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Doctor–patient relations in selected American and British medical memoirs of the twenty-first century

Relacje lekarz-pacjent w wybranych amerykańskich i brytyjskich pamiętnikach medycznych XXI wieku

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Toruń 2022

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INTRODUCTION

The main aim of the undertaken research is to explore personal relations in doctor–patient communication, based on an analysis of selected doctors' memoirs, which form the research material of the dissertation. The secondary goal is to draw conclusions concerning the education of medical staff, and the possibility of using medical self-reflection captured in the memoirs to improve the current state of these relations. The topic of this dissertation is: *Doctor–patient relations in selected American and British medical memoirs of the twenty-first century*, which mirrors the above-mentioned goals. The dissertation concerns the borderland of literary studies and a contemplation on the role of the doctor in the society; hence, its purpose is both to enrich literary studies by triggering considerations on practical applications of literature as well as to provide new impulses in the field of medical and social research. The thematic area of the dissertation corresponds with the field of medical humanities; which are of interest to a growing group of scholars, including Paul Crawford, Brian Brown, Charley Baker, Victoria Tischler, and Brian Abrams, and constitute an interdisciplinary field of medicine, which comprises the humanities, social science and the arts (literature, theatre and visual arts) and how they can be applied to medical practice and education.[1] As Alan Bleakley argues in one of his books, *Medical Humanities and Medical Education* (2015), the term medical humanities was coined in the United States in 1948, but it did not spread in other regions at that time. Bleakley proposes a model in which patients, doctors and other health professionals cooperate with each other. He is convinced that including medical humanities into the medical curriculum allows students of medical fields to become fully caring, humane and empathetic medical staff. Following this concept can also enhance doctor–patient communication. Bleakley includes in his book practical examples and case studies to help him get his message across to the reader, among them medical educators.[2]

Due to the thematic richness of the raised issues, this dissertation draws on the following areas and disciplines: humanities (literary studies), medical and health sciences, as well as social sciences (sociology, pedagogy and psychology).

[1] Paul Crawford, Brian Brown, Charley Baker, Victoria Tischler, Brian Abrams, *Health Humanities,* New York: Palgrave Mcmillan, 2015, p.4.
[2] Alan Bleakley, *Medical Humanities and Medical Education: How the medical humanities can shape better doctors,* London: Routledge, 2015, p.12.

Bearing in mind the fact that the profession of a medical doctor is one of the specialties characterized by a particularly high degree of responsibility for the effects of treatment, the importance of decisions taken by representatives of this profession requires a great cognitive effort and high concentration on purely medical aspects (symptoms, causes, etc.) that allow making an appropriate diagnosis. This may sometimes lead to the situation, in which doctors are not capable of focusing on the patients' feelings, namely on working out mechanisms of interpersonal relations that would meet the existing demand for this type of behavior, and would ensure a proper dose of comfort to the patient. Patient-centeredness, an approach currently recommended in doctor–patient communication[3] justifies an insightful look at existing texts of memoirs written by representatives of the medical staff. Considerations included in memoirs, with the use of the appropriate research apparatus, can constitute a source of aesthetic stimulus resulting from literary values, but also inspiration for implementing specific organizational solutions.

There are diverse models of communication between the medical staff and a patient, which sometimes remain only at a theoretical level and are not properly applied in practice. The thematic scope outlined above may be subject to numerous debates; therefore a thorough exploration of these issues is necessary. For the purpose of this dissertation the following theses have been formulated:

1. The need to document by the medical staff their own reflections on their relations with the patients is a result of a growing humanization of the medical profession.

2. The evolution of standard doctor–patient relations stems from the doctor's increased autobiographical reflection.

3. An analysis of medical memoirs gives a possibility of examining the quality of doctor's involvement in a patient's situation.

4. Memoirs written by representatives of the medical profession enable verification of the training quality of the future medical staff.

Thus the conclusions of the research presented in the present dissertation can serve as recommendations for future training of the medical staff with respect to doctor–patient communication. The methodology adopted in the present study can be extended to the study of memoirs in general. The chief advantage of the project is that the data gathered in the course of

[3] See Anna Bączkowska, https://www.ateneum.edu.pl/assets/Uploads/003-baczkowska.pdf, accessed on 12.04.2022.

research will be useful for illustrating the approach of the medical staff towards patients on the interpersonal level and the complexity of their relationship with patients. The formation of a specific pattern of attitudes towards patients may exert a beneficial effect on the overall number and choice of the undertaken therapeutic processes. As the dissertation seeks to demonstrate, it is justifiable to expect that all the professional remarks, present in the analyzed texts and formulated by the medical staff can be one of the foundations for creating a universal behavior pattern recommendation in interpersonal relations between the doctor and a person visiting him/her for consultation and treatment purposes.

Whereas writing medical memoirs has become more popular recently with doctors and other medical specialists, academic studies of medical memoirs are rare. So far, two books were devoted to analysis of medical memoirs. *Doctors in the Making: Memoirs and Medical Education* (2009) by Suzanne Poirier analyses medical memoirs published in the United States, whose time span ranges from the 1950s to the mid-2000s. The focus of Poirier's attention is medical training and how it affects future doctors; she concentrates on unofficial stories connected to medical education told by medical students and graduates. She sees the power and meaning in the narrative and story-telling present in autobiographical writing. Poirier views authors whose memoirs she scrutinizes as those who aim at a better understanding of the situations they face. However, in her analysis of other memoirs, Poirier does not focus on practical training at work (on the job) or doctor–patient relations, which is one of the differences between her study and mine. She focuses on the gender and race of the authors of medical memoirs, and concludes that authors of medical memoirs are mostly white males.[4]

The other book whose author analyses medical memoirs is *Contemporary Challenges in Medical Education: From Theory to Practice* by Zareen Zaidi (2019). It is a recent work in the form of a guide, which addresses the usefulness of sharing medical cases faced by doctors in social media for educational purposes. The author of this book refers to blogs or contents posted in social media such as Facebook by doctors as electronic health record (EHR) and perceives them as "a hidden curriculum" on professional attitudes and skills rather than a formal one. Zaidi wonders about the benefits and drawbacks of electronic health records for medical students. The difference between Zaidi's and my research lies in the fact that she takes a closer look only at experienced clinicians and educators, and not beginners in medical profession. Those educators' role is to provide examples of clinical and pedagogical scenarios with

[4] Suzanne Poirier, *Doctors in the Making: Memoirs and Medical Education*, Iowa: University of Iowa Press, 2009, p. 7.

approaches based on theory, which will support a better professional development of the addressees of her guidebook. Beyond promoting well-being and relaxation techniques, educators help confront aggression faced by female patients and minorities, and encourage discussing ethical dilemmas. Zaidi is convinced of the role of electronic health records in improving the quality of medical care.[5]

Apart from books on medical memoirs, in 2022 reviews of medical memoirs have been published by the doctor Danielle Ofri, who offers critical perspectives. She reviewed three memoirs, each of them written by a different medical doctor. The first of the reviewed memoirs is *Internal Medicine: a Doctor's Stories* by Terrence Holt. Ofri values this memoir for illustrating human fragility and recreating experiences from an intern's professional life, for example, seeing a patient with shortness of breath. In her review of *Working Stiff: Two Years, 262 Bodies, and the Making of a Medical Examiner* by Judy Melinek, a young forensic pathologist, Ofri looks at both informative and literary value of this book. On the one hand, Ofri praises the author for providing an accurate account of a daily life of the medical profession. She appreciates the ways in which Melinek reports captivating cases, death scenes, autopsies and conversations with grieving relatives. On the other hand, however, Ofri complains about the missing depth of a record of the doctor's progress in some chapters of the memoir. The third review by Ofri concerns the memoir *On the Cancer Frontier: One Man, One Disease, and a Medical Revolution* by Paul Marks and James Sterngold. Ofri outlines and discusses the topic of this memoir, which is cancer and research on it. She stresses that the research in Marks and Sterngold's memoir is viewed as a factor contributing to the successful fight against this illness. Ofri detects that the authors of this memoir include plenty of plot twists and she continues with a general summary of the memoir themes.[6]

The research materials used in this dissertation constitute doctors' and a nurse's publications in the form of memoirs, which include personal comments and thoughts of the medical staff concerning their work, the nature of performed tasks, the assessment of their attitudes towards their own profession and patients and types of emotions experienced while fulfilling their duties. The publications came out in the 21st century, their authors are British and American writers (doctors and a nurse). Special attention is paid to the specificity of memoirists' records, which are not only impersonal descriptions of events and facts from personal and professional life, but also the testimony of the authors' emotions. Taking into

[5] Zareen Zaidi, *Contemporary Challenges in Medical Education: From Theory to Practice*, University of Florida Press, 2019, p. 54.
[6] https://danielleofri.com/medical-memoirs, accessed on 07.09.2020.

account the highly personal nature of these texts, they are useful for preparing forward-looking projects to modify programs, which prepare future medical staff for the performance of tasks related to the medical profession.

As far as sources are concerned, the dissertation is based on: primary sources – i.e. medical memoirs comprising case studies, histories of patients' illnesses and treatment, stories of their families and relatives and the way they behave, as well as reactions and actions of the medical staff themselves in these situations. Apart from these primary sources, the methodology relies on secondary sources, which comprise e-books, printed books and magazines, and other researchers' surveys conducted on patients and doctors (concerning the quality of their relations). Surveys results are also discussed. Another important source includes audio materials, such as an interview with the nurse Theresa Brown. The dissertation is also based on the methodology of memoir research developed, for instance, by Philipp Lejeune and quoted in Sidonie Smith and Julia Watson (2011), Andrzej Cieński (2002), Regina Lubas-Bartoszyńska (2003) and Małgorzata Czermińska (2009). Undoubtedly, the selection of sources is crucial for the entire course of research procedures and necessary for obtaining reliable results of the analyses. This dissertation is based on an analysis of documents. The applied research procedure assumes collecting documents (physicians' and a nurse's memoirs), pre-selecting them, establishing the authenticity of the available materials, verifying their credibility, carrying out analytical activities, and drawing conclusions.

Referring to the above elements, it needs to be stated that the biggest difficulty lies in the aforementioned credibility verification of the selected sources, since memoirs are based on the internal feelings of the doctor–writers, who may diversely interpret certain events, filtering them through their own cognitive apparatus shaped by heterogeneous experiences. Therefore, it cannot be unequivocally stated that the recalled events are fully compatible with the actual state of affairs. It should be assumed, however, that while some facts may be distorted to some extent, their essence remains intact, and the presented feelings and impressions are genuine (although in this case it cannot be excluded that certain embellishments were added), which is worth remembering while analyzing such a material. Notwithstanding, the selected sources provide an opportunity to become acquainted with deepened characteristics of a job of the medical staff, the joy and pain connected with it, together with insights that can be shared and applied by others as well. Another aspect to bear in mind is that memoirs are written by only a fraction of the medical staff, who are particularly reflective and feel a literary calling, which

may make this group of the medical staff not fully representative of their whole professional group.

Due to a great diversity of the raised issues, the content of this dissertation has been divided into four chapters. The first chapter sketches out the field of non-fiction writing, with a particular emphasis on the genres of memoir, diary and autobiography. It also includes examples of themes discussed in those non-fiction genres. A blog is also highlighted as a new form of autobiographical work posted on the Internet, which thanks to the scope of this medium can reach a wide range of audiences, who – in addition – have the possibility of interaction.

The second chapter focuses on doctor–patient communication. The functioning models of interpersonal relations constitute a reference point for further discussion, while the presence of particular models is traced by analyzing primary sources, discussing them in detail and raising the question of communication among the medical staff.

The third chapter explores emotions experienced by the medical staff and patients. Those emotions are exemplified; the instance of a doctor's strong involvement in a particular patient's medical case is described, and the problem of excessive emotionality influencing a professional sphere in a negative way is emphasized. The situation of a physician who turns into a patient due to the appearance of an ailment is recalled, which gives the doctor a chance of glancing at his behavior from a different perspective, which can result in a potential change in his attitude towards his patients.

The fourth chapter is devoted to the matter of training medical staff. This chapter focuses on an analysis of the physician's professional transformation from a beginning adept at medical arts into a more confident and competent representative of this profession. The circumstances in which a sense of lack of sufficient preparation both in terms of medical competence and emotional intelligence are portrayed. An emphasis is put on systemic deficits concerning monitoring doctors' work. Self-reflection leads to eliminating deficiencies and targeting actions that are supposed to contribute to a doctor's professional development. Presenting the doctor's medical mistakes is counterbalanced by self-diagnosis of patients. They both seem to be new phenomena closely related to the technological revolution of the past decades.

The order of chapters is determined by the assumed sequence that takes place during the doctor–patient or a nurse–patient confrontation. At first, the two parties communicate during a medical visit, then both or one of them may experience emotions as a result of this exchange.

Teaching in the form of self-training takes place as the last step. Some untypical patient's condition may motivate a doctor or a nurse to share their take on it with other medical specialists at a conference or medical council.

The memoirists whose books I selected for analyses are all related to the medical world. Their depiction of medical environment and issues is thus authentic, provided at first hand. They represent the perspective of practitioners who both reminisce about past experiences and seek to improve medical professionalism in one way or another. The books discussed in the present dissertation have all been written relatively recently, i.e. within the past eleven years. All the writers are alive and professionally active, which makes their perspective a current one. One of the doctors – Marsh has already retired, but he still operates on patients. Moreover, the books selected for discussion in this dissertation give the reader an insight into hospital life from the point of view of doctors and nurses. A large number of people know hospital reality because they were patients or else heard about it from family members, but relatively few know the perspective of medical staff. All the books discussed in this dissertation fall into the category of medical memoir, which is a genre that rests on reflections and conclusions drawn from past events. Sometimes memoirists explain how they learned from their own or somebody else's mistakes to do things better in the future. Apart from the medical knowledge and jargon, which may be of interest to medical workers, the books are filled with universal reflections on life and work, made by writers who have witnessed extreme or unusual situations. Thus the memoirists' recollections and ideas may be found crucial by both medical and non-medical audience.

Most of the authors whose memoirs will be discussed in this dissertation are of American origin (Lisa Sanders, Theresa Brown and Matt McCarthy) and one of them (Henry Marsh) is English. Of all these memoirists, Marsh has the longest medical experience and his specialty, which is brain surgery, seems the most demanding. That is why his views and recollections are juxtaposed with those of other medical staff in the present study. Some of the selected authors are involved in teaching, namely Matt McCarthy, who has been teaching since 2014, and Lisa Sanders, who has been lecturing at Yale University School of Medicine since her graduation in 1997. The writers represent distinct branches of medicine, in which they specialize: Henry Marsh is a neurosurgeon, Lisa Sanders and McCarthy – internists, and Theresa Brown – a clinical nurse. All of them share a genuine calling and dedication to their jobs, as well as concern about the well-being of the patients they work with, even though for two of them medicine was not the first choice in professional life. Theresa Brown and Lisa Sanders first graduated in English, and after some time decided to turn to medical professions,

resigning from their previous jobs. Apart from working daily with patients, the four authors took time to write medical memoirs. For Henry Marsh, a memoir was the main genre he practiced, even though he used to write poetry as a young man. The remaining writers have also produced other, more concise forms of writing, for example, journal articles, columns, and book reviews. Whereas Lisa Sanders writes mostly columns, Matt McCarthy is also known for articles, book reviews, and a multitude of specialist publications. Theresa Brown began by writing essays, then turned to a blog, and afterwards moved on to books. In the following paragraphs, I present short biographies of the four authors to contextualize the discussion of their works in further parts of this dissertation.

Born in 1950, Henry Thomas Marsh is a leading English neurosurgeon, and a pioneer of neurosurgical advances in Ukraine, where he was working with specialists in the same field. Marsh was the senior consultant neurosurgeon at St George's Hospital, in London, one of the country's largest specialist brain surgery units. As Joshua Rothman indicates, he became a brain surgeon by chance. At the age of twenty-one, he left London and went to Newcastle to get over unrequited love, where he began to write poetry. While working as a hospital porter, he saw surgery for the first time. In 1973 Marsh completed his degree and entered the Royal Free Hospital School of Medicine. He glimpsed an anesthetized woman sitting on an operating table, which was a life-changing experience for him.[7] The scene in front of his eyes made him discover his vocation, he suddenly found a passion for this profession. He came to specialize in operating on the brain under local anesthetic.

His achievements gained the attention of the press and popular media. He became the hero of the BBC documentary *Your Life in Their Hands* and later of the film *The English Surgeon*. He is the author of two memoirs: *Do No Harm: Stories of Life, Death and Brain Surgery* (2014), and *Admissions: A Life in Brain Surgery (*2017). Marsh is primarily a doctor and the idea of writing books about his work appeared spontaneously. His wife read a fragment of a diary he kept just for himself, without the aim of publishing it. She showed the diary to a literary agent, who became interested in it. Marsh started rewriting his diary as a narrative, which took him the next ten years. He plans to write his third memoir, which is supposed to be less medical and more philosophical. Although he is retired, he cannot part with his profession

7 Joshua Rothman, https://www.newyorker.com/magazine/2018/05/18/anatomy-of-error# Anatomy of Error, A *surgeon remembers his mistakes*, accessed on 18.05. 2018.

and continues to perform neurosurgery in Ukraine, Albania and Nepal, where he started working in the early 1990s.[8] He represents a humanistic and holistic approach to practicing medicine, which goes beyond the medical treatment of his patients. For example, he is convinced that hospital buildings and design have an influence on the patients and the staff, which he stresses in his broadcasts. Marsh was appointed Commander of the Order of the British Empire (CBE) in 2010.[9] The two memoirs published so far constitute his only writing, which focuses on depicting his professional experiences and his reflections connected with them.

One of his memoirs – *Do No Harm*, written in 2014 is the memoir which includes a long time span. The author comes back to the time when he was a student himself and describes his attitude towards his patients (p. 83). He mentions the year 1979 – the time of his training as a junior doctor (p. 79) and later as a houseman in the Casualty Department in a dilapidated old hospital in the south of London. Once he moves thirty years back to refer to his personal memory from the 1980s, when his son was three months old (p. 107). However, most of the book is set at St. George's Hospital, in London, where the author is a senior consultant. Besides, there are also episodes of stories taking place in Ukraine, Kiev, where he periodically worked with neurosurgeon Igor Kurilets and they both performed modern procedures with second-hand surgical equipment. Then Marsh describes the terror of operating in a strange place and having substandard equipment at his disposal. By writing his book, the author wants to atone for his medical errors. Recalling them allows him to confess them and show that the doctor does not always succeed in healing his patients. The author stresses the fallible nature of a human being and at the same time the shortcomings of his profession in the following sentence: "You will inevitably make mistakes and you must learn to live with the occasionally awful consequences" (p. xi). The writer is prone to reflection. *Do No harm* is an attempt to answer a startling question: "How can one cut into people's brain and emerge whole?" (p. xi). Even though Marsh is retired, the thoughts of his surgical job stay with him, and his memoir is a way of taking care of his own well-being: "The stories in this book are about my attempts, and occasional failures, to find balance between the necessary detachment and compassion that a surgical career requires, a balance between hope and realism" (p. xi). This memoir serves the author as a means of reaching equilibrium between worrying too much about his medical cases from the past and keeping calm. Stories recounted in the book allow other surgeons and medical doctors in

8 https://www.theguardian.com/books/2019/nov/24/how-to-save-the-nhs-by-five-medical-memoirists-henry-marsh-adam-kay, accessed on 24.11.2019.
9 https://www.townandcountrymag.com/society/tradition/g25574123/celebrities-with-royal-honors-knights-dames/, accessed on 04.01.2018.

general to understand what it is like to deal with complicated cases, which are never the same. The author also wishes to dispel the myth that doctors are equipped with some magical power, and he argues that the outcome of their work is often a matter of luck, beyond their control: "If the operation succeeds the surgeon is a hero, but if it fails he is a villain. The reality, of course, is entirely different. Doctors are human, just like the rest of us. Much of what happens in hospitals is a matter of luck" (p. xi). This fragment shows that Marsh feels the need to share his reflections with others and he does it with sincerity. He builds a self-portrait, gives an account of his professional life, writes about the lives he has saved and those he has irrevocably wrecked. He wishes to help others understand the differences of a human, rather than technical nature that doctors face.

Lisa Sanders was born in 1956. She is an American attending physician at Yale – New Haven Hospital, and an associate professor of internal medicine and education. Besides, she is also a medical journalist and author. However, her path to medicine was not as straight as in the case of other medical students. At first she graduated in English from College of William and Mary. After working for 10 years for CBS News and winning an Emmy Award for Outstanding Coverage of a Breaking News Story for her report on Hurricane Hugo, she decided to take up medicine as her professional choice. She apparently realized that it was the field that intrigued her most among other subjects she covered in her job as a journalist. Thus Lisa Sanders found a way of combining her literary and medical interests. Her writing developed gradually, with small steps. In 2002 she started writing a popular column entitled *Diagnosis* in *The New York Times*. This column inspired the television series *House M.D*, to which she served as a consultant. In this column Sanders includes either her own patients' undiagnosed, "mysterious" cases or those that challenged her colleagues. She presents medical dilemmas thoroughly and then describes the solutions proposed by the patient's doctor alongside their attempts at diagnosis. Thus, reading her column, readers can often confront their own medical problems, which may be analogous to the cases she describes. Each case is given a title which signals briefly the medical problem, for example, "A Runner Suddenly Developed Asthma. It Was Stranger Than It Seemed." Through her column in *The New York Times*, Sanders' medical experience serves a greater audience than just her patients who visit her in her office. In 2019, her column *Diagnosis* became an inspiration for a program featured on Netflix, in which some cases from her column were presented.[10] In this way Sanders popularizes the idea of looking

10 Ibid.

beyond stereotypes in order to reach a proper diagnosis. By discussing openly various common symptoms, she renders them less embarrassing and shameful to people who would perhaps hesitate to ask their doctors. Sanders is a progressive and practical doctor. As Christopher Florentz argues, she relies on the concept of crowdsourcing as a way of helping patients. The idea of crowdsourcing in medicine means that after some ailment has been described on social media, readers or medical staff, such as nurses, paramedics and doctors, can state what they suspect the diagnosis may be in connection with the presented ailments.[11] The democratization of medical diagnosis – indebted as it is to the new technologies – seems evident in this new phenomenon of crowdsourcing.

Another column Lisa Sanders writes is *Think Like a Doctor*, which is featured in *The New York Times* blog. It bears a certain resemblance to the column *Diagnosis,* with a difference that this column is more interactive and hence more appealing to the readers. A particular medical problem is posed as a challenge, frequently in the form of a question, for example, "A 50-year-old woman has fevers and vomiting after visiting her family in Kenya. Can you figure out why? Conditions embrace: travel sickness, headache or stomachache." The patient's medical situation is described thoroughly, along with actions taken so far. The material appeals to visuals – there are colorful pictures for example of M.R.I. (magnetic resonance imaging) of the brain or paintings of an artist, whom the problem concerns. Sanders engages readers in a competition and encourages them to figure out an answer to problems presented by her. The first reader to solve the dilemma correctly is promised to receive Sanders' book. Curious readers have the possibility of finding out the proper diagnosis and the winner at the corresponding site, where each problem is solved.[12]

In addition to journalistic work, her published books include: *The Perfect Fit Diet: Combine What Science Knows About Weight Loss With What You Know About Yourself* (2004), *The Perfect Fit Diet: How to Lose Weight, Keep it Off and Still Eat the Foods You Love* (2005), *Every Patient Tells a Story: Medical Mysteries and the Art of Diagnosis* (2009), and *Diagnosis: Solving the Most Baffling Medical Mysteries*, which is her most recent book, published in 2019. Additionally, she is currently involved in collaboration with *The New York Times* on an eight-hour documentary series on the process of diagnosis. She is also researching clinical decision

11 Christopher Florentz, "Can Crowdsourcing Solve Medical Mysteries?, More heads are better than one", https://www.cslbehring.com/vita/2018/crowdsourcing-and-medical-mysteries-0628, accessed on 28.06. 2018.

12 Think Like a Doctor: The Painter's Headaches - The New York Times (nytimes.com), accessed on 25.07.2019.

making and the way diagnostic decisions and errors are made.[13] She frequently compares the art of making a diagnosis to solving a detective mystery, and in *Every Patient Tells a Story*, she mentions Arthur Conan Doyle, whose fictional detective – Sherlock Holmes fascinated her in the childhood.[14]

In the aforementioned book *Every Patient Tells a Story*, published in 2009, Lisa Sanders makes retrospections to different times and aspects; scientific ones and those related to her career path. She does it by referring to studies conducted in the 1960s and 70s, whose aim was to pinpoint the most useful tools in making a medical diagnosis (p. 56). She does not indicate any particular names of those researchers. The author also refers to the early 1990s, when the physician and researcher Salvatore Mangione began studying doctors' abilities to interpret the results of heart examinations (p. 42). She then comments on the university curriculum, which has been binding since 2004 (p. 9). Sanders also discusses a survey done in 2005 by the Pew Centre. Its goal was to find out what were the sources of obtaining health information by the Americans. The survey results indicated that 95 million of American chose the Internet for that purpose (p. 231). As for memories connected to her professional life, Sanders recollects her application to the Yale School of Medicine. The reader finds out that she completed her residency training at Yale's Primary Care Internal Medicine program, where she has stayed since then to look after patients and teach doctors. As for patients' stories the author relies on, they date back to 2003 (p. 58).

Sanders seeks to make the medical world comprehensible to the reader by exposing the doctor's feelings of uncertainty or curiosity in confrontation with the patient and his/her problem. Sanders wishes to portray the doctor's cognitive processes involved in finding out what the cause of the patient's disease is. She also aims to share her passion for medical issues with the reader, which she does by discussing medical stories that she finds fascinating. She collected those stories at the formative stages of her career. Her decision to write resulted from her passion for medicine, but her writing was developing gradually: "This book has its roots in a column I have written for the past six years […]. The column has been my opportunity to share with general readers my personal collection of fascinating diagnostic histories." (p. xxvi-introduction)

13 Parry, Julie. "Meet Yale Internal Medicine: Lisa Sanders, MD, FACP, Associate Professor of Medicine (General Internal Medicine).", https://medicine.yale.edu/intmed/people/lisa sanders. Profile, accessed on 02.02.2019.

14 https://www.nytimes.com/2019/08/16/reader-center/diagnosis-tv-netflix.html, accessed on 16.08.2019.

Her next goal is to prepare the reader for the role of a patient; she is convinced that the more one knows about the process of healing, the better one is likely to understand and contribute to it.

> In writing my columns and now this book, I try to share a face of medicine that is both exciting and important. Exciting because the process of unravelling the mystery of a patient's illness is a wonderful piece of detective work [….]. Important because any one of us might someday be that patient. (p. xxvii-introduction)

She also wishes to share and convey some important messages concerning the education of medical staff. For example, she argues that medical schools fail to consider patients as human beings, they are instead referred to as medical cases. Furthermore, she poses some questions to encourage (self-)reflection. For instance, she juxtaposes two attitudes to medical examination: the claim that it is a thing of the past, and the opposite stance, that it is a key to the right diagnosis and a means of connection between a doctor and a patient. Sanders adopts the latter attitude and argues that this type of a basic examination cannot be replicated by any machine (p. 53).

