How to Listen for the Talk of Pain

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Abstract

Complex events occur in the high-stakes conversations between relative strangers that are told and heard in physicians' offices, emergency rooms, hospital wards, and on house calls. The patient has to find the language to first represent and then convey bodily sensations and the meanings tentatively attached to them. Slippery and often unavailable, the expression of this language of pain, of suffering, of doubt, of fear is often, perhaps typically, unequal to its task. Concurrently, the reception by the listener of what is conveyed by the patient is similarly unequal to its challenge. Although I disagree with Elaine Scarry's statement of wholesale failure on this front when she asserts that there is no language for pain, I realize the lengths to which clinicians and patients must travel in order that the patient's corporeal and affective experience be communicated in some way from the one who experiences it to the one who has to diagnose the problem and help to solve it in some way.

I've been teaching clinicians close reading and creative writing in an effort to improve their power of listening to their patients and receiving what they convey. More recently, my colleagues and I have been teaching attentive listening through drama, dance, and visual arts too. If the listener knows the power of features of narrativity—temporality, spatiality, genre, metaphor, narrative situation, desire—he or she might value the message-carrying capacity of all that the patient emits, whether in words, silences, gestures, or bodily signs. By respecting the integrity and epistemic wealth of the patient's meta-language, the clinician might be less likely to be trapped into prematurely categorizing the patient's utterances into restricted diagnostic

categories and more likely to at least wonder what all this might represent and mean. And then, perhaps, there is the beginning of telling about and listening to pain.

What does it take to listen to the talk of pain? The listener has to be open to hearing about suffering, whether or not that listener can offer remedies. To listen to the talk of pain, the listener must walk into the room of pain, not just mentally noting but actively imagining what is being undergone by the sufferer.[1] Leaning forward to understand and assuring that the whole story is told may enable the listener to be in pain's presence instead of being shielded by diagnostic questions and clinical maneuvers. This kind of listening *for* the pain may give patients a greater chance of being witnessed in their struggle toward relief.

How pain exposes deep problems of meaning

Unremitting pain is our contemporary iconic health dilemma. Replacing the infectious disease plagues of earlier centuries and neck-and-neck with the today's coeval plagues of chronic multi-system illness, untreatable pain—cancer pain, war veterans' post-battlefield disorders, and the sufferings of trauma survivors—has become the signature disease of our time.[2] Conflating physical and psychical sources, unremitting pain not only bests our best efforts at controlling it but gives the lie to the mind/body dualism that, until recently, obscured true attention to the problem of pain. Pain is an etiologically democratic force: it does not discriminate among biological disease, the effects of war, the results of trauma, the sequelae of poverty, the result of mental illness, and the consequences of natural disasters. The contemporary opioid addiction epidemic in the United States demonstrates that no class or group is excluded from a risky search for relief of pain, including the pain of boredom and meaninglessness.[3]

Physical, psychical, existential, and oppressive, pain can come, unannounced, to those who have done nothing to deserve it. From forest fires or tsunamis to an osteosarcoma in a ten-year-old, some forms of pain and suffering seem, by nature, to be sacrificial, as if brought either as a test of virtue or a lurid occasion of grace. Other pain seems translational, as if pain becomes the only language for a hurt so deep it is unsayable and unhearable either by the person suffering the pain or by those who might help to mitigate it.[4] More sinisterly, sometimes pain is inflicted as a means of transactional messaging: the beheading of *Wall Street Journal* journalist Daniel Pearl by the Islamic State or the abducting of young Nigerian girls in by Boko Haram are examples of pain inflicted as a means of informational currency in large-scale power conflicts. Finally, some pain is inflicted indiscriminately in order for someone else—for example, slumlords or proprietors of unsafe nursing homes—to reap monetary profit. This is criminal pain.

How we encounter others' pain

> There are many uses of the innumerable opportunities a modern life supplies for regarding—at a distance, through the medium of photography—other people's pain. Photographs of an atrocity may give rise to . . . a call for peace. A cry for revenge. Or simply the bemused awareness, continually restocked by photographic information, that terrible things happen.[5]

Susan Sontag describes the contemporary threat that ubiquitous representations of pain can dull the sensations of spectators to its reality. The bombardment of viewers of movies, video games, and internet sites by graphic depictions of wholesale violence has concerned teachers and psychotherapists for decades; such excessive exposure to other peoples' pain threatens to alter viewers' thresholds for the unacceptable.

