Enthymema XVI 2016

The Shock of Attention

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Abstract

Narrative Medicine is a clinical practice, a scholarly field, and a site of intensive research worldwide. This essay describes the inauguration of the field of narrative medicine in 2000 at Columbia University in New York, NY, USA and the principles and practices that have devolved from the initiating work. Clinical implications of narrative concepts of health care as learned from actual medical practice are described. The three movements of narrative medicine—attention, representation, and affiliation—are explored as means of engaging participants in creative acts of discovery and relation. Examples are provided of narratively-informed teaching and health care practice. Conceptual frameworks from aesthetic theory, phenomenology, literary and narrative theories, and cognitive sciences are advanced to portray the integrated study of individuals-in-the-world made possible by contemporary narrative medicine thought. Emerging concepts of enchantment, embodiment, and enactivism suggest future directions for the field.

Keywords

Narrative medicine; attention; representation; affiliation; creativity; intersubjectivity; enactivism; embodied mind

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1. Introductory Scenes

A first-year Columbia University medical student, Andrew Chen, stands in front of Max Beckmann's surreal *Bird's Hell* at the Metropolitan Museum of Art as part of his required course in Narrative Medicine (Beckmann, Chen). He describes what he sees: a "grotesque portrayal of torment and violence." A man is being sliced open by a large bird, who itself seems to be being wounded by the blade it wields; a four-breasted woman erupts from a giant bird shell. A big laughing bird eats a smaller bird alive. Mr. Chen calls it a "location of perpetual suffering." He may or may not know that the German Beckmann wrought this 1938 work as an allegory of Nazism, having been forced to flee from Hitler's persecution of "degenerate" artists. One way or the other, the student finds himself, without having meant to, coming to an awareness of the lived reality of his suicidal patient always seeking means to harm herself. In front of this painting, he sees something about his patient he could not otherwise see.

A group of social workers, nurses, physicians, and writers, most of them strangers, brainstormed in a narrative medicine workshop on means to improve health care team collaboration. I read with them the first page-and-a-half of Michael Ondaatje's novel *The English Patient*—the scene-setting in which Hana the nurse cares for the fatally burned pilot in the abandoned post-WWII Italian estate, an excerpt of which I reproduce here:

> She stands up in the garden. She has sensed a shift in the weather. . . . She turns and moves uphill towards the house. . . . She turns into the room which is another garden—this one made up of trees and bowers painted over its walls and ceiling. The man lies on the bed, his body exposed to the breeze.
>
> Every four days she washes his black body, beginning at the destroyed feet. . . . She has nursed him for months and she knows the body well, the penis sleeping like a sea horse, the thin tight hips. Hipbones of Christ, she thinks. . . . She puts her hand into her pocket. She unskins the plum with her teeth, withdraws the stone and passes the flesh of the fruit into his mouth.
>
> He whispers again, dragging the listening heart of the young nurse beside him to wherever his mind is, into that well of memory he kept plunging into during those months before he died. (3-4)

As we talk about the text, my readers recognize the doubly ironized Edenic scene, the inside-out Christian iconography, the innocent erotics of clinical care, the blasted well of memory. I give them a writing prompt—"Write about a room of care"—and each one falls into his or her own well of memory, going without friction to the bedside of a patient 20 years ago, to the aftermath of a recollected childhood tonsillectomy, or to yesterday's session of a decade-long psychoanalytic treatment. Clustered in groups of 4 or 5, they read to one another what they wrote, recognizing the forms and moods and plots of one another's texts. They experience the startling ease of discovery through writing, bringing with it a lucky and rare chance at intersubjective contact.

These examples of Mr. Chen's seminar at the Metropolitan Museum of Art and my workshop on health care team collaboration demonstrate some of the methods and goals of narrative medicine. Following a brief account of the rise of this field, I will suggest some of the principles that underlie this work and some emerging directions at the boundaries between medicine and narratology in which the field is heading.

