Close readings

John Launer

When I was at school I had an English teacher who taught us how to read literature very closely. We might spend a whole hour looking at six lines of a Shakespeare sonnet or a single paragraph from one of Jane Austen's novels. Our teacher had been trained in the golden age of English studies at Cambridge. He was influenced by some seminal books about how to read literature carefully. These included *Practical Criticism* by the literary scholar I A Richards,¹ and *Seven Types of Ambiguity* by the poet William Empson.² Books such as these showed that any single line of great writing could be mined to great depths for complex meaning and insights into human life. Their writers believed that understanding literature wasn't about gaining a fuzzy impression of what the author might have meant, or like a visit to a historical theme park. It was a combined intellectual, emotional and moral enterprise to discover what the greatest minds of the past were trying to convey. It was akin to the reverent attention that previous generations applied to the Greek and Roman classics, and followers of the world's main religions brought to their scriptures—and still do.

In recent years, a number of people have proposed that literary studies should form part of the curriculum in medicine as well, either at medical school or in postgraduate training. Some have even set these up within programmes for teaching medical humanities. Others have done so as free-standing ventures, driven by their own individual passion. In New York, Rita Charon—a hospital physician and a literary scholar in her own right—runs a Masters' course in narrative medicine at Columbia University. Its aims include enriching students' skills in close reading and literary analysis.³ In London, John Salinsky has for many years encouraged trainees in general practice to read great novels, as well as joining group visits to the theatre during their specialty training.⁴ These projects are based on the belief that literature can help doctors learn important truths about the human

condition and increase their compassion at work. More specifically, they draw on the idea that if you learn to read a written text properly, you may become more expert in concentrating on the words that patients say as well. It can transform your understanding of what it means to listen, *really* listen, to what patients have to say.

DEEP LISTENING

There is a standard medical way of listening, but there is also a deeper and more human way of listening that is in fact remarkably similar to studying a line in a poem or a sentence in a novel. For example, if a patient says 'this bunion is driving me to despair', the routine medical response is to look at the bunion. But why exactly has the patient chosen the word 'despair', and what does that signify? If we develop the art of attentive listening, and follow this up with the right question, this apparently random word may open up a far more elaborate story, steeped in personal meaning: 'I slept badly last night because I was so worried about my job interview, then on my way to the job interview I was so distracted that I tripped over my bunion, was in agony, made a mess of the interview, my husband is furious because we need the money, I don't know how much longer I can cope....'

Although we often only choose to listen to the 'thinner' version of such a story, we know—at least in principle—how important it is to try to engage with the 'thicker' one. It makes an enormous difference to the relationship with the patient, the quality of the encounter, the kind of treatment decision that is reached, the likelihood that the physician's recommendations will be followed and the clinical outcome improved. The risks of a failure to pay attention to the words go beyond mere misdiagnosis or poor concordance with treatment: they encompass what the sociologist Arthur Frank has called 'misrecognition', a fundamental failure to engage with what patients have come about, and who they are.⁵ They also include the risk of letting the story remain 'stuck'. Without active listening and attentive questioning, the patient's story may remain the same as it always was, rather than evolving into

something more creative and more helpful.

POETRY WORKSHOPS

I have always been attracted to the idea of teaching doctors how to do close textual reading, and on a few occasions I have been able to put this into practice at residential workshops for GP trainers. Each time I have chosen two poems for them to study. The first is 'The Collar' by the seventeenth century priest, George Herbert. It describes his struggle with his religious vocation: the 'collar' in the title refers to his clerical neckwear but also to the yoke he felt his role imposed on him.⁶ The other poem is 'The Building' by Philip Larkin—one of the most acerbic but evocative poets of more recent years.⁷ The 'building' is a large general hospital. In the course of the poem, Larkin draws his readers into it, following human beings from the waiting room into their appointments and on to the wards, from where they may or may not ever return to their normal lives:

'Humans, caught
On ground curiously neutral, homes and names
Suddenly in abeyance; some are young,
Some old, but most at that vague age that claims
The end of choice, the last of hope; and all
Here to confess that something has gone wrong'.

Neither of these poems is straightforward. Both contain words and phrases that are unfamiliar, or used in unusual ways, particularly in the older poem. The first effect of reading them is to slow the reader down, not just from the ordinary pace of life but from the usual speed of reading as well. Both poems have their own rhythm—choppy and agitated in Herbert's poem, lilting and hypnotic in Larkin's—each creating an entirely different emotional response. They aren't short poems either. 'The Collar' is around a whole page long, and 'The Building' around twice that length. They require sustained concentration, not just the brief glance one might give to an email or someone's medical notes.

DEEPLY MOVED

When I studied them with the GP groups, we needed every moment of the 2 h we had assigned to the exercise. What we got out of it in consequence was very rich. Some of the doctors present were deeply moved by Herbert's confession of inner

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turmoil, and it helped them express similar feelings in relation to their own work. Others said that Larkin's account of a medical institution helped them to see these through different eyes. Many of them said it was the first time they had understood why close reading of difficult poetry was worthwhile, or that they were capable of doing so.

Would workshops such as this make a difference to the way that doctors practise, or improve the care of their patients? In previous generations, educated people would have assumed that the answer was yes. In terms of today's standards of evidence-based training, it might be harder to prove such a claim. Yet

it makes intuitive sense. Learning this kind of linguistic attentiveness cannot possibly do any harm to doctors and their patients. It is unlikely to be neutral in its effects either. Learning that words are important, and studying them with care, are parts of a rounded education in any subject. In medicine, close reading may in fact matter more than anywhere else.

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Competing interests None.

Provenance and peer review Commissioned; internally peer reviewed.

Postgrad Med J 2012;**88**:429–430.
doi:10.1136/postgradmedj-2012-131123

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