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# Between Stillness and Story: Lessons of Children's Illness Narratives

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## ABSTRACT

In answer to an increasingly impersonal medical environment, educators in the medical humanities frequently turn to narrative studies to teach students for an emotionally fulfilling and interpersonally related professional practice. However, to elicit, to interpret, and to integrate patient stories into their work effectively, physicians must be in a state of awareness and attention, attuned to their emotional and intellectual reactions. The experiences of children and their families, in the form of pediatric illness narratives, hold unique insights for physicians in how to engage in an ethical, empathetic, and self-reflective practice. In particular, these narratives demonstrate the importance not only of story but also of stillness or silence to the practice of medicine. The voices of patients and their families hold both literal and allegorical lessons for physicians in how to move toward a medical practice involving not only diagnosis and treatment but also recognition and healing.

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YEARS AGO, I attended a talk at Columbia University by the renowned Buddhist scholar Robert Thurman. It was in a packed lecture hall, with a few hundred individuals in attendance. Before beginning his talk, Thurman had us do something that I have never seen done before in an academic environment; he had us sit in silence.<sup>1</sup> We should be still, he told us, dutifully counting our breaths, closing our eyes, and being quiet. We should, in short, allow ourselves to simply be. The experience of sitting silently in a meditative stillness allowed the audience to leave aside external concerns and attend Thurman's lecture in a full and present way. Although I have neither the renown, nor perhaps the courage, to ask such a thing of a live audience, I ask you, my readers, to sit with this story for a moment before you continue with this essay.

Breathe in.

Breathe out.

Gong. (Thurman simulated the sound, confessing that he had not been mindful enough to remember to bring a bell.)

As such stories are, this story has been told here for a reason. As Thurman used his lecture to suggest a central role for meditation in higher learning, this essay will similarly suggest a central role for stillness, what Thurman might call inner silence, in the work of caring for the ill, the work of medicine. Claude Debussy once said that music is the space between the notes.<sup>2(p147)</sup> To pose it a little differently, if the beauty of a sonata emerges from the balance of notes and silence, then this essay posits that the heart of medicine beats in the space between stillness and story.

The modern health care crisis has been framed in many ways as a crisis of story. Shortened visit times, increased reliance on technologic tools for diagnosis, and a lack of focus on the individual physician-patient relationship has created a medical environment fraught with dissatisfaction and frustration for both ill individuals and their providers. Medical educators have turned increasingly to the humanities, particularly narrative studies, to bring storytelling back to the center of health care. One prevailing perspective in medical humanities is that being able to understand the patient story in all its nuances (ie, metaphor, frame, plot, and point of view) is the avenue through which to enter more fully into patient stories and thus a more ethical, empathetic, and satisfying professional practice.<sup>3</sup> Narrative-based educators teach medical trainees close reading of classic literary texts (from Dostoyevsky and Chekhov to James Joyce and Henry James) that deal with the universal human experience but not necessarily the experience of suffering and illness. Other humanities educators have turned to autobiographical narratives authored by individuals suffering from illness and disability, as well as biographical narratives authored by their family members and caregivers. By learning to witness the textural voices of

those affected directly by illness and disability, students learn a skill parallel to that they will use in their future health care practices. Students begin to ask themselves what it is to experience suffering, what it is to represent that experience (in written text or oral story), and what it is to be a witness (professional or familial) to the experience of suffering.

One aspect of this renewed medical conversation regarding story is an investigation into the act of listening itself. What is it to be a witness to suffering? What skills are required for physicians to elicit, to receive, and to interpret their patients' illness stories effectively? In his classic work, *A Fortunate Man: The Story of a Country Doctor*, John Berger describes the work of the physician as that of recognition. "This individual and closely intimate recognition is required on both a physical and psychological level," he writes. "On the former it constitutes the art of diagnosis. Good general diagnosticians are rare, not because most doctors lack medical knowledge, but because most are incapable of taking in all the possibly relevant facts—emotional, historical, environmental as well as physical. They are searching for specific conditions instead of the truth about a man which may then suggest various conditions."<sup>4(p73)</sup> Physicians writing on this subject have described this activity as being in the present moment and practicing medicine mindfully.<sup>5-7</sup> Similarly, physician and literary critic Rita Charon has called this state of being one of attention, in which there is an "emptying of self so as to become an instrument for receiving the meaning of another."<sup>8(p132)</sup>