In contrast to regarding the pain of others, *witnessing* the pain of others can advance a true acknowledgment of experienced suffering. The Greek chorus in ancient drama enabled theatre-goers to vicariously stand by the victims of violence or pain in the play. Truth and Reconciliation Commissions give citizens the means to bear witness to atrocities done in the name of their country, whether in South Africa in the wake of apartheid or in Canada in response to systemic violence against First Nation peoples. The constant public presence of the Mothers of the Plaza de Mayo on Buenos Aires's central plaza steadfastly kept alive the plight of the 'disappeared' during Argentina military's Dirty War in the 1970s and 1980s. As I jog around Washington Square Park in New York City on a Sunday morning, I pass a group of Quakers standing under the Arch, silently holding signs for peace. They stand there all morning, enacting for those of us enjoying the park the necessity to add our voices and bodies to struggles for justice and the end to war.

Witnessing the pain of others is a reciprocal act. The witnessing can afford relief and recognition for the sufferer. And, when authentic, such acts embroil the one witnessing in some degree of suffering. Literary scholar Geoffrey Hartman and psychoanalyst Dori Laub established the Fortunoff Video Archive at Yale University to gather videotaped testimony of Holocaust survivors. They emphasize the requirement that the one listening not treat the testimony as data or information but rather that the witness enter the effort of the one giving testimony to find and articulate the core of the experience being relived.[6] When the listener is able to achieve such authentic listening, he or she is exposed to the presence of the evil suffered, getting 'second-degree' trauma, or what those who work in trauma care call the traumatization of the listener.

Not only the receiving of testimony but the giving of it is a reciprocal act. Hartman describes how the Holocaust survivor experiences a reciprocity even within the self, in effect, witnessing oneself witnessing:

> If authenticity is to prevail, the survivor as witness to the traumatic event will be at once a first person and a second person: one who is able, despite everything, to say 'you' to the self that has remained, one who seeks an 'I-Thou' relationship with a disappeared or damaged self. [7]

How powerful an act is it to tell of one's pain. Through the process of articulating the world of suffering in the presence of one committed to authentic listening, the teller meets and recognizes the suffering self, perhaps helping the process of reintegration of the suffering self with the knowing self.

Pain as an intersubjective event

'The Death of Ivan Ilych' is perhaps the best-known fictional representation of unwitnessed pain and suffering. St. Petersburg lawyer and judge Ivan Ilych suffers a horribly painful terminal illness alone, severed from his family and friends by their refusal to acknowledge what he suffers and by the pervasive deceit that prevents any of them from frank confrontation with his plight. He is rescued from his torture when he recognizes the suffering that his disease causes in his young son: by compassionating his family, his own pain diminishes:

> And suddenly it grew clear to him that what had been oppressing him and would not leave him was all dropping away at once from two sides, from ten sides, and from all sides. He was sorry for them, he must act so as not to hurt them; release them and free himself from these sufferings. 'How good and how simple!' he thought. 'And the pain?' he asked himself. 'What has become of it? Where are you, pain?'

He turned his attention to it.

'Yes, here it is. Well, what of it? Let the pain be.'

'And death . . . Where is it?'

He sought his former accustomed fear of death, and did not find it. 'Where is it? What death?' There was no fear because there was no death.[8]

Within health care professions and the lay public, the realization grows that pain is an intersubjective event. Not only is the transaction a reciprocal one with suffering on both sides; it brings the full subjectivity of both sufferer and witness into pain's act. The only instrument that can register the presence and intensity of pain is the human witness, because pain has no objective outward signs or biological markers that can be measured and confirmed. Asking a patient to rate the level of pain on a scale of 1 to 10—an absurd effort that, in retrospect, we learn was introduced into clinical practice with the help of the pharmaceutical industry trying to enlarge the market for opioids—has led only to confusion about experienced pain.[9] We might consider pain to be, primarily, a semiotic phenomenon. Whether in the parlance of anesthesiologists and neuroscientists who speak of 'nociception' as the noxious sequela of tissue damage[10] or in the parlance of poets and memoirists who tell us that 'pain has an element of blank,'[11] we can but treat pain as a signal from deep inside one person that is emitted first to alert the sufferer that some damage is underway and then to communicate its presence to another, if only to the anonymous reader.

