphor. In this phase I'm infatuated with my cancer" (Broyard 7). To him, life is no longer seen as purely tangible; instead he paints life around him in colorful metaphor-ladened strokes. Reflecting on illness in a positive light and writing about the ways it has transformed him allows Broyard to

take control of his illness. Remembering back to his diagnosis he writes, “My initial experience of illness was a series of disconnected shocks, and my first instinct was to try to bring it under control by turning it into a narrative. Always in emergencies we invent narratives. We describe what is happening, as if to confine the catastrophe” (Broyard 19). Broyard demonstrates exactly what Selzer, Ofri, and Talve-Goodman exemplify through each of their stories—narratives help the self reconcile with the unknown—be it changes in what it means to be a doctor, or the transition between sickness and health. Broyard extends his individual experiences to the generalization of others revealing his desire to spread what he deems, as the power of the narrative, to others. He writes about his experience narrating his story, “I do think I may be able to shrink it a little by pointing out its limitations, by being critical of the way people bow down to it. I can treat it like an overrated text” (Broyard 18). His present tense reveals that the act of writing this illness narrative, the one we are reading, is his therapy. His way of coping with cancer is taking ownership of it, doing so through narrative agency. In addition to gaining control over illness, just by putting pen to paper, narrative also offers the gift of metaphor, which Broyard sees are as, “necessary to illness as they are to literature, as comforting to the patient as his own bathrobe and slippers. At the very least, they are a relief from medical terminology…Perhaps only metaphor can express the bafflement, the panic combined with beatitude, of the threatened person” (Broyard 18). Often doctors and patients communicate to each other through metaphor, because the medical legalese (as Ofri refers to it) is often inaccessible to the patient, while the emotional turmoil is difficult for the patient to express. By transcending literal words into a reflexive vocabulary of shared image, the communication between patient and doctor is improved. Broyard extends upon storytelling as the link between patient and provider: “Inside every patient there’s a poet trying to get out…My ideal doctor

would read my poetry, my literature. He would see that my sickness has purified me, weakening my worst parts and strengthening the best" (Broyard 41). Here literature plays a twofold role as Broyard likens himself to a poem needing interpretation—similar to Talve-Goodman's explicit mention of her illness narrative—and also allows him to once more gain control over his illness, painting his experience as a positive "purif[ying]" experience. Narrative isn't solely a way to help individual patients and doctors reconcile with their own roles in healthcare, it also helps them define their roles *in relation to* each other. Broyard sees narrative as a way for doctors to have a "more total embracing of the patient's condition" (Broyard 41). When describing his ideal doctor, Broyard mentions the writer-physician Dr. Oliver Sacks stating, "I can imagine Dr. Sacks *entering* my condition, looking around it from the inside like a kind landlord, with a tenant, trying to see how he could make the premises more livable. He would look around, holding me by the hand, and he would figure out what it feels like to be me" (Broyard 43). Only through narrative can the doctor truly take the perspective of the patient. Reading Broyard's narrative demonstrates just how important it is for the patient to be understood, for their perspective to be acknowledged. Noting the imbalance of vulnerability between the patient-doctor interaction, Broyard sees narrative as the way to somewhat narrow this deficit: "To the typical physician, my illness is a routine incident in his rounds, while for me it's the crisis of my life. I would feel better if I had a doctor who at least perceived this incongruity" (Broyard 43). When one is faced with a doctor like Dr. Franciscus, pre-Imelda, "when a doctor refuses to acknowledge a patient, he is, in effect, abandoning him to his illness" (Broyard 50). Broyard wrote this narrative in the late 1980s, before the role of empathy and storytelling was properly understood in medicine. And while immense progress has been made in acknowledging the patient, it is critical to look back at

illness narratives, like Broyard's, to see how far the medical community has come and how much further there is to go.

Intoxicated By My Illness is a metanarrative demonstrating the profound impact of story telling. Broyard writes "to make sure [he'll] be alive when he dies" because telling one's story allows one to shape their illness identity (Broyard 30). In fact, he writes, "To die is to be no longer human, to be dehumanized–and I think that language, speech, stories, or narratives are the most effective ways to keep our humanity alive. To remain silent is literally to close down the shop of one's humanity" (Broyard 20). It is human nature to share experiences as relationality and recognition gives meaning to even the most mundane of occurrences. But for an ill individual, storytelling and the narrative is especially therapeutic, "For a seriously sick person, opening up your consciousness to others is like the bleeding doctors used to recommend to reduce the pressure" (Broyard 22). Writing helps Broyard deal with his terminal diagnosis, and sharing this learning further adds to the legacy he wishes to leave behind. But it also helps with the doctor-patient relationship and the experience of being ill, and treating the ill. There is a lot to learn from experiencing narratives, writing narratives, and using narrative interpretation as a tool, and Broyard's illness narrative in and of itself epitomizes these lessons.