The book Sanders wrote is for her a way of evaluating her own abilities and potential. Personal aspects are present to confront her lack of skills, oversight, as well as her own mistakes. She frequently states her personal opinion, for example on the importance of personal medical examination and admits to the lack of skills on how to conduct such an examination at the early stages of her career (p.48). With time, she became more skillful at performing it; she learned cautiousness, which let her not to ignore clues that can save patients' life in the long run. The book helps her realize her professional aims, which are patient- and healing-oriented. Sanders treats her book as an opportunity to present studies results, new trends and views among doctors and patients (for example, the new trend among patients to diagnose themselves). She presents a patient who, after surfing the web for diagnosis, comes up with her own diagnosis, or follows up on her doctor's diagnosis, and finds out that she suffers from Rocky Mountain spotted fever. Another attitude Sanders addresses is some doctors' rejection of a computer-based diagnosis, to give priority to their personal knowledge, experience and intuition (p. 238).

Theresa Brown, who was born in 1965, works as a clinical nurse in Pittsburgh. She received a PhD in English from the University of Chicago, but after becoming a mother, she decided to leave academia and pursue nursing. It turned out to be the right path for her and she never regretted it. In addition to working in a hospice, she is on the Advisory Board of the Jewish Healthcare Foundation, and lectures nationally and internationally on issues connected with nursing, health care, and the end of life. She started with the essay "Perhaps Death is Proud*",* which after its publication in *The New York Times* kindled the interest of other

publishers as well. Her writing has appeared in different venues, both academic journals, such as *The American Journal of Nursing* or *The Journal of the American Medical Association,* and popular and online newspapers, such as the *Pittsburgh Post–-Gazette* or CNN.com. She still remains a frequent contributor to *The New York Times.*[15] For example, Brown has chronicled her experiences as a nurse in an opinion column in *The New York Times*. As a columnist, Brown raised issues previously unexplored, such as the cases of doctor-nurse bullying. She also commented on healthcare reform in the United States. Due to her public involvement, in 2009 she was invited to the White House to meet President Obama and attend an event in support of the Affordable Care Act.[16] Brown promoted the idea of healthcare reform: "I have no statistics to support the need for reform; I can only describe what I have seen, because what I have seen brings the discussion of healthcare reform down to the level of individuals". Brown claims that those who oppose the reform ought to consider what they would do if they found themselves in the situation of her patients.[17] Theresa Brown attempts to speak on behalf of the society. In this way, she extends her care for the health of society beyond her immediate workplace, i.e. the hospital. In the interview with Christopher Springmann, Theresa Brown reveals that she defended the legislation mentioned above and argues that by regulating insurance companies, the Affordable Care Act is trying to ascertain that more people can obtain the care they need by making health insurance more affordable. She is convinced that the government ought to intervene and offer the care people need. The nurse views this act as a step forward for those, who have never had an insurance or lost it because of losing their job. Without this legislation, people would not be able to cover the costs of their treatment. She elaborates on the concept of this act in the interview:

> TB: And the good that it's done so many people who can now actually afford healthcare because they can afford health insurance that's good health insurance [….]. Yes. And the people who've had their bills for insurance go up, what the Democrats weren't great at saying is because their insurance wasn't really going to cover them if they got sick. And I think that's a sticking point for people is they don't really understand how expensive healthcare is.[18]

Brown was also a guest on NPR's *Fresh Air and* MSNBC Live on March 26, 2013. Her first book, *Critical Care: A New Nurse Faces Death, Life, and Everything in Between* (2010) was

15 Cynthia Saver, *Anatomy of Writing for Publication for Nurses*, Indianapolis: Honour Society of Nursing, 2017, p. 357.

16 https://www.pghcitypaper.com/pittsburgh/author-and-nurse-theresa-brown-discusses-hospitals-nursing-and-her-new-book-the-shift/Content?oid=1857103, accessed on 23.03.2021.

17 A Nurse's View of Health Reform - The New York Times (nytimes.com), accessed on 13.04.2019.

18 Podcast: Loving The Affordable Care Act Nurse Theresa Brown, RN (linkedin.com)

classified as a book of nursing narratives by Rojann Alpers, an associate professor in the College of Nursing and Health Innovation, an American nursing educator, curator, and a certified practice nurse. Brown's memoir chronicles her initial year of nursing and has been adopted as a textbook in Schools of Nursing across the country.[19] Rojan Alpers recommends *Critical Care* to nurses, nursing students, service professionals, and caregivers. She wishes her students could "hear, understand and experience" the insights and reflections Theresa Brown shares with her readers. Alpers highlights the fact that Brown writes about universal themes, such as conflicts, challenges, victories and confrontation, but what distinguishes her from other authors is a new and engaging manner of writing about these themes. In her review of Brown's book, Alpers draws attention to her style, in which writing is descriptive and expressive.[20] *Critical Care* is not Brown's only memoir. Her most recent, well-reviewed book, *The Shift: One Nurse, Twelve Hours, Four Patients' Lives* (2015), is a *New York Times* Bestseller, in which Brown focuses on her patients, about whom she writes with deep empathy. The events described in the book take place during a twelve-hour shift in an oncology ward. In a self-effacing manner, she presents the patients' perspectives and thus makes her readers aware of what a challenge it is for them to suffer from debilitating diseases far away from their homes. Brown also detects the patients' discomfort, at being subjected to hospital staff schedule, for example being woken up at 4 or 5 a.m. to have their blood taken.[21] Her aim in describing medical reality around her is clearly to sensitize all stakeholders in the healthcare system.

Her memoir *Critical Care* (2010) covers a short range of time. Cases described by her include the author's first year of working as an oncology nurse – since 2007 until about 2009. For privacy reasons, she does not disclose the names of the hospitals in which she worked. The nurse only mentions floors of the hospital, she moves from one floor to another, but does not give names of departments, either. She only reveals that she was an Emergency Department patient and gives the name of Pediatric Intensive Care Unit.

Firstly, writing about nursing became realization of Brown's dream at the time when it was just taking shape. Describing nursing matters was helpful in understanding the intricacies

19 http://www.theresabrownrn.com, accessed on 10.12.2018.

20 Rojann Alpers (2010) A Review of "Critical care: A new nurse faces death, life and everything in between", Health Care for Women International, 32:1, p. 96.

21 https://www.pghcitypaper.com/pittsburgh/author-and-nurse-theresa-brown-discusses-hospitals-nursing-and-her-new-book-the-shift/Content?oid=1857103, accessed on 24.03.2019.

of her job. While she was writing about her confrontation at work, she automatically started putting more effort in caring about patients than she previously had.

Secondly, writing also helped her go through difficult experiences at work (for example a patient's sudden death), which she recalls:

> There was a lot of blood, and even days afterward I was having a hard time putting the experience behind me. I decided to write the experience down, simply in the hopes that I could contain it. I thought that putting my memory into three pages of text would make it less all-consuming. (p. x preface)

Moreover, writing supported Theresa Brown emotionally (the book was a listener, interlocutor she could confide in). She found a therapeutic power of writing (in the face of an intense year of nursing) and felt the need to record her professional progress. She could see her growth in the job:

> Part of me, I discovered, loves to write. I had an intense first year as a nurse, and writing about it was therapeutic. As I progressed from chapter to chapter, roughly parallel to each month of my initial year, I also was able to see how much I had grown in the job. At the start, it seemed that I had only my instincts and a very basic understanding of how hospitals and bodies work. By the end of the year, I was giving my cancer patients chemotherapy with a fair amount of confidence, for the most part talking easily with doctors, and navigating the social environment in the hospital without too much effort. These are big accomplishments, but also normal milestones for any new nurse. (p. xi)

Thirdly, writing gave her an opportunity to reflect, share her reflections and draw conclusions. She realized that in the face of violence, cruelty and illness, the doctor can always try to show an interest in the patient or offer hope (p.88). Brown shows in her book how hard it is to worry over the people we love, communicate some general truths to them, or portray the hospital life. The book contains personal remarks and an account of emotions. Although Brown was jotting down these notes for herself, her family encouraged her to write a book and publish it.

McCarthy is an assistant attending physician at New York-Presbyterian Hospital, where he serves on the Ethics Committee. He is also an assistant professor of medicine at Weill Cornell Medical College. He prefers not to reveal his birthdate, for fear of the intrusion of the public into his personal life.[22] In McCarthy's memoir *The Real Doctor Will See You Shortly*, he discloses that he graduated from Harvard Medical School in 2006 (p. 1). In addition to his medical profession, McCarthy is also a truly prolific author. Writing is a passion, which McCarthy discloses in the interview with Christy Duan in 2016. He explains in it that initially he dreamt of becoming a lab scientist, but when he began working there he lost interest in it and realized his aspiration was to become a physician and a writer. In his present position, the

[22] Dr. Matt McCarthy Bio–Wiki, Age, Books, Superbugs and Net Worth. - Wiki, accessed on 21.10.2019.

working system in medical sector enables him to write. He sees patients 28 or 14 days in a row, which is followed by the same number of days off, during which he can do writing.[23] McCarthy is the author of two national bestsellers which are classified as memoirs: *The Real Doctor Will See You Shortly: A Physician's First Year* (2015) and *Odd Man Out: A Year on the Mound with a Minor League Misfit* (2009). In both of them, he recounts his experiences, but from two completely different periods and areas of his life. The former memoir focuses on the stage of being an intern, whereas the latter book is an account of the time when he was a professional baseball team player, representing of the Provo Angels.

Another book he published is entitled *Superbugs: The Race to Stop an Epidemic* (2019). This work is of a different nature than the previous ones in the sense that the author looks into the future medical situation of mankind. McCarthy seeks to explain why the financial system discourages pharmaceutical companies from introducing innovative drugs for use in hospitals.[24] His writing has increased in scope, and his articles and columns include *The New York Times*, *Slate*, *Sports Illustrated, The Atlantic Stat News*, and *Reuters.* McCarthy also writes Medspin columns for Deadspin – a website devoted to sports news. An excerpt from his book *The Real Doctor Will See You Shortly* appeared in the form of an article entitled "Hippocratic Oath: My First Day as a Doctor in the Atlantic." He also reviews non-fiction for *USA Today* and is editor-in-chief of *Current Fungal Infection Reports*. Some of his Book Reviews for *USA Today* include *A Book about Love* by Jonah Lehrer, *Blitzed* by Norman Ohler, *Ripper* by Patricia Cornwell, *Between Themes* by Richard Ford and *Blue Dreams* by Lauren Slater.[25]

The cases and stories included in McCarthy's books are all based on real events, although patients' names are changed for the reason of data protection. McCarthy's books focus on stories of patients, thus preparing the readers for the role of a patient or a patient's relative. *The Real Doctor Will See You Shortly* was written in 2015. In his book, McCarthy goes back to 2006, the time of his third year of studies at Harvard Medical School. The third year, as McCarthy explains is a breakthrough in medical studies, since at that point students begin to see medical procedures going on in hospital in practice. He reports his work as an intern and a resident. The book setting is Massachusetts General Hospital, which the writer calls Mass General. It is a large teaching hospital of Harvard Medical School.

23 Christy Duan, Q&A with Physician-Author Dr Matt McCarthy, https://www.studentdoctor.net/2016/05/04/qa-physician-author-dr-matt-mccarthy.
24 https://scribepublications.com.au/books-authors/books/superbugs, accessed on 24.05.2019.
25 http://www.drmattmccarthy.com/bios/matt-mccarthy, accessed on 26.10.2019.

In an interview, McCarthy reveals that he wrote the book with the objective of illustrating how difficult and insecure an intern can feel in his position. The sense of insecurity is also experienced by medical workers at other stages when they feel helpless because they cannot give answers or solutions or do not know what to say. McCarthy wanted his memoir to serve as a kind of proof that other medical workers can also brave their professional and emotional challenges; if he went through tough situations and is still satisfied and fulfilled, then other medical workers can, too.[26]

> As I became more comfortable doing my job, I felt less like an actor, less like someone playing a part. Medicine was a job and I was now comfortable doing it. I didn't need a script to follow […]. (p. 306)
>
> I was still trying to work out a reasonable work-life balance, and through that struggle I had come to view my job like a new family member, an unpredictable stepbrother whom I mostly adored but, on occasion, couldn't stand. (p. 307)

For McCarthy, his book is a pretext to look back at himself and his medical skills. He gathers different cases and situations to analyze past events. It is an account of his professional progress: "After nearly a year of being an intern, I knew I was almost a real doctor." (p. 286) "Over the months I had become better at so many aspects of being a doctor." (p. 203) However, McCarthy does not limit himself to describing his development as a doctor (p. 262). He also presents his development as a person. He records his transformation into a real doctor, by showing his innermost doubts, thoughts and the uncertainty he faced at first. He exposes the evolution of his attitude and the way in which this change helped him develop both as a doctor and a human being. In his book, McCarthy recollects his "initial incompetence" (p. 269), which helps him become aware of the progress he had made. Gradually, he reached the point at which he gained experience in treating hundreds of patients and hence the confidence to contradict his superior (p. 203). McCarthy's book expresses his satisfaction with the career of his choice. He also shows his personal involvement in his work, and how it affected his private life. He voices the need to empathize with a patient, which is visible in the description of his feelings as a patient in several book chapters. He often puts himself into the patient's shoes and is interested in the patient's physical state and thoughts. Furthermore, McCarthy deplores the shortage of physician–writers and is of the opinion that there ought to be a number of doctors who cover certain issues and also have a say when some medical issues, such as autism or vaccination are raised. Currently, in such cases, there is just one "science journalist" to tackle the issue.[27]

26 Christy Duan, Q&A with Physician-Author Dr. Matt McCarthy, https://www.studentdoctor.net/2016/05/04/qa-physician-author-dr-matt-mccarthy, accessed on 06.05.2018.

27 Ibid.

The authors of all the above memoirs explore different aspects of the doctor –patient cooperation and relation. *Critical Care*, Theresa Brown's medical memoir portrays healthcare over a patient, and helps comprehend its nature. Brown depicts the perspective of the medical staff, and points out that they need as much care as their patients. *Every Patient Tells a Story* by Lisa Sanders is helpful in understanding the doctor–patient relations; it shows that patients need to be active in presenting their symptoms, which is necessary for a proper diagnosis, and may prevent a doctor from making an erroneous one. The author treats the process of making a diagnosis as comparable to resolving a criminal case, thus comparing a physician to a detective. Yet, mistakes in the doctor's diagnosis – which are sometimes unavoidable – may become an incentive to reflection. *The Real Doctor Will See You Shortly* by McCarthy tells the story of a doctor who focuses on his transformation from an uncertain resident into a skilled physician, as if from a caterpillar into a butterfly. In this book, one can observe the fulfilment of the role of an autobiography, which consists in observing and acknowledging one's own progress. In addition, this book is a valuable item for medical workers, since the main protagonist puts himself in the position of a patient when he himself waits for the information on the state of his health. It shows that a doctor can also become a patient at any time. *Do No Harm* by Henry Marsh addresses the problem of responsibility. By analyzing his mistakes at work, the doctor proves that self-reflection and alertness are crucial, even though mistakes are sometimes inevitable.

The following Chapter One outlines the tradition of autobiography and comments on various modes of self-writing, which the texts selected for analysis in the present dissertation also exemplify. The questions I address are the following: how do the doctors' memoirs fit into the long-standing and flourishing tradition of autobiography? What new trends in the evolution of autobiographical genres have appeared over the past decades? How do these new trends affect the relations between authors and their readers, and more specifically, between doctors who write and their patients.

CHAPTER ONE

SELF-WRITING: TRADITION AND NEW DEVELOPMENTS

In Section One of this chapter, definitions of creative non-fiction are presented, together with goals attributed to it. These goals include providing the readers with reliable information and allowing them to explore a given topic. Next, several forms of autobiographical writing (memoir, autobiography, journal and diary) are discussed in order to introduce the topic of self-writing. Various types of memoirs, as well as the similarities and distinctions between memoir and autobiography are presented.

Section Two of the chapter is devoted to the history and the role of autobiographical writing, in view of recent autobiographical research. This section of the chapter also refers to selected authors of autobiographical works written in the course of history, including Benjamin Franklin and Jean-Jacques Rousseau. This third section indicates how autobiographical writing is reflective of the times when it was created, including such external challenges as war or slavery. In addition to these contexts, autobiographical writing is frequently also motivated by the need of self-improvement. The section refers to a selection of memoirs created in the twenty-first century in which medical issues form either the main focus or the background, for example, Augusten Burrough and Rana Awdish, who represent medical memoirists. This overview of non-medical and medical memoirists serves the purpose of establishing how memoirists' concerns have evolved over time.

As far as the form of autobiography is concerned, a new trend has emerged over the past decades. This new trend, addressed in Section Three of this chapter involves the use of new technologies: computers and the Internet. Since autobiographical writing has recently taken on the form of a blog accessible on the Internet, and bloggers can also at times be memoirists and vice versa, this type of self-portrayal by memoirists is included in the subsequent discussion. The point made is that blogs as a form of autobiographical writing enable their readers to be simultaneously blog co-creators, at least to some extent. Analogously to the discussion on autobiography, in the final part of the chapter I seek to answer the question of what function blogs serve for their readers, how blogs are divided, and which themes are frequently raised in blogs.

1.1. FORMS AND FUNCTIONS OF SELF-WRITING

Creative non-fiction is defined as writing based on facts, which draws on the techniques **of** fiction to bring its authentic stories to life. Creative non-fiction is an expression of our times and is characteri**z**ed by **"**the truth-value of writing**"**. That is what distinguishes non-fiction as a genre. According to Margot Singer and Nicole Walker, there is a unique intimacy resulting from witnessing the memoirist wonder, think, reminisce, confess and reflect**.**[28] Gutkind sees the main goal of creative non-fiction writer in communicating the information, just like a reporter, but shaping it **"**in a way that reads like fiction**".**[29] Walker, however, perceives this definition as incomplete because in her view creative non-fiction is not only supposed to inform, but also to take the reader on a journey to let him/her experience and explore the world. For Walker, the writer's idea takes priority over the story and meditation over reportage**.**[30] Creative non-fiction goes back to the confessions of St Augustine, the letters of Lucius Seneca, the aphorisms of Francis Bacon, the meditations of Samuel Johnson, and the **"**non-fiction**"** novels of Truman Capote. Since the memoir's heyday in the 1990s, creative non-fiction appeared to be the most innovative and vital area of American contemporary literature. Surprising though it may seem, despite its long history and popularity, little attention has been paid to creative non-fiction by literary critics and theorists. Creative non-fiction is still largely unexplored**.**[31]

The basic terms associated with autobiographical writing include a diary and a journal. A diary denotes an autobiographical document created by an individual, which constitutes a record of the diarist's activities and events, created for the writer himself, not intended for the audience. Depending on whether it is a simple or a complex type of diary, it may contain or be devoid of personal comments on events or activities, or it may even include the author's feelings.[32] A diary is less detailed than a journal. A journal is defined as a record of experiences, reflections, or ideas. It is "an account of day-to-day events"[33] and in this sense a journal shares the features of a diary. However, a journal is associated with an anecdotal style, whereas the

28 Margot Singer, Nicole Walker, *Bending Genre: Essays on Creative Nonfiction*, New York: Bloomsbury, 2013, p. 2.
29 Lee Gutkind, *The best creative non-fiction,* vol.1, New York: Norton, 2007, p. XI.
30 Ibid. Bending Genre: p. 3.
31 Ibid. p. 2.

32 Andy Alaszewski, *Using Diaries for Social Research*, London: Sage Publications, 2006, p. 2.
33 https://www.britannica.com/art/journal-literature, accessed on 26.03.2020.

content and tone of a diary is more intimate. The journal may give details on a specific project in which the writer is involved.[34]

The word "memoir" stems from the French word *mémoire*, and it means memory or reminiscence. Memoir has its roots in ancient times. Julius Caesar is thought to have been the first memoirist. He recorded his personal experience in epic battles, and it later gave rise to a new literary genre. Memoir is "a written factual account of somebody's life". A memoir is specific, it focuses on a singular event, which took place at a specific time and place.[35] Christina Boufis defines memoir as "an autobiographical form of non-fiction based on personal experience". A memoir is constructed from a writer's memory, and shows the reader in detail what it was like to live through that time.[36] Couser sees the memoir as a literary mirror of ordinary human activity. The phrase "the narration of our lives in our own terms".[37] implies that the memoir allows its author to present the content from his/her own perspective. The autobiographical aspect is also stressed by Smith and Watson, who argue that the term "memoir" is used to describe different genres and practices of self-writing.[38] Couser also indicates that memoirs can take various forms, namely, from a conversion narrative, a confession and an apology, through a testimony to a descriptive account. He enumerates possible contemporary forms of memoir, such as: a documentary film and a biopic; a blog and an electronic diary; social media and Facebook; the scrapbook; the obituary and death notice.[39] Focusing on theme, rather than form, Herron distinguishes the following types of memoirs: travel memoir – the story of one's trip(s); spiritual memoir – the story of finding a spiritual revelation; memoir about family and friendship relationships; memoir about the dearest growing up dysfunctional – the story of a family pain; animal memoir – the story of a pet which was crucial in one's life; pastoral memoir – the story of a person, who has moved to the country out of love for it; celebrity or public figure memoir – the well-paid stories of famous people about their workplace or career business, frequently ghost written.[40] In this variety of themes to choose from, anyone who is interested in a particular topic, or found themselves in a new life situation can reach for a suitable memoir, either for practical reasons – to obtain clues on how

34 Linda Anderson, *Creative Writing: A Workbook with Readings*, London: Routledge, 2006, p. 302.
35 http://literarydevices.net/memoirs, Literary Devices Editors. "Metaphor" LiteraryDevices.net. 2013. Web. 4 Nov. 2014, accessed on 08.05.2019.

36 Christina Boufis, *The Complete Idiot's Guide to Writing Nonfiction*, New York: Penguin Group, 2012, p. 42.

37 Thomas Couser*, Memoir: An Introduction,* Oxford: Oxford University Press, 2012, p. 9.

38 Sidonie Smith, Julia Watson, *Reading Autobiography: A Guide for Interpreting Life Narrative*, University of Minnesota Press, 2012, p. 3.
39 Ibid. p. 9.
40 Rachael Herron, *Fast-Draft Your Memoir: Write Your Life Story in 45 Hours*, HGA Publishing, 2018, p. 150.

to act or for pleasure. Memoirs are also a source of general or detailed knowledge about the world and people.

Couser argues that one does not need to be a professional writer to create a memoir, and a large number of serious memoirs are written by people who are not strictly connected with the world of literature, but with other fields. There are also memoirs created anonymously, and the fact that they are published explains the popularity of this genre; it is open to anybody, which may also imply "nobody".[41] O'Connor detects a similar phenomenon and claims that anyone can create a memoir, regardless of their race and gender. However, some basic requirements do exist. Namely, the memoirist's experience is supposed to be portrayed truthfully and form a readable story. Since the memoir is a part of a bigger genre, namely 'creative nonfiction', the writers are expected to follow the techniques of creative writing with a view to making a stunning story out of their real experiences. Tools adopted in fiction, such as plot, character development, and the setting are also used in the case of a memoir and enhance the writer's story.[42] There are also other considerations to bear in mind while writing a memoir. Castro notes that a potential memoirist faces the dilemma which autobiographical information ought to be disclosed. It is necessary to decide which stories should be skipped for the sake of discretion, where to draw the line and which parts of autobiographical material they are permitted to reveal. Another question is how the memoirist's family is going to react.[43] This may be a problem in the event of the revelation of uncomfortable facts about family members.

Mendelsohn indicates that various forms of self-exposure are increasingly present in our culture, including addiction and recovery memoirs, reality television, Facebook, and stories of physical abuse by parents. The Internet is perceived as the largest space for self-exposure, which is also called personal narrative, and it is not subject to censorship. The demand for sharing the most intimate secrets of one's personal life is a new tendency, not very common before. This situation results from the blurring of the line between the real and the artificial (for example reality TV does not always show real people), and the blurring of the private and the public life (being exposed to loud, private phone calls in public is a good everyday example of this new phenomenon). In the past, memoirs, autobiographies, and diaries were regarded as personal and questionable, contextualized among different genres such as fiction, philosophy and history.

41 Ibid. Couser, p. 5.

42 Maureen O'Connor, *Life Stories: A Guide to Reading Interests in Memoirs, Autobiographies, and diaries*, Oxford: Libraries Unlimited, 2011, p. xxv.
43 Joy Castro, *Memoirists on the Hazards and Rewards of the Family Revealing*, London: University of Nebraska Press, 2013, p. 1.

The reason why a personal narrative has become so popular is that it is concerned with the essential issue of human life – "how to live better?". No matter what form it takes, whether "a desperate report by a recovering alcoholic" in contemporary culture, or an outstanding piece of Western literature, it deals with the same question, which motivated Augustine to write his *Confessions.*[44] That indicates that human nature is the same regardless of times, and a demand for memoirs will probably continue to exist.

Memoirs vary considerably. Apart from the demand for memoirs among potential readers, their writers have their own motivation to create them, too. The reasons why memoirists decide to write about their lives embrace the willingness to satisfy the reader's curiosity, gratitude, the need for self-understanding, profit, vanity, political ambition, love, the intention to share anecdotes or give advice to family.[45] In fact, Benjamin Franklin's autobiography was ostensibly written for the instruction of his son, the first part of which was in a form of a letter to him. The first part of his autobiography was more informal than its second part, and had a more personal narrative. Franklin started his work with a view to telling his son about himself and proceeded with writing it after others assured him that 'lessons of his life' could serve the young.[46] Above all, regardless of their motives, memoirs are the way of expressing, implying and defending a "value perspective", and their experience is the evidence.[47]

Memoirs have significant roles to play in the lives of both writers and readers. According to Couser, the memoir seems cathartic to its writer, since a convert or a confessor becomes the opposite of who he was prior to writing it.[48] This purifying or awareness-raising power of the memoir is also emphasized by Borofka in her book. She claims that "memoir requires a demonstration of some introspection, some evolving awareness of one's actions and choices". A cognitive role emerges, too, as she further argues, when a memoirist becomes aware of his/her own hidden agendas. Writing the memoir creates an opportunity to analyze one's personal experiences by their recollection and examination. This is all done in the light of the

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44 Daniel Mendelsohn, "But Enough about me: What Does the Popularity of Memoirs Tell Us About Ourselves?", in John Doody, Kim Paffenroth, Mark Smill**ie,** *Augustine and the Environment*, London: Lexington books, 2016, p. 9.