Intersubjectivity refers to the contact possible between two persons, not when they are present in their social or bureaucratic or economic roles but when they are present as their full selves, as that entity they refer to when they say 'me.' The German philosopher Edmund Husserl, who established the field of phenomenology in continental philosophy in the early 20th century,

posited the concept of intersubjectivity as a means by which two subjects can apprehend one another's independent existence through a practice of mutual empathic recognition. Such recognition enables both an awareness of self and awareness of Other within a shared sense of the life-world of humans or the home-world of a particular culture or community. The process of intersubjectivity starts with what Husserl called the 'phenomenological reduction': one puts aside or brackets the 'natural attitude,' defined as commonly held understandings of phenomena in the real world. Bracketing is necessary in order to actually perceive something or someone in the world, to freshly, unbiasedly perceive it, rescuing the perception from the homogenizing absorbed assumptions that can distort a view of the authentic. The phenomenologists who followed Husserl, including Maurice Merleau-Ponty, Edith Stein, Jean-Paul Sartre, Emmanuel Levinas, and Paul Ricoeur, added to Husserl's insights regarding the human being's capacity to perceive, with full subjectivity, the presence of another. Levinas regards the confrontation with the Other as not only the start of ethics but the start of subjectivity itself: 'A calling into question . . . is brought about by the other. We name this calling into question of my spontaneity by the presence of the Other ethics.[12]

Psychoanalysts deepen the meaning of intersubjectivity in another direction, describing the human being's capacity to pierce the boundaries of another's self, often wordlessly, toward experiencing that other's inner world.[13] In the well-going analysis, the analyst comes to recognize the analysand's ebb and flow of tides of feelings, the stops pulled, the barriers raised, the gates of trust opened, crack at a time, while the analysand finds the unexpected and unexperienced freedom to escape irony, to let fly, to do without the usual defenses because of finding the self in the presence of safety instead of existential danger. Over years, conditions of freedom happen. The patient comes to recognize his or her hiding from the self and then can

choose to avoid doing so. He or she comes to enter and experience feelings previously forbidden—rage, lust, profound tenderness, dependence, trust. All this takes place between two persons who simply talk to one another, in one another's presence. It gives promise for the good to any situation where two human beings make deep commitments to hear one another out, to respect the gravity of what is learned about the other, to reflect back what one hears and comes to know, and to forget nothing.

So to say that pain is an intersubjective phenomenon means that it is constituted by several entities—the consciousness of the sufferer, of the witness, of the sufferer's entourage, sometimes of the one who has caused the pain to begin with. Recognizing the intersubjectivity of pain calls for many fundamental changes in routine health care: family members require intensive care for their own wounds. Clinicians need expert care in response to their own sense of loss, sometimes guilt, always sadness. In the presence of trauma or violence, the perpetrators of the suffering must also be called upon to give accounts of themselves, either as individuals or in collective acts of reconciliation. Because pain is a universal truth in a life lived in time, all involved as witnesses of anyone's pain come to recognize their own futures in the pain of another. Such universalizing of the existential being-in-time changes profoundly the nature of the relation between sufferer and carer, calling us to discover our standing as fellow mortals in the face of time.

The telling of pain and the listening for pain

Pain does not only happen during terminal illnesses or in acute care hospitals. Most routine office visits contain descriptions of pain. Yet even these more routine episodes of pain are difficult for patients to express. Perhaps by examining why 'routine' pain is hard to describe, we might have more insight into the complexities of expressing severe pain.

Because pain is a multi-modal experience without commonly understandable or sharable metrics, anyone finds it hard to describe his or her own pain. It is not the same as saying 'cherry red' or 25^{o} Fahrenheit. Words come slowly to most persons who try to articulate what their pain feels like. Scholars and artists have turned to visual depictions of pain to better communicate the sensations being endured.[14] Even with words at the ready to articulate a sensation, some patients may withhold from their physician a description of pain because of fear of what it might connote. Patients may not realize what is 'worth' telling to their doctor. Elements of power and powerlessness enter these scenes of telling, for doctors or nurses or therapists control how much time is given for a medical appointment and what kinds of things merit discussion. Some symptoms are embarrassing to discuss, either because they are in an intimate part of the body or they may have been caused by something the patient ought not have done. To admit to symptoms is for some people diminishing, taking away from a sense of self as strong and inviolable. All of these factors are common and can silence a patient from even mentioning a symptom of pain.

