Literature, Humanities, and the Internist

Literature can be intimidating to anybody, certainly to those of us whose backgrounds are largely scientific. But this need not be so. If we dredge our memories, most of us can recall a time, in youth if not since, when we greeted books and stories with anticipation. To do so again is to gain gratification, to participate more fully in the world, and to become a better internist.

The essay by Charon and associates in this issue (1) discusses in considerable and illuminating detail both the formal study of literature in medical schools over the last 23 years and related developments. As worthwhile as the endeavors chronicled by these authors are, many resident and staff internists still feel inadequate as reader-interpreters of novels, poems, and stories. Why is this so, and what can be done about it?

We all carry the weight of our experiences with the worst English teacher to whom we have been exposed, the teacher who foisted such ridiculous but durable notions as that of "figuring out" a poem, of finding the "right" interpretation of it, or, worst of all, of reading as duty rather than as immersion in soul-satisfying, gripping, exciting, rebellious, or underground stories. Although many of us also had wonderful teachers of literature, damage from pedants—along with the tremendous and recurrent problem of finding time and energy amid the busy life of practicing medicine—has assaulted the habit of inviting books into our lives on a daily basis. This frame of mind can increase an unfortunate and unjustified suspicion when one notes that Charon and colleagues' paper about literature has the word 'clinical' in its title, and yet only two of its seven authors are physicians. Among its 149 references are many from the profoundly alien realm of literary criticism, some with titles incomprehensible to almost every internist.

Physicians are also ill at ease because of experiences during their years of professional schooling. Even if the decision to pursue medicine sprang not from technical orientation but from an attraction to the abundant interpersonal and social elements of medicine, one usual consequence is a distancing from narrative reading and writing. Another result is greater comfort with the concreteness of science than with the ambiguities of the humanities. One of us remembers thinking, joyfully, that with matriculation in medical school he would never have to write another literary analysis.

How, then, can we become at home with books and stories? First, we can regard the paper by Charon and associates as the *Harrison's Principles of Internal Medicine* for literature and medicine, that is, as a scholarly compendium full of important theory, basic science, and practice, an invaluable reference not meant for wholesale, cover-to-cover absorption in the short term. This granted, we can allow other sources, such as papers in the *Annals* series The Internist's Reading (2) and this editorial, to provide the humble but practical guidance of a *Washington Manual of Medical Therapeutics*.

A key element to the enjoyment of books is confidence about one's perceptions of and reactions to books, without reference to literary critics. Our experience as readers, and as teachers of literature and medicine, has consistently been that stories engage readers. If one wants orientation and background about a writer, the straightforward accounts in such reference works as the multivolume *Contemporary Authors—New Series*, available in many nonmedical libraries, serve this function. Nothing that a critic can say will undo the reader's personal, unprepared, and valid response to a story or poem.

As a first step, we recommend sampling many small, manageable works; completion and mastery are important elements of the satisfaction to be found in books and stories. Short stories are especially well suited to the half hour that may be at one's disposal of an evening, and our reference list provides a minute sample (3–5). Accounts and stories by physicians are especially likely to hold our attention (6–11), but don't stop there. Some anthologies are particularly convenient (12, 13).

The decision whether to buy books or borrow them from the library is a difficult one. For some, the comfort of being able to keep the book and even to write in it (something that one of us has nearly cured the other of doing) justifies spending the money. For others, a test drive from the library, or the habit of not acquiring, minimizes household clutter, particularly if the threshold for purchase is kept high. Even such preferences as ours for hardcover rather than paperback books need not be regarded as banal and can be dealt with if made explicit.

After reading, talking about stories is crucial. Discussion can be informal and extempore, and need not be any more pretentious than conversation. Although time constraints are a barrier, a reading group provides a wonderful opportunity for discussion. Having nonmedical members is vital. Physician and nurse colleagues, office support staff, patients, and family members can all illuminate and challenge one's perceptions of a book. Every person for whom one feels any respect or affinity at all is a suitable discussant with whom to enjoy the sharing of a story.

Let's get literature off its high horse. We advocate that books, stories, poems, and plays be enjoyed on one's own terms, that is to say, without enslavement to the pronouncements of any party besides the writer and the reader. If internists can regard and use stories on these terms, books will constitute not another burdensome demand on the overextended self, but an enrichment both of personal life and pleasure and, yes, as Charon and colleagues assert from experience and from the

limited data at hand, more humanely attuned physicians.

Henry Schneiderman, MD
Rosemaria Memoli Schneiderman, BS
University of Connecticut Health Center
Farmington, CT 06030-3950

Requests for Reprints: Henry Schneiderman, MD, University of Connecticut Health Center, Farmington, CT 06030-3950.
Current Author Addresses: Dr. and Ms. Schneiderman: University of Connecticut Health Center, Farmington, CT 06030-3950.

Ann Intern Med. 1995;122:618-619.