2. The Rise of Narrative Medicine

Medical Humanities and Literature and Medicine arose in the early 1970s, bringing ways of knowing from the humanities into contact with clinicians and clinical trainees. Early on, we felt it an accomplishment to assign a Chekhov story in a medical school course or to read a poem at attending rounds in the hospital. On the background of this early work in literature and medicine, my practice of general internal medicine at Columbia taught me how much I needed to learn about how stories work, and I was happy that the Columbia English department accepted me into their doctoral program. As my knowledge of a Jamesian and psychoanalytically-inflected narratology deepened, my clinical practice and my teaching in the medical school were transformed. My patients and I found new ways to understand one another through complex forms of writing together. I would write down what I had heard a patient tell me and then ask the patient to read what I wrote, in effect asking, "Did I get it right?" Several things would happen when a patient read what I wrote. Usually, he or she would correct things I had gotten wrong in my written representation of the patient's account of illness. But then, often, the patient would say, "We left something out." And then I would learn about deaths, loss, or trauma. A stillborn child had never been grieved. A fire destroyed the childhood home of a patient in South America. Sometimes, I'd learn about gifts and strengths—a time in prison on drug charges produced volumes of poetry. A film school assignment had led to a statement of self of a young cinema student. A so-called "dual diagnosis" psychotic young man—in addition to his

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mental illness, he had been a heroin user and heavy drinker—found Jesus, stopped all his substance use, and became able to live peacefully with his persistent auditory hallucinations.

Some of my colleagues began to recognize similar shifts in their clinical practices. Unlike the more academic model of medical humanities, what we were doing felt like a clinical discipline, for the humanities-inflected work *changed* what came to matter in a patient's care. In 2000, I coined the name "Narrative Medicine" to signify this work, being careful to choose a name that would not immediately drive away my clinician colleagues the way the word "humanities" could—humanities, humanism, humanitarianism, humane were all clumped into a category of "soft stuff" back then. By publishing papers about this fresh frame for clinical work in the medical journals, we tried to legitimate the inclusion of narrative knowledge and methods within a health care practice. (Charon 2001, DasGupta et al, 2006)

A group of scholars, clinicians, and writers joined with me in 2003 to think systematically about why literary and narrative work in clinical settings might help clinicians and their patients. With funding from the National Endowment for the Humanities, we met regularly over 2 years to take up these questions. The group included Victorianist and cinema scholar Maura Spiegel, phenomenologist Craig Irvine, novelist David Plante (replaced by novelist Nellie Hermann when Plante moved from New York), pediatrician and activist Sayantani DasGupta, psychoanalyst Eric Marcus, graduate students Rebecca Garden and Tara McGann, and patient advocacy student-intern Patricia Stanley, all of us engaged in some way with writing about and teaching humanities and medicine.

We taught one another theoretical frameworks from our disciplines that shed light on our questions—D.W.Winnicott on play and reality, Adam Smith on moral sentiment, bell hooks and Paulo Freire on liberatory teaching, Maurice Merleau-Ponty on the body, Henry James on the novel. Intersubjectivity, social justice, embodiment, relationality, reflexivity, creativity, and doubt were the signal concepts we worked with, while close reading and creative writing became signature methods of our work. We conceptualized and undertook research projects to learn about the consequences of this work in various settings (DasGupta and Charon 2004; Sands, Stanley, Charon 2008). With the inspiration of a number of consultants doing stellar work in medical humanities elsewhere, we emerged with a conceptual framework that focused on the development of attention, the necessity of writing or other forms of representation, and the ultimate goals of affiliation with patients, colleagues, society, and the self. By designing and teaching graduate courses and intensive introductory workshops for clinicians, we honed our original theoretical notions into a systematic and coherent set of principles and practices (Charon 2006). These have since been borne out in practice.

Since then, this work has evolved outward, inward, and depthward. (Irvine; Heiserman and Spiegel; Charon 2011; Spencer; Charon, Hermann, Devlin; Charon, DasGupta, Hermann et al). Our confluence of primary care medicine, narratology, literary theory, and phenomenology has evolved into a fluid, international, many-sourced convergence of thought and practice. From quarters as diverse as Zen Buddhist contemplative practice, relational psychoanalytic theory, and postcolonial theory, we and our colleagues have articulated rich, provocative, bottomless challenges to the current injustices and failures of health care (Lewis, Schafer, Tsevat). Our narrative medicine project at Columbia, initially funded by the National Endowment for the Humanities and subsequently by the National Institutes of Health and the Josiah Macy, Jr. Foundation, has matured into required curriculum in narrative medicine in all four years of Columbia's medical school, a Master of

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Science in Narrative Medicine degree at Columbia University, interprofessional education for students and faculty from 8 of Columbia's schools and programs in the health professions, thousands of persons trained in the basics of narrative medicine at intensive workshops at our medical school, a low-residence certification program soon to launch for distance learning, national and international partners working with us worldwide to develop narrative medicine programs elsewhere, and productive collaborative contact with groups far outside health care who find in the principles and practice of narrative medicine something of value.