Common to all of these perspectives is an element of passivity, an attitude that is seemingly antithetical to that of medicine. If anything, medicine acts; it examines, interprets, investigates, scans, incises, debrides, and sutures. In grammatical terms, almost all of medical practice occurs in the active voice. By this I refer to the voice of a verb that "denotes whether the subject performs or receives the action expressed by the verb."<sup>9</sup> The active voice "shows the subject as actor" as opposed to the passive voice, which "shows the subject as acted on."<sup>9</sup> Here, then, is one small beacon illuminating the crisis of story in medicine. If subjecthood in the medical profession is predicated on assuming an active voice in most professional activities (doing things), then it only follows that medical subjects, namely, physicians, should approach the witnessing of stories from a similar stance. We speak of "getting the story," as if it were an object to be found and fetched intact, an active, even athletic, process of discovery, archaeology, and search and rescue. However, the witnessing of suffering is a process of being "acted on," humbled, changed, and filled in addition to being informed. This sort of listening demands a radical shift in stance, in grammatical voice, such that physicians not only act but also allow themselves to be acted on.

Consider this popular quotation, which has been at-

tributed to the Buddha, "Don't just do something. Stand there."<sup>9</sup> Whether coined by the Buddha or by a T-shirt maker, these words do provide a revised understanding of active and passive voice. "Standing there," being still, takes on new meaning in this light, as a different deeper kind of doing, that is, an "un-doing," an opening, a laying bare. Much more than merely "do no harm," passivity in the medical relationship can, with this understanding, become an active process whereby stillness facilitates for the physician-listener a deeper understanding of the story being told. Consider the words of Ralph Waldo Emerson, who writes, "When I watch that flowing river, which, out of regions I see not, pours for a season its streams into me, I see that I am a pensioner; not a cause, but a surprised spectator of this ethereal water; that I desire and look up, and put myself in the attitude of reception, but from some alien energy the visions come."<sup>10</sup> The insight of Emerson's visions emerge from looking to the "ethereal water" with an "attitude of reception," as medical insight may emerge from a similar posture that allows physicians to wade in and become filled with the streams of their patients' stories. In an essay titled "Intellect," Emerson writes, as if about medical thinking, "Our thinking is a pious reception. Our truth of thought is therefore vitiated as much by too violent direction given by our will, as by too great negligence. We do not determine what we will think. We only open our senses, clear away, as we can, all obstruction from the fact, and suffer the intellect to see."<sup>11</sup> This endeavor in passive voice is not in lieu of the active work of medicine but in addition to or perhaps in balance of it. In the words, again, of Emerson, "It seems as if the law of the intellect resembled that law of nature by which we now inspire, now expire the breath; by which the heart now draws in, then hurls out the blood, the law of undulation. So now you must labor with your brains, and now you must forbear your activity, and see what the great Soul showeth."<sup>11</sup> We breathe in so that we can breathe out.

The question is how to teach transcendental objectives such as witnessing, attentiveness, recognition, and "pious reception." Given this problem of educating physicians in the skills of deeper listening, I imagine that Robert Thurman might suggest, in that unerringly contradictory way of Eastern mystics, that we teach students to listen to stories by first learning to listen to silence.