45 Mike Martin, *Memoir Ethics: Good Lives and the Virtues,* London: Lexicon Books, 2016, p. 2.

46 Thomas Streissguth, *Benjamin Franklin*: *Statesman-Scientist and The Father of Scientific Statecraft*, Minneapolis: Learner Publication Company, 2002, p. 18.
47 Mike Martin, *Memoir Ethics: Good lives and the Virtues,* London: Lexicon Books, 2016, p. 2.
48 Ibid. p. 9.

writer's own views, prejudices and conscience.[49] The role of the memoir is to preserve history through the writer's eyes. The memoir serves to provide an insight into the lives of others when, for example, celebrities tell about the hurdles they had to overcome, soldiers give account of war experiences, mentally ill describe ups and downs of the struggle for social acceptance.[50] The idea of reflection is visible in all such endeavors. Besides, while depicting adventures and experiences, the memoirist often provides his/her thoughts and observations on various topics, for instance, responsibility, coming to terms with sudden events in one's life or past, helping both oneself but also the reader realize what is important and valuable, and what is not when one looks from a longer perspective of time. This is visible in the case of James Bowen's *A Street Cat Named Bob* (2012), which is a record of the memoirist's life and describes how becoming responsible for somebody else rather than himself, improved the quality of his own life. In the long run, it can be observed throughout the book how taking responsibility for an animal was a way of coming to normal after the author's addiction, which he blames on loneliness: "I don't know why, but the responsibility of having him to look after galvanized me a little bit. I felt like I had an extra purpose in my life, something positive to do for someone – or something other than myself" (20-21).[51] The author – James Bowen stresses this fact more than once in his book. He derives pleasure from nursing a cat: "Bob's arrival in my life had dramatically changed all that. I'd suddenly taken on an extra responsibility […]. I enjoyed that" (p. 94). Not only is it the memoir's role to affect or transform the memoirist, but also the readers. While reading the memoir, the reader takes part in the author's struggle to recollect and make sense of experiences, events, fantasies and dreams. The memoirist's role is not restricted to confession, the reflection on experiences is an indispensable part of the memoir.[52] A story told by common people like the above James Bowen sounds convincing to the addressees and helps them discern the process of changing and understanding important changes. Borofka makes a similar observation and writes that the memoir serves as a means of participation in the struggle to understand the events. Different literary devices are applied by the author, such as shifting the time frame, using flashbacks, or recreation of dialogues. The author intersperses the scenes with musings over them. Borofka points out a conversational and reflective tone of the memoir and argues that this form makes it possible to speak intimately to its reader, thus encouraging him/her to reciprocal musing.[53] Hart explains how telling one's

49 Deb Everson Borofka, *Memory, muses, memoir*, New York: Universe, Inc., 2010, p.17.

50 Ibid. http://literarydevices.net/memoirs, accessed on 01.08.2019.
51 James Bowen, A Street Cat Named Bob, London: Hodder &Stoughton, 2012, p. 20-21.
52 Maureen Murdock in Dennis Patrick Slattery, Lionel Corbett, *Depth psychology: Meditations in the Field*, Carpinteria: Pacifica Graduate Institute, 2004, p. 132.
53 Ibid. p. 22.

story alters both us and the world. It strengthens and deepens its teller, making him/her more alive, empathetic, and compassionate. It also binds one's life to history and the surrounding world, connecting the writer "across time and people".[54] Maureen Murdock identifies four questions, that create a connection between the writer and the reader, who asks the same questions as the author:

1. "Who am I?"
2. "How do I make my way?"
3. "Who is my tribe?"
4. "Why am I here?"[55]

Building a kind of rapport between the writer and the reader also occurs in the case of an autobiography, and it is an important aspect of Pascal's study devoted to this genre. The word – autobiography itself combines three Greek words; *autos,* denoting "self", *bios*-"life" and *graphe* meaning "writing", which signal self-life writing. An autobiography is "the story of one's life written by himself". The French theorist Philippe Lejeune defines an autobiography as "a retrospective narrative in prose that someone makes of his/her own existence" putting an emphasis on one's life and development of personality.[56] Małgorzata Czermińska defines it as a literary genre in which the writer describes his/her own experiences. S/he presents his/her achievements and failures, and recalls the events in which s/he participated. The autobiographer confides in the reader, and the reader enjoys the privilege of being admitted to the author's intimacy.[57] In an autobiography, writers not only deal with their career and growth as a person, but they also use emotions and facts related to family life, relationships, travels, education, sexuality, and any internal struggles. It is possible for autobiographers to speak directly to the generation of their readers through their work. Then, the function of autobiography to leave a legacy for its readers is fulfilled. Thanks to writing an autobiography, the writer shares his failures and triumphs, as well as lessons learned, and allows readers to relate to and feel motivated by inspirational stories. Through life stories, the gap between people of differing ages and backgrounds is bridged.[58] An educational role of a memoir is fulfilled in the sense that readers see the consequences of certain actions and decisions and the author's reactions to the

54 Tom Hart, *The Art of the Graphic Memoir: Tell Your Story, Change Your Life*, St. Martin's Griffin, 2018, p.3.

55 Ibid. Depth Psychology: Meditations in the Field, 2004, p. 132.
56 Ibid. Sidonie Smith and Julia Watson, p. 1.
57Małgorzata Czermińska, *Autobiograficzny trójkąt. Świadectwo, wyznanie, wyzwanie*, Kraków 2004, p. 1, 11.
58 Ibid.

reality, and the readers can refer them all to their own lives. Memoirs also have other functions to play. One of them is an informative role, through which memoirs reflect the author's world views and memoirs are a source of information (for example about the history).[59] Another role is a cognitive one. Catherine Leach points to the fact that one type of memoir – a travel one "created a taste for the exotic" because it described many aspects of daily life such as dress, customs, landscapes, social and family events such as funerals. Through these depictions, descriptive skills were developed.[60] which enriched literary output. Memoirs also contributed to the creation of fiction; since they included prose and verse, subjective judgements and objective documents. A social and political role was performed by memoirs in the past (after the Cossack and the Swedish wars), they replaced the press.[61] Memoirs also play an entertaining function when readers find them amusing.

According to Pascal, it is difficult to draw a line between the memoir and an autobiography. "There is no autobiography that is not in some respect a memoir, and no memoir that is without autobiographical information".[62] The memoir falls under the category of autobiography as its subgenre.[63] Pascal argues that they are both based on personal experiences. However, he finds one distinction between them. In the case of autobiography, the author's attention is focused on the self, whereas in the case of the memoir, on others.[64] This issue is also addressed by Margaretta Jolly, who claims that memoirs are written out of the author's memory, and restore how the author felt at the time. In the memoir, the writer includes other people who influenced his/her life. He also stresses that the memoir and an autobiography are related as genres, however, memoirs are more subjective. As for a simple definition of an autobiography, Jolly sees it as a biography written by a person who is the subject, its author writes their own true experiences and story. It is an account of how he discovered himself, how he has lived, which he imparts to the reader. Autobiographies encourage an addressee to feel an affinity with the writer.[65] A higher degree of subjectivity in memoirs is also stressed by Yagoda,

59 Ewa Maciejczyk „Narrator i narracja w staropolskich pamiętnikach XVI i XVII wieku", p. 117. accessed on 03.08.2020.

60 Catherine Leach, *Memoirs of the Polish Baroque: The Writings of Jan Chryzostom Pasek, A Squire of Commonwealth of Poland and Lithuania*, University of California Press, Los Angeles, 1976, p. iv.
61 Ibid, p. vi.
62 Roy Pascal, *Design and Truth in Autobiography,* New York: Routledge, 2016, p. 5.
63Literary Devices Editors. "Metaphor" LiteraryDevices.net. 2013, http://literarydevices.net/autobiography,accessed on 09.11.2021.

64 Roy Pascal, *Design and Truth in Autobiography,* New York: Routledge, 2016, p. 5.

65 Margaretta Jolly, *Encyclopaedia of Life Writing: Autobiographical and Biographical Forms*, London: Fitzroy Dearborn Publishers, 2013, p.72.

who claims that the memoir is "how one remembers one's life", whereas in an autobiography the history with all the facts, dates and research is present.[66] According to Czermińska, memoirs are considered to be synonymous with an autobiography and a diary.[67] However, some differences are traced by O'Connor, despite the fact that, in his view autobiography and the memoir are used interchangeably. In the autobiography, events from the writer's life are recorded in chronological order, and they are designed for posterity. Autobiography is frequently written at a later stage of life. The memoir, on the other hand, comprises a shorter time span, and focuses on its writer as an individual. The memoirist usually narrows down his/her work to a certain vivid or meaningful period for example childhood, adolescence or life during a war, in other words the memoir aims to tell a specific story and focuses on an event at a specific time, whereas autobiography illustrates a line for instance from birth to fame.[68] One memoirist – Judith Barrington pinpoints the difference by concluding that an autobiography is a story of life, and the memoir is a story from life.[69] Boufis shares this opinion and argues that an autobiography constitutes the whole life account for posterity, and the memoir is an insight into one's life at a certain time. She provides an instance of autobiography – namely Bill Clinton's work: *My Life*, which illustrates the idea of an autobiography to tell the entire life story.[70] Thomas Larson expresses the same idea, arguing that the memoir is "a record of one part of the past".[71] From Borofka's standpoint, the distinction between an autobiography and the memoir lies in the choice of the subject matter. The memoirist needs to select a theme for his/her work. The intention is both to tell the story or recollect events and to find the meaning in them.[72] In this way, memoirists attempt to make sense of the story of their lives and help the reader understand both their story and message.

It is worth looking at an autobiography in terms of its usefulness to an addressee. An autobiography can influence the readers and modify their views or perception of a situation. An autobiography can bring benefits to both the writer and the reader and enrich them. For the writer, sharing stories with others may be therapeutic. It can be a form of catharsis which cleans

66 Ben Yagoda, *Memoir: A History,* New York: Penguin Group Inc., 2009, p. 2.

67 Małgorzata Czermińska, „O autobiografii i autobiograficzności", w „Autobiografia" pod red. Małgorzaty. Czermińskiej, Gdańsk, 2009, s. 13-14.
68 Maureen O'Connor, *Life Stories: A Guide to Reading Interests in Memoirs, Autobiographies, and diaries*, Oxford: Libraries Unlimited, 2011, p xxiii.
69 Judith Barrington, "Writing the Memoir" in Steven Earnshaw, *The Handbook of Creative Writing*, Edinburgh: The University of Edinburgh Press, 109-15.
70 Ibid. Boufis, p.56.
71Thomas Larson, *The Memoir and the Memoirist: Reading and Writing Personal Narrative*, Athens: Ohio University Press, 2007, p.19.
72 Ibid. p.22.

one's mind and emotions of everything that has happened beforehand.[73] For the reader, following an autobiography enables him/her to look at things that happen to them from other perspectives.

Authors decide to write autobiographies to share lessons they themselves learned. Autobiographies can let the reader understand another person's life by seeing it through his/her eyes. This type of writing can also provide an interesting "outsider-looking-in perspective". The purpose of autobiographies is to give an insight into the life of a person one is reading about at firsthand, and depict how autobiographers' experiences have shaped them as a person.[74] One example of a man, who gives an account of his internal life is the Vietnamese Redemptorist Marcel Van. His life story may be a source of inspiration to others. He goes back to the time when he was to die in a North Vietnamese prison camp in 1959, and felt Jesus confided a mission to him, to turn suffering into joy. His joy is to love and to be loved.[75] The idea of sharing one's own personal story by an author is also realized through sharing "triumphs and defeats" and the wish to share touching moments from one's life.[76] An example of an autobiography, adapted into a film, in which both elements occur is *The Story of My Life* by Helen Keller. In this book, she reveals how frustrated she was because of going deaf and blind one day as a girl. Her victories are her courage and an unbreakable will, together with educational success in the face of these tribulations.[77]

Cieński emphasizes that writing an autobiography leaves a substantial mark on its author, altering their life attitude, both in reference to the environment or oneself.[78] Pascal distinguishes autobiography's role and influence on a reader, too. He claims that firstly, it arouses a reader's curiosity about others, since autobiographers allow us to get into somebody else's world, whether it is a stranger or someone known to us, enabling confrontation of one's private or social life, prejudices, passions, emotional involvement and beliefs. Secondly, reading an autobiography may be the only way to discover somebody's secrets. This knowledge is not particularly necessary in itself, but it may open one's eyes to what human beings are

73 Katie Sewell, https://theboar.org/2016/04/i-think-autobiographies-important/ April. 8, 2016.

74"Why does a writer write an autobiography? What is it trying to achieve ? *eNotes Editorial*, 29 Mar. 2012, https://www.enotes.com/homework-help/why-does-writer-writer-autobiography-what-try-405935. accessed on 12 Feb. 2020.

75 Marcel Van, Autobiography of Brother Marcel Van, Gloucester: Action Publishing Technology Ltd, 2006, p. 360.
76 https://www.enotes.com/homework-help/why-does-writer-writer-autobiography-what-try-405935, accessed on 09.11.2018.

77 Helen Keller, *The Story of My Life*, New Delhi: General Press, 2018, p. 2, 7.
78 Andrzej Cieński, *Z dziejów pamiętnika w Polsce*, Opole: Wyd. Uniwersytetu Opolskiego, 2002, p.16.

capable of, and in this way may prevent the reader from making mistakes. Thirdly, the autobiography does not only serve to arouse interest or give instructions on particular issues, but it also permits the reader to know somebody else's personality, and confront it with one's own. It all happens because the addressee is exposed to direct, historical or psychological knowledge, which broadens his/her mind.[79] Much also depends on the reader, whether s/he just reads the text as a pastime, or is able and willing to draw conclusions. Memory plays an important role in the creation of an autobiography. It is necessary to narrate the past and to situate certain stories within the present. Autobiographies are constructed from fragments of experiences, which are organized into complicated constructions and become stories of one's life.[80]

1.2. THE AUTOBIOGRAPHICAL TRADITION

The beginning of autobiographical writing dates back to around 557 BCE, when the earliest Western writings were created by Herodotus, who in his *Histories* described his travels and reported on the Persian wars. Around 421 BCE Xenophon's *Anabasis* appeared, which dealt with the topic of war. This topic was also explored by previously mentioned Julius Caesar. Autobiographical writing underwent a change due to St. Augustine, who was the first to initiate in *The Confessions* in the late 4th century, a focus on the writer's inner life and his spiritual journey to God. This was called a spiritual autobiography. Another figure who had his share in the construction of autobiographical writing as a genre was Pierre Abelard with *The Story of My Misfortunes: The Autobiography of Peter Abelard* (1134), which is classified as a misery memoir. The reason for it was that the author revealed his tribulations, namely suffering inflicted by unhappy love to Heloise. The 16th century philosopher Michel de Montaigne looked deep inside himself and is credited with the initiation of a personal essay. His originality lay in recording not only his weaknesses, but also focusing on his strengths.[81] He managed to keep balance between the two.

Autobiographical writing was also popular with the Puritans. Among other genres, such as chronicles, the New England settlements also produced private journals. Introspection through keeping a diary was common among Puritans, although not everything was intended

79 Ibid. Pascal, p. 9.
80 Ibid. Sidonie Smith and Julia Watson, p. 22.

81 Ibid. Maureen O'Connor, p. xxxiii.

for publication. Since Puritans followed strict moral and religious principles, keeping diaries helped them record how God was present in their daily existence. The puritan mentality is reflected in *The Scarlet Letter*, in which Hester was 'pilloried' by the local community for having an illegitimate child. A piece of cloth on Hester's gown with the letter A performed the role of a memento. The narrator finds the scarlet letter twisted in "a small roll of dingy paper".[82] It gave account of Hester's romance, which was shrouded in mystery. The narrator's voice in the introduction to the book thus recollects the moment of unfolding this document:

> This I now opened, and had the satisfaction to find, recorded by the old Surveyor's pen, a reasonably complete explanation of the whole affair. There were several sheets containing many particulars respecting the life and conversation of one Hester Prynne, who appeared to have been rather a noteworthy personage in the view of our ancestors. (p. 32)

Nigel Scotland argues that keeping diaries helped Puritans organize and spend their time more productively and efficiently.[83] Keeping a personal diary definitely enables its authors to reflect on their actions, people and events around, and to learn from their mistakes. Instances of such texts include Samuel Sewall's *Diary* or Sarah Kemble Knight's account of a trip made from Boston to New York in 1704-5.[84] Richard Baxter – an English Puritan – is also credited with autobiographical writing. He wrote *Autobiography* containing thoughts concerning his plans and actions. It gives an idea of both the Puritan mind and society.[85] Likewise, some of John Bunyan's writings constitute the culmination of the 17th-century Puritan writing. This occurs in *The Holy War*, *Journey to Hell*, *How to Pray in the Spirit: Thirty-One Devotional Readings on Personal Prayer*, later discussed *Grace Abounding to the Chief of Sinners* and *The Pilgrim's Progress.* In all these texts, the reader's attention is drawn to non-material, spiritual matters. The reader is told what is truly important in life (improvement in one's way of acting) and what is just a waste of time (namely, gossip, thefts and greed). By quoting lines from the Scriptures and offering examples, the author urges his readers to think their lives over and change their ways. Everyone can apply his "parables" to their own life and make use of them. *The Holy War* illustrates the Christian's spiritual journey and presents human life as a battle between good and evil. It takes place at two levels – a general one, showing the world, and at

[82] Gaul Johnson, Michael Soto, *A Companion to American Literature,* Wiley-Blackwell, 2020, p. 32.

83 Nigel Scotland, *Christianity Outside the Box: Learning from Those Who Rocked the Boat*, Oregon: Cascade Books, 2012, p. 101.

84 Mario Klarer, *A Short Literary History of the United States*, London: Routledge, 2013, p. 38.

85 https://www.10ofthose.com/uk/products/2579/richard-baxter-autobiography, accessed on 21.09.2018.

an individual level of a soul's fight to gain salvation. Spiritual and theological issues are the main appeal of the book.[86]

Bunyan's next *Journey to Hell* contains a lesson and serves as a warning against making errors that lead to hell.[87] The author fills this book with lines from the Scriptures, which may be a source of religious education to some: "For from within, out of the heart of men, proceed evil thoughts, adulteries, fornications, murders, thefts, covetousness […]. All these evil things come from within, and defile a man" (Mark: 7: 21-23), (p. 28). The book *How to Pray in the Spirit: Thirty–One Devotional Readings on Personal Prayer* explains different aspects of praying and can deepen the reader's relationship with God by improving the understanding of faith.[88] Bunyan is renowned for spiritual autobiography and allegory, which had their roots in the Puritan tradition. Bunyan was concerned about sin and vocation. His doubts about his own choices tortured him. These deep feelings motivated his thoughts about salvation and progress in leading a holy life.[89] Despite the difference in ideology, Bunyan was also an inspiration for Benjamin Franklin.

Bunyan's spiritual autobiographies include *Grace Abounding to the Chief of Sinners* (1666), which is his spiritual journey from "profane life to a new creation". He honestly records both his bad and good conduct, combining realistic depictions with references to his spiritual experience. Bunyan uses his own example to illustrate what the road to deepening one's faith may be like. In his case, it begins with the conviction of sin, which is followed by struggles with his vices. One can observe a purifying feature of autobiographical literature in his case. Bunyan describes his road to conversion and the progress he makes is evident; in the beginning he is full of guilt and despair, but in the end his heart feels comfort and gratitude. Throughout, he illustrates in detail the states of his mind, and writes about his emotions. *Grace Abounding to the Chief of Sinners* is a story of human soul comparable with Augustine's *Confessions* and Baxter's *Autobiography.*[90]

86 https://www.ccel.org/ccel/bunyan/holy_war.html, accessed on 30.03.2019.
87 https://www.goodreads.com/book/show/6527849-journey-to-hell, accessed on 10.02.2017.
88 https://www.goodreads.com/book/show/770451.How_to_Pray_in_the_Spirit, accessed on 20.02.2017.

89 Paul Delany*, British Autobiography in the Seventeenth Century*, Routledge, London, 2016, p. 36-7.

90 John Bunyan, *Grace Abounding to the Chief of Sinners*, Destiny Image Inc. , 2007, p.2-3.

Bunyan's most famous work, which appeared in two parts, is *Pilgrim's Progress* (1678) and (1684). In them, he looks at human life as a journey, and presents a vision of life in a form of allegory. Bunyan describes Christian's journey from the city of Destruction to Salvation and Heaven. He provides a detailed illustration of life, scenery and people known to him with humor, and includes anecdotes, as well as abstract descriptions. Despite its spiritual meaning, his narrative had a realistic aspect due to the combination of detailed description, with allegory. Bunyan's focal interest lies in the struggle for the man's soul, against sin. In the second part of his work, the analogous pilgrimage is made, this time by Christina – Christian's wife and her children. Her pilgrimage resembles a tourist's visit to certain places. In this book a character meets different places and learns new truths concerning life like the tourist gets to know new attractions while travelling. All along, the author focuses on the religious life of the Christian community.[91] The above books, and especially *The Pilgrim's Progress*, have exerted an enormous influence on generations of Anglophone readers. Isabel Hofmeyr, the author of *The Portable Bunyan*: *A Transnational History of The Pilgrim's Progress* praises Bunyan's literary skills. She says that from the mid-19th century Bunyan has been regarded as "the father of an English novel.[92] Hofmeyr draws attention to powerful images and engrossing plot present in Bunyan's parable – *The Pilgrim's Progress*, thanks to which the story provides the reader with "biblicist theology". Besides, Hofmeyr notices that there is more to Bunyan's book than a story; Bunyan also provides his readers with the language which helps them describe their emotional and personal experience of religion. She continues that *The Pilgrim's Progress* is suitable to all stages of human life, among them to children, who were amused by enacting scenes of the book. Hofmeyr says that the book also served as a friend and teacher during childhood of the many.[93]

Other examples of autobiographical writing include, for example, the 17th century English diaries written by John Evelyn and Samuel Pepys. However, their diaries vary from spiritual autobiography practiced by Bunyan's *Grace Abounding.*[94] Pepys and Evelyn were close friends, who shared an inexhaustible curiosity for life and for the exotic, and their interests involved science and travel. They both loved books. Whereas Pepys had a passion for theatre and music, Evelyn was interested in horticulture.[95] They both kept diaries and depicted their

91 Michael Davies, Robert Owen, *The Oxford Handbook of John Bunyan*, Oxford University Press, 2018, p. 394.

92 Isabel Hofmeyr, *The Portable Bunyan: A Transnational History of The Pilgrim's Progress, Oxford:* Princeton University Press, 2004, p.1.

93 Ibid. p. 59.

94 Michael Aleksander, *A short History of English Literature,* London: Palgrave Macmillan, 2007, p. 165-6.

95 Margaret Willes, *The Curious World of Samuel Pepys and John Evelyn,* Yale University Press, 2017, p.160.

own lives including every detail of existence. John Evelyn's diary was informative of his public, rather than private life. He gave a confident account of things he did, saw and of his thoughts. The reader can find the information on things he was fond of, such as gardens and courts. Other topics include fashion, urban planning, or even the weather in London. Evelyn was an accomplished gardener, who specialized in trees, and offered advice on arboriculture and gardening. After his travels to Europe, he brought some ideas to England and raised his contemporaries' awareness on town planning and landscape architecture.[96] From Pepys' diary the reader learns that he was not only a faithful government servant, but also a sociable man and a passionate theatre-goer. He was also religious, he took pride in his country and valued his profession, family and home. In his diary he paid attention to detailed descriptions of events like the Plague and the Fire of London, the latter of which he observed from the boat: "So I down to the water-side, and there got a boat and through bridge, and there saw a lamentable fire" (p. 9).[97] Pepys' conclusion was that greed governed social life. Such common human vices as vanity, lust and ambition are carefully depicted in his diary.[98] Pepys disclosed a lot, since he kept his diary for pleasure, in shorthand, and it was only in the 19th century that it was deciphered. His diary gives the reader an access to his private life, including his romances and other pleasures.[99]

More serious tone is present in James Boswell, whose writing abounds in contradictions, and expresses a conflict between free will, necessity and fate. His works contain confession to guilt as well as his craving for forgiveness and eternal life. Some of his features like vanity, self-consciousness, drinking habits and narcissism, compelled him to record his activities and feelings on a daily basis. He experienced melancholic fits, fretted about his religion and the nature of the next world.[100] He made a name for himself as a biographer of the 18th century literary luminary, Samuel Johnson, in which he recorded the subject's conversations and epistolary correspondence with eminent people. One of them was Sir Joshua Reynolds, to whom the book is dedicated.[101]

96 John Dixon Hunt, *John Evelyn: A Life of Domesticity*, London: Reaction books Ltd, 2017, p. 2.

97 Brenda Keyte, Peter Brown, Southband diarists, *The London of Samuel Pepys*, Pedia Press. 2011, p. 61.
98 Travis Elborough, Travis Elborough's top 10 diarists, 1 Jan 2014, accessed on 08.05.2019, https://www.theguardian.com/books/2014/jan/01/travis-elboroughs-top-10-literary-diarists, accessed on 25.09.2017.
99 David Deiches, *A critical history of English literature*, the Ronald Press Company, 1996, p.313.
100 James Boswell, *Boswell's Life of Johnson - Including Boswell's Journal of a Tour to the Hebrides and Johnson's Diary of a Journey Into North Wales*, London: LULU Press, 2010, p. 141.

101 Ibid. p. 142.

One important 18th century autobiographer, especially in the American context, is Benjamin Franklin. He started writing his work at the age of 65, when he had retired. He assumed that future generations would find his autobiography useful and could draw conclusions for themselves from it: "My posterity may like to know, as they may find some of them suitable to their own situations, and therefore to be imitated".[102] He wrote it from the position of a person who is satisfied, content with his life, and wishing to spread his joy:

> […] were it offered to my choice, I should have no objection to a repetition of the same life from its beginning, only asking the advantages authors have in a second edition to correct some faults of the first […]. The next thing most like living one's life over again, seems a recollection of that life, and to make that recollection as durable as possible by putting it down in writing.[103]

His words indicate a wish to share his life with others, while writing about it has a positive effect of re-experiencing it. Initially, he intended to write it for the private purpose – for his son and family. Franklin hoped his autobiography could serve his son as an example of living a good life and "getting through hardships". After having received letters expressing gratitude for the lessons in Part I of his *Autobiography*, he modified this vision and addressed Part II to the general audience. He was convinced his story might be imitated, and not merely serve as a source of enjoyment to his son. At first he seemed to have lost himself in recollecting the formative period of his life, and it was only later that he wished his story offered instructions rather than merely pleasure.[104] He conceived his *Autobiography* as advice for his son, in which he presented his own practice of virtues. Then, he was urged by his friends to resume the work with a view to influencing the "minds of the young" with his example.[105] Franklin believed the ideas and solutions he adopted in his life could be followed by others, in similar situations. In his work, he presented the pattern of behavior and the role of a successful man. He claims that the secret of success lies in courage and persistence.

The whole tradition of narratives about American boys rising from rags to riches originated from this vivid picture.[106] The example of *Sink or Swim* and *Bound to Rise* by Horatio Alger can serve as examples. Alger created books for boys which are stories about success. In

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102 Franklin Benjamin, *The Autobiography of Benjamin Franklin*, Philadelphia: University of Pennsylvania Press, 2005, p. 4.

103 Ibid. p. 4.

104 Matthew Matheny, ''The Autobiography Of Benjamin Franklin", available on https://www.bartleby.com/essay/The-Autobiography-Of-Benjamin-Franklin-F36ZT9LJPLLX, 23 November 2014, accessed on 08.05.2019.

