

**How Doctors Make Stories Matter. Review of Atul Gawande.
Being Mortal: Medicine and What Matters in the End &
Terrence Holt. *Internal Medicine***

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[See table of contents](#)

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REVIEW ESSAY

How Doctors Make Stories Matter

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Atul Gawande. *Being Mortal: Medicine and What Matters in the End.* Toronto, Canada: Doubleday Canada, 2014. 282 pp. ISBN: 978-0-385-67700-4.

Terrence Holt. *Internal Medicine.* New York, NY: Liveright Publishing Corporation, 2014. 271 pp. ISBN: 978-0-87140-875-4.

Near the end of *Being Mortal*, Atul Gawande writes: “For human beings, life is meaningful because it is a story. A story has a sense of a whole, and its arc is determined by the significant moments, the ones where something happens” (p. 238). “Peaks of joy and valleys of misery” are part of “how the story works out as a whole” (p. 239). That whole, both a story and a life, depends crucially on how it ends. “In stories, endings matter,” Gawande writes (p. 239).

These may be familiar observations, but they bear restatement in the context of Gawande’s meditation on what kind of ending dying can be, depending on how a person dies. Gawande tells stories in order to advance an argument that can be called polemical in the most honourable sense. He wants to mobilize people to demand better conditions of dying. Gawande, a surgeon now at Harvard and a staff writer for *The New Yorker* (in which two chapters from this book first appeared), has been called the most influential physician-author in the United States, which in this case probably means North America. Timothy Holt, also a physician, is less well known at present. Holt tells stories to a different purpose.

Holt entered medical school comparatively late in life, after a career as a creative writer. In *Internal Medicine*, he looks back, ten years later, on his medical residency. He introduces stories of medical practice

by telling us that he writes “in an attempt to make sense of the process of becoming a doctor” (p. 1). Again, that objective of storytelling is hardly original, but it is given weight by appearing on that same first page of the book with an epigraph from the physician-writer Richard Selzer: “Did you ask me why a surgeon writes? I think it is because I wish to be a doctor.” For Holt to become the doctor he can be, he needs to make sense of the process through which he became a doctor, and for that he needs to tell these stories. In one sense Holt’s stories are less personal than many of Gawande’s. He makes only passing, impersonal references to his wife and children, whereas Gawande tells quite intimate stories of deaths in his family. But even though Holt’s stories are exclusively about his professional self, his stories are consistently more personal in their shifts of narrative voice, revealing his various personae. Each of these versions of himself does his best, but each remains incomplete, and that is what Holt must make sense of.

These two books thus present us with two immensely skilled writers, telling stories that matter, but matter to different ends. Both books were extensively reviewed at their respective times of publication, and I need not add to the praise that other reviewers have correctly given them. Gawande continues to generate more press coverage--his book has become a PBS series--but it is arguable that in the long run, Holt’s work may be the more enduring, possibly earning a place beside the doctor stories of Anton Chekov (Coulehan, 2003) and William Carlos Williams (1984). My interest in this review is neither to compare nor evaluate, but rather to use these books, different as they are, to observe how physician-writers tell stories. The respective differences that Gawande and Holt each wants his stories to make reflect the range of differences that stories can make. Observing how doctors make stories matter is a significant case study in how any storyteller makes his or her stories matter.

The Force of Woven Stories

I asked myself, as I read *Being Mortal*, what makes this such a page-turner, can’t-put-it-down book to read? The stories told nothing I had not heard before, and the arguments, stated in their simplest form, are familiar to those who study end-of-life care: long-term care facilities demoralize many of their residents; hospital deaths are often agonizing for patients and families and a waste of medical resources, and hospice

care can work but is underfunded and undervalued. Although I had every right to read the book with weary resignation, it engaged me completely.¹

To understand my engagement, I went through the book mapping the different forms of narration Gawande uses. His art as a storyteller seems to lie in how he mixes different forms of narration. I once heard a musician remark that not least among Beethoven's talents was his capacity to know exactly how long something ought to last. Gawande has that capacity. He weaves forms of narration in a style that can be called musical: a theme is introduced by one group of instruments, then played by other instruments, then a new theme enters, then we return to the original theme, and so on. When, then, are these forms of narration?

My mapping shows Gawande utilizing eight forms of narration. These forms have fuzzy boundaries, overlapping and intersecting. My point is not to claim reliability of these forms but to observe their diversity. The forms of narration are, in approximate order of page length: (1) personal stories of dying trajectories in Gawande's family, primarily his father and his wife's grandmother; (2) clinical reports about Gawande's own patients; (3) case histories of people, not Gawande's patients, who are both ill and are health-care professionals reflecting on and seeking to optimize ways of dying; (4) medical journalism that is *not* storytelling, focused on epidemiological data (how people die) and institutions; (5) medical journalistic stories focused on individuals who have organized interventions in end-of-life care; and then, less frequently, (6) reminiscences of Gawande's medical education, his medical practice, and notably, one dream he had; (7) retold stories (i.e., Tolstoy's *Death of Ivan Ilych* and a segment from Plato); and finally, (8) retold literary histories (Emily Dickinson and Stephen Jay Gould). Again, what counts is not the reliability of these types, but rather the movement of storytelling between these different forms.