Physicians are particularly accustomed to hearing and interpreting silent stories, such as the surgeon who interprets the story told by the anesthetized bleeding body, the rheumatologist who hears the inarticulate story told in symptoms of pain, or the geriatrician who daily witnesses the silent story of death. Pediatricians, I posit, are more accustomed than most to negotiating the fine balance between silence and story. Indeed, our work incorporates a daily practice of listening to at least outward silence. Charon writes:

We clinicians . . . act almost as ventriloquists to give voice to that which the patient emits. I put it this way because the patient cannot always tell, in logical or organized language, that which must be told. Instead, these messages come to us through the patient's words, silences, gestures, facial expressions, and bodily postures as well as physical findings, diagnostic images, and laboratory measurements, and it is our task to cohere these different and sometimes contradictory sources of information so as to create at least provisional meaning.<sup>8</sup>

Pediatricians feel in our core this lesson that Charon helps us articulate. We know that much of the pediatric story emerges from nonverbal communication on the part of the child. Very young children are developmentally unable to access and to use language in the same manner as adults, but even older children are often unable to articulate their experiences, because of their social voicelessness. Despite efforts on the parts of pediatricians to elicit and to hear the voices of their patients, stronger still are the nonverbal messages transmitted to children through their parents' expectations of docility and obedience as integral to good public behavior, adults' often obvious preference to speak directly to one another, and the very situation of being small, ill, and disrobed in a room with a stranger to whom one's parent has inexplicably conferred the power to gaze on, to probe, and to invade one's body. For adolescents, voicelessness may be a manifestation of internal emotional struggles. Consider the words of Jenn, a 15-year-old girl with anorexia. "I like to be alone," says she, "There are a lot of expectations, and you can kind of let those go for a while. When I'm alone, I feel like I can be sad. I don't talk about my feelings to other people. I keep them to myself. I don't know myself that well and speaking about it, you kind of have to know how you feel. I definitely care about what other people think about me; that's a huge part of me, so that could be it. I like to be alone, then I don't have to know, I just am."<sup>12(p71)</sup> From the prelinguistic damaged infant in the NICU to the frightened, distrustful, or sullen teen in the adolescent clinic, pediatricians become skilled at constructing stories from silence, as if creating matter from what was once ether.

Recognizing and interpreting the silence of others is not the same, however, as training students in mindful practice, attentiveness, or the ability to listen to one's inner silence. Jenn, the adolescent of the earlier example, retreats inward, to a place where she can freely identify and experience herself through her emotions. It is this inner place of self-observation that we in narrative medicine are trying to help our students reach. It is not emotional detachment from one's patient or a sentimental overattachment that makes a good physician but speech and action that emerge from an awareness of one's inner landscape. "Speaking about it, you kind of have to know how you feel," explains Jenn. Both speak-

ing and acting as a doctor require knowing how one feels. This emotional self-awareness cannot, of course, overwhelm the listener or transgress into emotional self-indulgence. Inward retreat cannot be an escapist venture, as Jenn's experience seems to be, away from demanding human relationships, because a physician's work is predicated on such interactions. In a surprisingly profound conclusion that sounds a bit more like Eastern philosophy than teenage angst, Jenn states that when she is alone she does not have to know, but just is. This is the difficult part. How do we hyperintellectual physicians get from that place of knowing to a place of just being?

During that talk long ago, Robert Thurman suggested that the way to construct an undergraduate education that created responsible global citizens was not simply to suggest but actively to teach students the skill of looking mindfully inward. Buddhism and Western education, Thurman posited, share the goals of investigative and penetrative knowledge, because Buddhism considers understanding and knowledge liberating forces. He quoted his friend and teacher, the Dalai Lama, as being concerned with the fact that Western education relies solely on developing the intellect in this process, whereas a Buddhist education also focuses on developing "the good heart." The rest of Thurman's talk took up this challenge by the Dalai Lama for Western education to focus on the "good heart" as well as a good intellect. Basing his comments on Buddhist teachings, whereby an ultimate presence in the body is seemingly contradictorily used to transcend the body, whereby an inward solitary gaze is used to recognize one's connections to the universe, whereby the still passivity of the meditative stance enables the most active state of being, Thurman suggested that one answer to the crisis in education might be to turn vast university gymnasiums into communal meditation chambers, that educators should look beyond a classical humanities education to train pupils in humanity. In Buddhism, as in many Eastern religions, meditation becomes the means to channel one's focus and to achieve a deep inner knowledge.<sup>1</sup> Meditation breeds recognition of self, and self-recognition enables recognition of others. Although extending Thurman's argument to medicine and turning our anatomy and histology laboratories into meditative rooms may not be a practical solution, we may imagine that one answer to the crisis of modern health care, the crisis of story, lies in teaching all medical students the skills at the heart of meditation and self-recognition, skills central not only to eliciting and witnessing our patient's stories but also to integrating them fully into our own consciousness.