105 Peter Shaw, Bantam Classis, *The autobiography and other writings* of Benjamin Franklin, New York, 2008, p. ix.
106 Ibid. p. x.

some of them, he introduced a hero who overcomes some kind of plight to attain wealth as a reward for his diligent and honest life.[107] Alger's protagonists imitate Franklin, who embodied such American virtues as determination, diligence, error correction and self-sufficiency.[108] Mike Martin addresses in his study the virtues discussed by Franklin, who understood them as moral strengths. These virtues are connected with the ideals pursued by the subject. For example, Franklin valued philanthropic ideals, which to him meant being helpful to the community. The ideals of liberty led him to participate in the Revolutionary War. Sincerity meant thinking fairly about others, moderation – having control over resentment, in the face of injuries. Humility meant modesty about oneself, tranquility – not getting annoyed by unimportant matters, frugality – disapproval of waste. He emphasized that frugality and diligence helped his parents live a long and happy life.[109] Diligence in his case was realized by devoting his leisure to intellectual productivity. Most of all, his autobiography promoted self-improvement. People around him were a point of reference in making his progress; he measured himself with others. The concept of imitation is thus related to improvement. A keen wit and a gift for improvement through imitation are emphasized in Franklin's work. He treated his poor performance as a challenge to improve himself, and not as an offence. He gives an example of how he improved his writing skills by rewriting and imitating Johnson's style, whom he considered an authority in the field. In this way, Franklin turned his inability into a skill, through which the idea of error correction is fulfilled. Franklin also refers to correcting his piece of writing by analyzing it. The passage below exemplifies his determination to make progress:

> By comparing my work afterwards with the original, I discovered many faults and amended them; but I sometimes had the pleasure of fancying that […]. I had been lucky enough to improve the method of the language, and this encouraged me to think I might possibly in time come to be a tolerable English writer, of which I was extremely ambitious.[110]

These words show his modesty reflected in a will to improve his imperfections instead of giving up. The reader can observe his development from a simple tradesman to a renowned salesman. Reflection, which is usually present in autobiographies, is mirrored in his work. He expressed his gratitude to God for good things that happened to him in the following words: "And now I speak of thanking God, I desire with all humility to acknowledge that I owe the mentioned happiness of my past life to His kind providence, which led me to the means I used and gave

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107 Frederick Lewis Alle, *The Big Change: America Transforms Itself, 1900-50*, New York, Routledge, 2017, p. 63.

108 Ibid. http://www.bartleby.com/essay/ The-Autobiography-Of-Benjamin-Franklin- F36ZT9LJPLLX, accessed on 04.07.2018.
109 Mike Martin, *Memoir Ethics: Good Lives and the Virtue*, London: Lexicon Books, 2016, p. 39.
110 Ibid. p. 4

them success".[111] From the above fragment the reader can infer that Franklin was a true believer of deep faith. At the same time, his modesty is visible when he attributes his success to God as the source of everything that is good, regarding himself as someone who merely makes use of given resources. Even greater humility emanates from the next lines of his autobiography. He prepares himself for the situation in which his good fortune may end, since God knows better what is appropriate to Franklin and everything is in His hands. Franklin's role in such a case is to accept what God gives him:

> My belief of this induces me to hope, though I must not presume, that the same goodness will still be exercised towards me, in continuing that happiness, or enabling me to bear a fatal reverse, which I may experience as others have done; the complexion future of my future fortune being known top Him only in whose power it is to bless even our afflictions. (p. 4)[112]

He is pleased with his life and comes to the conclusion that if he could live his life once more, only some errors would need correction.[113] Errors are what thematically bind Franklin with the contemporary medical memoirist – Henry Marsh, who is going to be discussed in Chapter Four, and believes that his writing can prevent other medical staff from performing professional mistakes made by himself. Steve Shipside finds Franklin's philosophy timeless, and expands on the problem of learning from the mistakes of others. In one of the chapters: "Make friends with a mentor", Shipside explains Franklin's idea that one's life is too short to learn from one's own mistakes, so people ought to draw conclusions from the mistakes of others. He also advises setting goals for relationships.**[114]** These tips are simple and practical, but also thought-provoking. Everyone can make their own interpretation out of them as people have different ideas and aims of a relationship.

Franklin's *Autobiography* does not merely serve the addressee as a manual of strategies. It also has a narrative value, which makes the work useful as an educational tool and the reader gets more involved in following it. The autobiographer follows his favorite author, John Bunyan, and his narrative technique, by including dialogues in his account. Franklin also reveals his literary influences – pioneered by Bunyan and Defoe, where dialogue is mixed with

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111 Ibid. p. 14.
112 Ibid. p. 4.
113 Jacob Fournier, "The Autobiography of Benjamin Franklin Themes: Vanity and Humility" *Lit Charts.* LLC, available on http://www.litcharts.com, accessed on 7 May 2019.

114 Steve Shipside, Benjamin Franklin's the Way to Wealth: A 52 brilliant ideas interpretation, Oxford: Infinite Ideas Limited, 2008, p. 89-90.

exposition, which is the technique of prose narrative. He includes rich sensory and novelistic details for example "the fire was made from the planks of a rotten fence."[115]

Jean-Jacques Rousseau was another influential autobiographer of the 18th century. He was a Genevan philosopher and writer who contributed to the Enlightenment spirit in Europe. He was a unique figure because of giving a lot of thought to human nature in his writing. His assumption is that human beings are good by nature, but certain historical events corrupt them. Rousseau proposes solutions which can make man happier and better. He is interested in what moves the human heart and thinks most people are governed by passions, finding it hard to resist temptations of evil, to which they succumb as a result. In his opinion, the understanding of passions is helpful in imposing order on them and in doing what the reason tells.[116] His *Confessions* recorded in the form of diaries, belong to distinguished works of the world literature. In his diaries, Rousseau revives the idea of confessional self-writing; namely he does not appear in it as a witness of history or its co-creator. In his work, the processes of history are only a background to a personal story that portrays a certain stage of his soul. He offers himself as an example to expose to the reader the human nature in general. He frankly outlines beginning in the childhood. He also makes a reference to his quite reckless youth. Rousseau confesses his sexual promiscuity and getting involved in affairs with different types of women. He accepts and justifies his past, claiming that he looked for compensation for the lack of his mother and because of the inspiration he found in women.[117]

In his *Confessions* Rousseau was aware of the unique nature of his autobiography: "I have entered upon a performance, which is without example, whose accomplishment will have no imitator." (p. 1)[118] In *Confessions* Rousseau devotes some attention to his family and his parents' mutual affection to each other. The author also recalls relations with his father, with whom he stayed after his mother's death:

> My birth cost my mother her life, and was the first of my misfortunes. It looks his father loved him, but was unhappy. I know he was ever after inconsolable. In me he still thought he saw her he so tenderly lamented, but could never forget I had been the innocent cause of his misfortune, nor did he embrace me. (p. 2)

115 Ibid. http://www.litcharts.com, accessed on 26.09.2018.
116 Joseph Reisert, *Jean-Jacques Rousseau: A Friend of Virtue*, London: Cornell University Press, 2003, p. 14.
117 Peter Robinson, "Jean-Jacques Rousseau and history: moral truth at the expense of facticity, rethinking history", in *The Journal of Theory and Practice*, Vol. 12, 2008 - Issue 3, pages 417-431.

118 Jean Jacques Rousseau, *The Confessions of Rousseau,* Munich: Book Rix GmbH and Company KG, 2019, p. 1.

However, Rousseau refers to the straightforward and plain communication between the two of them. They were capable of discussing what was in their hearts, and neither suppressed their feelings nor escaped from them. The father would say: ‘’Jean Jacques, let us talk of your mother”, to which the son would answer: “Yes, father, but then, you know, we shall cry. Give me back my wife, at least console me for her loss; fill up, dear boy, the void she has left in my soul.” (p. 15)[119] Rousseau also gives an account of the experiences that shaped his social personality and provided him with closeness and security: “How could I become cruel or vicious, when I had before my eyes only examples of mildness, and was surrounded by some of the best people in the world? My father, my aunt […], our friends, our neighbors, all I had any connection with […] loved me tenderly, and I returned this affection.” (p. 19) These descriptions of his childhood background and family relations are impressive. True relations, which he experienced had the potential to equip him with strength and a point of reference in the future. Rousseau also refers to his friendship with his cousin Bernard; the ambient atmosphere let him develop positive relations and united both of them: “The simplicity of this rural life was the infinite advantage in opening my heart to the reception of true friendship.” (p. 22) The author can appreciate what was given to him. Besides showing his family background, he reveals his opinions on life. Rousseau does not see money as a source of happiness itself, but finds enjoyment in people and situations on condition that they are accompanied by affection:

> None of my predominant inclinations center in those pleasures, which are to be purchased, money empoisons my delight; I must have them unadulterated. I love those of the table, for instance, but cannot endure of the restraints of good company, […]. I can enjoy them only with a friend, for alone it is equally impossible. (p. 48)

The same refers to other aspects of life: “My beating heart cannot be satisfied without affection; it is the same with every other enjoyment, I am fond of these things which are only estimable to minds formed for the peculiar enjoyment of them.” (p. 49)

All in all, Rousseau revealed much about himself and his background concerning his relations with his parents and relatives. These disclosures were likely to exert a positive effect on his readers and convince them about the writer’s frankness. The spectrum of matters about which Rousseau writes is wide, and comprises both sorrowful sides of his life (his mother’s death) and bright ones (his friendship with a cousin). His turn to the areas of personal feelings,

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119 Jean-Jacques Rousseau, *The Confessions of Jean-Jacques Rousseau Complete*, The Floating Press, 2012, p. 15.

rather than his ambitions, aspirations or achievements makes him an original and influential writer.

Another representative of the autobiographical genre is John Stuart Mill. His autobiography was posthumously published and he wrote about a political system based on the "great happiness" principle, in which sympathy with human beings is crucial. *George Borrow's Lavengro*, *Romany Rye* and *Wild Whales* are mixtures of fiction and autobiography. *The Bible in Spain* is an account of his adventures as an agent of the Bible society in Spain. He also wrote in it about his personal life. It belonged to the category of travelogues, which were popular in the 19th century.

Thomas de Quincey is another writer who took interest in human freedom. His *Confessions of an English Opium Eater* (1821) emanates a philosophical movement – German idealism, which emerged in the late 18th century. His work concerns his early life, his magnificent and terrifying dreams, stimulated by taking opium. He developed this habit to alleviate neuralgia, but it stayed with him later on. The purpose of this work is to warn the reader of dangers of opium. It is a first person narrative. At the same time, he gives the reader food for thought by presenting a battle between euphoria and freedom. His literary output inspired many, among them Edgar Allan Poe, and gave birth to the genre of "addiction literature", which was later popularized in the West.[120] In his other literary pieces, *Autobiography* and *Suspiria De Profundis*, Quincey's interest in his own psychology and attitude to the significance of dreams are conspicuous.

An intriguing example of a writer who is worth mentioning, since he is known for writing the classic American memoir *Two Years Before the Mast*, is Richard Dana. In this work he included an autobiographical element, which is an autobiofictional narrative, the genre of sea diaries. He describes two years spent as a sailor. The reminiscences were constructed on the basis of a journal he had kept on his voyage. Since it got lost, Dana recreated his story with the help of his notes. Dana spots a change in himself; at first he was a young, self-confident sailor. The transformation he portrays is from an inexperienced to a mature sailor. He gives an account of his progress, the sea lets him test his strength and character. His perception of the ocean altered dramatically. He achieved maturity due to numerous battles with the ocean, and gained a huge knowledge of the nature of the sea. Along with it, his enthusiasm and optimism from his

120 Thomas De Quincey, *Confessions of an English Opium Eater*, (to the reader), 2019, p. 2.

youth vanished. He perceives the sea as a force, which encourages him to come out of himself and go beyond the limits. It is sea experiences that helped him grow mature and become a reasonable seaman. The immensity of the sea released him from limitations and opened up new horizons. It can be called the "journey of self-discovery."[121] This is another work promoting activity and achievement of progress in self-improvement, which was also present in Franklin's *Autobiography.* Facing tough conditions at sea is not the reason to give in, but to struggle and achieve a victory.

Another literary figure who deserves mention in the context of autobiographical writing is Mark Twain. What makes him significant is that in his writing he refers to critical issues in the American society of his time. These included class division, racism and slavery. Twain makes observations of society, and his writing is still relevant at present. He includes autobiographical elements in all of his works, evoking real experiences and places from his childhood that make his books authentic**.**[122] Twain created a multitude of masterpieces known up to now for example *The Adventures of Tom Sawyer* and the memoir *Life on the Mississippi.* While creating his autobiography, he assumed it would be his last bestseller. What may seem curious is that he presents himself as very progressive, contrary to what was thought of him. He wished to familiarize the reader with himself very thoroughly, hence he included plenty of personal stories and descriptions of himself. For example, Twain mentions that he challenged his acquaintance, Nevada newspaperman – James Laird to a duel but resigned from taking part in it because it was against the law. The author also recounts another unfortunate event when he worked as a pilot of a steamboat on the Mississippi River and as his companion died as a result of an explosion.[123] Twain also brings back vivid memories from his childhood, some of which he spent at his uncle's farm, and a joy that came from spending time there. He describes the farm as a "heavenly place for a boy" (p. 30). The farm was full of animals, and Twain presents his feeling of fright when he saw some of these animals roasted or cooked for meals and served at the table. Another moment of dread from his childhood was when his family forgot about him and left him after camping because they focused on other children.[124]

121 Mstowska Joanna, "Various aspects of Mimesis in Selected Sea novels of Frideric Marryat, James Cooper and Richard Dana", Toruń: 2013, p. 108-118.

122 https://www.ool.co.uk/blog/why-is-mark-twain-still-so-important-today, accessed on 11.08.2019.

123 Mark Twain, *Autobiography of Mark Twain:* Volume 1, Reader's Edition, Volume 1, London: University of California Press, 2012, p. 149.
124 Ibid. p. 30.

When Twain started writing his autobiography he was thinking about the audience and had a certain intention in his mind. As in the case of Franklin, whose *Autobiography* presented a blueprint of behavior, Twain's account was supposed to serve as a model for other autobiographies. Twain wanted it to be published posthumously. He seemed not to be modest about his writing abilities, and expected readers to admire this work for many centuries because of the form and method it had. In his work, the present and the past are confronted, which makes it possible to see the contrast between them. What characterizes his autobiography is a depiction of common experiences as they took place, the ones which an average person could face, without any selection of particular, outstanding moments. He saw the point in describing plain experiences, since he thought the reader would find them interesting, seeing in them a reflection of his own life. In contrast to some other autobiographers he knew, Twain did not need to search and record moments or confrontations of meeting famous people. He did not follow any special code or rules of writing, creating instead his own principles of self-narrative. The author was convinced that his work would last long, once it was written.[125] Twain refers to different stages of his life. In *Chapters from my Autobiography,* he brings back memories from his childhood, how he lived on a farm where colored children were his friends. He remembers intact nature, full of rattlesnakes, which they killed. Some things he describes are different from today, namely the fact that doctors were not necessary for common medical cases. It was the family grandmother's role to treat the ill, and each grandmother had her medicines in the wood at her disposal.[126]

As can be seen he writes about daily things which surround him. It is also in this book that he refers to the problem of slavery, which Twain himself did not regard as a negative phenomenon because of lack of awareness. Twain says local newspapers did not disapprove of it, and this topic was not discussed. His mother helped him look at a slave child in a different way. Twain thus recalls memories from his boyhood: "All day long he was singing, whistling, yelling, whooping, laughing-it was […] unendurable. At last, one day I lost my temper, and went raging to my mother, and said Sandy had been singing for an hour without a single break, and wouldn't she please shut him up" (p. 182). The mother explained to her son that he would

125 Mark Twain, William Dean Howells, Albert Bigelow, *The Mark Twain Autobiography + 3 Biographies*, 2014, p. 2 (intro).

126 Mark Twain, *Chapters from my Autobiography*, U S, Read how you want, 2008, p. 186.

understand it in the future, that singing allows Sandy to forget about the absence of his mother, and she is lucky about that boy's singing.[127]

Twain tackles various matters in his writing. In his travel book *Life on the Mississippi*, a completely different theme is touched upon. It is an autobiographical account of his past adventures from the training as a steamboat captain. He brings back memories of his steamboat journey he made from St. Louis to New Orleans, on the Mississippi River.[128] In this book, Twain shows how his self-confidence in his navigating abilities disappointed him and turned into a fright: "[…] if anybody questioned my ability to run crossing from Cairo and New Orleans without help or instruction I would have felt irreparably hurt" (p. 96).[129] He reveals his further fright and depicts dramatic states he suddenly found himself in and his body and mind's reactions to them. It makes a vivid picture:

> My imagination began to construct dangers out of nothing and they multiplied faster than I could keep the run of them. (p. 97)

> I was helpless. I did not know what […] to do. I was quaking from head to foot, and I could have hung my hat on my eyes, they stuck out so far. My hands were in a nervous flutter. I could not ring a bell intelligibly with them. I flew to the speaking-tube and shouted to the engineer. (p. 99)

Aside from a detailed description of his effort to survive, this book is an example of airing his views. Twain let the reader know what was precious to him, similarly to Franklin, who revealed which rules of conduct were crucial for human success and well-being. Namely, Twain valued his profession of a pilot, which he considered the most independent one in comparison even to, for example, the king who serves the parliament and the citizens. Twain thinks that other jobs, such as an editor, clergyman or a writer, serve the public, too, and may be responsible to the party, patron or parish. Hence, such jobs would not allow a free expression of opinion. By contrast, a pilot takes decisions on his own, and does not have to follow anybody's commands.[130]

One more famous person who wrote about himself is Albert Einstein, who at the age of 67 created his own *Autobiographical Notes*. He was the most famous theoretical physicist. As he reveals in his work, he was persuaded to narrate his life by Doctor Schlipp – an educator and

127 Ibid. p. 182
128 https://www.spokanepublicradio.org/term/bookshelf, accessed on 17.06.2018.

129 Mark Twain, *Old times on the Mississippi*, Toronto: Belford Brotaers Publishers, p. 100.
130 Ibid. p. 100.

philosopher.[131] Like Twain, who decides to tackle certain issues that he considers important, Einstein chooses particular concepts such as: an individual in society, freedom, politics, friendship, wealth or medicine, and his goal is to focus and elaborate on these topics by presenting his views on them. Einstein offers in his book a description of his life and what took place at its particular stages. However, in his work, Einstein puts less emphasis on himself and more on the events that took place around him. That makes a difference in comparison with Twain, who makes references to different stages of his life and derives pleasure from writing about his own experiences. Above all, Einstein focuses on the evolution of his works and develops his ideas. His aim is to describe general and detailed theory of relativity, and he mentions his keen interest in geometry. On top of that, he formulates his reservations as to the assumptions concerning quantum mechanics and expresses his disillusionment with religion. Einstein strives to introduce the reader to his life. He puts more emphasis on his professional than private life. His autobiography is a first person narrative. Each viewpoint and situation is referred to as 'I'.[132]

Autobiographical literature is for Einstein a means of sharing his opinions and life goals and realizing the reader and himself who he is. His view on life and some traits of his personality are also presented in letters, essays and occasional writings compiled in *The World as I See It*, written by himself. In it, he also refers to religion with reservations: "In human freedom in the philosophical sense I am definitely a disbeliever. Everybody acts not only under external compulsion but also in accordance with inner necessity" (p. 90)**.**[133] He may reject religion, but he still has his principles and feels responsible to those who surround him. In spite of being talented and engaged in the world of science, which would suffice some, he stresses human dependence on others, and sees himself as reliant on other people. Einstein views himself as a part of the community he lives in, to which he feels obliged to contribute:

> But from the point of view of daily life, without going deeper, we exist for our fellowmen-in the first place for those on whose smiles and welfare all our happiness depends, and next for those unknown to us personally with those destinies we are bound up by the tie of sympathy. A hundred times every day I remind myself that my inner and outer life depend on the labors of other man, living and dead, and that I must exert myself in order to give in the same measure as I have received and am still receiving. (p. 8-9)

131 Albert Einstein, George Bernard Shaw, *Einstein on Cosmic Religion and Other Opinions and Aphorisms* , New York: Dover Publications Inc., 2009, p. 29.

132 Ibid. p. 29.

133 Albert Einstein, General Press, *The World as I See It*, Snowball Publishing, 2018, p. 9.

He also thinks about the sense of his life, and addresses the issue explicitly. He sees high values, truth or goodness, as crucial ones. Finding a common ground with people living around him is significant, too:

> And yet everybody has certain ideals which determine the direction of his endeavors and his judgements. In this sense I have never looked upon ease and happiness as ends themselves. The ideals which lighted me on my way and time after time given my new courage to face life cheerfully, have been Truth, Goodness and Beauty. Without the sense of fellowship with men of like mind, of preoccupation with the objective, the eternally unattainable in the field of art and scientific research, life would have seemed to me empty. (p. 10)

Einstein adds that he looks at outward success, luxury and property as contemptible. Besides, he expresses his opinions on different topics, namely advancement of technology, a huge role of an individual and his creative achievements, due to which communities and societies develop. In other words, to him, the individual's existence only makes sense in confrontation with others (the society), otherwise the existence is of no value. An individual's value can be measured by how one's thoughts, feelings and actions serve the good of society. Creative individuals are especially precious because they have the potential of contributing to the development of humanity by starting the use of fire, inventing a steam engine or creating new values or moral standards**.**[134] Einstein seems to have high ideals, which some people may find irritating today and impossible to approve of or follow. However, he just fulfils the writers' role to spread a positive message, to discourage hatred or defeatism, which would not bring any benefit to others.

Anne Frank is an exceptional autobiographer because of her young age. She was thirteen when she started her diary, which is an account of growing up during a a global conflict. Frank touches on various issues, such as relations with her peers and family, school life, daily activities like riding a bike, but a substantial part of her diary is devoted to the question of how war changes everyday life. This topic is still current today in war-stricken countries, where children are deprived of their childhood. Frank's diary is a meaningful document of its time because it helps preserve the memory of average people and their daily struggle, quite apart from political strategy and historical generalization. In the introduction to her diary, Frank predicts that her readers "will do an introspection of themselves and on humanity" in general and claims that her diary is likely to exert an impact on them.[135]

134 Ibid. p. 16.
135 Anne Frank, *The Diary of a Young Girl,* General Press, 2012, introduction, p. 3.

Frank's diary serves as a testament of courage during the Holocaust.[136] While writing her diary, she was staying with her family and friends in hiding during the German occupation of the Netherlands. The first part of the diary, from the period of approximately the first three months is written in a traditional form. The next part addresses a fictional character with whom Frank identified – Joop ter Heul from four books by Dutch novelist Setske de Haan. Frank also adopts the epistolary style of those novels. In fact, in her diaries Frank addresses her friends, whose names are turned into the names of characters from this book.[137] Although her life was very short – she died at the age of fifteen, during the war, it was meaningful. Frank was living under threat and was aware of the danger she and her family were constantly facing. They were hiding from German soldiers. Yet, she became a symbol of hope, in a sense that "she remained hopeful about the world" although awful things were taking place around her. Anne Frank drew inspiration from the beauty of nature, despite staying inside.[138] Because of living in a state of peril, this diarist could cherish the moment, to which she was also encouraged by her father: "Make the most of your carefree young life while you can" (p. 22).

The topic of friendship occupies a substantial part of her diary. She recalls people, whom she regarded as friends. At length, a diary turns out to be her best friend. The person named "Kitty" in her diary is her imaginary friend. Frank's writing skill lies in combining real people and events with imagined elements. Her writing, thinking and ideas strike the reader as mature because she is capable of looking at herself from different angles as she evolves from a child into a teenager. Anne Frank informs the reader of her need to have the most genuine friend and entrust the closest person with her thoughts and feelings. She admits to feeling lonely: "The reason for my starting a diary: it is that I have no such real friend" (p. 8)[139]. Hence, she assumes that the diary will play the role of a friend to her and will not let her down: "I hope I will be able to confide in you completely, as I have never been able to do in anyone before, and I hope that you will be a great support and comfort to me" (p. 3). Her sincerity is visible when she reveals that although there are many, whom she calls friends and admirers, she still does not have the one and only, dear friend, who would match her description of friendship:

136 Melissa Müller, *Anne Frank: The Biography*, New York: Bloomsbury, 2013, p. ix.

137 Jeffrey Shandler, "Anne, from Diarist to Icon", available on https://www.annefrank.org/en, accessed on 08.05.2019.

138 ''Who Was Anne Frank?", Ann Abramson, New York: the Penguin Group, 2007, p. 3.

139 Anne Frank: *The Diary of a Young Girl,* General Press, 2012. p.8.

> Since no one will believe that a girl of thirteen feels herself quite alone in the world […]. I have darling parents and a sister of sixteen. I know about thirty people whom one might call friends-I have strings of boys friends, anxious to catch a glimpse of me, and who failing that, peep at me through mirrors in the class. (p. 9)

She repeatedly shows how keeping this diary is a way of coping with loneliness. Frank points to the lack of real contact or a conversation with those around her, although she is surrounded by many. This is expressed as follows:

> I have relations, aunts and uncles, who are darlings, too […]. But it is the same with all my friends, just fun and joking, nothing more. I can never bring myself to talk of anything outside the common round. We don't seem to be able to get any closer, that is the root of the trouble. Perhaps I lack confidence, but anyway, there it is a stubborn fact and I don't seem to be able to do anything about it. (p. 9)

Written between 1942–1944 in hiding, Frank's diary gained popularity after the war. Films and plays about her were made. Her diary won prizes, including the New York Drama Critics' Circle Award for Best Play, the Pulitzer Prize for theatre and a Tony Award. It was translated into many languages and was sold in millions of copies. To this day, Frank still inspires many young people searching their identity. She is associated with humanity, tolerance, human rights and democracy.

Today's memoirists touch a diversity of themes, and their works usually mirror the roles memoirs are supposed to play: a reflective, therapeutic, purifying or awareness-raising one. In a selection of memoirs discussed on the following pages, I address the question of what kind of issues are of interest to memoirists in the 21st century and whether topics raised by them differ or not from those with which authors were concerned in the past. To do that, I analyze at first several memoirs which are not strictly medical, and then turn to the medical ones to form the background to the four main memoirs that are the focus of attention in this dissertation.