¹ In defense of this regrettably cynical statement, I recommend a Google search for the Project on Death in America, funded by the Open Society Foundation for a decade beginning in 1994. That massive funding umbrella included a four-part series on PBS, hosted by Bill Moyers. At least in his book, Gawande does not refer to this earlier version of what he seems to be attempting. Nor have I seen the earlier Project mentioned in reviews of Gawande. The template of Gawande's narrative structure is also preceded by the medical journalist Tim Brookes (1997), who described the institutional development of palliative care within a frame story of his mother's dying. None of this diminishes the value of Gawande's work, but he might have asked why progress in public education about dying and in institutional change does not seem to have much cumulative force.

On my unverified count (again, the principle of storytelling technique matters more than the specific numbers), Gawande tells five stories that are broken into segments, interspersed with other forms of narration. Most are told over about fifty pages. That builds a degree of suspense, it allows tying a specific story segment to an argument about an institutional organization of dying, and it satisfies the Beethoven principle of not letting anything last too long. The other stories in the book—and I unreliably count about fifteen—are told without interruption. The segmented stories thus give the book its continuity and are the primary focus of a reader’s involvement, while the other stories enter as supporting actors, literally supporting arguments and expanding the scope of interest.

The longest of these five segmented stories—and the book’s frame story—is the illness and dying of Gawande’s father, also a physician. The family narrative begins on page 13, in India, with the old age and death of Gawande’s grandfather. It is told in four segments, about 45 pages total, or one-fifth of the book. The longest single segment is only 11 pages; the accumulation of the segments makes each seem longer. The story ends back in India, where Gawande scatters his father’s ashes on the Ganges River.

So much for the structure of Gawande’s storytelling; what stories does he tell? I was surprised, reviewing my notes, that only a couple of stories follow the care-going-badly plot. Telling these stories early allows them to set a tone that makes other stories more suspenseful, because we know what can go badly and how. We read the later stories on alert for what might be; the essence of any storytelling is suspense, requiring imagination. Most of the stories follow what might be called the looking-for-a-better-way narrative. In some of these stories, the protagonist is critically ill (my type 2, above), which raises the stakes on what happens. In most of the stories (both type 2 and type 4, above), the story begins with the protagonist having a dramatic personal or professional experience that raises the stakes on finding better ways to care for the dying, and then gradually building a service project.

What, then, can we call Gawande’s method? *Medical narrative journalism* is serviceable as a description, but does not suggest how Gawande makes the stories he tells matter to his readers. A better description, I believe, is the phrase used by the William James biographer Robert Richardson (2006) to describe James’s method in *The Varieties of Religious Experience*. Richardson understands James’ developing “the

testimonial method” consisting of “examples given in narrative form, which a hostile critic would call anecdotal evidence and what an admirer might call documentary evidence, a method analogous to the medical history every good doctor learns to work up on each new patient” (p. 244). James, like Gawande, was a physician. Richardson (2010) expands this description of James’s technique: “Readers have the feeling they are hearing one witness after another give personal testimony. Each is allowed his or her own voice for his or her own experience” (p. 145). The result is a constantly shifting point of view that coalesces into an argument made more undeniable by its pluralism.

“You’d think people would have rebelled,” Gawande writes, about contemporary care of the dying. “We haven’t, though, because we find it hard to believe that anything better is possible for when we are so weakened and frail that managing without help is no longer feasible. We haven’t the imagination for it” (p. 79). The singular force of Gawande’s testimonial method—his storytelling—is to restore a sense of imagination. Stories, woven together so that each reinforces the others, might give rebellion a sense of purpose and direction. As Richardson (2006) says of William James’s form of argument, “Such a cloud of witnesses and such a crowd of narratives are not easily brushed aside, silenced, or answered” (p. 414). At best, the reader adds his or her own stories to the crowd, reinforcing its strength.

Confusion and Truth

“Sometimes,” Timothy Holt writes about medical practice, “I find myself in a situation so confusing that the only thing to do is tell the truth, I think” (171). That tag line, “I think,” is one opening to the dialogical quality of Holt’s writing. The best medical writing develops a tension between the physician’s need both to act and to project certainty about that action, yet undercutting this, the pervasive uncertainty of clinical work. This uncertainty begins in the chaotic overload of being a medical resident: “I’m worried about one patient who might be hemorrhaging, another who could be going septic, and still another who simply isn’t getting better for reasons no one understands. I’m worried that there might be yet one more on my list that I should be worrying about, but try as I might I can’t recall which one that might be. It’s unlikely I’ve eaten since five that morning. My feet probably hurt. I know I’m tired. Details blur” (p. 2). Descriptions of such moments are conventional in medical-training narrative, but then something distinctive happens. The part of

Holt's consciousness that was a creative writer before becoming a doctor is able to observe: "*This is not narratable*" (p. 2). Holt evokes a medical version of what I have called, referring to stories about being ill, the *chaos narrative* (Frank, 2013): the immersion of consciousness in a condition of not-being-narratable; an anti-narrative.