This is the point at which we medical humanities educators might throw up our hands and turn over our responsibilities to chaplaincy, religious studies, or the meditative disciplines. Although I encourage closer ties with such colleagues, this essay also suggests a role for

narrative studies, and scholars of illness narratives, in helping students negotiate the relationship between stillness and story. Here is where my own argument takes a Thurman-esque contradictory turn. If Thurman might suggest that we teach students to listen to stories by first teaching them to listen to silence, then my own work with illness narratives suggests that the best way to teach a student to listen to silence might be through reading stories.

Illness narratives (autobiographical or biographical stories written by those suffering illness and their caregivers) represent a genre of writing that has grown significantly in the past few decades. Sociologist Arthur Frank has suggested that such stories, or pathographies, are a postmodern phenomenon, in which narratives authored by the ill give voice to an experience that was once narrated solely by the medical establishment. In other words, illness stories speak where there once was silence, giving voice to what once was inarticulate.<sup>13</sup> Narratives written by the ill hold more than lessons about the experience of illness; they also hold lessons directly applicable to the work of inward recognition and outward witnessing. The reason for this is twofold, attributable to both the nature of stories themselves and the particular position of the authors of such stories. Regarding the first, it is again Emerson who can help us understand the power inherent in narration:

Each truth that a writer acquires is a lantern, which he turns full on what facts and thoughts lay already in his mind, and behold, all the mats and rubbish which had littered his garret become precious. Every trivial fact in his private biography becomes an illustration of this new principle, revisits the day, and delights all men by its piquancy and new charm. Men say, Where did he get this? and think there was something divine in his life. But no; they have myriads of facts just as good, would they only get a lamp to ransack their attics withal. We are all wise. The difference between persons is not in wisdom but in art.<sup>11</sup>

In the process of narrating their stories, authors of autobiopathographies or biopathographies hold lanterns up to illuminate the experiences of their lives and give them an existence that both belongs to and transcends the idiosyncratic author. In addition, illness stories are inherently social and bring attention to the relationships of tellers to listeners, sufferers to caregivers, and patients to physicians. Frank writes, "Any person's story depends on others who become less other as the enmeshment of stories teaches interdependence. I confess to believing that in learning this interdependence patients have a qualified advantage over clinicians. This advantage may have less to do with physical suffering . . . and more to do with not having a particular institutional face that must be sustained before one's colleagues."<sup>14</sup> These stories are steeped, then, in lessons of relationship and

interdependence, lessons directly relevant to the physician's work.

Pediatric pathographies, published stories about children's illness experiences, are a particularly small subgenre of this writing, perhaps because of some of the same issues of social voicelessness discussed earlier, as well as children's lack of access to formal written language and publishing. Although published narratives regarding children's illness experiences tend to be written by either adults remembering their childhood illness experiences or the parents of ill children, they are no less the narratives of the children about whom they are written, in the sense that all illness stories are cowritten, some by caregiver and patient, some by sufferer and loved one, and some by present and past selves. These stories make clear not only that children transmit a nuanced, often silent, story that their physicians must mindfully attend but also that ill children and their families have much to teach us about the process of attention itself. The 2 particular narratives I visit in this discussion were chosen because they hold lessons that are both literal, giving insight into the experience of being an ill child, and allegorical, in that these stories seem to hold some lessons central to an ethical, empathetic, and spiritual (or perhaps centered) practice of medicine.