One of the typical memoirists of the 21st century is Augusten Xon Burroughs. He is an American writer known for his *New York Times* bestselling memoir *Running with Scissors* (2002). At the age of 43, Burroughs had already written five memoirs, detailing his adolescence, his life as an advertising man, and his struggle with alcoholism.[140] In his autobiographical work *Running with Scissors*, Burroughs refers to his past – more precisely, his youth, by describing his problems with abusing substances, which form the main topic of his memoir. Unfortunately, this dilemma is a frequent problem in today's culture. He admits to an occasional use of

140 Ibid.

imagination in recreating certain episodes and to changing characters' names in order to protect the real individuals.[141]

Another topic is the illness of the author's brother. In this way, Burroughs goes beyond his troubles and devotes a part of his attention to his older brother. The author focuses on his sibling's strange behavior, which was only later diagnosed as a mild form of autism – Asperger's syndrome. There was a demand for such topics, which was visible when Burroughs went on a book tour, and people suffering from Asperger's syndrome appeared and greeted him thanking him for raising this matter and being open to advice on this medical problem.[142]

Burroughs' adolescence is inseparably related to living in a dysfunctional family, which forms another topic of his memoir. The reader gets to know his family when he introduces his parents. Although they both belong to an intellectual elite, his mother is a poet, and his father a maths professor at the University of Massachusetts, they are far from successful in their daily life. His mother's dream is to gain fame, which has not happened so far, and this is the reason for stress and frustration. Her husband is an alcohol addict. While portraying his parents' situation, the author also shows how it all contributed to the atmosphere at home, which was unstable. He frequently witnessed fights between his parents, which with the progress of time became more dangerous**.**[143] This also exemplifies his parents' inability to create a successful relationship**:** "As time went on, my parents' relationship became worse, not better. My father grew more hostile and remote, taking a particular liking to metallic objects with serrated edges. And my mother began to cry" (p. 30).[144]

Abusing privileges by medical workers becomes another topic of Burroughs' *Running with Scissors*. The medical theme is introduced because of the family situation. Disagreement between his parents is the cause to seek medical intervention. Referring to the example of their psychiatrist, Burroughs illustrates the doctor's inadequate behavior, which is illegal. Cheating insurance companies and overmedicating his patients, the psychiatrist seeks to manipulate them and manages to involve them in sexual relations. Burroughs presents the psychiatrist as an insane man, who is even crazier than his patients and ignores the boundaries necessary in a medical environment. For example, the psychiatrist identifies movements in his bowels as

141 Michael Angrosino, *Exploring Oral History: A Window on the Past*, Illinois: Waveland Press, Inc., 2008, p. 28.

142 John Elder Robison, *Look Me in the Eye: My Life with Asperger's*, (foreword), Reading: Ebury Press, p. XII.
143 https://www.enotes.com/topics/running-with-scissors, accessed on 30.05.2018.
144 Augusten Burroughs, Running with scissors: A Memoir, New York: Picador, 2002, p. 30.

messages from God. The author operates at two levels, he uses "superficially amusing anecdotes" to address serious topics such as abuse and neglect.[145]

On balance, Burroughs touches many deep topics, which may be close to the reader's mind. Drawing on his imagination is a technique that distinguishes him from other memoirists and is a stepping stone to hurtful reality surrounding him. The reality portrayed by Burroughs is harsh. Creating a memoir in his case, can be viewed as a therapeutic device, in a situation when nobody else can help him with his family troubles and with himself. The act of writing this memoir replaces a psychologist who would listen to him. It may also have a therapeutic effect on some readers, who can see that such ridiculous things happen to others, too. The matter of abusive substances may be a point to evoke the reader's reflection on the fact that positive family bonds can prevent the young from resorting to such means.

The motif of youth is also explored by the next memoirist – Brook Busey – Maurio, known by the pen name Diablo Cody, an American screenwriter, director and producer. What brought her fame was her memoir *Candy Girl: A Year in the Life of an Unlikely Stripper* (2005), which was preceded by her blog.[146] Her memoir falls into the category of adolescent crisis or "quarter-life crisis", which also includes girlhood memoirs describing early towards mid-twenties years of life. A great number of such memoirs have been released after the year 2000 and contributed to the evolution of the public literary form of contemporary life writing.[147] The above-mentioned memoir mainly presents experiences from her job as a stripper and the industry related to this branch. It may be read by someone out of curiosity, as a way of confrontation of the memoirist's life with a reader's own. She does not provide any blueprints or models to follow, as Benjamin Franklin did, but merely gives an insight into her life.

The topic of childhood in connection with dysfunctional family life had already surfaced in the late 20th century. It was also discussed by Mary Karr, an American poet, memoirist, essayist and university professor who became famous in 1995 with the publication of her bestselling memoir *The Liars' Club.* Mary Karr tackles basic problems, which seem close to a

145 Ibid.

146 "List of Famous Memoirists", https://www.ranker.com/list/list-of-famous-memoirists/reference, accessed on 12.04.2019.

147 Kate Douglas, Anna Poletti, *Life Narratives and Youth Culture: Representation*: London: Agency and Participation, Palgrave Macmillan, 2016, p. 150

common human being. As Gale comments on them,[148] they involve family, love, challenges that life brings, and forgiveness. She comes back to her difficult childhood~~,~~—in Texas. The title of the memoir stems from how her father's friends were called, and it was where she got to know the information about her father's childhood. The father was telling these stories to his friends, while drinking at the American Legion.

Besides, in her story the author devotes a lot of attention to her parents and their marriage. She introduces her mother, who came from an ordinary family, and her father – a World War II veteran. The parents' negative behavior – her father's alcohol addiction and the mother's emotional instability, which made her focus on herself and not her family members, was a challenge to the author, and the cause of her problems, which she enumerates: walking in her sleep, nail-biting, being suspended from the class for attacking children. Karr's mother suffered from a mental breakdown, which caused trauma in her and her daughter, making her feel as if she did not have a mother. Her mother went through an addiction to diet pills and alcoholism, the result of which was the will to kill her offspring. Simultaneously, she was emotionally unstable. Karr mentions her mother's habit of marrying many men in her life: "My mother didn't date, she married. At least that's what we were said when I finally found out about all her marriages before Daddy. She racked up seven weddings in all, two to my father" (p. 22).[149] Karr gets to the root of her mother's immaturity and inability to function in a family life. She shares the facts she discovered later. Her mother's previous husband had run away with their two kids, whom her mother did not manage to find. This, as the daughter explains, may have contributed to her instability[150]. Like in Burroughs' case, Karr's family situation fails to provide safety and is not an oasis of peace. This memoir is a way of analyzing and explaining to the author – herself and others why her mother did not fulfil her role in the family. Sheila Ballantyne points that Karr's memoir also serves as an attempt to comprehend her parents, their lives and relationship they formed with her and her sister. Her memoir may be a way to cope with tough events in her life.[151] It is also a therapy for the writer. The function of making sense of one's life is conspicuous in this case. The topics raised by Karr seem real, that is why her

148 Ibid.

149 Mary Karr, *The Liars' Club: A Memoir*, Picador, 2004, p. 22.
150 Gale, Cengage Learning, *A Study Guide for Mary Karr's The Liar's Club*, 2003, p. 2 (intro).

151 Sheila Ballantyne, The Thousand-Yard Stare, available on http: //archive.nytimes.com/books/97/03/02/bsp/liars.html?module=inline, July 9, 1995, accessed on 22.12.2019.

memoir can catch attention of average readers, who are likely to find their own experiences as if reflected in her story, though perhaps not identical.

The problem of the parents' death and a state of being an adult child can be traced in Patricia Hampl's memoir *The Florist's Daughter* (2007). She has won numerous awards, including *The New York Times* 100 Notable Books of the Year and the 2008 Minnesota Book Award for Memoir and Creative Non-fiction. Published in 2006, *Blue Arabesque: A Search for the Sublime*, was chosen for The Best Spiritual Writing 2005. She first won recognition for *A Romantic Education* – a memoir about her Czech heritage. This book along with subsequent works have established her as an influential figure in the rise of autobiographical writing in the past 25 years[152]. *The Florist's Daughter* focuses on experiences accompanying death. She includes her thoughts connected with these moments. Soon after her mother and later her father perished**,** the author realizes she will no longer be a daughter. She, however, recalls memories to stop the time and avoid feeling lonely because of the loss of parents**.**[153] She is well aware of the situation: "So here I am, still dragging at her side **[**…**]** never have I lived more than a long walk from my girlhood home. Still a daughter. But soon, in hours apparently, I'll be nobody's daughter" (p. 10)**.** [154] The predicament she is in, makes her think about facts of life, such as the transience of her role as a daughter, the possibility of having "broken away" from her parents a long time ago to become he self.[155] As Beth Kephart adds, Karr's memoir touches the problem of growing old, in particular that it is difficult to understand this phase until a child sees it happening to his/her parent and is the parent's companion in it.[156] A reflective role of a memoir is realized in Hampl's analysis of her experiences and recollection of the earlier period of being a daughter. These steps help her and the reader make sense of the events in life.

Another issue that Hampl raises is daydreaming and getting lost in thoughts. She finds these activities positive, and they are the topic of *The Art of the Wasted Day* (2018). Hampl stresses they are valuable because they can be stimulating for one's mind, and those who do not daydream or get lost in thoughts miss a lot. Unfortunately, some who daydreamed as kids now

152 Patricia Hampl, https://www.goodreads.com/author/show/3195, accessed on 17.08.2019.

153 https://www.nytimes.com/2007/10/07/books/review/Trussoni-t.html, The Hopelessness of Escape, Danielle Trussoni Oct. 7, 2007, accessed on 26. 01. 2020.

154 Patricia Hampl, *The Florist's Daughter,* Florida: Mariner Books, 2007.

155 Ibid. p. 11.

156 Beth Kephart, *Handling the Truth: On the Writing of Memoir*, New York: Penguin Group, 2013, p.19.

replaced it with only showing off their chores, and achievements. Hampl talks about the benefits of daydreaming:

> I already know that daydreaming does not make things up. It sees things. Claims things, twirls them around, takes a good look. Possesses them. Embraces them. Makes something of them. Makes sense. Or music. How restful it is. How full of motion. […]. It is pure pleasure. Indefinite delight. For this a person goes to hell. (p. 8) [157]

While reading her memoir, one has a chance to understand what makes life worth living.[158] It can be seen that although Patricia Hampl is the memoirist of present times, she does not seem to follow shallow trends launched by the modern world such as exhibitionistic behaviors to capture others' attention on social networking sites, boasting and promoting oneself there, or persuading people that they desperately need the latest types of mobiles, cars to mean something to others. She prefers to look inside herself and is concerned with intangible matters that go on in people's minds. She describes and recommends such activities as daydreaming, immersing into oneself and reflection, which are accessible irrespective of one's social or economic status.

There are also theme memoirs, including those that deal with medical issues and patient-related environment. They are often written by doctors, especially surgeons, but other medical staff, such as nurses and physiotherapists, also create them. The first two examples: *The Language of Kindness: A Nurse's Story* – a medical memoir published by Christie Watson in 2018, and *Counting Backwards: A Doctor's Notes on Anaesthesia* (2017) are worth discussing because these books comment on the work of the medical staff and the theme of doctor–patient relations. Therefore, these memoirs are closely connected with the main concern of this dissertation. *The Language of Kindness: A Nurse's Story* addresses the question of a nursing profession and comprises medical cases gathered by the author, who is a nurse. She depicts how she finds herself in this profession and explains what it means to be a nurse and to care for patients. She underlines sympathy, compassion and empathy as indispensable features of a good nurse. Watson's book goes beyond a memoir, she includes detailed information on the history of nursing and provides medical explanations. The stories come from different hospital wards, as being a resuscitation nurse, the author keeps moving from one ward to another and in this way has contact with different patients. This circumstance helps her fill her

157 Patricia Hampl, *The Art of the Wasted Day*, New York: Penguin Books, 2018, p. 8.
158Maureen Corrigan, http://www.npr.org/2018/04/23/604910290/art-of-the-wasted-day-makes-a-case-for-letting-the-mind-wander?t=1580037607684, April 23, 2018, accessed on 26. 01.2020.

memoir with various experiences. The author engages the reader because a passion for her profession can be felt throughout the book:

> I want to share with you the tragedies and joys of a remarkable career. Come with me on the wards, from birth to death; past especial Care Baby Unit and the double doors to the medical ward; run through the corridors to answer the crash bleep, past the pharmacy and staff kitchen, and to Accident and Emergency. We will explore the hospital itself, as well as nursing in many of its aspects [...]. We will meet people on the way: patients, relatives and staff. (p. 14)[159]

Including different people – both patients with their families and medical staff – also allows for showing situations, in which each of them found themselves, and their reactions to hospital reality.

The work of an anesthetist is skillfully and accessibly portrayed in the aforementioned *Counting Backwards: A Doctor's Notes on Anesthesia* (2017) by Henry Jay Przybyło. It is a pediatric anesthetist's account of things that happen when the patient is anesthetized and wakes up again. Like other memoirists, the book provides patients' stories and tells about medical procedures.[160] The book title comes from a method used with patients on anesthetic wards. When they are given anesthesia, they are asked to count backwards to fall asleep.

Although an anesthetist's contact with patients when they are aware is short and his task is to erase consciousness and immobilize the body, the author stresses his crucial role for the patients and other doctors. His work enables other medical specialists – for example gastroenterologists, surgeons and cardiologists to perform their job – that is to probe or cut. Even though the anesthetist's patients get to know him only for a few minutes, and usually forget his name after the operation, their faith in him is indispensable. He, on the other hand, must trust the gas he uses for analgesia. In fact, he does not know how it happens that this gas anesthetizes, and that is why he compares himself to a faith healer. An anesthetist must be flexible, since he switches from one branch of medicine to another during his work; from internal medicine to obstetrics because a child who is supposed to have a skin mole removed, may also have a failing heart and the anesthesiologist must act accordingly.[161] Przybyło discusses a problem of inadequate pain relief, which he witnessed in China and touches upon a

159 Christie Watson, *The Language of Kindness: A Nurse's Story*, Tim Duggan Books: London, 2018, p. 14.

160 https://www.medscape.com/slideshow/medical-memoirs-6009897#4t, accessed on 19.01.2019.

161 Henry Jay Przybylo, *Counting Backwards: A Doctor's Notes on Anaesthesia*, New York: Norton and Company, 2018, p. 2-3.

challenge it poses for abusive use of narcotics.[162] The memoirist introduces the reader to the complexities of his job, which the reader may not have realized. This memoirist does not stick strictly to medical aspects of his job, but to other skills such as the role of cooperation and trust, which are part of doctor –doctor and doctor–patient relations.

In other two medical memoirs: *In Shock. My Journey from Death to Recovery and the Redemptive Power of Hope* (2017) by Rana Awdish and *The Neuroscientist Who Lost her Mind: My Tale of Madness and Recovery* (2018) by Barbara Lipska, the patient's predicament and the doctor–patient relations are again the focus of attention. The memoir *In Shock. My Journey from Death to Recovery and the Redemptive Power of Hope* has been chosen because the doctor's reflection on her past attitudes and patterns of behavior at work are a way of looking at doctor–patient relations.

In this memoir a doctor recalls how she took a role of a patient after facing a catastrophic medical event.[163] Portraying this predicament, Rana Awdish shows the reader how medical staff can turn into a patient and then see things from this perspective. In her book she also includes suggestions on how to improve a doctor–patient relationship. She presents her own medical case; after an emergency trip, she had a hemorrhage, which was followed by surgeries. Fighting for her own life, the author felt certain defects in the standards of healthcare. She experienced indifference after a loss of her unborn child. In the light of suffering and emotional distance, the author becomes aware of the flaws of her profession, and looks at her past actions from a more critical perspective. Rana Awdish wishes to suggest a new approach, which builds upon an emotional bond between doctor and patient. Her experiences make her rethink things she was taught during her studies.[164]

Experiencing a hard medical situation allowed the doctor both to understand a potential patient's plight, and realize what it means to be dependent on medical staff and others in this position. She looked at doctors from the patient's perspective:

> I sat sore and exhausted, staring at the stupid yellow socks on my feet. I tried to integrate what had just happened into who I believed myself to be. I was apparently now a person who took over an hour to put

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162 Andrew Kadar, "Counting backwards, a doctor's notes on anaesthesia – a book review", available on https://csahq.org/news/blog/detail/csa-online-first/2018/02/26/counting-backwards-a-doctor-s-notes-on-anesthesia-a-book-review, accessed on 26.02. 2018.

163 Ibid. Christine Wiebe, MA, "10 Gripping Medical Memoirs" accessed on 26.02.2018.

164 http://goodreads.com/book/show/33574173-in-shock accessed on 27.05.2019.

> on socks using a sock-hook. And I was a person who found it incredibly difficult. It shook my head. I didn't recognize myself […]. I had to learn to soften. I had to learn to accept my body's limitations. I had to value humility and choose to surrender. (p. 121)[165]

This memoir shows how difficult it is to take courage and sincerely admit things the way she does. Awdish's memoir has an awareness-raising function. What is more, writing about events from her life contributes to her own transformation.

The Neuroscientist Who Lost her Mind: My Tale of Madness and Recovery puts emphasis on empathy for patients. The author argues that understanding patients by medics constitutes an element of communication in healthcare institutions. The book depicts a member of medical staff as a patient and analyses miraculous recovery from an illness, revealing a range of states the doctor went through. After being an expert on the brain, a neuroscientist fell ill with dementia and schizophrenia. Following her recovery, she managed to describe her experience:

> In addition to providing insight into mental illnesses such as schizophrenia and dementia, my experiences gave me a greater understanding of other brain disabilities, […]. Many people may someday face in themselves, their partners or their parents the bewildering changes I had-memory loss, disinhibited and inappropriate behaviors, altered personality. (p. 11)[166]

From a scientist studying mental disorders, she becomes a mental patient herself.[167] She clearly states that by experiencing unpleasant states of mind on her own, the doctor gained empathy. Different symptoms like forgetfulness, which normally happen to evoke contempt and incomprehension, even in medical staff, became known to her.

The topics of *Open Heart: A Cardiac Surgeon's Stories of Life and Death on the Opening Table (*2017) by Stephan Westaby is concerned with care about a patient and a wish to improve patients' situation and give them the chance of more effective treatment, among others by the use of new technologies in medicine. Information on progress in medicine can be found in this memoir, which describes complicated cases of cardiologic patients requiring new heart technology. A British cardiologist gives his autobiographical background and account of his

165 Rana Awdish "In Shock. My Journey from Death to Recovery and the Redemptive Power of Hope", p. 121.

166 Barbara Lipska, *The Neuroscientist Who Lost Her Mind: A Memoir of Madness and Recovery*, Houghton Mifflin, 2018, p. 11.

167 Ibid. p. 12.

surgeries.[168] He also gives a biting commentary on the UK National Health Service. Commenting on his mother's case, Westaby shows how slow the help was in an urgent situation. This heart surgeon records unusual achievements in the field of artificial heart technology. The reader finds out that the author uses these techniques and solutions for his operations, and Westaby describes the cases patients whom he did not want to deprive of hope. To be precise, Berlin Heart device made it possible for 10-year-old Stephan to live until a donor heart was found for him. A half-year old Kristy can be helped with cardiac stem cells, which are able to regenerate her heart muscle. In his daily job, Westaby followed the maxim of never giving up.[169] The cases presented by him are detailed and could be of interest to medical specialists because of the complicated medical knowledge and concepts that Westaby includes in his account. His involvement in heart surgery, determination to fight for the patient and a sense of mission are visible throughout the book.

Becoming myself: A Psychiatrist's Memoir (2017) by Irvin Yalom is worth mentioning as a patient's voice, which is "heard" in this memoir. The focus on the patient's situation is present through gathered stories of his patients, with which he interweaves his memoir. Its topic is a reflection on a doctor's life and his professional development. The memoir depicts the writer's general family background and illustrates his interest in psychotherapy. It includes memories of childhood, college and professional career. What distinguishes this book from the previous ones is the presentation of views and thoughts from a philosophical perspective. Yalom goes back to his childhood and growing up in Washington D.C. His wish to escape from his mundane childhood led to a dream of becoming a doctor in the future. Apart from depicting a story of his life, which serves as a starting point of his memoir, Yalom also reflects on his existence and development. The thoughts he shares encourage readers to dwell on the meaning of their life, too. As Yalom was a psychotherapist by profession, he refers to his work in a group psychotherapy. He explains how he became a practitioner of existential psychotherapy. He explains that existential psychotherapy is an approach that focuses on existential concerns, some of which are: freedom, meaninglessness and isolation. It boosts making rational choices and developing one's fullest potential. Existential psychotherapists aim to get to the essence of symptoms such as addiction, anxiety, lack of purpose in life and psychosis and to attempt to alleviate them. Psychotherapists of this field concentrate on "life-enhancing experiences",

168 Ibid. Christine Wiebe, MA, "10 Gripping Medical Memoirs**".**

169 https://www.publishersweekly.com/978-0-465-09483-7 accessed on 04/24/2017.

which among others are: commitment, love and relationships. He claims that writing was an excellent means of exploring human psyche.[170]

All in all, similar topics can be traced in autobiographical writing created up to the 21st century and memoirs written in the 21-st century. Although the writers represent different centuries and environments, certain themes and motifs persist in the memoirs. These are: relationship with others and with the family, depiction of relationship between the author's parents, the author's feelings in the face of death of family members, perception of a memoir as a friend to confide in, the topic of adolescence and a problem of addictions to drugs and alcohol. One distinction is that in very early autobiographical writing – 557 BCE and later authors concentrated on religious matters and God to a large extent, which is not so visible in the 21st century writing. In the case of medical memoirs from the 21st century, some authors characterize their profession and share experiences as well as present patients' stories. Other doctor –memoirists open their own and readers' eyes to phenomena such as a patient's situation in healthcare institutions.

1.3. NEW TRENDS

Popularization of a computer and the Internet over the past years brought substantial modifications concerning the way different types of writing, and among them memoirs are created. A computer keyboard superseded a typing machine. Works are being transferred to the net, and more than once created there from scratch.[171] Blogs are an example of the phenomenon of writing online, with no prior paper-written form. Michael Dennis defines blog as "an online journal where an individual or a group presents a record of activities, thoughts or beliefs."[172] Sarah Pedersen indicates the changing nature of a blog and claims that it is "a frequently updated, reverse-chronological entry" on a website[173]. Some blogs operate as news filters, collect different online sources and add brief comments as well as Internet links. Blogs often provide a forum and enable visitors to leave a comment and interact with the author. Apart from

170 https://www.karnacbooks.com/product/becoming-myself-a-psychiatrists-memoir/94383/backgroung accessed on.28.05.2019.

171 Maciej Maryl, „Blog jako dziennik elektroniczny. Analiza genealogiczna blogów pisarzy" w *Zagadnienia Rodzajów Literackich,* Łódzkie Towarzystwo Naukowe, Łódź nr 55/109, zeszyt 1, 2012, p.106.

172 Michael Aaron Dennis, "Blog Internet", available on https://www.britannica.com/topic/blog accessed on 14.05.2020.

173 Sarah Pedersen, "Why Blog? Motivations for Blogging", available on http:// www.researchgate.net/profiles/sarah-pedersen, accessed on 12.08.2022.

written materials, which predominate, pictures, audio-visual materials and videos are a crucial part of blogs. Today blog entries contain eye-catching titles, banners calling to action, or images in the form of a photo.

The term "blogosphere" denotes the online universe of blogs.[174] The form of a personal blog is unique in confrontation with traditional personal documents because of participation of the audience, which co-creates the text and affects its shape. Blogs are the result of the culture of personalization, in which the addressee affects the sender, encouraging him/her to modify the message. Blog is exposed to diverse audience, which influences its language and blog success. Blog as a form of electronic discourse is chiefly focused on an active response of addressees, which is the best evidence of its importance. Recipients co-create the content of a blog and influence its structure.[175] Modification of this type can also take place in the case of a topic offered by a blogger. Readers have the power either to maintain the topic or suggest another one, "tabled" by other blog addressees. This change occurs when a reader posts a comment, which is off the topic and it is responded to by the next reader, and in this way a new topic comes on and is maintained. Bloggers expect their recipients to give a comment on the introduced topic.[176] Spontaneity and unpredictability are inseparable parts of a blog and probably this is also the reason why this form of writing appeals to the young audience. It allows for freedom and is an innovative form of interactive writing, non-existent in the past. Blog is "a venue of self-expression". A blogger is free to fill it with whatever s/he wants. It is open in a way that it contains links to websites, other blogs, stories, commentary on the news or videos.[177] This openness goes even further. The question arises whether a blog can be considered literature, since it does not have a closed form. It lacks a thought-out composition of the traditional text. A blogger does not know where his text is aiming, what it is going to look like in a year, or when it is going to end.[178] It is software that decides what we see on the screen. A blogger's possibility to edit and delete responses is limited.[179] There are no editors like in the case of traditional books. The idea of blogs has something in common with the existing concept of self-publishing, in which there are no barriers to publication or quality control. Apart from

174 Ibid. www.britannica.com.
175 Ibid. p.106.

176 Brook Bolander, *Language and Power in Blogs: Interaction, disagreements and agreements*, Amsterdam: University of Zurich, 2013, p. 51.
177 Arie Kaplan, *Blogs: Finding Your Voice, Finding Your Audience*, New York, 2012, p.4.
178 Maciej Maryl, „B*log jako dziennik elektroniczny. Analiza genealogiczna blogów pisarzy"* w *Zagadnienia Rodzajów Literackich*, Łódzkie Towarzystwo Naukowe, Łódź nr 55/109, zeszyt 1, 2012, p. 92.
179 Serfaty Viviane**,** *The Mirror and the Veil: An Overview of American Online Diaries and Blogs*, Amsterdam: Rodopi, 2003, p. 66.

objectionable content, which would probably be deleted by software specialists, it is readers who "review" the quality of the blog content by continuing to read it or not.

Aimeée Morrison divided blogs into public and private ones; they are HTML paper heirs of personal writing (life writing): autobiographies, memoirs, diaries and albums with cuttings. In terms of communication, there are monologue blogs (aimed at expression, not allowing for discussion) and dialogical blogs (allowing for discussion at least to some extent).[180] Dialogical bogs seem to be read more frequently by the common audience, due to the possibility of interaction. At the time of poor readership in today's society, dialogic blogs may be a stimulus to begin reading at all. Through the participation of people from different social strata and of different age groups, readers can broaden their horizons on various matters, get to know the others' way of living and even change their views. One example is a situation when some think that staying at home in order to bring up children, instead of continuing professional activity is a sign of laziness. A blog written by a mother may show the readers that staying at home also necessitates getting up early or at night or visiting a pediatrician in the middle of the night. A blog offers an insight into another person's life.

Morrison does not develop his division on types of blogs, but public blogs can comprise those kept by, for example, politicians. Marek Jeleśniański states that such blogs are a source of information for traditional media. They contain controversial ideas that can be quoted or serve as a starting point in an information broadcast. Readers can form their opinion on views presented by a blogger who is involved in politics. Politicians' blogs became popular in the U. S. during a presidential election campaign in 2003. Both candidates: John Kerry and George W. Bush made use of this solution in their efforts to win votes.[181]

Private blogs are just a way of following the trend of moving from writing on paper to the Internet. The distinction between public and private blogs is that public ones may be an option in one's professional life, and therefore will attract addressees interested in less personal issues; precise information; such as the strategy and motives of a politician or a businessman, their actions or specific plans for the future. Representatives of different professional groups, for example, sportspeople, can write blogs, in which they comment on fitness and give advice

180 Morrison Aimeée, "Blogs and Blogging: Text and Practice", w *A Companion to Digital Literary Studies*, red. R. Siemens, S. Schreibman, Blackwell, Oxford, 2008, available on http:// www.digitalhumanities.org/companionDLS/, accessed on 05.05.2019.

181 Marek Jeleśniański, eredaktor.pl/teoria/typologia-blogow-czesc-5-blogi-publicystyczne-i-blogi-politykow/reredaktor.pl – dziennikarstwo internetowe accessed on 11.12.2018.

on bikes. Sentiments, feelings and emotions are more likely to occur in private blogs. It can happen that public blogs are created to achieve some aim – to gain popularity or voters, and private blogs may just be written for pleasure and self-development because it also gives a chance to modify or improve one's views through confrontation with readers, who respond to bloggers. Readers can sometimes see themselves reflected in a person from a blog.