Roles, Communication, and the Narrative

As the field of medicine continues to evolve in recognizing the importance of communication within the doctor-patient relationship, it becomes increasingly critical to go beyond studying and quantifying solely the verbal and physical interactions, and to look into the lasting impressions felt by both patient and physician after an event has occurred. A written narrative provides a vehicle to such analysis. In examining the doctor narratives *Letters to a*

Young Doctor and *What Patients Say, What Doctors Hear,* themes emerge concerning the physician's role in morally complex situations, as well as power dynamics, and the doctor's identity when a mistake has occurred. In patient narratives, *Your Hearts, Your Scars* and *Intoxicated by My Illness,* issues of burden and the value of one's mortality are intimately explored. Putting these in conversation with each other, it becomes clear that both patients and doctors struggle with their identity within the healthcare system and use narrative to reconcile with this difficulty. Understanding that doctors, with their strict hierarchy of power and professional identity, struggle with defining their job, and themselves, is helpful for improving physician quality of life, and offers a way for patients to understand the system in which their providers work. On the other hand, seeing the way in which patients struggle with their illness identity, be it engulfment or enrichment, and understanding that illness can make up a large part of a patient's life and can involve complex emotions, demonstrates certain behaviors and choices that patients might make regarding treatments. These ideas aren't easily accessible in the constraints of an exam room, but are offered via narrative to bridge these gaps between roles. In the same way, writing narratives offers an outlet for patients and providers to discuss and grapple with their identities. Therefore both reading narratives and writing narratives can help strengthen the communication between both parties. Anatole Broyard writes, "Without some such recognition, I am nothing but my illness" (Broyard 45). Narrative holds the key to recognition, to agency, and to perspective taking. This paper elucidates the ways in which adopting a metanarrative approach and putting narratives written by both patients and doctors in conversation with each other can be applied to improve the doctor-patient relationship. It is through this method that narrative emerges as paramount to the practice—and experience—of medicine today.

Works Cited

Broyard, Anatole. *Intoxicated by My Illness : And Other Writings on Life and Death*. Fawcett Columbine, 1993.

Chipidza, Fallon E., et al. “Impact of the Doctor-Patient Relationship.” *The Primary Care Companion for CNS Disorders*, vol. 17, no. 5, Oct. 2015, p. 10.4088/PCC.15f01840. *PubMed Central*, https://doi.org/10.4088/PCC.15f01840.

Elias, Norbert, and John L. Scotson. *The Established and the Outsiders*. 1994.

Freeman, Mark. “Narrative, Ethics, and the Development of Identity.” *Narrative Works: Issues, Investigations, & Interventions*, vol. 4, no. 2, 2014. *www.erudit.org*, https://doi.org/10.7202/1062097ar.

Gerada, Clare. “Doctors’ Identity and Barriers to Seeking Care When Unwell.” *The British Journal of Psychiatry*, vol. 220, no. 1, Jan. 2022, pp. 7–9. *Cambridge University Press*, https://doi.org/10.1192/bjp.2021.52.

Haddow, Gill. “Ambiguous Embodiment and Organ Transplantation.” *Embodiment and Everyday Cyborgs: Technologies That Alter Subjectivity [Internet]*, Manchester University Press, 2021. *www.ncbi.nlm.nih.gov*, https://www.ncbi.nlm.nih.gov/books/NBK571746/.

Kaba, R., and P. Sooriakumaran. “The Evolution of the Doctor-Patient Relationship.” *International Journal of Surgery*, vol. 5, no. 1, 2007, pp. 57–65, https://doi.org/10.1016/j.ijsu.2006.01.005.

Mauthner, Oliver E., et al. “Heart Transplants: Identity Disruption, Bodily Integrity and Interconnectedness.” *Health (London, England: 1997)*, vol. 19, no. 6, Nov. 2015, pp. 578–94. *PubMed*, https://doi.org/10.1177/1363459314560067.

McWhinney, I. R. “Are We on the Brink of a Major Transformation of Clinical Method?” *CMAJ: Canadian Medical Association Journal*, vol. 135, no. 8, Oct. 1986, pp. 873–78.

Meretoja, Hanna, et al. “Narrative Agency and the Critical Potential of Metanarrative Reading Groups.” *Poetics Today*, vol. 43, no. 2, June 2022, pp. 387–414. *Silverchair*,

https://doi.org/10.1215/03335372-9642679.

---. *The Ethics of Storytelling: Narrative Hermeneutics, History, and the Possible*. Oxford University Press, 2017.

Ofri, Danielle. *What Patients Say, What Doctors Hear*. Beacon Press, 2018.

Oris, Leen, et al. “Illness Identity in Adults with a Chronic Illness.” *Journal of Clinical Psychology in Medical Settings*, vol. 25, no. 4, Dec. 2018, pp. 429–40. *PubMed*, https://doi.org/10.1007/s10880-018-9552-0.

Selzer, Richard. *Letters to a Young Doctor*. Harcourt Brace & Co., Cop, 1996.

Strull, William M., et al. “Do Patients Want to Participate in Medical Decision Making?” *JAMA*, vol. 252, no. 21, Dec. 1984, pp. 2990–94, https://doi.org/10.1001/jama.1984.03350210038026.

Talve-Goodman, Adina. *Your Hearts, Your Scars*. Bellevue Literary Press, 2023.

Van Bulck, Liesbet, et al. “Illness Identity: Capturing the Influence of Illness on the Person’s Sense of Self.” *European Journal of Cardiovascular Nursing*, vol. 18, no. 1, Jan. 2019, pp. 4–6. *Silverchair*, https://doi.org/10.1177/1474515118811960.

Yardley, Sarah, et al. “‘What Do We Do, Doctor?’ Transitions of Identity and Responsibility: A Narrative Analysis.” *Advances in Health Sciences Education*, vol. 25, no. 4, Oct. 2020, pp. 825–43. *Springer Link*, https://doi.org/10.1007/s10459-020-09959-w.