Ordinary language many not be adequate as an avenue to tell about pain. I have found in my practice that patients often use detours in conversation to arrive at a description of their pain. One patient, a jazz bass player, could not even talk about the post-operative pain he suffered since major abdominal surgery. Instead, he told of his deep regret that he could not stand with his bass through a set. He was beset with great loss, lethargy, hopelessness along with anger toward the surgeon who, he thought, must have botched the operation to have left him with such pain. Why had he even agreed to this risky operation if this life with pain would be the result? I remember talking with him about jazz musicians that we both knew—I live in Greenwich Village in New York City and have come to know a fair bit about the contemporary jazz scene. We met not over his abdominal CT scans but over Ron Carter's unending brilliance and what

about that phenomenal Christian McBride? Somehow, after two or three visits pretty much devoted to jazz—and also getting results that showed good progress since the operation—the patient could listen to my explanation of the pain of post-operative adhesions and could try the simple means I described to lessen the pain. He gradually was able to hear my assurance that he was, in fact, healing from the operation and that he could look forward to resuming his life in music. Some months later, he springs into my office for a follow-up visit, and with dramatic flair says, 'I got a gig to play at Lincoln . . . Hospital!' Playing music in the lobby of the local city hospital was just as great for him as playing at New York City's famed Lincoln Center!

The most complex uses of language are recruited in describing pain by not just the metaphysical poets but all of us common sufferers. Another patient with diffuse and migratory symptoms said that as soon as he drank anything, it came right out the other end. He seemed so fixated on this feature of his illness. I remember asking him, 'Is it as if you're a metal pipe that water flows through? He says, 'Yes!' with great energy, as if I were the one to have come up with the image and not he. And what a strange image it was, the more we inspected it: emptying out his own body and replacing it by the inorganic, cold outlines of plumbing. By our using his own visualized representations of his body in our conversation about his illness, we were able to stay focused on his phenomenal experience of his symptoms without escaping to abstract pain scales or hackneyed overused adjectives. We were working from *his* data base of sensations toward a far more explicit and accurate shared understanding of what he was going through. In this case, the use of a complex metaphor tipped me off to the depth of work this patient was doing to undergo and represent to me his bodily sensations. (I cannot tell whether the clinical benefit flowed from the productive interpretation of the metaphor or simply the effort to take the metaphor seriously, but I am confident that the acknowledgment of it was important for the

eventual good outcome.) Although it took a long time and consultations with many brilliant specialists, his symptoms were finally diagnosed as a rare neurological disorder whose treatment has dramatically ameliorated his symptoms.

Many factors interfere with listening for pain. Clinicians listen to their patients within diagnostically salient frames of reference. They hear with more fidelity patients' utterances that point to a specific diagnosis that might, in turn, point to a helpful intervention. So a complaint of crushing, sub-sternal chest pain (suggesting coronary artery disease, an entity we know how to treat) will elicit far more interest than will a complaint of migratory, non-localized, fuzzily described total body pain. Implicit bias and prejudice can cause clinicians to disregard complaints of pain offered by a patient—certain cultures are thought to have low pain thresholds; persons who are substance users will almost invariably be thought to be magnifying pain in order to obtain pain medicines.[15] Doctors are trained to make decisions, and many of them are intolerant of ambiguity or uncertainty. The premature jump to closure, often leading to a faulty conclusion, is the casualty of the refusal to live in doubt.[16]

Although medical and nursing schools and clinical training programs realize that they have to give their trainees some sort of skills for listening to their patients, typically short courses in 'communication skills' are thought to be adequate. Sadly, such communication skills sometimes amount to providing some scripted lines (sorry for your loss), canned quasi-emotion (I know how you feel), or routinized responses to complaint (we'll see what we can do about that). Since patients' memories of having been ridiculed or scorned have long lives, lack of skill in listening to patients and respecting their concerns may diminish the effectiveness of care throughout a patient's career of illness.[17]

Listening *for* pain requires personal commitment, bravery, generosity in the use of the self, and a battery of hard-won skills. These skills are necessary in all realms of health care, from intensive psychoanalysis to routine primary care. Perhaps the clinicians with most need for and most benefit to be gained from rudiments of training for listening are 'clinicians of the body' who practice their discipline without a psychological or mental-health focus on emotions, language, or relationships. They are often the ones to whom are offered those first, tentative, pivotal descriptions of pain. If a physician or nurse or physical therapist were to dismiss an early description of pain, there might not be a second chance to hear it. Yet if they register the gravity of the complaint and demonstrate a desire to join with the patient in addressing it, they open a door toward a future of care.

Close readers, radical listeners

My colleagues and I in the Program in Narrative Medicine at Columbia University in New York City have introduced the practice of teaching and practicing skills of close reading and creative writing as a means toward deepening the listening capacity of our learners.[18] Briefly, close reading is what used to be restricted to literature majors or creative writers: the kind of reading that reads and rereads and rereads, the reading in which every word counts, in which importance is attached to the words themselves and to what they point to, to the plot, to the form, to the music of the language. It is a reading aware of the time frames, space frames, figural language, and frames of reference of a text. The close reader is one who values what language conveys, who treasures the words, who does not squander the evidence of talk.