By no means a unitary field by now, narrative medicine has come to stand for a set of convictions and methods that fortify clinical practice with narrative skills to listen, to recognize, to witness, and to be moved to action on behalf of patients through close attention to their situations. We hope that our underlying commitments to attention, representation, and affiliation continue to guide others who join us in this effort to improve patient care through strengthening clinicians' narrative capacities.

3. Interior Interlude

I have been thinking lately about the underneath of my work. While teaching internal medicine and narrative medicine (sadly, they are not yet synonymous) and caring for patients, I have come to see, gradually, the ways in which my own evolving narrative skills have exposed the world to me. I go through days now simply *seeing* more than I used to see. The steady habits of attention and representation, born of narrative practice, have grooved into my ways in the world. I accept invitations from far and near to facilitate narrative medicine seminars and workshops, because every time I teach narrative medicine, I get to write myself. I might bring a poem, a paragraph from a novel, or an operative note dictated after surgery; or I might show a series of Salgado photographs, maybe a pair of Cézanne card players, a few savage Hoppers. I might play a recording of Gershwin's "Rhapsody in Blue" or the slow movement of Schumann's violin concerto in D minor. We talk about what we see, what we notice, what we wonder about. And then I give a writing prompt, an invitation created to expand the mind, with around five minutes in which to write. At the close of our silent minutes, many participants are eager to read aloud what they've written. They've surprised themselves into writing, and they then become one another's readers, able always to help the writer to recognize what he or she has discovered in the act of writing. Thus is created an intersubjective space of recognition, a demonstration of creativity, and always a narrative discovery of self and other. When done longitudinally, these narrative medicine seminars develop into clearings of safety and trust where colleagues or classmates experience mutual respect that "spills out" onto the ward, into student life, and toward self-making. It becomes a part of life.

In ways that I have had to live through to understand, I see now that my own narrative-medicine-prompted writings constitute a record of perception that in turn stirs a round of experience. Writing about an experience, no matter how far or near in time, enables one to *undergo* it, or at least to experience it anew. Not a journal, not a diary, not bits of an essay, each of these spontaneous compositions, written in the shadow of a great text or image or composition and surfaced through an exposing contact with others who share my commitment to discovery stands as a fragment of an increasingly powerful miscellany of self. Subtending the practical clinical routines of narrative medicine practice, the scholarship and research, the teaching, and the moves toward social justice that our work entails lies the mysteriously powerful individual-facing-the-world/world-engaging-the-individual

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capacity to be embroiled in the moment; to not squander any aspect of what is given; to be alive to the time, space, sound, sense, words, line, and beauty of the beheld; and to do this all with others who are doing the same thing. The dividend is not only to sense the worth and the cost of this thing we call living but also to catch a glimpse of its meaning.

4. Attention, Representation, Affiliation

The skilled perceiver—whether of a painting, a poem, a partita, or a patient in the Emergency Room—exposes what can be observed in one act of witness. Shocked into attention, the observer achieves what Husserl named the phenomenological reduction, whereby the "natural attitude" of unexamined assumptions is bracketed away, leaving the beholder radically fresh to undergo an unsullied experience of the beheld. Required in aesthetic, creative, and clinical work, such heightened attention invests the observer in the fate of the observed, donating the presence of that observer to reveal what is to be seen or heard. Abstract expressionist Mark Rothko has a name for the state of the witness's attention: in the gallery notes posted at London's Tate Modern installation of Rothko's Seagram murals, Rothko explains that he insists on dim lighting and proper seating where his paintings are displayed so that viewers can achieve a state of "absorption." Absorbed in his or her acts of looking, wondering, interpreting, the viewer "absorbs" the painting itself, almost like an act of ingestion. The paintings, when granted full absorption or attention, become a part of self, while the witness contributes to the on-going life of the work.