Let us consider first Lucy Grealy's memoir of her childhood experience with Ewing's sarcoma of the jaw, *Autobiography of a Face*.<sup>15</sup> Grealy's narrative, which was first published when she was in her early thirties, is simultaneously a reflection back to her childhood cancer and a rumination on the lifelong effects of that cancer and the subsequent, seemingly endless, operations to reconstruct her face. Although Grealy does locate the source of her identity in her face, writing, "my face, my self," it would be a mistake to consider this text a mere reversal of the Narcissus myth, a girl's quest to find her own beauty after disfigurement. The face that Grealy sees in the mirror causes her distress and shame, and she struggles even to recognize it as her own. The face in Grealy's mirror is made completely "other" not only by her disease but also by the lifetime of surgical interventions she experiences to reconstruct her jaw. She writes, "Even as people confirmed that this was now my face, even as people congratulated me, I felt I was being mistaken for someone else. The person in the mirror was an imposter—why couldn't anyone else see this?"<sup>15(p220)</sup> "I could not recognize my own self as a part of this world."<sup>15(p205)</sup>

In reading this, my breath is taken away, not only by the beauty of Grealy's writing and her power to transport me into the body of an ill 9-year-old girl but also by the resonance of her images to the work of medicine itself. The ethical work of medicine is situated in the very sort of recognition with which Grealy struggles, the recognition of the face that is not the self, the face on the

other side of the mirror, the face of the suffering patient. In his discussion of the work of philosopher Emmanuel Levinas, medical educator Craig Irvine writes, "Like Narcissus, medicine is stupid with, in thrall to its own reflection . . . [but] medicine is a moral endeavor, commanded by ethics, by transcendence, by an infinity beyond its comprehension."<sup>16</sup> What lies beyond the comprehension of the self, Levinas teaches us, is the other, and the "calling into question of the same" by the presence of the other is what Levinas calls ethics. Irvine here helps deepen our understanding of Berger's "recognition," Charon's notion of "attention," even Thurman's Buddhist mindfulness. Ethics precedes even knowledge, according to Levinas, and the primordial ethical act is to answer the call of other's suffering, to see what Levinas terms the other's "face." In Grealy's text, it is her own changed image that calls into question the sameness of that which she calls self, and her quest to recognize her own face is the ethical struggle in which she engages.

Grealy's narrative can be read as a manifestation of medicine's ethical struggle, but she also illustrates the skills necessary for "recognition" to be enacted. Grealy's youthful self exemplifies the attentive state central to physicians' ethical work, even as her own physicians seem barely to see her. In the following passage about Grealy's first visit to the oncologist, it is young Lucy, rather than her doctor, who is still, vessel-like, filled with the environment and people around her, taking in the minutest details of her world. She writes:

When we were finally in Dr Woolf's office . . . we encountered his telephone, apparently a permanent appendage. He could carry on a conversation with my mother, me, his nurse, the secretary down the hall, and someone on the phone simultaneously, he had it down to an art. His manner was gruff and unempathetic. . . . His office was as drab as the waiting room but saved by a large, multipaned window that looked out onto a well-tended courtyard with banks of blue flowers and ivy-clenched trees. I spent a lot of time forcing myself to look out that window, because even on that first visit I knew that room was no place for me. . . . The first examination . . . I was asked to strip down to my underwear, which I did, feeling humiliated and exposed. While the doctor talked to the nurse, my mother, and the person on the phone tucked beneath his chin, he prodded me with his hands, hit me just slightly too hard with his reflex hammer, and spoke far too loudly. When he touched me, I could feel the vibrations of his voice in my own chest, feel them lapsing through my body's cavity the same way you feel a car passing too closely.<sup>15(pp73-74)</sup>

Here, medicine is practiced the wrong way around, with the child patient emptying herself and being filled with the reverberations of medicine's boorish care. Repeatedly, Grealy's narrative references the notion of silence and disappearance. After her first chemotherapy treatment, her father asks her, "That wasn't so bad now,

was it?" The 9-year-old Grealy does not answer, and her adult counterpart writes, "Speaking seemed like something one would grow tired of."<sup>15(p77)</sup> The ill child becomes the mirror that shows the world around her. It is her own otherness, brought on by medicine, that causes her to doubt her very existence as a part of this world she now reflects.