The narrative problem confronted by the writer Holt—now a decade past his residency training—is how to shape narrative out of what was not narratable, while keeping the fundamental non-narratability at least in the background of the reader's awareness. A further writing problem is ethical, how to avoid "making a spectacle of somebody's suffering" (p. 4). That, Holt observes, is bad not only for patients, but for writers as well.

The nine stories that make up *Internal Medicine* would be easily readable as fictional short stories, but what takes place is not imaginary; these things happened. Holt's memorable description of the genre he fabricates is that the stories are "assemblages drawn from a variety of sources, compiled from multiple cases, transformed according to a logic not of journalism but of parable, seeking to capture the essence of something too complex to be understood any other way" (p. 4).

Gawande's narrative logic, even at its most personal, remains journalistic. Holt's interest is in watching "the narrator of these pieces evolve into someone else" (p. 4), that someone being, presumably, Holt himself as the present-time writer and practicing physician, although we do not see him in the present. Thus, when I wrote earlier that Holt's narrations are dialogical, the sustained dialogue that unifies the stories is between the different narrators of the stories. I found myself imagining what each might say to one of the others, what assurance or comfort he might offer, because most of the doctors who are first-person narrators of these stories need both assurance and comfort.

In the later stories, Holt's narrator has become one of the senior residents who once supervised his younger self, but uncertainties have intensified. The uncertainty is more fundamental than matters of what tests to order or what standard of care applies. The issue is how to tell a true story. "In any war story," Tim O'Brien (1990) writes, "but especially a true one, it's difficult to separate what happened from what seemed to happen. What seems to happen becomes its own happening and has to be told that way" (p. 71). Holt is writing war stories about medicine. Telling a true story is essential to being a good doctor.

Holt's stories could be read separately—each is self-contained—but as arranged in the book, their sequence creates a *Heart of Darkness* journey. As the stories progress, more is at stake in the need to make sense of what happens, because what happens is more unfathomable. The narrators, while never unreliable, struggle to hold more complexities together within a single narrative. The stories' apparently transparent naturalistic style eventually has the effect of reminding us that as clearly as we see what we see, there is more that we are *not* seeing, and that complicates what we think we *do* see. Many of the plots involve a reversal of an initial evaluation; in one story, a patient whom Holt (or, Holt's narrator persona in this specific story) "hates" (p. 136) turns into someone with whom he is willing to cross a boundary of personal disclosure. He not only shows her pictures of his children, he tells her their names. In another story, a diagnosis that seems certain proves wrong; not mistaken, just not what happens. In another, a symptom that defies diagnosis turns out to be so unexpected that the initial confusion was justified. What elevates these reversals beyond standard storytelling technique is how their accumulation in the progression of the stories affects the reader's identification with the narrator as someone confronting, in narrative, the problem of making sense of life.

It is commonplace to notice that as life is lived, humans endow what happens with a narrative shape, but as actors in any present moment, we have no idea where the plot is leading. Expressing that sense of being in the moment, compelled to act but unsure where events are going, is, I think, what makes Holt's stories matter. His reader's identification is with how the narrator's vision is limited; they can see only so far. So they miscalculate. They worry about what they cannot yet (or maybe ever) make sense of. They worry about what they are not seeing at all.

"You can tell a true war story by the way it never seems to end," O'Brien (1990) writes. "Not then, not ever" (p. 76). Holt's stories never end, in O'Brien's sense. The ending of each story is provisional, as that narrator morphs into the next narrator. The maturing physician-narrator certainly learns, but the progression is not linear. Dialogue upsets any claims of teleology.

Why read Holt? If that question were asked about Gawande, a specific answer could be given: we read to learn how badly too many people die and to imagine better ways to organize dying; we read to learn to demand new institutional possibilities. Holt also teaches his readers to learn to imagine, but what he seeks to imagine goes well beyond medical institutions—although Holt can be usefully read as an ethnographer of

hospitals, and in my own future writing on health care, I will probably quote his observations.

For the present purpose of understanding something about how narrative works, I believe Holt's medical storytelling has a fundamental purpose shared with all storytelling. As he tells us in his introductory pages, he tells his stories to make sense of who he is. What elevates that above being cliché is how effectively Holt evokes being someone unhinged by the non-narratability, the chaos, of his experience. Regaining a sense of himself is a matter of survival. We who attend to Holt's stories learn, by a kind of osmosis, something about the multiple narrators whom any human calls *myself*. Hospital residency may, like war, be life at its most intense, but the difference from any other life seems more quantitative than qualitative. Life is always about restoring narratability to what seems unending chaos.

In the story that may be Holt's most confessional, a hospice nurse with whom the narrator is visiting patients asks the narrator, based on how he failed to act when they saw this patient before, "Are you going to show up this time?" (p. 185). The complementary question is when the patient asks him if he is afraid of her (p. 191). These questions cut through all the confusions to tell a fundamental truth about how to live. As Holt tells enough truth to ask these questions of himself, those who show up to hear his stories ask the same of themselves.

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