John Dewey insists that such acts of perception *constitute* experience. In *Art as Experience*, Dewey proposes that aesthetic events are transformative eruptive events that change the viewer. We do not passively gaze at or listen to great art; rather we are crucibled in our entanglements with them. "Perception . . . is an act of reconstructive doing, and consciousness becomes fresh and alive. *This* act of seeing involves the cooperation of motor elements . . . as well as coöperation of all funded ideas that may serve to complete the new picture that is forming. . . . Perception is an act of the going-out of energy in order to receive, not a withholding of energy" (Dewey 54-55, italics in original). When done intentionally—having put into place Husserl's phenomenological reduction—the perceiver is exposed to the matter of the art, its creator, and reflexively to the one doing the perceiving.

This helps to explain the clinical transaction. When done properly, the witness—the doctor, nurse, social worker, physical therapist, clinic secretary—is wholly present. The state of attention, like Rothko's absorption, heightens the witness's availability to the patient. During their transaction, nothing exists for the clinician but the situation of the patient. Freud's "evenly hovering attention" is not reserved for the psychoanalyst but is achievable by any clinician properly trained to respond to the call of the sick person. My team's exploration of the narrative dimensions of health care has convinced us that the clinician's absorption in or attention to the situation of the patient is akin to the close reader/observer's experience in front of a text or an image or the close listener's transport by a piece of music. The "receiver" of text, vision, or sound takes in, engulfs, accepts, does not turn away from that which is being perceived, thereby igniting the process itself of perception. Such a form of reception of what patients unveil is what we hope to achieve as clinicians.

The next step in this process requires creativity. One does not perceive something until one represents it in some medium—words, painting, sculpture, movement, music, maybe dream. Philosopher and aesthetic theorist Nelson Goodman writes, "The object as we look upon or conceive it [is] a version or construal of the object. In representing an object,

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we do not copy such a construal or interpretation—we *achieve* it" (Goodman 9, italics in the original). Representation here refers to the conferring of form on an erstwhile formless experience. Goodman asserts that the act of conferring form on the perceived is what makes the perceived visible, either to the one seeing it or others who can now learn about it, not as a "copy" in the mind that is filed away for future reference, but as a creative invention, an artisanal craft, a *something* where there had been nothing, a making, resulting in a drawing, a paragraph, a partita, a poem. Writers and writing teachers know that writing is discovery, that the writer gains access to that which is known by virtue of composing its description. Writing scholar Ann Berthoff's "Learning the Uses of Chaos" explains this concept clearly:

> We don't have ideas which we put into words; we don't think of what we want to say and then write. In composing, we make meanings. We find the forms of thought by means of language and we find the forms of language by taking thought. . . . Meanings do not come out of the air; we make them out of a chaos of images, half-truths, remembrances, syntactic fragments, from the mysterious and unformed. (648)

The perceiver may, then, have a *duty* to represent what is observed or noticed or, in the case of the creative writer, imagined. Maurice Merleau-Ponty writes that "the artist is the one who arrests the spectacle in which most men take part without really seeing it and who makes it visible to the most 'human' among them" (Merleau-Ponty 18). This may be the case with the clinician too, this imperative to "arrest" what is witnessed in the clinic or the hospital ward and to make it visible to those who seek care and those who try to give it. The one who represents what is observed or undergone—whether clinician or artist—produces a unique réalization (the French "réalization," unlike English's "realization," means not just recognizing something but accomplishing, implementing, carrying out—the "réalization" of a movie is done by the film's director. It is to make something *real*.) By coupling attention with representation, narrative medicine recognizes that creative representation toward interpretation and visibility is a necessary part of clinical practice. We insist that our students and trainees write or otherwise represent what they observe, thereby providing them with tools with which to fully perceive it. Narrative medicine's practices of attention and representation spiral toward *affiliation*, the partnerships and mutual commitments that stand as the ultimate goals of health care. Whether with the individual patient, the clinical colleague, the public engaged in health care issues, or the self, this affiliation brings forth the powerful dividends of narrative medicine work.

