Call me what you want, the student who mistook her book for a doctor, the student in virtual Ward No. 6, the student cutting pages for stone, or Alexandria Yap Alexandrias. But I’ve been reading and writing about physician-writers a lot lately.

Like so many other trainees, I have had to figure out how to continue clinical activities, in lieu of the clinic, in lieu of the real doctor-patient encounter, in the midst of a pandemic. The “new normal” universally converted in-person lectures onto online distance learning platforms. But the “new normal” has not had any uniform solutions for in-person clinical experiences. Medical educators and trainees have attempted to access the clinic in various ways: from grassroots PPE donation campaigns to online standardized patient and case-based learning.

I’m a recently graduated, pre-med, English major. So, for many, it might seem obvious that I personally would try to access the clinic through physician-writers, whom many assume are my role models. But until recently, I have actually tried to avoid reading physician-writers and medically inspired texts. After all, we read to escape our daily lives. But suddenly withdrawn from the real clinic, I have used physician-writers to escape back to the clinic.

I have realized that treating physician-writers’ texts as real-life encounters is no different than the close reading of texts I have been trained to do in my college English courses. I chose to study literature not because I want to join this robust legion of physician-writers. In fact, my university offers degree tracks in either literature or creative writing, so if I pompously did want to stand amongst Oliver Sacks or William Carlos Williams, then I could have studied how to do so and pursued the creative writing track instead. But I chose to study English literature simply because as doctors accompany diverse patients through their pain, I’ve wanted to analyze and understand how those dissimilar to myself navigate difficult situations. I’ve treated my characters as my patients and followed them through their plots so that the classroom becomes the clinic. I’ve analyzed descriptions and dialogues, asking “Why Ophelia drowns herself? Why Frankenstein’s monster begs for a mate?” I am not a 15th century highborn maiden or 18th century grotesque creature, yet I’ve learned how my patient-characters navigate these difficult situations. Both the maiden and monster suffer from loneliness, rejected by their lover or creator. I’ve diagnosed their ailments. I’ve advocated for them in discussions or essays, but I’ve also accepted their ambiguities.

My practice is not groundbreaking. Since the 1970s, numerous studies and essays have validated the place of literature in medical education as a method to train more empathetic doctors, and today the field is known as Narrative Medicine. Developed by general internist and literary scholar Rita Charon, Narrative Medicine is the interprofessional and interdisciplinary practice that trains clinicians in literary theory and skills. Narrative medicine asks clinicians to read their patients just as they would close read a story. This narrative competence is then hopefully transferred from the classroom to the clinic, where details read as written and unwritten become those noticed as spoken and unspoken.

In order to evaluate her practice, Charon has instituted an intervention she calls her “witness project.” She invites students into her clinic, asking them to take detailed notes on her clinical encounters: to this end, “narrative medicine witnesses attend clinical encounters in order to give to their participants a finely perceived written representation of the events of their meeting.” Essentially, these witnesses are charged with the practice of close reading the encounter and then testifying through a written representation. Through her witnesses, Charon has “changed basic routines” and “learned things about [her] patient and about [herself] that [she] would never have learned on [her] own.”

In my experience as a clinical witness, physicians find it helpful to reflect on their work from a new perspective. Physicians see how their clinical skills already at play can be seen as narrative techniques and can more confidently implement them in their future practice. A general pediatrician, whom I have witnessed monthly for over 9 months before COVID-19, mentioned to me that we had a breakthrough by the end of our fourth month together. At the end of an encounter, I noticed how she gently rested her palm on a patient’s knee. I read this movement as a signal, the completion of her work and transference of the patient back to his mother. While a primary care physician’s work is a longitudinal narrative, this gesture signaled the end of one chapter and the start of the next. The pediatrician momentarily narrated this chapter’s visit, giving her professional advice. As the patient returned to his mother, a new chapter towards better health began orchestrated by the patient’s original caregiver. My pediatrician mentor found...
this testimony particularly moving. She annotated on my written testimony, "This helps me recognize/name things I do that I’m not always conscious of." She also has told me in-person that when I, the clinical witness, am not there, she now, on occasion, imagines I am. As she practices in real-time, she sees the encounter also through my perspective. Through testimony, the witnessed doctor gains insights that improve his or her practice.

Charon proposes witnessing as a useful practice for practicing physicians to continue to hone their craft over time. But I have found that witnessing has been an integral clinical experience for a trainee as well. I have learned how to close read a real encounter, moving literary skills that were nurtured in my English classes to the clinic. I have also learned how to communicate with doctors about their practice on paper and orally. From close reading, I think I can pinpoint when the doctor has realized facts or nuances, but it is helpful to review the epistemology of the encounter with the doctor—that is, to compare a timeline of when certain facts became apparent—before I write my testimony. In my testimony, I then elucidate the narrative processes already at work in the encounter. Or I suggest small areas in which narrative can be introduced. Once the doctor has read the account, we meet again, revising each of our perspectives once more. As witnessing has grown my narrative competence, it has changed the way I observe at large in clinical practice.