References

1. **Charon R, Banks JT, Connelly JE, Hawkins AH, Hunter KM, Jones AH, et al.** Literature and medicine: contributions to clinical practice. Ann Intern Med. 1995;122:599-606.
2. **Verghese A.** The internist's reading: one kind of 'success.' Ann Intern Med. 1994;121:821-2.
3. **McIntyre VN.** Of Mist, and Grass, and Sand. In: McIntyre VN. Fireflood and Other Stories. Boston: Houghton Mifflin; 1979:25-46.
4. **Singer IB.** Neighbors (1969). In: Collected Stories of Isaac Bashevis Singer. New York: Farrar Straus & Giroux; 1982:592-9.
5. **Mitchell J.** Mr. Hunter's grave. In: Mitchell J. The Bottom of the Harbour. London: Chatto & Windus; 1961:89-132.
6. **Aoun H.** When a house officer gets AIDS. N Engl J Med. 1989;321:693-6.
7. **Chekhov AP.** Heartache. In: Yarmolinsky A, ed. The Portable Chekhov. New York: Viking Pr; 1986:118-25.
8. **Chekhov AP.** Eleven Stories. London: Oxford Univ Pr; 1975.
9. **Williams WC.** Jean Beicke. In: The Doctor Stories. New York: New Directions Paperbook; 1984:158-66.
10. **Devassy KS.** The empty times. JAMA. 1989;261:2699.
11. **Verghese A.** The agent of his death is a white woman. The Black Warrior Review. 1991;17:118-25.
12. **Kohn M, Donley C, Wear D, eds.** Literature and Aging: An Anthology. Kent, Ohio: Kent State Univ Pr; 1992.
13. **Cole TR, Winkler MG, eds.** The Oxford Book of Aging. New York: Oxford Univ Pr; 1994.

Identifying Ethnicity in Medical Papers

"Be not the first by whom the new are tried, Nor yet the last to lay the old aside." Pope aimed his couplet (1) at literary criticism in the 18th century, but it makes sense for medicine in the 20th century. Be not the first to recommend to patients a new treatment with value not established by a rigorous clinical trial. Be not the last to discard antique habits of practice. An example of this second fault is the subject of the "Perspective" essay by Caldwell and Popenoe (2) in this issue. For years, medical students have been taught, with good reason, to systematically record every fact ascertainable from a patient, no matter its final relevance or irrelevance to deducing the diagnosis or selecting treatment. To show their thoroughness in history taking and physical examination, they have generally been expected to trot out all of these details when presenting cases. Among these details has often been a term for the patient's "race." Hence, a case presentation would typically open with a description like "This 69-year-old black male came to the clinic with a chief complaint of . . . ." As Caldwell and Popenoe point out, what is the listener to make of the statement, as in this example, of "black"? What value does such "racial" designation have for diagnostic analysis in most cases? In rare instances, it might be a clue to the genetic determinant of a disease, as with sickle cell anemia, but even in such cases, far more convincing markers than skin color for genetically determined diseases are now likely to be available. Perhaps more frequently, a "racial" term might be a clue to some nongenetic risk factor for a disease. In such cases, specific inquiries into potential risk factors are much more likely to be fruitful. Caldwell and Popenoe emphasize this point by recommending that simplistic "racial" terms such as "black" and "white" be dropped and that more attention be paid to detailed history taking that can yield "invaluable information" on "ethnic background and possible risks for certain diseases" and "potentially important cultural information."

Caldwell and Popenoe's analysis is just as relevant to case reports for publication as to oral presentations. Efficient and effective scientific prose proceeds with "precision and brevity," a phrase coined in another field (3) but relevant to medical writing. Readers of case reports wish to have only what they need to know and no more. They need a presentation of the facts that were efficiently relevant to diagnostic analysis of the case or to therapeutic decisions. They do not need details that simply represent old habits in the ritualistic presenting of cases. A case report properly prepared for publication will not open with a "racial" or ethnic term unless a fact represented by that term was crucial to decisions in the case. Facts representing apparent influences on the patient's problems from genetic or cultural factors related to the patient's ethnic background will be stated as specific facts and not left to be possibly inferred from an ethnic term.

You may be asking, why quotation marks around *race* and *racial* and not around *ethnicity* and *ethnic*? The concept "race" was derived from taxonomic concepts long applied in botany and zoology. As one medical dictionary (4) puts it, a "race" is "a subspecies or other division of a species." But taxonomic assignments require precise and detailed descriptions that justify creating taxonomic categories. Three longstanding traditional categories of "race" (4) have been "Caucasoid (white), Negroid (black), and Mongoloid (yellow)." Unfortunately, as the same dictionary points out, "a limited range of visible characteristics [of "races"] tends to oversimplify and distort the picture of human variation." The concept of "race" implied a degree of genetic homogeneity among persons designated as members of a "race." Modern genetics has trashed that view (5). As one detailed discussion (6) concludes, "Although estimates of [the amount of genetic variation in human populations] vary, all agree that the amount of variation within any ethnic group is much greater than the difference between groups."

From these and related considerations, thoughtful judgments (5–8) have concluded that "race" has little or no