Like meditation, where stillness of the body encourages alertness of the mind and spirit, Grealy's enforced external stillness or silence is accompanied by great internal attention. Her silent observations of her outside world are brought forth by her increasing self-presence in her inner world. Illness is the medium through which she is both introduced to her own body and simultaneously betrayed by it. Grealy describes the experience of chemotherapy in this way:

For a split second, a split of a split second, the sensation was almost pleasurable, a glowing, fleshy sense of my body recognizing itself as a body, as a thing in the world. But immediately it was too much: I felt the lining of my stomach arc out and pull spastically back into itself like some colorful disturbed sea anemone. It was like an anatomy lesson. I had never known it was possible to *feel* your organs, feel them the way you feel your tongue in your mouth, or your teeth. My stomach outlined itself for me; my intestines, my liver, parts of me I didn't know the names of began eating up, trembling with their own warmth, creating friction and space by rubbing against the viscera, the muscles of my stomach, my back, my lungs.<sup>15(p75)</sup>

Grealy's narrative has obvious literal lessons for those of us who deliver care to either children or adults. We must attend our patients with our entire beings, Grealy teaches us, and thereby make space for them, their fear, their voice, and their presence, in the rooms of medicine. If we read Grealy's narrative on a more-allegorical level, however, gleaning lessons about our own doctoring, then we begin to discover one path to achieving our ethical goal of fully present care. The attention that the physician brings to the clinical encounter comes not from losing ourselves, abandoning our intellectual, emotional, or cultural senses of self and overidentifying with our patient, but from being fully present as listeners. As Grealy describes being able literally to feel her internal self, this sort of witnessing on the part of physicians comes from being fully aware of one's emotional viscera, one's affective anatomy. What stories are easier for us to hear because they remind us of, or do not remind us of, our personal and family histories? Which patients evoke unarticulated anger or frustration? What personal emotional needs affect our clinical care? Grealy's narrative suggests that we physicians must receive the stories around us not through an emptying of the inner self but through a heightened self-awareness that does not go down the road of solipsism but helps facilitate an ultimate state of inner stillness. The ability to engage in such

self-reflective, attentive practice is not just an ideal but is a necessity for the work of doctoring. Without it, as we see from Grealy's narrative, we physicians risk transferring to our patients the burden of recognition, making them into the mirrors that reflect back to us our own narcissistic reflections.

Narratives of pediatric illness written by parents can similarly shed light on an ethical, attentive practice of medicine. In Asian religion scholar Sam Crane's memoir about his son, *Aidan's Way*,<sup>17</sup> the relationships between stillness, spirituality, and interrelatedness are explored. Crane's son Aidan is literally and socially voiceless, in that he is so damaged from anoxic birth trauma that he is unable to see, to walk, or to speak, he is confined to a wheelchair, and he must contend with a seizure disorder and multiple other difficulties. Crane's narrative is simultaneously about a parent giving voice to the experiences of his voiceless child and about the profound lessons this child silently speaks to his parent and, through the parent's narrative, to the physician-reader. Crane formulates his narrative, and his title, as a Taoist quest, which is a search for the *Tao* or "The Way." In Crane's words, "The Way is, simply put, the complex unity of nature. It is not a transcendent God standing above and apart from His creation; it is more like a common, earthbound origin from which all things grow and are sustained."<sup>17(p47)</sup> Crane's tale is interspersed with ancient Chinese fables and scriptures, all of which resonate with lessons of inward attention and universal interrelatedness.