There is an obligatory social and even intersubjective dimension of representation, for every writer needs a reader. "No object of composition, that is, no work of art, exists in the absence of a spectator," wrote aesthetic theorist (and brother of Gertrude) Leo Stein (Stein 51). Even the most secretive diarist asks himself or herself in another time to function as "surrogate other" to read what has been written. Isolated acts of perception may be accomplished in solitude, but acts of representation remain radically unfinished until they are received in the world by another. W.J.T. Mitchell makes this clear even in the title of his *What Do Pictures Want?*, in which he explores the intrigues, invitations, and sensual to's-and-fro's between an image and its on-looker as well as between an image and its creator. "Like people," Mitchell suggests, "pictures may not know what they want; they have to be helped to recollect it through a dialogue with others" (Mitchell 46). Pictures, or representations, are not just copies. Concepts of mimesis have undergone radical shifts away from the Aristotelian model of being copies of things toward being recognized as autonomous, sensuous, wily, original *supplements* to the initiating stimulus that themselves

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constitute a "real" while calling into question the "reality" of the thing being "copied" (Derrida 141-64, Taussig 44-46). The series of supplements to the inciting thing beheld provides "a sensuous knowledge in our time, a knowledge that in adhering to the skin of things through realist copying disconcerts and entrances by spinning off into fantastic formations" (Taussig 44). Although each copy might well realistically "adhere to the skin of things" being observed, each supplement, coming from a singular observer, cannot help but achieve a fresh, entrancing, even fantastic, view of the thing observed. Such formations are the genesis of knowledge.

5. Enchantment, Embodiment, and Enactivism

Attention and representation may indeed result in entrancing, or enchanting, knowledge. The opposite of entrancement or enchantment, disenchantment is easily enough identified around and within us these days. In early 2016, an enormous billboard occupied the face of a large industrial building on First Avenue around 23rd Street in New York City . The sign had to have been two or three stories high and as wide. The background was painted a deep matte charcoal. A black circle occupied most of the great square. At the very bottom of the circle, in an arc of perhaps 30°, was a slim crescent of moss green. The tag line read: "It is not warming. It is dying."

Such disenchantment or disillusionment—"Don't kid yourself; what is happening to the globe cannot be fixed"—is a routine staple in political and social life. Max Weber's elegy for the enchantment of the pre-industrial revolution world continues to ring true today (Weber). *Believing* that things will improve is ridiculed as naïveté or, worse, proof of having been taken in by the enemy. An example of saturating disenchantment arises in literary criticism. Eve Kosofsky Sedgwick, in *Touching, Feeling*, called for a hermeneutics of reparation to replace what Paul Ricoeur named the hermeneutics of suspicion, the deconstructionist form of criticism in which the critic undoes the text, going after the suppressed, the repressed, that which lies hidden under the surface of the text, exposing whatever the writer was "up to" with or without having known it. In her *Uses of Literature* and *The Limits of Critique*, literary scholar Rita Felski joins Sedgwick in challenging this suspicion-riddled doxa of literary criticism, proposing instead that "reading involves a logic of *recognition*; that aesthetic experience has analogies with *enchantment* in a supposedly disenchanted age" (*Uses,* 14).

Following the lead of Sedgwick and Felski, narrative medicine, too, seeks to replace mainstream medicine's hermeneutics of suspicion with a hermeneutics of reparation. Routine medical language reveals a surprising and unnecessary stance of suspicion—a patient is reported as having "denied chest pain" if she simply said that her chest does not hurt. More fundamentally, the act itself of diagnosis can seem to embroil the clinician in a detective-like enterprise of gathering clues to expose disease, a disease often unbeknownst to the one who harbors it. We "suspect" tuberculosis or HIV in trying to diagnose a fever of unknown origin. This mode of suspicion can carry with it the impression that the patient is trying to hide something from the snooping detective: remember in William Carlos Williams's story "The Use of Force," the febrile little girl fights against the exposure of her diphtheric throat: "I forced the heavy silver spoon back of her teeth and down her throat till she gagged. And there it was—both tonsils covered with membrane. She had fought valiantly to keep me from knowing her secret" (Williams 60).

Instead of a hermeneutics of suspicion, narrative medicine methods allow the clinician to enter the narrative world of patients, trying to imagine what it might be like to live in it,

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accepting the role of guest in the life-world of the patient. And so, when a narratively trained clinician represents a patient's account of illness or even represents that patient's body or mood or behavior, the representational act is accomplished, in part anyway, from the perspective of the subject, seeking not only to report what can be seen by the observer but also to capture something of the patient's lived experience. To do this requires something beyond a reductive replicative observation and report; it requires an intersubjective gamble, letting more than facts travel across that semi-permeable membrane between clinician and patient.