Sarah Pedersen finds other reasons why people write blogs, which are expanded on by Dan Morrill. One of them is documenting the author's life. Bloggers inform others about what they are doing, and what involves them. They explain to themselves and others the causes of taking up certain initiatives. Another ground for blogging can be a wish to come up with ideas while writing. Authors of blogs hope to find a solution to their problem and other participants can appear helpful in it. Forming and maintaining forums and communities is the next factor that encourages blogging. Addressers and their recipients feel united, blogging ties them up. They may feel like a community in which one has an influence on other members. Every day new situations happen in one's country and around the world, and some want to present their comments and views on them. Blogs enable people to detect and talk about good and bad things around them. Bloggers and their readers can discuss terrorism, religion, human rights, personal tragedies like terminal diseases, their business, technologies, relationships, friends and family. Some just wish to earn money and fame and feel the need to be recognized. Writing a blog provides a chance to express deep emotions (blogs play the role of catharsis). Bloggers want to share their experiences, ambitions and anxiety, interests and personality with others. They confront their life and the surrounding reality. In this way, a blogger can see that s/he is not alone in their passions, aims and tastes in music or sports team.[182], [183] According to Arie Kaplan, blog can be a way of keeping or catching up with the surrounding world. It is supposed to be a very up-to-date 21st century equivalent of diaries in the previous era. A blog is also a forum for ideas and views.[184]

Bloggers may give or get support through their blogs. It happens when they write about their ailment, such as Hashimoto's disease, obesity or even anorexia (or any other non-medical problem), and readers realize that somebody else also faces a similar dilemma, whereas they were convinced they were alone or among few with their trouble, and feeling helpless. Thanks

182 Sarah Pederson, *Why blog? Motivations for blogging,* Oxford: Chandos Publishing, 2010, p. 7.

183 Dan Morrill, *Boom and Bust in the Blogosphere: Case Studies of the Blogging Industry*, 2008, p. 8.

184 Arie Kaplan, *Blogs: Finding Your Voice, Finding Your Audience*, New York: The Rosen Publishing Group, 2012, p. 4.

to reading a blog about a similar case, they become stronger, obtain new ideas, and can share their own ones, and by this support the blogger. It shows that interaction and reciprocity is possible through blog. Maciej Maryl lists the main themes of blogs, which include: family events, gossip, accounts of social celebrations, matters from public life, jokes and anecdotes. Thus blogs are a combination of important with unimportant, private with public. Authors of blogs comment on current phenomena of cultural, social and political life. The inspiration for creating a blog content can be press articles or controversial problems discussed in a broadcast. Bloggers can continue with plots, for which there was no time during the broadcast. Other topics include: Antisemitism, death penalty, religious education at school, auto-thematic discussions, favorite books and types of anxiety.[185]

The language of a blog has a certain code**.** Firstly, it is characteri**z**ed by abbreviated utterances because the entry ought to be concise**.**[186] It consists of using as few words as possible. For instance, in the reader's response to a blogger's text, the omission of verbs is observed in the following sentence: **"**Maciej, damn brave decision […]. Good luck on your further offline life way**.**" In a formal book it would probably be stated: **"**Maciej, it is a damn brave decision […]. I wish you luck.**"** Apart from skipping some parts of a sentence, abbreviated forms (contractions) are common**:** "When I shared this with my boss, Seth Barnes, he told me he was proud of me, that he'd been expecting this conversation. I told him I didn't want to do it without his blessing."[187]

Secondly, the language of a blog ought not to be too grave or "hard";[188] too formal or sophisticated utterances could confuse some readers. The example quoted and discussed below exemplifies casual language:

> Friends, something is wrong here. Something is wrong when we've lost so much touch with the birth of Jesus that we grumble and grunt about seeing relatives or make up excuses to stay home on Dec. 25. Something is wrong when we're dreading a season that should be marked by generosity and gratitude. Something is wrong when we'll do anything we can to avoid Christmas -- even explore alternative holidays [**…**]. This weekend, I had my sister up from Alabama to visit. On Saturday, I thought that it'd be nice for us to go shopping. You know, brother-sister bonding or something. Oh. my. word. I was wrong [. ..]. Shopping with a bunch of crazy idiots just brings out the idiot in me."[189]

185 Maciej Maryl, „B*log jako dziennik elektroniczny. Analiza genealogiczna blogów pisarzy"* w *Zagadnienia Rodzajów Literackich,* Łódzkie Towarzystwo Naukowe, Łódź nr 55/109, zeszyt 1, 2012, p. 95.
186 Ibid. p. 98.
187 https://jeffgoins.myadventures.org/post/my-last-day-at-adventures-in-missions accessed on 19.03.2020.

188 Ibid. p. 98.
189 https://jeffgoins.myadventures.org/post/a-festivus-for-the-rest-of-us-sick-of-christmas accessed on 15.07.2020.

At first, the blogger builds a sense of partnership and belonging in readers by using the pronoun "we". Despite the fact that s/he makes a significant point, namely tries to make readers realize or remind themselves of an essential issue, which is remembering to celebrate Christmas, and not miss the essence of it, at the same time the blogger expresses his message in a delicate way, and clarifies it by examples of having his sister as a guest and planning a shopping visit with her. In addition, he intersperses his blog with simple, colloquial phrases like: "You know", or expressions normally present in a spoken language – "it'd be nice", "or something", "Oh. my word" or calls potential customers – idiots, which is insulting.

Thirdly, direct communication is underlined by addressing the reader: "Hello' or 'Dear Mark' – (based on oral or epistolary forms).[190] Examples of addressing the reader directly can be detected in Jeff Goins's blog: "Dear friends'", or even: "Friends". The author of a blog addresses the reader directly: "I'm grateful to all of you — friends, supporters, colleagues — and hope to stay in touch in this next season of life" (p.98).[191] By using the expression "friends", he seeks to establish familiarity with the reader. He also refers the addressee like in a postscript:

> P.S. "If you'd like to continue following along, you can visit my personal blog here. Also, if you've been supporting me, please know that future donations on my behalf will go to Adventures in Missions, not me. Thanks again for your partnership."[192]

Finally, colloquial language can also be found in blogs, as in the following sentence: "So, I guess, this is goodbye." Through these words, the reader is likely to feel like s/he is reading a note or a letter or an e-mail from a friend, and not a serious piece of writing. This permits focusing on the content or a blog message, and one does not get tired of a complicated train of thoughts, which could appear in a scientific text or a novel. One can relax while reading a blog. Equally colloquial is a blogger's way of finishing an entry:

> "But for now, I'll close with this: Here's to new beginnings, Jeff."[193]

In comparison with the past, nowadays there are fewer diarists or journal writers who stick to traditional forms, despite the fact that computers contribute to the loss of individuality and uniqueness, and their material value is lost.[194] The reader no longer has a book with a characteristic cover in front of him/her, which may be of sentimental value. Instead, the text of

190 Ibid. p. 98.
191 Ibid. p.98
192 https://jeffgoins.myadventures.org/post/my-last-day-at-adventures-in-missions accessed on 09.08.2019.

193 Ibid.
194 R. Lubas-Bartoszyńska, *Pisanie autobiograficzne w kontekstach europejskich*, Katowice, 2003, p.51.

a diary is available on the Internet site or on a computer desktop. It may occur that after being a blogger, a person can turn to writing a memoir, the example of which is Nancy Hinchliff. She collected all her stories into a book, included vivid descriptions and worked on character development and dialogues.[195]

On the whole, autobiographical literature is important to the reader. It forms a part of the history, depicts past events, frequently in a different light than readers knew them. It can be a reliable source of information since it is presented at first hand by the writer. Autobiographical literature also includes medical memoirs, which provide medical knowledge, and apart from reflections and feelings, present the doctor's and often also the patient's situation.

195 Nancy Hinchliff, "From Blogging to Memoir", available on https://seriousreading.com/blog/18856-from-blogging-to-memoir.html, accessed on 07.05.2019.

CHAPTER TWO

THE ROLES AND MODELS OF COMMUNICATION IN MEDICAL CONTEXT

In this chapter, the term of communication is defined as a key concept in doctor– patient relations and the main component in the process of healthcare. I begin with a presentation of some Polish and foreign researchers, such as Keating Platt, Danielle Ofri, Katarzyna Jankowska and Tomasz Pasierski, who underline the significance of communication in medical environment. Their viewpoint is a starting point to discuss benefits of proper communication in the context of medical environment and to illustrate how proper communication can contribute to more effective treatment and mutual satisfaction. Next, the concept of narrative medicine, coined by Rita Charon is introduced to indicate its crucial role in understanding patients and their needs. This notion is highlighted since it is closely related to writing memoirs, in which either the medical staff or the patient include stories of their illness. Narrative medicine seems vital because it is a way of combining medicine with literature. The further part of the chapter shows that in the past doctors, for example, Mikhail Bulgakov sought to put their medical experiences and autobiographical elements into fiction writing. The final section comprises the claim that medical progress is not fully compatible with a humanistic one; some weak points in doctor–patient relations are detected, which is corroborated by surveys and examples presented by researchers in a corresponding field. Causes of dissatisfaction felt by both sides – the medical staff and patients are analyzed and models of doctor–patient communication are presented to see how those models are subsequently reflected in selected memoirs. This analysis of doctors' memoirs also shows how the medical staff change their attitudes or assessment of their professional reality after or while writing.

Communication plays a crucial role in daily life. People communicate for different purposes. One of researchers on communication, Michela Rimondini defined it as an interaction between two or more agents sharing signs and semiotic rules. During this interaction, the messages are transmitted from a sender to a receiver, who are at the same time senders and receivers of the messages.[196] Communication is "a process of organizing information", which allows for creation of meaning. Significant terms in this definition are: messages, organizing

196 Michela Rimondini, *Communication in Cognitive Behavioural Therapy*, New York: Springer, 2010, p. 107.

and meaning (Wiertlewska: 2014).[197] The better the communication, the higher the interlocutors' satisfaction.

In the context of doctor–patient communication the sender's message can be information about symptoms and the return message from the receiver can be instructions or recommendations in a medically simpler case or giving a diagnosis. Communication between the doctor and the patient is the main component in the process of healthcare. Since doctors are in a unique position of enjoying respect and power, they may influence patients' health also in the way they speak. This suggestion was proposed ages ago by Hippocrates who lived in 460 B.C.[198] In her recent study, Danielle Ofri detects the importance of communication in medical environment. She proves that the conversation between a patient and a doctor still constitutes the main diagnostic tool, in spite of the following two factors: some branches of medicine rely on visual aspects, for instance dermatology, or procedural aspect for example surgery. Yet, the patient's verbal description, and the doctor's questions are decisive in the process of setting a diagnosis. Another factor is that some diagnoses are made by means of hand-held machines such as magnetic resonance imaging (MRI), positron emission tomography (PET) scans and advanced computer tomography (CT) technology. Even in these cases, the patient's story still constitutes an essential data, playing a key role in guiding a diagnosis, making a clinical decision and treatment.[199] This conversation can consist of additional questions. For example, seeing skin irritation or skin inflammation, a dermatologist can ask about the circumstances which in a patient's view could have caused this medical condition. Such query allows for a small story and enables giving further recommendations (for instance: "be careful which washing-up liquid you use"), instead of restricting oneself to just mechanical prescription of an ointment. The same can happen with bladder problems. In a conversation, it can turn out that the patient can stop drinking diuretic teas so often, and maybe no pill or treatment is necessary.

197 Janina Wiertlewska, „Ekolingwistyczne podejście do nauczania języków obcych na przykładzie języka angielskiego – wyzwaniem dla glottodydaktyki XXI wieku", in Barbara Skowronek, *Glottodidacticca An International Journal of Applied Science*, Toruń/Bydgoszcz: UMK w Toruniu, Collegium Medicum im. L. Rydygiera w Bydgoszczy, 2014.
198 Jennifer Fong Ha, Nancy Longnecker, "Doctor-Patient Communication: A Review", in The Oschner Journal, 2010 Spring 10 (1): 38–43.
199 Danielle Ofri, *What Patients Say, what Doctors Hear*, Beacon Press: Boston, 2017, p. 5.

2.1. THE BENEFITS OF EFFECTIVE DOCTOR–PATIENT COMMUNICATION

The benefits of a conversation in the medical context have been emphasized by many. Conversation is a factor, which can resolve tensions between the doctor and the patient and restore a smooth interaction. Although a physical exam and tests have a role to play, a doctor–patient conversation, or a medical interview, is the most significant diagnostic tool in medicine. The task of the conversation is to yield the diagnosis or pave the way to it. Besides, it establishes the doctor–patient relationship. It has been pointed out in a study by Ofri that if patients became more engaged in their medical care by asking questions, they would be more satisfied with the overall process.[200]

Platt distinguished three main goals of doctor–patient communication, which are: establishing a good interpersonal relationship, involving patients in making decisions, and facilitating the exchange of information. According to Platt, patients judge the effective skill of doctor–patient communication as a principal indicator of the doctors' general competence.[201]

An internist – Lisa Sanders points to the practical benefits of proper communication. She spots that taking a good history from a patient enables doctors to do fewer tests and give fewer referrals, which saves time. In fact, taking the history properly also shortens the time of a visit. Doing it right includes listening to the patient's symptoms, but also taking interest in the background or circumstances connected with the patient's medical problem in order to find out the real cause of illness. In addition, a patient is more content, adheres to his therapy more willingly, and what is vital, patients opt for lawsuits less frequently.[202] The same remarks have been made by Katarzyna Jankowska and Tomasz Pasierski, who noted that complaints about doctors usually concern the lack of communication rather than their clinical competence. They also contend that an effective doctor–patient communication means fewer lawsuits, even in case of an adverse outcome. Physicians who can skillfully diagnose and treat illnesses and communicate effectively are valuable to patients. Doctors who communicate well also feel upsides; they derive more satisfaction from their job, experience less work stress, and are less prone to burnout. Reduction in diagnostic tests and referrals has also been spotted by the aforementioned Jankowska and Pasierski.[203] A good doctor–patient communication helps

200 Ibid, p. 17
201 F. Platt, K. Keating, "Differences in physician and patient perceptions of uncomplicated UTI symptom severity: understanding the communication gap", in [PubMed] [Google Scholar], 2007;61((2)):303–308.
202 Sanders Lisa, *Every Patient Tells a Story*, New York: Broadway Books, 2009, p.8.
203 Katarzyna Jankowska, Tomasz Pasierski, „Medical communication: a core medical competence", in Polskie Archiwum Medycyny Wewnętrznej, 2014, 124 (7-8).

patients regulate their emotions, facilitates comprehension of medical information, and enables doctors to identify patients' needs, perceptions, and expectations in a better way.[204] Patients who have a proper communication with their doctor are usually more satisfied with their care, feel more ready to share information useful for accurate diagnosis of their problems, follow advice, and comply with the prescribed treatment. If patients agree with the doctor about the nature of the treatment and understand the need to follow it, the recovery is more likely[205]. Haennifer Fong and Nancy Longnecker concur with previous authors on the matter of increased job satisfaction, which stems from a good doctor–patient relationship, and they list further advantages of effective doctor–patient communication, namely it is a source of motivation, incentive, support and reassurance. They also add that a proper doctor–patient relationship can motivate patients and lead to their self-confidence, perception of their health status in a positive light, which may affect their health outcomes.[206]

Patients may at first sight not like the doctor by appearance, or may simply be afraid of him/her, which may result from the patient's insecurity, shame of an illness or inferiority complex. However, when this physician shows an interest and asks: "What do you do?", the patient's attitude changes and a will to visit him/her enhances. This idea is expanded by the internist and nephrologist Jacek Imiela, who is the author of a memoir *Medycyna, moja miłość* (*Medicine, my love*, 2012). He draws attention to the direct contact with an ill person and thinks there is no chance of diagnosing a patient properly without an honest conversation with him. Knowing something about patients, their views and perception of the world leads to getting to know them better, and may also determine a mode of treatment, which is convincing to a particular patient. The doctor asks about everything, including questions about the patient's profession and the way s/he feels about something or a taste in books. Ideally, he also gives the patient as much time to answer as s/he needs. That is the first step to discover what is the matter with the patient and only after this step comes the time for specific examination. A good doctor does not accept defining the patient as "the case", but Imiela diagnoses and treats "an ill person". He adds that specialist equipment and tests cannot become more important than the direct contact. He also considers improper a situation in which doctors must be in a hurry

204 Ibid. p. 38–43.

205Wei Chen, H. Starks, C. Shiu, et al. "Chinese HIV-positive patients and their healthcare providers: contrasting Confucian versus Western notions of secrecy and support", [PMC free article] [PubMed] [Google Scholar] ANS Adv Nurse Sci. 2007;30((4)):329–342.

206 Ibid. p. 38–43.

because of too much administration and a load of duties. Then, crowds of patients make hospitals become similar to an industrial plant, in which a human being gets lost.[207]

Imiela develops his view by stressing that a doctor will not solve a medical problem properly unless he understands an ill person. He seeks to achieve that aim and knows that one needs to have extensive medical knowledge and update it all the time. However, this professional attitude is not sufficient. Comprehensive humanistic education is desirable, due to which a person treated by the physician becomes closer to him. Finally, one needs to like one's profession and apply all its rules with heart and soul. The doctor recalls his past patient, with whom he was on good terms, but he remarks that he was also acquainted with this patient's family. Whenever this patient meets the doctor at the clinic, he obeys his recommendations and also this patient's relatives consult the doctor on important matters. On their random encounters with the doctor on the hospital premises, they also express their trust to the doctor.[208]

Imiela gives the example of a conversation with a dying patient, through which he illustrates how fruitful this communication can be. He is honest about his state when asked by him and answers that the patient will not live long. The patient asks the doctor to tell his family that he loves them a lot and that he is going to keep an eye on them. Although the patient told this himself to his family, he thinks they will remember it better when they hear it from the doctor.[209] It can be observed that the doctor's approach is humanistic. His communication with the patient and family members is deep and effective. They talk about meaningful matters, including personal ones, which is normally rare. The doctor can even replace a psychologist, who has the ability to listen.

A crucial role of doctor–patient communication is also discussed by Anna Zembała. She argues that it is one of the most important variables, which affects the process of recuperation, as well as prevents the relapse of a disease. Furthermore, effective doctor–patient communication is related to better indicators of somatic, mental and social health. Proper doctor–patient communication is also helpful in regulating emotions and identifying the patient's needs, perception, expectations, and what is particularly valuable – it boosts the patient's involvement in the recommended therapy. Since each patient experiences an illness in

207 Jacek Imiela, *Medycyna, moja miłość*, Kraków: Wydawnictwo Literackie, 2012, p. 13-14.

208 Ibid. p. 34-5.
209 Ibid. p. 102

their own way, mental support is what they require, apart from professional and medical care.[210] This view is shared by Amy Windover, who claims that in order to provide care of high quality, effective communication must take place between the doctor and the patient. This communication demands a strong and meaningful relationship, which has a healing potential not only for the ill, but also for care givers.[211] A dialogue, rather than a monologue, involves the patient in the learning process, reflecting on the importance of his role as "head of his or her treatment team."[212] Pasierski and Jankowska also see the connection between communication skills and the quality of medical care. Effective communication between the two sides influences the way patients perceive the quality of care. Nowadays patients regard themselves as health consumers and want to participate in making medical decisions. In their minds, their agreement with physicians about the nature of treatment is associated with recovery.[213] Mutual agreement and harmony can be achieved through narrative medicine.

2.2. THE ROLE OF NARRATIVE MEDICINE

While discussing the role of communication in medicine, the term of "narrative medicine" ought to be explored, which is a relatively new approach in medicine. In 2000 there were already active participants of narrative medicine in the fields of primary care medicine, healthcare communication, medical humanities, literature and medicine.[214] The notion of narrative medicine implies incorporation of the art of story-telling or/and listening to patient's stories, into the treatment process. Narratives, that is stories with a teller, listener, a plot and meaningful content, are helpful not only to doctors, nurses and social workers, but also to patients themselves. Narrative skills or skills necessary to listen and understand the narratives of illness, to gain accurate interpretations of these stories and to grasp the patient's plight, enable one person to make sense of a story told by the other one. This is crucial because only in the situation when the physician understands the position of his patient can medical care be provided with "trustworthiness, humility and respect". By narrative medicine, Rita Charon

210 Anna Zembała, „Modele komunikacyjne w relacjach lekarz-pacjent", in *Zeszyty Naukowe Towarzystwa Doktorantów UJ Nauki Ścisłe*, Nr 11, 2/2015, Uniwersytet Jagielloński, p. 50-51.

211Amy Windover, Adrienne Boissy,"The REDE Model of Healthcare Communication: Optimizing Relationship as a Therapeutic Agent, J Patient Exp", 2014 May; 1(1): 8–13.
212 Yael Schenker et al., "Interventions to Improve Patient Comprehension", [PMC free article][PubMed] [Google Scholar], 151–73.
213 Ibid. 124 (7-8).

214 Rita Charon, *The Principles and Practice of Narrative Medicine*, New York: Oxford University Press, 2017, p. 2.

understands medicine practiced with these narrative skills, which allow for recognizing, interpreting and being moved by patients' stories of their illnesses. Narrative medicine is attributed with offering the hope that the system of healthcare can become more effective in disease treatment by showing respect and recognition to patients afflicted with it and "feeding" caregivers.[215] The innovation of narrative medicine lies in the focus on subjectively written testimonies namely personal descriptions, considerations, interpretations and contextualization of the disease. The information on different forms of narrative literature and its influence on its readers is obtained by "researchers" interested in narrative medicine from resources such as health and Quality of Life Assessment questionnaires, surveys and diaries. Narrative medicine is gaining popularity, contributing to the fact that medical staff see the patient as a human being and his personality with sensations, and not only a medical case. Prior to the existence of narrative medicine, the concept of subjective testimonies was not treated seriously, nor was it considered of any value to scientific research. Even in the case of surveys containing open questions, responses were not used for the research. This may have resulted from the lack of tools to analyze and deal with descriptive content. With the technological advancement over the last few years, analysis of narrated texts, non-numerical and unstructured data became possible. The progress in linguistics and information science introduced instruments for text analysis, for example "the semantic mapping software", which serves to analyze words, expressions, synonyms and metaphors. Semantic software enables users to examine relationships within the data.

Narrative medicine seeks the causes, analyses and gives answers which cannot be deduced from clinical trials. Its task is to uncover the patient's deepest needs, and the way the person's identity has changed in confrontation with the disease.[216] Some claim empathy and understanding cannot be taught, one either has it or not, but exposure to narrative medicine in a form of patients' stories or diaries can open up medical workers' eyes to matters they would not see themselves. These are patients' limitations triggered by an illness, for instance inability to walk because of physical weakness, which doctors would attribute to laziness without getting to know patients' mental states, thoughts and moods.

215 Rita Charon, *Narrative Medicine: Honouring the Stories of Illness*, New York: Oxford University Press, 2006, p. 3-4.

216 Maria Giulia Marini, *Narrative Medicine: Bridging the Gap between Evidence-Based Care and Medical Humanities*, Springer: Milan, 2015, p. 59- 61.

Narrative medicine is also defined by Stephanie Hilger as "the analysis of the narrative dimension of doctors' and patients' stories', the therapeutic use of reading and writing literature – (biblio- and scriptotherapy); writing about the disease – (pathography) are indicated, showing that medicine and literature can be connected for the patient's and doctor's good.[217] There are some reasons why the call for combining medicine with literature exists. Crisis in the humanities has encouraged scholars in literature to admit that humanistic field is not self-referential, but responds and involves other fields, too. In fact, medicine and literature should never have been separated, and therefore should now be reconnected.[218] The instances of doctors who make good writers and vice versa are common in the world literature.

One of them is Mikhail Bulgakov, for whom medicine was an inspiration for literary works, in which he included such themes as: birth, death and illness. His characters were frequently: scientists, professors of medicine and surgeons who transplanted organs. Bulgakov took an interest in pediatrics, surgery, cardiology and venereology. He worked at the medical cente as a Red Cross volunteer, where he amputated body parts, did skull trephining and treated typhoid. His job exerted an influence on the literature he wrote, which reflected his professional experiences and contained autobiographical elements, as in the book: *Morphine*. In his works, he included and described medical staff, hospitals, medical surgeries, and doctor–patient relations. The phenomena and challenges the writer–doctor faced and saw around him made him think and present them in literature. Some of those issues are the problem of drugs and their effect on people, distrust against doctor's recommendations, or types of wounds sustained during the war.[219]

Rita Charon, who is an outstanding specialist in narrative medicine, points out that even though a progress has been made in medicine in diagnosing and treating diseases, and doctors have learned to eradicate once untreatable conditions, transplant organs and prevent heart attacks, they still have difficulty in recognizing their patients' plight, showing empathy towards them, not to mention joining patients with honesty and courage in the struggle leading to recovery in the face of chronic illness or in case of death. Patients claim that physicians do not listen to them and show indifference to their suffering. Another problem is being referred to a number of specialists and procedures, which results in patients feeling abandoned with the fear

217 Stephanie Hilger, *New Directions in Literature and Medicine Studies*, Urbana: Pelgrave Macmillan, 2017, p. 4.

218 Stephanie Hilger, *New Directions in Literature and Medicine Studies*, Urbana: Pelgrave Macmillan, 2017, p. 2-3.

219 Ganczar Maciej, Wilczek Piotr, *Literatura Piękna i Medycyna*, Kraków: Wydawnictwo Benedyktynów, 2015, p. 207-211.

and outcomes of illness, despite being provided with technically appropriate care.[220] Rita Charon presented her idea of how the patient can be approached. The scientific advancement needs to proceed along with a humanistic one; namely doctors should gain more experience in listening to the patients, understanding the "ordeals of illness", respect their patients' narratives of illness and be moved by them to be able to act on their behalf. She thinks doctors are on the way to master all those skills, and nurses and social workers who rely on their internal intuition and do not seek prestige often outdo them in it.[221]

Ofri, who is a doctor, also expresses her doubts about the doctor–patient communication. She points out to some incoherence in its pattern. According to her, a doctor and a patient seem to speak at cross purposes. In her book *What Patients Say, What Doctors Hear*, (2017), Ofri investigates the cases of several patients and doctors, and endeavors to look at how the story is transmitted from person to person in a medical context: "There were so many layers of emotions, frustration, logistics and desperation, that it was almost as if we were in two different conversations entirely."[222] Patients complain that doctors do not listen to what they want to say. Therefore, patients feel dissatisfied and frustrated with their visit, and what is connected with it, misdiagnosed or mistreated. The doctors' perception of the situation is no different. The patient's story does not appear coherent to them, which happens especially in the event of patients with "inscrutable and complex symptoms."[223] Zembała appears to corroborate that and notices that both sides are not fully prepared to perform their functions in a doctor–patient relationship. She explains that physicians frequently cannot communicate with their patients in a way that is comprehensible to them, nor can they initiate a contact that raises trust. Patients, on the other hand, are not aware of their rights, do not possess knowledge of their health and illness and are not fully prepared to play an active role in a therapeutic process.[224] Lisa Sanders is also convinced that neither the doctor nor the patient appreciates the significance of the patient's verbal input to make a diagnosis. The cause of the patient's suffering could be figured out by finding a clue in the patient's story, which is also the oldest and most reliable diagnostic tool often overlooked by physicians. In her view, the patient's description outdoes

220 Rita Charon, *Narrative Medicine: Honouring the Stories of Illness*, Oxford University Press, 2008, p. 3-4.

221 Rita Charon, Narrative Medicine: *Honouring the Stories of Illness*, Oxford University Press, 2008, p. 3.

222 Ibid. p. 6.
223 Ibid. p.

224 Ibid. p. 51.

high-tech tests and a physical exam. Talking to the patient matters after making a diagnosis, too. The point is that the patient is frequently deprived of the chance of telling a story. Doctors only want facts, so patients provide "a limited eye witness account of what happened."[225] In reality, two sides – a doctor and a patient should be active in this communication. The patient contributes by providing unique facts of his/her life and illness, whereas the doctor's knowledge and understanding serve to make sense of this story to arrive at a diagnosis.[226] For this to take place, it is necessary that medical staff and patients treat each other equally. Some research results indicate that the reality is different. Unfortunately, both foreign and Polish researchers stress the lack of the will in doctors to form any relation with their patients. Doctors do not see the point in it, placing themselves as the more important part of a treatment process.