Aidan's very existence raises the questions that we are accustomed to thinking of as those of medical ethics. Crane is called on repeatedly to justify the meaning of Aidan's life to family, friends, community, and the insurance companies that cover Aidan's medicines and his expensive nutritional supplements. After one such confrontation, Crane is able to reflect on the broader social, ethical, and spiritual implications of these questions:

The whole affair . . . [was] representative of the broader domination of utilitarian thinking. Aidan was costly, his care was using up finite resources that might have gone to some other good purpose. For what the company spent on him, several other cases might be supported. The greatest good for the greatest number could arguably be better served by cutting off Aidan . . . each dollar had to be made to go farther, money could not be wasted on just one profoundly mentally retarded boy who would never walk or talk or see anyway. *It's their fault, the parents, for keeping these kinds of kids alive.*

It's not just money that distorts our view of human worth. Social status, cultural attainment, physical beauty: all of these and more creep into our calculations of an individual's value. These sorts of criteria are so commonplace that it sometimes seems remarkable when we are reminded that none of them fully capture the possibilities of personhood. And that is what Aidan does. His value comes precisely from the challenge he poses to the usual definitions of "value." He is a living reminder that

the range of human experience is broader than the narrow confines of balance sheets and business plans. Without a word, he poses the deepest questions. What is life? What makes any life, even one so limited, worth it? Strangers have come up to us on crowded streets, touching his shoulder or tousling his hair, giving us their abbreviated answers. Usually they say something about love or grace, something well beyond the material concerns of everyday life. We are constantly reminded of these more sublime things because, with Aidan, it's never about utility or efficiency or productivity, it's about humanity.<sup>17(p247)</sup>

Crane uses the Taoist metaphor of the useless tree to describe Aidan's life. He writes, "The central image is a gigantic tree, gnarled and knotty, with rotting wood and fetid leaves. It is apparently worthless, devoid of alluring fruit or durable timber. Attracting little attention, it has grown unencumbered, spreading out its branches so that it could shelter a thousand teams of horses in its shade. It stands in silent denial of our obsessions with the useful, the productive, the efficient, the worthy."<sup>17(p269)</sup> We see in one of the interpretations of the useless tree a, dare I say, useful correlation to the work of medicine. In one version of the story, the enormous tree stands next to, and in its stillness shelters, a village shrine, "becoming, through its impressive immensity, a part of the shrine itself."<sup>17(p269)</sup> So too can the attentive listener, the mindful physician, stand next to the shrine that is the patient's story and, through his or her very being, his or her ability to resonate and to reverberate from the chants emanating from the shrine, become part of it.

Like the physician who functions as the still vessel, Aidan's stillness indeed invokes the stories of those around him. After the initial questions, Aidan's mainstream classmates accept him completely into their community. Crane writes, "Their abilities were magnified in the mirror of his limitations, so they were pleased to congregate around him."<sup>17(p149)</sup> Crane tells the story of a little boy with a speech impediment in Aidan's class who is too shy to speak in front of the other able-bodied children but befriends Aidan, chatting away to him because Aidan is silent, still, and nonjudgmental, the best sort of listener. Aidan's relationships in the world emerge from a spiritual balance; Crane describes Aidan as the "yin" to his classmate's "yang."<sup>17(p150)</sup> Crane quotes the words of the ancient Chinese philosopher Chang Tzu, "A man . . . cannot see himself in running water, but in still water. For only what is itself still can instill stillness into others."<sup>17(p151)</sup>

Aidan offers his father a similar gift. Crane writes:

We do not banter, Aidan and I. There is no verbal jousting, the child exercising mind and language in a match of wits against the parent. . . . Aidan is unspeaking. His sounds certainly tell us when he is tired or hurting or happy. But our intellectual exchanges are based largely on his silence. He inspires silence in me. When I walk into his room, I do not want to speak, but, rather, absorb

the surroundings as he does, radiate my presence to him without words. . . . All the therapists tell us that we must engage him orally to alert him to our approach. . . . I have to fight back against Aidan's stilling effect. I want to follow him into his quiet, but I ought to bring him into the world of the talking, they say. Since he has no conventional voice of his own, we find ourselves speaking for him, narrating his life to the world. . . . For myself, I have found that I can write his life as well as speak it. . . . I write his life for others, and, through these stories, find new life for myself.<sup>17(p252-255)</sup>

Crane's relationship with Aidan is one of inspiration and "intellectual exchange," whereby, even silent and still, Aidan engages in narrative co-creation. Aidan does not reflect back to his father an unadulterated version of Crane's self but changes it with his very presence, pulling Crane into his own silence, just as he changes his classmates' perceptions of their own abilities, "magnifying" them through his own limitations. Crane's narrative, which is Aidan's narrative as well, helps clarify not only why stillness works but also how it works. Stillness, or passive voice, in medicine, becomes active in its very relational abilities, in its ability not only to stand next to but also to become part of the stories of suffering.