An enchantment is experienced, I submit, by both the observer and the observed when the hermeneutics of suspicion are bypassed. In clinical settings, a diagnostic interview not governed by suspicion becomes a conversation. The bureaucratic or biomedical transaction opens up, retaining room to accomplish the technical tasks at hand while inviting the unpredictable, mysterious, pleasurable experience of making contact with another. I learned to open interviews with a new patient with the simple invitation, "Tell me what you think I should know about your situation." If I listen without writing, typing, or interrupting, chair rolled away from the computer monitor, hands-in-lap and absorptive, I learn exactly what a doctor would have to know in order to be of help. Since the work of medicine involves the patient's body, life, and health, its transactions are by definition characterized by bodily contact, intimate talk about emotions, and discourse (however hedged) about meaning. Although much of mainstream health care, sadly, is conducted without any meaningful interpersonal contact between clinician and patient, narrative medicine routines like my opening question can encourage a deeply personal engagement, mutual investment, bilateral trust, and the willingness to be exposed one to the other. This bilateral engagement—whether with an individual patient, a colleague, or the general public—is what we mean by affiliation, the third movement of narrative medicine. Is it a surprise that the ensuing relationship not only can do effective health care work but also brings both participants satisfaction and even joy? (Charon 2012).

Perhaps the presence of the body in medicine is what will save it from being destroyed by corporate greed and revenue-hungry institutional priorities. Almost all forms of health care—excepting psychiatric and psychoanalytic practices—involve touch of one body by another. Sometimes the contact is painful; sometimes it is invasive; sometimes it borders on the assaultive. Medical touch must be sanitized so as to guard against inappropriateness, and yet, when effective, it retains elements of support, comfort, and recognition. The body of the clinician, though, is typically overlooked. Those who work among the sick and dying can trick themselves into believing that their exposure to sickness will somehow render them immune to illness or death themselves. Mortality exists on the other side of a divide, many convince themselves, even though doctors and nurses do not typically indulge in magical thinking. What would happen if physicians and other clinicians could accept their own bodily frailty, could appreciate and accept their existential parity with their patients? I find that my narrative medicine practice gives me opportunities to learn, from my patients, that I too will become ill and that I too will die. Stabilizing, this gradually dawning realization intensifies the contact the clinician can make with patients. Once achieved, this realization allows the clinician to be present in the medical office or hospital ward as an embodied person, joining the patient—who is by definition present with his or her body and life and health—in equality. The shared predicament of a measured life brings patient and clinician within reach of one another, facing, eventually, the same mysterious end.

How, now, to consider the meeting between the embodied patient and the embodied physician? Help in considering this question comes from a surprising source: the branch

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of cognitive sciences called the embodied or enacted mind. Study of mind, brain, and behavior has exploded since the cognitive revolution of the 1940s released psychology from behaviorism to let it wonder about the mind (Miller). By the 1970s, the more and more sophisticated technological ability to image the brain's structure and analyze its actions allowed cognitive scientists to locate functions in the brain and to map the neural networks that undergird every action from waving a hand to writing a sonnet. Compared by many neuroscientists to a super-computer, the brain was conceptualized as a formidable information-processing input-output machine able to use vast amounts of stored data and signals from sensory perception to inform and guide behavior in a linear or predictable or even programmed way.

A fork in the cognitive sciences road opened up in the 1990s between the so-called representationists and the enactivists. Using a concept of "representation" that differs fundamentally from my use of it in this essay, representationists assert that the brain makes internal cognitive models of the real world, laying them down in memory and consulting these cognitive models as the basis for action. Enactivists propose that the perceived world is experienced by the embodied subject, not by registering, filing, and later consulting with cognitive representations of things and events but rather by moving through the sensate world and acting on the basis of the mind/brain/body's experience of it. In *The Embodied Mind*, Varela, Thompson, and Rosch introduce the term *enactivism:* "We propose as a name the term *enactive* to emphasize the growing conviction that cognition is not the representation of a pregiven world by a pregiven mind but is rather the enactment of a world and a mind on the basis of a history of the variety of actions that a being in the world performs" (Varela, Thompson, Rosch, 9).