One of the surveys was conducted by Wiertlewska in 2017, in which a group of ten family doctors employed in state local health centers were exposed to the question relating to establishing a doctor–patient relationship. The question was: "Do you think it is possible to establish a doctor–patient relationship, which allows a doctor and a patient to become partners. None of the respondents answered in the affirmative.[227]

Another research on patients was carried out by Agnieszka Sowińska and Sławomir Czachowski, in which the researchers looked into the problem of communication. They focused on MUS patients (patients with medically unexplained symptoms). The results of their study done on the patients indicate the demand for care about patients' needs. The authors stress that while treating the patient, their most essential needs and concerns ought to be taken into account in primary care. In Poland, for example, family medicine is relatively new, and there are no guidelines for management of patients with MUS. Hence, Polish family doctors are not always responsive to the patients' needs for empathy and reassurance[228]. While teaching clinicians, Amy Windover and Adrienne Boissy also recognized that a lot of medical staff did not think it necessary to form relationships with patients, or did not notice the benefits of this mode of communication. By relationship they mean smooth communication and mutual understanding.

225 Ibid. p. 6.
226 Ibid. p. 8.
227 Janina Wiertlewska,"Partnership relations in doctor-patient communication in medical English didactics-introductory considerations" , In: Scientific Publishing House of the Nicolaus Copernicus University: Toruń, 2017, p. 122-116.
228Agnieszka Sowińska,"I must do everything to eliminate my negative attitude: Polish general practitioners' emotions toward patients with medically unexplained symptoms", in: Florence Baider and Gordon Cislaru , *Linguistic approaches to emotions in context*. Amsterdam: John Benjamins; 2014, p. 309–30.

The medical staff even felt excluded or ignored when the attention focused on patients' experience, not on them.[229]

2.3. MODELS OF DOCTOR–PATIENT COMMUNICATION

The two sides – physicians and patients – co-exist and communicate with each other. Each form of cooperation can be classified under some model of doctor–patient communication. Certain models determining communication between the doctor and the patient have been created over the years. It is worth looking at these models to see what the role of each side is in them, and how each party can contribute to the process of treatment.

One of these models is a paternalistic one, which includes several models, whose creators are: Talcott Parson (1951) and Thomas Stephen Szasza and Marc Hollender (1956). Paternalistic and other remaining models are described by Ezekiel Emmanuel and Linda Emanuel in their article from 1992. The oldest one is a paternalistic model, in which the doctor is regarded as the highest and only authority who takes decisions concerning a patient on his own. Another model – a partnership one puts the patient on an equal position with the doctor, who presents medical facts for the patient to decide commonly on an appropriate action. Systemic–partnership model treats the patient as a whole, the emphasis is on the doctor's communication not only with the patient, but also with the patient's family. In the next model – an informative one, as the name indicates, the physician's main role is to provide the patient with information on his/her medical problem to let him make a decision compatible with the patient's values. This model can be criticized for its instrumental treatment of the patient. In an interpretative model, the doctor's role is to help his patient interpret his values by discussion in the face of an ailment in order to choose the best option or intervention in this situation. Deliberative model assumes that the doctor's role is also to facilitate the patient's interpretation, but the doctor is more involved, he justifies his perception why certain choice is worth attention. Instrumental model is different from the rest, in the sense that communication is less direct; namely it takes place through the computer screen. This idea includes a wide spectrum of activities; from obtaining the information about medical problems from other patients to discussing them with medical specialists. Each model is characterized in detail below.

229 Ibid. p. 1.

As Mirosław Jarosz describes, paternalistic (sometimes called the paternal or priestly) model is characterized by the dominance of the doctor over the patient. In some cases, partnership and cooperation is possible, but decisions concerning the choice of the most effective method of treatment are taken by the physician. The patient's opinion is very limited or is not taken into consideration at all. The physician provides the patient with selected information with a view to encouraging him/her to consent to the intervention regarded by the doctor as the best one. At the extreme, the physician authoritatively informs the patient on the date of initiating the intervention.

Within paternalistic model, one can distinguish radical and moderate paternalism. In the radical model, the patient's emotions are marginalized, and the need of extending the doctor's knowledge of interpersonal relations is not detected. The patient's family does not matter, either. Communication is one-sided and characterized by emotional distance. Moderate paternalism rests on less extreme assumptions. It takes into account the need of the information exchange between the doctor and the patient. This exchange is crucial for both sides: it helps the doctor in a diagnostic procedure and motivates the patient to follow a recommended therapy. Two-way communication can be observed in this case, as interpersonal knowledge on the part of the doctor is required and emotional distance is lower.[230] The advantage of a paternalistic model is a sense of responsibility for the patient's fate. The doctor is considered the patient's guardian whose role is to articulate and implement what is best for him. This model is considered to be mostly justified in emergencies when the time to get a consent from the patient could actually harm him.[231]

In the next model – a partnership one the illness is analyzed from all possible levels: a biological, mental and a social one. The relation between the body and mind is taken into account.[232] The patient has become a co-participant of the treatment process and s/he is co-responsible for its results. The patient's role does not merely consist of fulfilling the doctor's orders, but s/he is the central link in this relation. Doctors start taking a role of advisers, whose task is to present all the possible methods of diagnostics and treatment. The doctor's task is to present to the patient understandable, possible, alternative therapies, along with the effects of

230 Mirosław Jarosz, Zofia Kawczyńska-Butrym, Anna Włoszczak-Szubzda, „Modele komunikacyjne relacji lekarz-pacjent-rodzina, w *Medycyna Ogólna i Nauki o Zdrowiu*, 2012, Tom 18, Nr 3, s. 212–218.
231 Emmanuel, Ezekiel, Emanuel Linda, "Four Models of the Physician-Patient Relationship",in Jama, April 22/29, 1992-Vol 267, No. 16 pages. 2221-2226.
232 Barbara Ślusarska, Beata Dobrowolska**,** Danuta Zarzycka**, „**Metateoretyczny kontekst zachowań zdrowotnych w paradygmatach zdrowia", Problemy Higieny i Epidemiologii" w Grażyna Dolińska-Zygmunt (red)., Elementy psychologii zdrowia. 2013, nr 94 (4), s. 667–674.

accepted options and take realistic treatment decisions. It is definitely easier to put in practice a partnership model if a patient has some medical knowledge (at least a basic knowledge on human anatomy and functioning of the body).[233] The patient's rights are respected, and the ill person's autonomy during hospitalization is regulated by legal acts.[234] As for communication between the doctor and the patient, it is two-sided[235] and based on understanding. Both sides are emotionally close, for which the doctor needs to be empathetic and emotionally supportive.[236] Patients have the possibility of talking about their illness and they are heard. Conversation with the medical staff affects the treatment process positively, shaping in a patient a sense of belonging to the society. Patients trust doctors, which results from the conviction of their competence and certainty of being treated with respect and dignity. In this model, family has a supporting role to play. The doctor's duty is to make his patient realize how significant his role in the treatment process is. The drawback of a partnership model is giving patients too much autonomy, which they may not be able to use reasonably.

In a systemic-partnership model there are partner relations between the doctor, patient and his family and the doctor is supposed to influence psychological, social and environmental aspects. The patient is treated as an individual and during examination is treated as a whole, which stems from a holistic approach of living organisms – where all body parts are seen as mutually dependent and combined into one system. A lot of emphasis is put on environmental influences, family relations and emotional problems. As in the previous model, family is not overlooked. The doctor cooperates with the patient and his family while setting a diagnosis and planning a therapeutic action. Particular stages of therapy concern not only the patient's health but also the patient's family. The physician bears in mind problems which may pose health hazards in the family such as lifestyle, existing conflicts and disorders. Knowing the patient's family enables the doctor to adjust the form of support and increases the chance of a positive treatment effect. A doctor is a guide and a consultant. S/he is an expert on health and medical education, who also tries to listen to his/her patient and their family, shows them respect and treats them with due dignity. The doctor supports them, approaches them with sensitivity and delicacy, and aims to understand them. Communication is two-sided. Participation of the family in this model requires that apart from having skills in interpersonal communication, the doctor

233 Henryk Domański, Antonina Ostrowska, Paweł Sztabiński „Paternalizm czy partnerstwo? Relacje między pacjentami a lekarzami w Europie (red.), W środku Europy Wyniki Europejskiego Sondażu Społecznego". Warszawa: Wydawn. IFIS PAN, 2006, p.185-200.
234 Thomas Szasz, Marc Hollender, *A Contribution to the Philosophy of Medicine: The Basic Model of the Doctor-Patient Relationship, w Encounters between Patients and Doctors: an Anthology*, ed. J. D. Stoeckle, Cambridge, 1987, p. 165–177.
235 M. Kęsy, op. cit.
236 Mirosław Jarosz, Zofia. Kawczyńska-Butrym, Anna Włoszczak-Szubzda, op. cit. p. 212–218.

have contact with the family. That allows for cooperation and enables the doctor to obtain about the patient and his/her background, for example about the patient's daily routine and lifestyle or family medical history, which the patient may not be fully aware of .[237] In case of dysfunctions on the part of the patient's family, systemic–partnership model turns out unreliable.[238] This feature can be classified as a drawback of the model. Lack of willingness to cooperate on the part of the patient's family also belongs to disadvantages. Despite these pitfalls, systemic–partnership model is likely to gain popularity in the future because patients' families are interested in cooperation with doctors and the information coming from them can help in treatment.

Dominic Wilkinson indicates that the aim of the doctor–patient interaction is to present the patient with all the relevant information, which is supposed to enable him/her to choose the medical intervention preferred by the patient, and thus help the doctor conduct this intervention. In practice, this entails informing the patient of the state of the disease by the doctor, as well as of the nature of possible diagnostic and therapeutic interventions. Other details involve the probability of intervention, related hazards and benefits, as well as uncertainties of knowledge. At the extreme, available interventions along with all information, relevant to the disease are revealed to the patient to let him/her realise their advantages. Since patients lacks facts, the doctor's role is to provide them so that the patient can opt for treatment after confronting it with his values, which take priority over the ones doctor holds. As a performer of technical expertise, the doctor is obliged to impart truthful information and remain competent. S/he can consult others in case s/he lacks skills or knowledge. It is the patient, however, who exercises control over making a medical decision.

In an informative model, there is little doctor–patient discussion on the best decision and little attention is devoted to the patient's and the doctor's values, which makes the informative model resemble the paternalistic one. The informative model can be criticised for insufficient support for the patient in arriving at the decision. Further criticism builds upon the assumption that patients are prone to making wrong decisions, which could be avoided if things were discussed with the doctor, who usually has experience in similar cases.[239] Because this model excludes discussion and the doctor's interference in the patient's preference or view, it

237 Mirosław Jarosz, Zofia Kawczyńska-Butrym, Anna Włoszczak-Szubzda, op. cit.
238 Ibid. p. 49.

239Dominic Wilkinson, Julian Savulescu, Tony Hope, Judith Hendrick, *Medical Ethics and Law: The Core Curriculum*, Oxford: University of Oxford,, 2008, p. 62.

is believed to damage the doctor-patient relationship because it discourages the doctor from being empathetic towards the patient.[240]

Another model of doctor-patient communication is an interpretative one, which is analyzed by Harry Lesser, who argues that in it the doctor–patient interaction aims to elucidate the patient's values and priorities, and helps the patient choose the medical interventions which realize these values and priorities best. Another similar feature to the previous model is that the physician advises the patient of the nature of ailment together with the risks and benefits of possible interventions. The distinction between this and the previous model is that here, the interpretative physician goes deeper; namely, s/he assists the patient in elucidating and articulating their values. The doctor and the patient are colleagues, whose aim is the elimination of suffering and illness. The relationship is based on trust and no side is superior. The doctor also helps the patient to interpret his values, understand and use them. This model assumes that the patient's values may not be completely comprehensible to him. Therefore, the doctor works with the patient to reconstruct his goals, aspirations and commitments. However, the doctor does not decide for the patient, the patient decides which course of action and values best fit him/her. The doctor serves as a counsellor who engages the patient in "a joint process of understanding". The patient has a chance to understand better who s/he is and how medical choices influence his/her identity. A discussion has a significant role to play, since while discussing, the doctor makes it possible for the patient to clarify his values and help him/her reach a decision in accord with them. In case of short consultation time, the doctor may not have a chance to get acquainted with the patient's values, which poses the risk of imposing his/her own way of thinking.[241]

The next model, which also involves discussion is a deliberative one. Through the physician–patient interaction a deliberative model aims at helping the patient determine and opt for the best health-related values. That is why, as in the case of two previous models, all the information on the patient's clinical situation must be given by the doctor, and s/he is helpful in elucidating the values that certain medical interventions embody.[242] This model is more extended, since the physician's goal is to explain the reasons why certain health-related steps are worthwhile and ought to be aspired to. The physician's role is that of a teacher and a friend,

240 Munir Hossain Talukder, *Nature and Life: Essays on Deep Ecology and Applied Ethics*, Cambridge Scholar Publishing, 2018, p. 111.

241 Harry Lesser, *Justice for Older People*, New York: Editions Rodopi, 2012, p. 67.

242 Ezekiel Emmanuel, Linda Emanuel, "Four Models of the Physician-Patient Relationship.", In: *Jama*, April 22/29, 1992-Vol 267, No. 16, p. 2221-2226.

who involves the patient in a dialogue on what course of action can turn out most beneficial. The doctor indicates what the patient could and should do, and suggests which decisions would be reasonable. The key matter in patient's autonomy lies in moral self-development. This model leads the patient to considering, through dialogue, alternative health-related values and their worthiness.[243]

One more model is an instrumental one, which is considered an aberration and is not recommended to follow. The reason for it is not taking into consideration patient's values, and the physician's interest in the good of the society or aiming at scientific knowledge, for example prevention of the further spread of venereal diseases.[244] Aside from the above models of physician–patient interaction, a new trend in medical communication has appeared in recent years, which may be viewed as an alternative to real communication. Some people who feel ill choose not to visit the doctor in person, but seek consultation via the Internet. This concept can take at least two forms: either opting for an online consultation with a real doctor or healthcare professional, or expecting the computer to formulate a diagnosis once the symptoms have been revealed. Since one out of four memoirs analyzed in this dissertation, *Every Patient Tells a Story* tackles the issue of digital diagnosis and using the computer by patients for medical advice, it is worth looking at this matter as well.

At the initial level, the so called "medical end users" do not limit themselves to visiting a single website only, they find plenty of Internet sites with the information on their particular concern and they create online networks. They also search the site for medical information, seek guidelines from other online patients, take part in online support groups, follow online medical guidance to find out how drugs interact. At the more interactive level, e-patients converse with volunteer healthcare professionals and local clinicians, use paid advisers' and consultants' counselling, receive one-way messages from clinicians. According to Agarwal, online medical consultations mean free-text formats, in which patients write about their health concerns experienced by them and describe their syndromes. Consultations may also include questionnaires, relevant to the patient's choice of symptoms, which are mostly clarification questions and multiple choice ones. It is believed that online consultations are a growing trend

243 Donna Dickenson, Richard Huxtable, Michael Parker, *The Cambridge Medical Ethics Workbook*, Cambridge University Press, 2010, p. 142.
244 Ibid. 2221-2226.

and have the potential to substitute the doctor's office in non-urgent cases. The effectiveness of such consultations has not been checked by the author of these observations.[245]

The tendency among Internet users to find a diagnosis for one's symptoms is also discussed in a study by Rowena Cullen. This trend was observed by family doctors in New Zealand, where patients sought self-diagnosis and self-treatment through information from the Internet.[246] Whereas certain models of doctor–patient communication were created a long time ago, recognition of the electronic form in the treatment or diagnosis process is new, and may never be accepted as a proper one by some. The idea of relying on the Internet for self-diagnosis rooted in the instrumental model is going to be explored in Chapter Four of the present dissertation, which tackles the issue of teaching the medical staff. Occasional examples from medical memoirs and published research indicate that self-medication with the use of the Internet and in cooperation with the attending doctor is satisfying for both sides.

2.4. THE REFLECTION OF DOCTOR–PATIENT COMMUNICATION MODELS IN MEDICAL MEMOIRS

In their medical memoirs authors present patients' illnesses and reactions to them, ways of treatment. They also frequently provide information about the patients' family background. Communication is ubiquitous and occurs at various levels, first and foremost, between the medical staff and the patient and/or the patient's family. Communication also concerns medical staff as a team. It can be observed that the mode of communication either flows from one's own style or has been learned from somebody, for instance a work mate. A doctor may alter the way of communication on account of certain experiences.

This part of the chapter addresses the question of which models of doctor–patient communication previously described are reflected in the medical memoirs studied in this dissertation, that is models adopted and practiced by doctors and the nurse in their daily work. Particular characteristic features within previously presented models of communication are mentioned and exemplified by situations from these four memoirs. At the end, a new trend of incorporating the Internet in doctor–patient communication is discussed as well.

245 Renu Agarwal, Willem Selen, Göran Roos, Roy Green, *The Handbook of Service Innovation*, Sydney: Springer, 2015, p. 307.

246 Rowena Cullen, *Health Information on the Internet, A Study of Providers, Quality, and Users*, London: Praeger, 2006, p. 149.

Mostly, five models of doctor–patient communication are visible in memoirs; namely, partnership, systemic–partnership, interpretative, instrumental and paternalistic. Some models, such as a deliberative and an informative one do not occur. Doctors sometimes strive to find or work out their own way of dealing with the surrounding reality and the patient, and they wonder whether their way of acting is right. At first, instances of a partnership and systemic–partnership model are gathered, then examples of other models are portrayed. Examples which illustrate models of communication are put together in accordance with the similarity of features of a particular model. One feature, for instance, the doctor's sincere communication with the patient appears more than once.

Prior to presenting how models of communication are mirrored in the four memoirs, it is worth looking briefly at the type of language occurring in communication between patients and the medical staff. In *Do No Harm*, the language of a doctor–patient communication is not colloquial, but neutral, the surgeon builds full sentences, without omission of words, for example: "Do you want to see your brain scan?" (p. 36). The doctor also includes difficult medical terms – mainly names of ailments – in his conversations with patients, for instance, "obstructive hydrocephalus or endoscopic ventriculostomy" (p. 3). In *Critical Care* by Theresa Brown, the language of the nurse–patient communication is plain and simple. Sophisticated semantic constructions are not observed. These are sometimes routine questions: "Do you have any questions?, "Do you understand what was happening?" (p. 7). Some extra words, which are colloquial can be spotted: "Yeah, we couldn't keep his pressure up" (p. 8). "Hey, I've got friends, and I' m not good at using a cell phone" (p. 104). In *The Real Doctor Will See You Shortly*, the physician chiefly describes a stage when he was an intern, so it may be his young age that determines his use of colloquial expressions. The use of informal language is visible in the skipping of verbs when the physician asks the patient:

> Doctor: "You doing okay"?
>
> Patient: "Yeah, yeah. Just need a check-up" (p. 275).
>
> Doctor: "Why did you leave the hospital?"
>
> Patient: "Long story"
>
> Doctor: "I got time" (p. 275).
>
> Patient: "Cool. Hope it's soon" (p. 250).

In terms of degree of formality, this type of conversation could very well take place between teenagers. Abbreviated language appears, too: "And you need to get back on your HIV meds" (p. 154). The above instances are representative of the whole memoir by Matt McCarthy.

In *Every Patient Tells a Story* by Lisa Sanders, communication in the form of dialogue is rare. There is more reporting of events. Patients' stories included by her are often complex and long-lasting, presented from the beginning till the end, which may have determined this form of presenting them. It may mean that Lisa Sanders prefers to talk and interpret on her own what other medical workers and patients have said rather than listen to the patient's words. In several conversations, the language is neutral: "I'm glad to hear you're feeling better, but these fevers worry me", "I don't think that's what you have, but let's add it" (p. 234).

In general, the time in which the patients' stories from all four memoirs are set, is the decade after the year 2000, with the exception of Henry Marsh, who describes patients from the 1980s and later. All authors work in state hospitals. As for patients' stories from *Do No Harm*, most of the book is set at St. George's Hospital, in London. The patients described in all four memoirs are staying, for example, in the Intensive Care Unit (ICU) and Emergency Department.

To be precise, In Lisa Sanders' memoir, cases included by her date back to 2003. The author also analyses studies conducted in the 1960s, 70s and 90s and discusses a survey done in 2005. She completed her residency training at Yale's Primary Care Internal Medicine program, where she has stayed to look after patients and teach doctors. In *Critical Care* Theresa Brown describes her medical work from the period between 2007 and 2009. Her working place includes one floor of a hospital whose name, she does not reveal. *The Real Doctor Will See You Shortly* encompasses the first decade of the 21st century. The book setting is Massachusetts General Hospital, which is a large teaching hospital.

2.4.1. THE PARTNERSHIP AND A SYSTEMIC–PARTNERSHIP MODELS

One feature of the partnership and the systemic–partnership models is two-sided communication, in which understanding plays a key role. Another trait of these models is emotional closeness between both sides: the doctor and the patient, or the doctor and a family member. These two models can be discussed together, since sometimes it is difficult to separate communication from empathy or support. This is because the doctor's support may occur or be shown during a doctor–patient conversation.

In *Do No Harm* by Henry Marsh, deep communication based on honesty can be observed. These situations from this book are selected because they illustrate the essence of the partnership and the systemic–partnership model, that is a sincere dialogue. The author, a neurosurgeon, reveals his routine of talking with his patients on the night before the surgery. In this communication, the patient or the family member has a chance to discuss the matter or ask questions. In case of a patient who required operating the pineal gland (which is in the middle of the brain), the surgeon presents to his wife the procedure plan and possible operation strategies. A specimen is going to be obtained and after examination by a pathologist, the whole or part of the tumor would have to be removed. Furthermore, the doctor explains to the patient risks of the surgery, which involve a major stroke or death, by which his straightforward attitude is shown. That is why he does not dwell on the risks of the operation directly the day before it, but in advance. The element of emotional support is also present because the doctor reassures his patients and lessens their fear, which means he makes himself more anxious. The physician says this strategy of making the patient aware of the dangers helps him feel less responsible if anything goes wrong:

> It is easier to carry out difficult operations if you have told the patient beforehand that the operation is terribly dangerous and quite likely to go wrong – I will perhaps then feel a little less painfully responsible if it does. (p. 3-4)

The surgeon does all he can to make things clear.

Another medical predicament recalled by the same author, which reflects communication with the patient, is when he discusses the medical situation with his patient, a forty-year-old accountant. The surgeon offers to show him his brain scan, the thing he normally does with all his patients. He explains the scan to the patient and they discuss his symptoms. He expresses his close certainty of the tumor being benign, when the patient says he has never been ill before. The surgeon delivers his standard speech on operation risks, informing that they outweigh the risk of not taking any action. The surgeon refers to his universal tactic of maintaining truthfulness. The doctor says he has to overcome his instincts when talking to patients about their illness and be careful about comforting and reassuring them, which means not being too optimistic before an operation to avoid repercussions afterwards (p. 36).

In the above examples it can be seen that the surgeon has a humanistic mind and makes a habit of discussing patients' medial matters with them, even though he has a large number of hospital patients and each medical case is complex. This attitude is beneficial for the patient, who can pose questions or express doubts concerning the treatment plan. An interpretative model is also visible in the above communication, as the surgeon combines a thorough

presentation of treatment options with an illustration of their possible outcomes, that is risks and benefits of possible interventions. However, he allows the patient to decide on his future treatment. The interpretative model is realized through an element of discussion.

Doctor–patient communication is portrayed in other situations of the same memoir, too. In *Do No Harm* the surgeon shows empathy and listens to the sick person patiently. This is visible in the case, when the physician knows he cannot help the patient who has undergone some unsuccessful treatment, but he attempts to use words of sympathy, sits quietly, focuses his eyes and waits for the patient to finish pouring out her misery to him. Only then does the doctor explain to the patient the medical essence of her ailment (p. 271). It seems that in some moments listening is helpful. The doctor shows that communication is also the art of listening and saying little, but the patient feels s/he is not alone, and that there is somebody they can talk to about things related to their illness.

Further instances of truthful communication with the patient's family, which is indicative of the partnership model of communication appear in *Do No Harm.* This communication can be seen in a brief confrontation with a patient's daughter when the doctor admits to her that the operation went well largely because of a matter of luck (p. 105). He does not attribute it to his talent or skills.

Being a doctor necessitates communicating skills and breaking hard news. It matters a lot how this news is broken. The examples below are the picture of presenting facts and information by the surgeon as they are, without coloring. In one case, the reader is confronted with this type of revealing the information. To do this, the doctor sat down with the family in a room dedicated to talking to the family. The doctor did his best to lower the family's expectations. He went on to inform that the operation was not going to bring any change and it was only a matter of time before Helen would perish. The patient's brother expressed their gratitude to the doctor, anyway and added that none of the other doctors would listen to them (p. 138).

In another case, the surgeon notified the patient and his wife that the operation was not straightforward, one of the nerves became damaged and therefore he could not bend his foot up. It might recover, but he did not know for sure, and it might be a slow process taking months. The patient inquired if it should get better, to which the doctor admitted he could only promise to tell the truth in the future (p. 174).

The above situations indicate that in order to communicate successfully, a physician needs to play different roles; that of a psychologist, a therapist or a caregiver. Sometimes communication is just the exchange of thoughts. Listening to the patient has a positive effect on him/her and the treatment process. Discussing things with patients gives the surgeon a sense of feeling at ease and a relief. His words confirm that: "Once I have seen the patients, however, and spoken to them, and discussed with them what will happen to them next day, the fear leaves me and I return home happily enough, ready for the next day's operating" (p. 22).