Witnessing has changed how I observe at large in clinical encounters, but it still distinguishes itself as a separate practice. Witnessing calls me to act and testify with my own voice. As a witness, I add to the encounter, so that once a linear relationship, the encounter becomes a triangulation or a "clinical trinity." This "clinical trinity" separates witnessing from other learning experiences such shadowing or scribing. A shadow or a scribe preserves the linear form of the encounter between patient and doctor. A shadow and scribe are placed behind the doctor, acting as a copy and a ghostwriter, respectively. Both shadowing and scribing are valuable forms of clinical exposure still; they just view the encounter through a different perspective. Whereas a witness attends to both patient and doctor through a nonlinear vantage point, a shadow or scribe views the encounter through the doctor.

When I have been in a shadowing role, I know that I am not expected to understand all of the medical terminology. I am less attentive to every word choice, every silence, every mannerism. Because I also will not have to testify "that this event happened and this event matters," I am less involved or invested in the encounter overall.

While witnessing, I have talked to scribes, curious to see how our impressions of the same encounter are different. One scribe told me that she screens out a lot of the small talk. As a clinical witness, I have found that small talk often becomes the most interesting part of my testimonies: nonclinical conversations establish familiarity and rapport between physician and patient. As the scribe follows the presence of medical language in the room, I attend to the presence and absence of all language in the room. Our responsibilities are just different.

It’s been months now though since I have been able to conduct any in-person narrative medicine witnessing. I instead have been moved to witness the clinical encounter through literature. I’ve transferred literary skills back to literature. Perhaps call me then not your clinical witness, but your clinical reader–witness.

Witnessing physician–writers is not the same as cozying up with a cup of tea and book. As a clinical reader–witness, I close read, respond, and testify to encounters between physician–writers and their patients. I find myself in an uncomfortable dance, similar to the movements I balance in real-life witnessing. I often catch myself only focusing on the physician–writer’s voice, like the scribe and shadow do. But in order to measure the physician–writer’s narrative competence, I must attend to the patient’s and my own responses as dependent variables of sorts. I must reorient myself to a point equidistant to all 3 perspectives so that I teeter in the same triangle amidst the physician–writer’s, patient’s, and my own impressions.

Sometimes the dancing triangle evolves into a foursquare. I’ve been recently witnessing Oliver Sacks through his clinical tales The Man Who Mistook His Wife For a Hat, and in the titular chapter, the patient’s wife enters the encounter. She acts as an advocate. As I watch as Sacks grapples with another voice in the encounter, I too must determine her role: does her voice muddle or clarify the conversation? She calls Sacks a “Philistine” who is blind to her husband’s artistic side. Her comment is memorable: for, if anything, Sacks is more often criticized as too artsy of a physician. I close read her diction and tone though. Rather than indicting him, she teases Sacks playfully with her language: “Can you not see artistic development—how [my husband] renounced the realism of his earlier years, and advanced into abstract, nonrepresentational art?” Through the italicization of her words, Sacks shows that not only does he remember the tone in her voice, but also he notes that she helped widened Sacks’ perspective of his patient. He retracts his initial absolutist statement that the “wall of paintings was a chaos and agnosia” when his patient describes the artistic and pathological interpretations—can coexist. He reports that he prescribes his patient “a life of music.”

As a clinical reader–witness though, I am unable to consult Sacks about the advocate’s influence. I cannot go through my usual motions and consult any of the physician–writers with my testimony. To this end, none of the physician–writers
improve upon their craft. I am left alone with my testimony, and I instead am called to live it out. I am equipped with new insight and skills to apply in my future practice as a doctor or even in the more near future when I can safely return to the clinic as trainee.

Trainees are slowly being welcomed back into the clinic now. But the “new normal” ensures that clinical learning experiences will most likely not look the same. COVID-19 has shown medical educators and trainees that we must find alternative learning methods to access the clinic, pandemic or not. Witnessing the clinical encounter in literature becomes a valuable method that can easily coexist amongst other clinical opportunities. The clinical reader-witness becomes a more narratively competent, future clinician, an end-goal that harkens back to narrative medicine’s original objectives: “to recognize, absorb, interpret, and be moved to action by the stories of others.” All one needs is a close reader’s eye, a written clinical encounter, and a testimony.  

Disclosure Statement

The author(s) have no conflicts of interest to disclose.