A tremendous challenge to the reigning paradigms of the time, enactivism recentered brain studies on the individual person, making his or her way through a world that includes light and sound, touch and movement, beliefs and ideas, love and hate, imagination and beauty. Beyond motor control of one's limbs or the capacity to compute complex calculations, the brain could be conceptualized as one of several actors in the development of contact between an individual and the world. Such concepts allow philosophers, psychologists, physiologists, linguists, and artists to think together about a life of the mind, a life of "its" body, and the creation of a reality birthed between them and the world. That these ideas emerge from within cognitive science, arguably the most authoritative voice speaking today of matters of thought and experience, offers a tremendous opportunity to influence this conversation while directly challenging some of it most fundamental and faulty assumptions. The implications for health care of the shift from representationist to enactivist models of the mind are vast, especially for fields, like narrative medicine, that strive to counter fragmentation and reductionism in understanding human beings' lived experience.

6. Conclusions

In caring for patients or in teaching others to do so, narrative medicine practitioners seek to reconcile biological and experiential phenomena toward an ecological awareness of health and consciousness. Appreciating, as social constructivists, the on-going creation of reality by those embroiled in it, we are on a quest to learn how to recognize the thick, rich, messy terrain of an individual person's life. In effect, enactivist models join with narratological models to make possible a storied grasp of an individual's subjective experience, melding temporal, spatial, sensual, relational experience into a singularly meaningful occurrence. What more important domain for these ideas to achieve influence than in the

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settings of health care, where physical sensations, biological states, mental perceptions, and the existential consciousness are exposed and their meanings sought? Where else do we, finally, confront and live in the shadow of our own deaths?

This moment is worth seizing. The shock of attention opened Andrew Chen to new and consequential dimensions of knowledge about a suicidal patient. The shock of attention moved my health care team members to recognize the gardens in their own lives. Exposure to creativity, like Dewey said, engaged them all in acts of reconstructive doing, acts of making. In the light of post-deconstructive thought of reparation, vanguard thinking in cognitive science, and the mysteries of being beckoned toward enchantment, narrative medicine keeps growing, seeking, learning, never knowing. We welcome others in continuing to create this field of narrative medicine, to be poised to pay attention to what it next reveals, and to be ever committed to the health of patients who seek unified, recognizing, and effective care.

Works Cited

Beckmann, Max. "Bird's Hell." http://www.bing.com/images/search?q=max+beckmann+birds+hell&view=detailv2&qpvt=max+beckmann+birds+hell&id=1D241C10BE6C4259B18F587E8F777A4D8E853DED3&selectedIndex=0&ccid=qiEIBXFG&simid=608019906787479141&thid=OIP.Maa2108057146f40d4914cca0299baac7o0&ajaxhist=0 Accessed 7.23.16. Web image.

Berthoff, Ann E. "Learning the Uses of Chaos." In *The Making of Meaning: Metaphor, Models, and Maxims for Writing Teachers*, 68–72. Upper Montclair, NJ: Boynton/Cook, 1981.

Charon, Rita. "Narrative Medicine: A Model for Empathy, Reflection, Profession, and Trust." *Journal of the American Medical Association* 286 (2001): 1897-1902. Print.

---. *Narrative Medicine: Honoring the Stories of Illness*. New York: Oxford University Press, 2006. Print.

---. "The Novelization of the Body, or How Medicine and Stories Need One Another." *Narrative* 19, no. 1 (2011): 33-50. Print.

---. "At the Membranes of Care: Stories in Narrative Medicine." *Academic Medicine* 87 (2012): 342-7. Print.

Charon, Rita, Nellie Hermann, and Michael Devlin. "Close Reading and Creative Writing in Clinical Education: Teaching Attention, Representation, and Affiliation." *Academic Medicine* 91 (2016): 345-50. Print.

Charon, Rita, Sayantani DasGupta, Nellie Hermann, Craig Irvine, Eric Marcus, Edgar Rivera Cólon, Danielle Spencer, and Maura Spiegel. *The Principles and Practice of Narrative Medicine*. New York: Oxford University Press, forthcoming 2017. Print.

Chen, Andrew. Commentary on *Bird's Hell.* Unpublished essay written for Narrative Medicine Seminar, "Observation and Uncertainty in Medicine." College of Physicians & Surgeons of Columbia University. The author grants me permission to publish this comment on his paper. May, 2016. Print.