The best way to establish close reading as a habit is to pair it with creative, responsive writing. Whenever we teach these skills, we guide learners in very close readings of texts or very close inspection of visual images. (Close looking is akin to close reading. We have been

expanding the media of our texts to include visual arts, cinema, sculpture, drama, dance, and music, because the closeness of attention can be achieved with all these senses and forms. These different media hold in common the capacity to represent some reality so as to convey it to another.[19]) We follow this *perceiving* stage with a *representing* stage in which learners write—freely, spontaneously, first-draft—in response to an expansive writing prompt that does not restrict the writing to a particular topic or genre. When students read aloud what they've created in a few minutes to their colleagues, they discover what they didn't even know they knew! Hence is proven for them right there in class the power of reading, of seeing, and of conferring form, through composing the written text, onto their own arising thoughts and sensations and realizations. Narratively-trained clinicians use these skills in routine practice, writing their impressions of a complex encounter with a patient to discover themselves what they have perceived about the patient. Showing what they've written to the patient proves to the patient their desire to understand and often deepens what the patient chooses to share next: it is a narrative path toward clinical intimacy and trust.[20]

The next step in this creative pedagogy is to recognize the parallel between close reading or looking and close listening. The close reader learns to hold in mind multiple contradictory interpretations of statements or multiple contradictory versions of events, and these capacities can migrate to their listening practices as they learn to 'listen like a reader' in close listening. To be a close listener is to accept paradox, ambiguity, and doubt; to not prematurely close on the meaning of what is said. We have of late been calling this form of listening 'radical listening' to bring into view the power of listening to another without exporting one's own implicit biases, one's limited world view, one's private calculus of value or worth onto the utterances of another. Repeating Husserl's practice of bracketing in the phenomenological reduction, the radical

listener intentionally sets aside the 'natural attitude' of one's own beliefs and prejudices to open the self to whatever is being emitted by the teller, framed within that teller's world view and imagined from the originating perspective. Imagine how such radical listening might change what happens in the clinical setting, the political setting, the religious setting, the highly polarized and divisive settings that now are endangering us all.[21]

The close reader and the close listener will let themselves be transported where the words bring them. Enchantment and recognition occur with regularity for the reader/listener who is not a suspicious reader bent on ferreting out secrets or adept at getting *under* what the speaker says to what he or she might *really* mean.[22] Instead, a different covenant between speaker or writer and listener or reader emerges: they give one another 'the benefit of the doubt' and, simultaneously, the benefit of doubt. We try to encourage in our learners the practice of focusing on the text itself, the habit of inviting and recognizing all possible meanings, and the experience of *joining* with the teller (be that a long-dead author or a patient sitting with one in the clinic) in creating meaning from whatever code has been used to represent it.

We have brought our teaching of close reading and close listening to a great variety of learners. The graduate students in the Master of Science in Narrative Medicine graduate program at Columbia and its associated Certification of Professional Achievement on-line course rely heavily on the the skills of close reading and responsive writing. Under Narrative Medicine's guidance, medical students at Columbia University are required to write in their Portfolios, electronic archives where students collect all their writing and visual art work over their four years of medical school. A faculty member, who has received rigorous training in close reading himself or herself, is allowed to read and respond to the portfolio writing that the student elects to share. This faculty member accompanies the student throughout the four years of training

becoming an ever-more-capable reader for the student, whose writing typically increases in its capacity to capture and represent very complex lived experience in the course of medical training.[23]

Beyond academic settings, we have brought the teaching of close reading and responsive writing to inmates in prisons, trauma survivors, patients with dementia, high school students aspiring to health professions, persons living with cancer, students and trainees in multiple health professions, and clinicians of many specialties and disciplines. In all these settings, we coach readers and those who look at visual images to take in all that the medium is able to emit in an effort to expand their 'bandwidth' when meeting with patients. We have found that such training leads to self-awareness and effective collaboration among members of groups. Narrative medicine methods improve the functioning of health care teams and curb the emotional exhaustion of burnout of clinicians. Current research underway at Columbia is examining the longitudinal writing of medical students as they traverse the identity-shaking ordeals of becoming doctors; our preliminary findings point to the capacity of students' writing itself to show them things about themselves.[24]

