The philosopher Emmanuel Kant wrote that the human dilemma is to exist as an object within nature and a subject outside of it. This idea inspired the creative writing exercises that comprise our biweekly inpatient narrative medicine rounds.

During these rounds, we take a four-part approach to writing about the clinical encounter. First, we read a selection from a notable physician-author. Second, we analyze the piece, discussing how and why it “works” and attempting to extract formal, practical principles. Third, we directly apply those principles in a short writing exercise in a similar form and style but using material drawn from personal clinical experience. Finally, volunteers share their writing with the group.

We choose our selections from three major literary forms: poetry, fiction, and memoir. Authors have included William Carlos Williams, Anton Chekhov, Rachel Naomi Remen, and Lewis Thomas, among others. Occasionally, we will read nonphysician writers, such as the poets Jane Kenyon and Anna Swir, when the subject or style is relevant.

In our discussion, we try to stick close to the text, highlighting specific elements that are so integral that they go unnoticed. For example, we have copied out a poem as a single line of text to explore the importance of its very shape on the page; tracked the central theme of a memoir through several deceptively rambling paragraphs, and explored the way that barely perceptible shifts in authorial voice can lead to major changes in perspective.

Of course, the techniques of literary analysis can also be applied to clinical practice, and our discussion sometimes takes this turn, resulting in surprising glimpses at the narrative essence of medicine. The literary analysis of a history and physical (H&P), for example, is a rewarding exercise that invariably reveals all sorts of hidden mechanisms at play.

The group is thus “primed” by reading and discussion, and we find that the writing flows most freely at this point. The depth and quality of what can be produced in a mere 10 or 15 minutes is always impressive and serves as a concrete illustration to the group of how the different literary forms exist to allow the expression of different sensibilities and facets of experience.

This particular format has proved successful for a number of basic reasons. Rounds take place during an inpatient adult medicine rotation, where the biomedical emphasis is primary and the emotional experience is intense; creative writing provides a forum for the expression of feelings and conflicts that arise in the course of patient care but have no other formal outlet.

The highly structured aspect of narrative medicine rounds is ideal
for those uncomfortable with creative writing, particularly in forms such as poetry, with which they may have little or no experience. Our model offers a procedural approach that, while putting few limits on subject matter, puts strict limits on form. Think of it as the “see one, teach one, do one” approach to creative writing.

Rounds are varied and fast paced, lasting about an hour, and designed to engage a group of residents and medical students with often vastly differing degrees of familiarity with literature. Those who dislike writing may benefit from the readings. Others may prefer to participate in discussion. And, we have found that, as often as not, those who seem to have the least to say will surprise everyone with the most striking pieces of writing.

On a deeper level, however, we believe that narrative medicine rounds are important for reasons relating to the nature of medical education and its attendant objectification of illness.

Medical students undergo an intense process, as much cultural as technical, of learning to apply the scientific method to the human body and experience. They learn through dissection and experimentation that there is a universal structure and function underlying each individual, that every living being is ultimately subject to the same biochemical laws, and that a medical diagnosis arrived at by objective reasoning should be generalizable to all patients with similar symptoms and findings.

By the time they graduate, a group of medical students presented with the same patient will ideally come up with the same diagnosis and treatment. This process of standardization intensifies in postgraduate training, where residents refine the skill of summarizing cases in the highly structured form of the H&P, written, of course, in the passive voice. To a large extent, this is all desirable, and a resident’s ability to identify and summarize objective medical information from a complicated human story is an excellent marker of progress.

Clinical objectification, however, while essential to medical practice, can be alienating both to doctors—who seek meaningful connections with patients as part of the reward for their work—and to patients—who want to be treated as subjects, not objects, during a time of personal vulnerability. Indeed, family medicine as a discipline was founded partly in reaction to the impersonal, reductionist, fragmented approach to illness that results from an overly scientific view of medicine.

The patient’s dilemma, then, to paraphrase Kant, is to exist both as an object and a subject within medicine. Consequently, one approach to the alienation caused by an overemphasis on clinical objectification is to correct the imbalance by some overt process of clinical subjectification—not to dilute the science, in other words, but rather to cultivate the art.

Art, after all, deals with subjects, not objects. While the term “the art of medicine” is often used to refer to situations of unfortunate indeterminacy (i.e., what drug to prescribe in the absence of good evidence), we prefer to think of it as that essential part of medicine that involves connecting with the patient as an individual subject—where the task is to identify, evaluate, and respond to those aspects of the clinical encounter that are important, not despite, but by virtue of, their uniqueness to the patient at hand.

This, then, is where we locate the deeper significance of inpatient narrative medicine rounds. They provide an arena for subjectification in an environment that emphasizes objectification, teaching clinicians to treat patients as subjects of their art as well as objects of their science. In so doing, they provide a glimpse of the power of medicine, when practiced with attention to this duality, to bring within reach E.M. Forester’s difficult and understated exhortation: only connect.

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