DasGupta Sayantani, Rita Charon. "Personal Illness Narratives: Using Reflective Writing to Teach Empathy." *Academic Medicine* 79 (2004): 351-6. Print.

ISSN 2037-2426 – http://riviste.unimi.it/index.php/enthymema

DasGupta, Sayantani, Dodi Meyer, Ayxa Calero-Breckheimer, Alex W. Costley, Gobeira Guillen. "Teaching Cultural Competence Through Narrative Medicine: Intersections of Classroom and Community." *Teaching and Learning in Medicine* 18 (2006): 14-7. Print.

Derrida, Jacques. *Of Grammatology*, corrected edition. Trans. Gayatri Chakravorty Spivak. Baltimore: Johns Hopkins University Press, 1997. Print.

Dewey, John. *Art as Experience*. New York: Berkeley Publishing Group, 2005. Print.

Felski, Rita. *The Uses of Literature*. Malden, MA: Blackwell Publishing, 2008. Print.

---. *The Limits of Critique*. Chicago: University of Chicago Press, 2015. Print.

Goodman, Nelson. *Languages of Art: An Approach to a Theory of Symbols*. Indianapolis, IN: Hackett Publishing, 1976. Print.

Heiserman, Arthur and Maura Spiegel. "Narrative Permeability: Crossing the Dissociative Barrier in and out of Films. *Literature and Medicine* 25, no. 2 (2006): 463-74. Print.

Irvine, Craig A. "The Other Side of Silence: Levinas, Medicine, and Literature." *Literature and Medicine* 24, no. 1 (2005): 8-18. Print.

Lewis, Bradley. "Narrative Medicine and Contemplative Care at the End of Life." *Journal of Religion and Health*. DOI 10.1007/s10943-015-0130-6. Web.

Merleau-Ponty, Maurice. "Cézanne's Doubt," in *Sense & Non-Sense*. Translated by Hubert L. Dreyfus and Patricia Allen Dreyfus. Northwestern University Press, 1964. 9-25. Print.

Miller, George. "The Cognitive Revolution: A Historical Perspective." *Trends in Cognitive Sciences* 7 (2003): 141-4. Print.

Mitchell, W.J.T. *What Do Pictures Want: The Lives and Loves of Images*. Chicago, IL: University of Chicago Press, 2005.

Ondaatje, Michael. *The English Patient*. New York: Vintage/Random House, 1993. Print.

Sands, Stephen, Patricia Stanley, Rita Charon. "Pediatric Narrative Oncology: Interprofessional Training to Promote Empathy, Build Teams, and Prevent Burnout. *Journal of Supportive Oncology* 6 (2008): 307-12.

Sedgwick, Eve Kosofsky. *Touching, Feeling: Affect, Pedagogy, Performativity*. Durham, NC: Duke University Press, 2003. Print.

Schafer, Roy. "Narrating, Attending, and Empathizing." *Literature and Medicine* 23, no. 2 (2004): 241-51. Print.

Spencer, Danielle R. "The Art of Medicine: All Creatures Great and Small." *The Lancet* 386 (2015): 22-3. Print.

Stein Leo. *Appreciation: Painting, Poetry & Prose*. Lincoln, Nebraska: University of Nebraska Press, 1996/1947. Print.

Taussig, Michael. *Mimesis and Alterity: A Particular History of the Senses*. New York: Routledge, 1993. Print.

Tsevat, Rebecca, Anoushka A. Sinha, Kevin J. Gutierrez, Sayantani DasGupta. "Bringing Home the Health Humanities: Narrative Humility, Structural Competency, and Engaged Pedagogy." *Academic Medicine* DOI 10.1097.ACM.0000000000000743. Web.

Varela, Francisco J, Evan Thompson, Eleanor Rosch. *The Embodied Mind: Cognitive Science and Human Experience*. Cambridge, MA: The MIT Press, 1993. Print.

Weber, Max. "Science as a Vocation." In *Max Weber: Essays in Sociology*. Edited by H. H. Gerth, C. Wright Mills. Oxford University Press, 1958. Ch. V pp. 129-158. Print.

Williams, William Carlos. "The Use of Force." *The Doctor Stories*. Compiled by Robert Coles. New York: New Directions, 1984. 56-60, Print.

ISSN 2037-2426 – http://riviste.unimi.it/index.php/enthymema