The healing word

Think how clinical care for pain might improve with deep attention to the language of pain. With commitment and skill on the part of clinicians to listen unguardedly for the pain and with risky willingness on the part of patients to tell of what they undergo, the ground of care will shift. Gates of trust will open to allow truth to be spoken and heard. Creative efforts will be poured into the large purpose of letting one person's lived experience be heard and comprehended by another. Patients will feel confident that their clinicians really want to know of all salient dimensions of their suffering and not only those that deal with physical or biological

aspects of their situation. They will be free, because of the mutually developing trust and trustworthiness, to tell of the serious matters that envelop a life with pain and suffering. Because both patients and clinicians accept that they live in this world of time, they will recognize themselves as fellow mortals, all contained within the human conditions of limited time. United existentially, they will be united creatively and clinically. Instead of existing at objective, clinical, arms-length distance, they will near one another toward recognizing and then relieving whatever parts of suffering can be lifted, in both the patients and the clinicians.

This will bring a new day for health care.

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[1] Fiction can be more powerful in capturing rooms of pain than are clinical texts. Some of the most memorable fictional apparitions of pain include *The English Patient* by Michael Ondaatje, *Austerlitz* by W.G. Sebald, *The Room* by Emma Donoghue, *Infinite Jest* by David Foster Wallace, and D.H.Lawrence's short story, 'The Odour of Chrysanthemums.'

[2] *Relieving Pain in America*, a report prepared by the Institute of Medicine, gives an overview of the scale and scope of the pain crisis in the US.

[3] 'Ending the opioid epidemic' by Murthy and Vivek and 'Opioid abuse in chronic pain' by Volkow, Nora and McLellan outline policy proposals for addressing the opioid crisis and discuss the complications of treating pain in the climate of the substance abuse epidemic.

[4] Susan J. Brison tells of being brutally raped in the mild countryside of the south of France; her writing of her ordeal had to wait over two decades for her to gather the wherewithal to tell of it. Pat Barker has written brilliantly about the telling of pain in the Regeneration Trilogy set in the WWI British army, especially in *Regeneration*.

[5] Sontag, *Regarding the Pain of Others.*

[6] Laub, 'An event without a witness: truth, testimony and survival.' In Felman, *Testimony,* 75-92.

[7] Hartman, *Scars*, 19.

[8] Tolstoy, 'The death of Ivan Ilych,' 155. 155.

[9] Keefe, 'Empire of pain.'

[10] Coakley and Shelemay, *Pain and its Transformations.*

[11] Dickinson, 'Pain has an element of blank.'

[12] Levinas, *Totality and Infinity,* 43.

[13] See Christopher Bollas, *The Shadow of the Object,* Hans Loewald, *Papers on Psychoanalysis*, Stephen Mitchell, *Relationality from Attachment to Intersubjectivity* for psychoanalytic theories of authenticity and intersubjectivity in analytic practice.

[14] Padfield, *Perceptions of Pain.*

[15] Hall W, Chapman M, Lee K, et al. 'Implicit racial/ethnic bias.'

[16] The meanings of pain over cultures and times are reported brilliantly in David Morris's *The Culture of Pain.* Catherine Belling treats the profound uncertainties of living through pain in the limit case of hypochondriasis in *Conditions of Doubt.*

[17] Thernstrom, *The Pain Chronicles*.

[18] See Rita Charon, Chapter 7, 'Close reading' and Chapter 8, 'A Framework' in Rita Charon, Sauantani DasGupta, Nellie Hermann, et al, *Principles and Practice* for a full description of the methods of understanding and teaching close reading within narrative medicine practice.

[19] Alber, 'Narratology and performativity.'
[20] Charon, 'The membranes of care.'
[21] We have been working with such scholars and activists as Carol Gilligan, Mindy Fullilove, and Colum McCann in developing training workshops in radical listening. See Gilligan's 'Listening Guide,' Fullilove's *Urban Alchemy*, and Colum McCann's creation of the 'Narrative 4' project.
[22] See Rita Felski's marvelous *The Uses of Literature* for discussions of transport, enchantment, and recognition in acts of reading.
[23] Hetty Cunningham, Delphine Taylor, Urmi Desai et al. 'Looking back to move forward.'
[24] See Eliza Miller et al, 'Sounding Narrative Medicine'; Stephen Sands, Rita Charon, and Patricia Stanley, 'Pediatric narrative oncology'; and Rita Charon, Nellie Hermann, Michael Devlin, 'Close reading and creative writing.'