It is thus that the stories of children like Lucy and Aidan intertwine with physicians' own stories, get into our bones, and provide us with an opportunity to learn something deeper about our work and ourselves. There is a wisdom emanating from these children's illness stories, and this wisdom is perhaps the key to an emotionally centered and spiritually fulfilling practice of medicine. Arthur Frank has suggested that we should not only think about illness stories, analyzing and critiquing their literary qualities, but also think with them, gleaning truths about our own lives in relation to these narratives.<sup>13</sup> In thinking with pediatric illness narratives such as those of Lucy and Aidan, we physicians have the potential to tap into a knowledge that precedes our technical and academic skills. Many Eastern religions do not consider adulthood as the highest stage of development. Rather, "the end of the cycle is that of the independent, clear-minded, all-seeing Child. That is the level known as wisdom. And so Eastern texts such as the Tao te Ching urge us, 'Return to the beginning; become a child again.'<sup>2(p151)</sup> Fully entering narratives of children's illness experiences, thinking with such stories, is one way to return to this place.

In a story called, "The Surgeon as Priest," Richard Selzer introduces a healer skilled in this sort of wisdom. Selzer writes about Yeshe Dhonden, the personal physician to the Dalai Lama, a saffron-robed, shorn, "golden" man who "receives" his patient through his presence and his touch, the palpation of her pulse. Through his wordless presence and his laying on of hands, the Buddhist healer not only diagnoses his patient but also engages in an act of deep spiritual recognition. "So!" writes

Selzer, "Here then is the doctor listening to the sounds of the body to which the rest of us are deaf. He is more than a doctor. He is a priest."<sup>18(p36)</sup>

During the process of his diagnosis, both Yeshe Dhonden and his patient are wordless; their storytelling and story-listening occur through silence. Although Selzer's narrator does not abandon his Western medical training, he suggests that his future work in healing will be infused with the spiritual lessons of the monk healer. "Now and then it happens, when I make my own rounds, that I hear the sounds of his voice, like an ancient Buddhist prayer, its meaning long since forgotten, only the music remaining. Then a jubilation possesses me, and I feel myself touched by something divine."<sup>18(p36)</sup>

Physicians have the rare privilege of not only caring for patients but also allowing them to become our teachers, schooling us in attention, awareness, presence, interdependence, and empathy. It is an act of profound humility to turn the tables of power and to learn at the feet of those one would teach, to listen to the voices and silences of the children and adults for whom we care, and, in doing so, to approach a more-mindful medicine. This sort of reciprocal practice, listening to and in doing so learning to listen to our patients, is an act that propels physicians one step further on the path of ethical work. There reverberates in the background a deeper lesson, one that it would be foolhardy to try to name. Instead, let me turn, as Crane does, to the words of Chang Tzu (the bold is mine):

Joy and anger, sorrow and delight, hope and regret, doubt and ardor, diffidence and abandon, candor and reserve: it's all music rising out of emptiness, mushrooms appearing out of the mist. Day and night come and go, but who knows where it all begins? **It is! It just is!** If you understand this day in and day out, you inhabit the very source of it all.<sup>17(p229)</sup>

When I am with a patient, I try to remember sitting in that room, in that moment before Thurman ended our silence, and I try to listen very carefully, to the story before me and to the stillness behind me. Sometimes, if I am very lucky, I hear them all, the monk, the healer, the child, and the philosopher, lifting their voices, music out of emptiness, mushrooms out of mist, singing, "We are! We just are!"

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