Apart from the truthful presentation of medical issues to the patient and the family, there is a certain delicacy in the doctor's speech and approach, which is also a feature of the systemic–partnership model. Concise instances show small nuances, which medical staff can follow in their practice. These nuances improve the quality of communication. In the same book, the doctor tries not to sound too strict, and in order to achieve this aim, he constructs his utterances in a certain way, for example, while warning of the danger connected with the surgery, he says that the risk was "not more than five per cent" instead of saying "as much as five per cent" (p. 128).

The above mentioned subtlety also occurs on a different occasion, during a conversation with the patient's family. He informs them of the patient's imminent death and tries to be delicate (he wonders whether to use euphemism for death). The doctor hesitated and lowered his voice, being aware that other patients were listening: "I reached out to put my hand on her shoulder. I am so sorry" (p. 128). This was supposed to comfort the patient's mother. The doctor felt uneasy having to talk to the family in inappropriate conditions; he had to stand above the dying woman and her family in the absence of empty chairs in the bay (p. 127-8).

Besides, in *Do No Harm*, the reader can find one more episode which shows the narrator's respect for patients and treating them with dignity, which is the trait of the systemic–partnership model of communication. This example illustrates a rare situation when a doctor is apologetic, that is why it is worth mentioning. It is visible when the doctor apologizes to his patients for cancelling the operation in the nick of time, on account of beds shortage. He explains to them that it is due to several emergency admissions at night and promises that the staff will try to bring the patients back as soon as possible. At length, the doctor wants to ascertain and asks his colleague if his apologies have been sufficient (p. 98). At this moment the physician – Henry Marsh – adopts the idea of assessment of his own behavior and a wish to know how others view his way of acting. This episode also constitutes the element of reflection and a chance of a change, if necessary.

Two-sided communication, filled with understanding, where both sides are emotionally close, which is the feature of a partnership model, can also repeatedly be observed in *Critical Care*, whose author, Theresa Brown, is a medical worker with dedication. The author included a number of examples which demonstrate support given by the medical staff. The instances from the memoir are expressive of a detailed doctor–patient communication. Those instances include conversations which are not frequently heard real hospitals, and only occasionally in medical serials. In one scene, the nurse attempts to explain to the boy, who came from the emergency department, the nature of his condition, when he poses questions to her. One instance is: "Why couldn't I breathe?" The nurse was able to speculate, sometimes she did not know the exact reason and gave simple answers: "It could be because your blood pressure was too low" (p. 6). Although the nurse's conversation with her patient Sean seemed only "patient education", the nurse felt they exchanged something more essential than just information when they talked. The boy managed to ask what is wrong with him and: "Am I going to die?" (p. 6). She answered she did not know, but assured him she was with him, and whatever happened, she would be there for him. Talking allowed the nurse and the boy to confront "the vagaries of life and death" (p. 6). It was also the nurse who benefited from this conversation, this moment also put at rest any questions she had about why she resigned from her job as a professor and decided to become a nurse (p. 6). This situation illustrates how she tried to surround the patient with care, which definitely was comforting to him and made the hospital stay an easier one.

The patient's family was not left alone, either. The nurse and the doctors also talked to Sean's father, the nurse asked the boy's father: "Do you have any questions" and "Do you understand what's happening" when he was waiting in his son's hospital room. She wanted to relieve the pain of the boy's father, but felt she could not take it away. Sean's father had to go through that experience on his own (p. 7).

Two-sided communication is illustrated in the same memoir, in which at first the nurse-Theresa Brown brings back memories of how the patient Bill expressed his appreciation of her work. While she was tucking the patients in and getting her patient settled for the night, he said that he needed to see her that day. She considered it one of the nicest things a patient had uttered, which also restored her faith in the work they all did in oncology (p. 180). The gratitude expressed by the patient brought her satisfaction with her work. This example shows that doctor–patient communication goes beyond the medical problem, motivates the medical staff

and gives some inspiration for future action. Communication can reinforce certain attitudes and patterns of behavior and encourage self-reflection.

Prior to this episode, the nurse held conversations with the above patient, through which their communication is shown. They were talking about common things. Whenever she entered the patient's room, he would always ask about how her children were doing. The patient gave his opinions on parenting, for example, he believed right upbringing was a matter of good instincts. The hospital room was also a place and an opportunity to share his concerns and fears with the medical staff. They exchanged a word about his work in the stock market. Bill expressed his regret that he had to sit in a hospital bed instead of working, and the prospective necessity of compensating for the time spent here in the future to earn for his retirement. He brought to mind the time when he was servicing helicopters in Vietnam, where he was shot several times, which was a scary experience to him. The reader can observe that the doctor talks to the patient's wife, too. This is characteristic of the systemic–partnership model. When Bill's wife visited him, the nurse dealt with her repetitive questions as best as she could. The wife asked: "Are you always this nice?" (p. 175-6).

The nurse's emotional involvement is also conspicuous in other fragments of *Critical Care*. She was reluctant to leave Sean, but other patients' and duties were calling her. In the evening Sean had gone to the Pediatric Intensive Care Unit (PICU) and it was the last time the nurse had seen him. Finally, she did not know what happened to him, but she hoped that he was still watching movies and eating chips with his father and would do so for years (p. 8). This fragment indicates she gave thought to the patient. The nurse's thoughts were around the patients and their matters in other situations, too. When she found out about the patient's death, she was wondering what his wife was doing while her husband was having treatment. "Was she trying to enjoy a cup of tea in the hospital cafeteria? Did she call their children to update on how the dad was feeling?" (p. 90).

Some other time, the nurse found a rapport with a patient who played music, which they both listened, and this made her feel like a human being, even almost a bit like a friend, not a nurse, a pill giver or a paper distributor. Later the nurse was devastated by her patient's death. Her reflection was that when she was at this patient's age, she had less serious problems. She worried about her weekend plans, and whether she would get an A at school (p. 79-80). Emotional involvement, which is characteristic of the partnership model, in the nurse's case may be considered as far-reaching and raise doubts as to its usefulness. Namely, the nurse seems to put a great deal of energy in participating in her patient's predicament, which may in

consequence result in her professional burnout or difficulty in giving her attention to the rest of her patients because involvement in one patient can overshadow the remaining ones. Another presumption is that her attitude may lead to her own fulfilment, and also support the patient. Certain involvement, for example, when a medical worker informs the patient that s/he was waiting for this patient's test results with fear, can make the patient feel they were not alone.

In the context of doctor–patient communication, one more situation can be quoted when the nurse raises the issue of communication with her patient and wonders if this rule of non-disclosure of personal information about herself, which was taught at school is right. This situation presents the nurse's personal attitude and opinion, which may be thought-provoking to the reader. The nurse follows her common sense and in confrontation with her patient, she reveals that her friends, that is other nurses use mobiles, instead of a landline. She is convinced a patient needs to be looked after not by saints, but by normal human beings. If an anonymous nurse without personality took care of patients, their hospital stay would be inhuman and "more emotionally restricted" (p. 104). She wondered if rules about not disclosing personal information served to protect the patients from talkative nurses or protect the nurse from establishing a relationship, which would be painful if the patient's health deteriorated (p. 104-5). The nurse came to the conclusion that keeping her life secret from patients would only make everyone more tense, rather than protecting her. That is why she talks about her kids, her professional past when she taught English, about where she lives, and how she rides a bike to work. Patients wish to know those things, which means that both she and patients are more human (p. 110). The nurse discovered how valuable it is to open up to her patients. When a true conversation arises, she accepts it: "If a conversational opening arises with a patient, I take it. It could be a chance for me to lead him back to his own humanity" (p. 111). The conversations the nurse has with the patients seem to be natural and rewarding for both sides. At the same time, the patients' time passes faster. During conversations with patients, the nurse finds out more about them, and their perception of the world. She starts to understand patients better. That in turn gives the nurse or any medical staff a higher chance to work out suitable solutions for more difficult patients and medical situations, which are likely to repeat in the future. Finally, when the nurse hears for example a patient's report from his/her previous treatment, this gives her a lesson and allows for seeing the consequences of erroneous approach and learning from somebody else's mistakes. Therefore, a medical worker can see things from the opposite side, that is from the patient's perspective, which she would not find out, but for conversation with the patient.

Truthful communication on medical matters occurs with the patient Mildred in the same memoir. This example aims to portray how a way of communicating matters to the patient changing the state of affairs. The nurse tried to tell her and her husband only what she was able to. She felt she was lacking knowledge on the prospect of the patient's treatment plan or diagnosis; and had little understanding of the tests given before treatment. In light of it, any questions posed by the patient and her husband were going to be embarrassing. They asked about the doctors' prognosis on her treatment. The nurse admitted that she could not give an answer to that question and did not know more about Mildred's illness than they did. Mildred asked what the treatment was going to be like. The nurse comprehended the question and thought the patient wished to know what the treatment would demand of her personally. The nurse realized the patient wanted an honest response, so she gathered herself together mentally. She found some difficulty in answering that question truthfully, but she tried her best. The nurse familiarized the patient with the reality and side-effects of treatment honestly, thus preparing her for them and telling about medicines to keep the effects like nausea and sores under control. In this way, the nurse wished to avoid a lie of pretence (p. 24). The nurse did not wish to tell a white lie by saying that everything was going to be all right. She was convinced that Mildred should be informed of her own situation, at least in general. Keeping the patient in the dark did not make sense. This is an instance of a brave and natural reaction, which not everyone would be ready to show. However, it may matter to the patient who can prepare herself for her situation. The nurse acts on her own, she follows her reason and a common sense and meets the requirements of the partnership model by putting the patient on an equal position with the medical staff, who presents medical facts to the patient.

In the memoir *The Real Doctor Will See You Shortly*, the doctor also aims at genuine conversations with his patients. It does not always come easy, sometimes he seems to care more than the patient himself. This situation shows that it is natural for a doctor to face doubts concerning his own conduct. He is reflective about his interactions. He wonders how often patients found his probing questions too difficult, and how frequently his attempts to connect with people backfired (p. 272). The doctor also dwells on his ex-patient Dre and her situation. On encountering her again after a long time, the doctor approaches her. Seeing Dre made his burnt thoughts emerge. He remembered that he had felt like a failure when she suddenly vanished leaving the hospital room in the middle of the night. The doctor had taken things to himself, which made him feel so miserable. He thought he was just like another person in her life who did not meet the patient's expectations, another medic in a white coat who was not

worth her time. Later on, he wanted to learn how to avoid taking failures personally. His emotional involvement in the patient's matters cannot be denied; Dre's departure still worried him. Even in retrospect it was hard for him to be rational about it. The doctor analyzed what he had done wrong and desperately wanted to know it. He wanted to confront his understanding of the situation with the patient and started a conversation with Dre by asking her where she had disappeared that night, to which she gave evasive answers. The doctor asked if she was taking her medicines then and told her he had been hurt by her vanishing in the past. Next, the doctor inquired if Dre had started taking medicines because of him and the conversation they had. She denied and went away (p. 275). The whole confrontation shows that the doctor's flexibility in approaching patients is recommended, since every patient is different and expects a non-identical approach. Sometimes a patient does not expect the doctor's involvement, but only instrumental or temporary help. In such cases, doctors' worrying or blaming themselves for a patient's behavior does not make sense. In cases of some patients like Dre, doctor–patient relations are restricted to giving medication, and in the event of the doctor's doubts, possible confrontation with the patient's family may give more clues about the patient's health state.

The situation with the patient Benny in *The Real Doctor Will See You Shortly* mirrors the doctor's connection with him. It manifests that a physician is capable of involvement in a patient, which makes his job better and more pleasant. The patient was after an operation of post-cardiac transplantation. Directly after that intervention, the author asked transplant doctors if anyone knew this patient's story and anything about Benny. The author must have felt sentimental about his patient Benny. The doctor thought that papers did not indicate how special Benny was. To the team of doctors, Benny was probably just another patient, who needed transplantation. When asked by doctors about Benny, the author realized Benny was someone important to him:

> I was about to elaborate, about to provide an anecdote that offered a glimpse into the life of this remarkable man, but I caught myself. How could I possibly explain what Benny had been to through or what that struggle meant to me? The stories could wait. Take good care of this guy. I said softly. I'm not his doctor any more. Now […] just a friend. (p. 323)

The author feels content with this approach to the patient. The doctor's familiarity with the patient Benny turned out to be useful for his medical treatment because the doctor had the knowledge of Benny's lifestyle and background, which was of value to medical specialists under whose care he was then. Had the doctor not conversed with Benny beforehand, he would not be able to tell much about that patient to the team of doctors.

In *The Real Doctor Will See You Shortly*, the author also presents the cases of involvement and interest in the patient. The examples are evidence of how certain attitudes and forms of communication can be learned from other colleagues. The situation also indicates how communication can be improved if one tries and has some role model. The physician is an intern at that time, so these topics are new to him. In his memoir, the intern provides an example of a workmate, doctor Jim O'Connell, whom he got to know at work, and who had a unique skill of interacting with patients. He never "cut anyone off", and could combine treatment with concern about a patient. He allowed the patients to talk about anything they wished, even things unrelated to their health. While the patient was talking, this doctor was examining different parts; ear, nose or throat. When the patient paused to catch a breath, he applied a stethoscope. This doctor could interact with every patient, especially those with mental illnesses. He also knew the names of their family members. The author even compares this colleague to a priest, whose patients were confessors. The colleague Jim advises the author to tell patients something about himself, about anything, to be himself and be sincere (p. 102-3). He also told him that the key is "to build a relationship". The doctor ought to resist condescending. "The problem is us, not them" (p. 105). The memoirist Matt McCarthy wanted to follow that tip and be like his colleague, the one with a set of principles, brilliant and capable of engaging patients in unusual ways (p. 109). The doctor listened to people when they wanted to chat while dispensing clean socks and foot ointment. During those night rides, the intern discovered how important connecting with patients was. He once chose a man on a stationary bike, who he could talk to and potentially connect with, he did not approach the most medically complex patients (p. 109). The author expresses the essence of the doctor's profession and the lesson he learned in these words: "From Jim I learned that through medicine it is possible to reach the unreachable – even the ones who most of us forget about or try to ignore. This is the power and beauty of our profession" (p. 109). By those ones as he later expands he means the homeless, for whom it is tough to enter a hospital's lobby and a waiting room, being embarrassed by their own condition. He wishes patients trusted him the way they trusted his colleague Jim: "They did it for Jim. And I wanted them to do it for me" (p. 109).

It can be seen that observation of how other physicians communicate at work has a role to play in shaping one's own means of communication. Doctor McCarthy has a chance to learn a new attitude towards patients. He also sees the effect of this conduct; namely, people from so-called "underclass", the homeless dared to visit the hospital with their medical problem, which they would never have done in the past. However, the attitude of McCarthy's colleague

to those people changes this state of affairs. McCarthy feels envious, in a positive way, of this doctor's approach, which at the same time gives him an incentive to work on his approach in his future professional relations.

Matt McCarthy is an example of how medical staff faces different, sometimes contradictory attitudes, and it is up to them to choose the most suitable approach and style. Namely, one view is keeping patients at a distance, another way of confrontation is being close to one's patients. The doctor's work mate Moranis warned him not to give his phone number to patients as a way of keeping an eye on them. In view of what Jim O'Connell did for his patients, the doctor thought he should give his phone number to patients. When he gave it to Sam and other patients, they were capable of feeling a connection with him (p. 27).

The author encounters and mentions more doctors who brought the idea of connecting with a patient by communication. He gives an example of another colleague, Benny, who explained to him how important it was to give his patients full attention and his time. The process of acting with higher awareness of the patient continued in his mind. It was then that he decided he should be more present with his patients, even if it was tough to do. It meant focusing on what his patients tell him and paying attention to their words. As an intern, he needed to be in many places at a time, and the pager kept buzzing constantly (p. 148).

The doctor endeavors to put in practice his colleagues' teaching. This is illustrated by another story he brings back of the already mentioned patient Dre. She suffered from HIV. He thought she wanted to connect with him. Then he could get through to her and unlock "the detail of medical history" the way his superior O'Connell would. He thought the more information the medical staff could obtain about her, the better. After interpreting and summarizing her case, the medical team examined the patient. It was possible to get to know her general situation better due to sitting and talking to her. Finding out about her situation and background would not come from reading a textbook. The doctor talked to her and heard intimate details from her life (p. 152). His tactic consisted of explaining the scenario of the treatment plan and making her comply with it by scaring her (p. 154). He wondered whether she realized the consequences of her conduct and wondered how to approach her in the light of her refusal to take medicines.

> Doctor: "You can die. Honestly".
>
> Patient: "Fine – she said. "let me" (p. 154).

This situation troubled the doctor. He marveled how to talk the patient into taking prescribed medicines, fearing it would take weeks or months to get to her, and she barely had that time.

The doctor drew parallels and analyzed how long it had taken his colleague Jim to persuade Sheryl to undertake a therapy session. He felt emotionally close to his patients and was consumed by thoughts of Dre and Benny, even when he was not at work (p. 171). The doctor's head was full of analysis and dwelling on patient–related issues. First, he asked himself a question why his approach to Dre's illness failed and if it could even be considered an approach. After all, all he did was explain to her the prospect of treatment and scare her into obedience, assuming that the specter of death would be sufficient. He realized he needed the skills like: patience, tact and empathy to tackle HIV, and that if he did not acquire these traits, it could signify patients' death. He considered Dre's situation from different sides, his other doubt was that something else might be going on with her, which he had entirely missed. What about some voices in her head whispering to her not to take the pills, and could the medical team actually coerce her into acceptance of the treatment? The thought of medical ethics entered his mind and bewildered him (p. 155). At this point the problem of the patient's autonomy is touched upon, which is high priority in the partnership model. The doctor did not want to neglect that autonomy.

His colleague Ashley advised him to renew his trials with Dre after lunch. He wondered whether Dre took any of the pills or felt embarrassed about taking them. Eventually, he tried to put himself into the patient's shoes and thought analogically; bearing in mind that his biggest fear is skydiving, "How could someone talk me into jumping out of a plane?" (p. 166). These reflections and empathizing helped him get some idea. The doctor felt Dre was engaging more with him than with other doctors. He talked to her, he explained to her what he knew about her condition and what still needed to be figured out. He resorted to negotiation and referring to himself and condescended by saying he once routinely neglected medical advice of wearing sunscreen, even though melanoma ran in his family. Then, he offered to take HIV medicines with her. He did not know if he himself had HIV because he stuck himself with a needle. She agreed to take one of the pills. He wanted her to break through her denial of illness, get angry, experience the stages of grief and accept that she suffered from a real, but curable condition. The doctor wanted Dre to realize she could win, and wanted her to undergo suggested medical procedure (the spinal tap). He still wished to search other ways of connecting with her. For the first time he felt like a real doctor. The doctor later negotiated with her taking more pills, too, which was accompanied by elaboration of the way the medications worked and why taking multiple tablets, not just a single one was the necessity to fight off the virus (p. 168).

In Dre's treatment process, one more element of the partnership model occurs, that is analyzing an illness from different possible levels by the medical team: a biological, mental and a social one. Doctors work as a group: "we examined her one by one". Doctors discussed the approach to her as to a difficult patient who did not want to take her medicines. Doctors agreed on adopting a multidisciplinary approach, that is the one that incorporates nursing, psychiatry, social work and other specialties, and discussed these options (p. 155). The doctor experiments with attitudes represented by other colleagues, finds them successful and feels satisfied with the result of such means of communication as personalization or negotiation; namely following indispensary medical recommendations and guidelines by the patient. It can be seen, that in the above example, smooth cooperation between physicians is necessary to affect the patient in a proper way. The doctor finds his attempts at convincing the patient to undertake treatment by her as successful. He tries diverse ways of reaching Dre.

In *The Real Doctor Will See You Shortly*, McCarthy tackles the issue of a doctor–patient communication, but in a broader sense than just talking about mundane matters. By drawing conclusions from a conversation with his work mates and observing them, the doctor becomes more skillful in approaching patients to find out necessary information and help them. The examples reveal that being a physician does not end on medical knowledge, but requires a certain versatility and opening up to other fields, such as the legal system. The examples also serve to illustrate the doctor's attempt to work out methods of communicating with patients. He touches upon the matter of doctor–patient confidentiality and its limits in case of the patient's announcing some dangerous plan, for example a plan to harm or murder somebody. The doctor says he would try to talk a patient out of it, or would consult a hospital ethicist. His colleague recalled the case from the newspaper when not reporting a patient's perilous plan by a doctor resulted in stabbing a woman to death. The privilege of ensuring protection for a patient should end "where public peril begins" (p. 253-4).

Therefore, the doctor decided to talk to the patient Darryl and realized he needed to understand bioethics beyond the medical knowledge, procedures, writing comprehensible and informative notes and interacting with various hospital staff. He also wanted to get familiarized with court cases and legal precedents. The doctor also needed the knowledge what to do in situations he had never considered. His colleague Don had encouraged Darryl to tell him more than the doctor had. Darryl divulged to him that his roommate called him "fat and fuck" (p. 254). The doctor wondered how Don had managed to make Darryl open up. He thought his residents were always a step ahead of him (p. 254). He wished to work out his own ways of

eliciting indispensable medical information from the patient in order to tackle the ailment properly. He was aware there was something for him to learn in the future in terms of doctor–patient communication, but since he was willing to acquire practical skills, he was on a good way. The doctor feels that he is not as competent to talk to the patients as some other colleagues, which to a great extent resulted from his younger age. However, he is making progress at work by trying out possible techniques such as: explanation, persuasion, negotiation, showing the consequences of a patient's behavior and personalizing, which in this case means referring to his own situation.

In his confrontation with the patient, the doctor also adopted ideas of approaching him successfully and showing he understood the patient. Darryl said he did not want to talk to anyone. The doctor answered he got the idea and promised to let him leave as soon as possible when the patient was safe and if Darryl let him ask several questions. The doctor assumed an intentional attitude, both verbally and non-verbally: he moved his head, so that it fully entered the patient's field of vision. The doctor showed his understanding of Darryl's situation and feelings when he declared he did not wish to talk to anyone and wanted to leave the place. In his utterance, the doctor referred to himself, namely he said that he had been sick and alone beforehand. It encouraged Darryl to cooperate and open up. Darryl admitted he had felt he was going to die, and nobody cared. The doctor offered consolation by assuring Darryl that everyone in the hospital cared about him. The doctor thought of asking about his family, but resigned from it not to risk opening a wound (p.251).

The doctor intends to find out from Darryl if he has ever thought of harming himself or somebody else (homicidal or suicidal thoughts). The physician feels it outgrows him, that it is a task for someone better trained than himself. He asks Darryl if in case when a psychiatrist was sent to him, Darryl would talk to him. The doctor manages to convince Darryl to consult one by adding that he himself would benefit from it, and so would Darryl. Again, the doctor repeatedly makes the patient open up by referring to himself; when asked about ever having depression, Darryl denies, but the doctor says he gets depressed in the winter. Then, Darryl admits he gets depressed in the summer. The doctor gets into details by telling about his health situation and uses empathy (p. 248). The doctor is convinced moving forward, even with bit faulty plan, is important. It is the only way to move beyond stupor (which his past patient Dre instilled in him by escaping the hospital room by stealth), and to gain patients' trust, like they trusted his colleague Jim O'Connell. The doctor mentions his symptoms when he is depressed, such as a lack of a will to talk to anyone and wishing the world to leave him alone. Then Darryl

agrees to see a psychiatrist and the doctor feels victorious. Darryl lets the physician create an opportunity for him to recover . It is as valuable as if the doctor made Darryl better himself. The doctor sets a long-term goal for himself, which is to encourage Darryl to care about himself in the future. The doctor realizes that is the game Jim O'Connell was playing with his patients, and the doctor would have to play it too with patients such as Darryl and Dre (p. 256). While reaching patients, the doctor becomes one of them, putting himself among them and trying to find a common ground with them. The partnership model is visible through the use of empathy and provision of consolation. These methods turned out fruitful in the case of his two patients described in the memoir.

Furthermore, he tries to be empathetic and in his thoughts, the doctor endeavors to visualize how difficult it would have been if like Darryl, he himself had to deal with a debilitating, chronic illness and had been left to deal with things on his own. The doctor tries to imagine Darryl's internal world, but he cannot. He just feels Darryl's life is different from his and Darryl did not give him a big chance to help him understand what he was experiencing or how he could help Darryl. Not being a mental health professional, he did not feel in the position to fully investigate these matters. Despite it, he put a lot effort and offered help (p. 252).

All of the above attempts at communicating with patients bring the doctor to a closer understanding of them. He learns how to approach the patient by trial and error and by following in another doctor's footsteps. Not all of the doctor's confrontations are successful, but they teach him certain resistance to failures and judging his actions not by the harvest he reaps but by the seeds he plants. It strengthens him in his profession.

The partnership model of a doctor patient communication is also presented in another fragment of the memoir *The Real Doctor Will See You Shortly*. Communication in this example can be categorized in these terms because of the existence of emotional closeness and the doctor's friendly approach to the patient. The example is used to portray a situation when a patient constitutes an incentive and consolation by appreciating a doctor. The author discusses his relation with the patient Benny, who appreciates the doctors in hospital he is in. They are emotionally close, the doctor once says he takes off his white coat as a symbolic gesture that he is now talking as a friend, not a physician. Benny says to him: "you give me hope". Benny also feels that the doctor invested in him and in things that happen around him , and he knows a lot about Benny (about his medical and personal history) and allergies. The doctor is thinking about his communication with Benny, he does not want to burden Benny with his HIV risk or the pills he took preventatively. He doctor wonders if he should tell Benny about it or not, since it could

be unfair to burden the patient with his own medical problem, while Benny is dealing with more serious medical dilemmas. He is in two minds about it, maybe the doctor should tell – "Isn't it what genuine friendship is about?" (p. 219).

The example of how the doctor was trying to reach the patient, but was rejected by him is also included in *Every Patient Tells a Story*. This patient, Maria Rogers suffered from nausea and vomiting, but eventually left the hospital against medical advice. The doctor detected that these symptoms were linked to marijuana. Dr. Hsia endeavored to stay in touch with this patient, but the phone number obtained from this patient was disconnected and after a few months, a letter with suggested treatment options and a diagnosis sent by Dr. Hsia returned. The doctor knew the disease the patient suffered from, however, she did not have enough knowledge about the person who had the disease. The story she presented to the patient stood to reason and was rational, but it was not the one the patient wanted to accept. In a confrontation with the vehement rejection of that story and the raw emotion displayed by the patient, the doctor retreated. The patient had rejected her care before she was able to regroup and try again. Rogers did not accept the doctor's story and her diagnosis and searched her own way to end her suffering and pain (p. 16). Mutuality in action is necessary to achieve results in treatment and that is why gaining the patient's trust by the doctor is so important.

The illustration of two-sided communication, in which emotional closeness occurs is present in other parts of Lisa Sander's *Every Patient Tells a Story*. She treats her memoir as an opportunity to present her and other doctors' attitudes to patients, views on treatment and making a diagnosis. In this book, various doctors' attitudes are juxtaposed and they are approved or criticized. Sanders thinks of the power of story as a valuable method of communication, and of the physical examination as its component. The author goes back to the the time of her studies for example, to the moment when she was given a stethoscope. Although it was an object, which looked ugly and industrial, she loved it because it was genuine evidence of where she was aiming. The patient and healing were her ultimate goal (p. 135).

A significant part of a patient's visit, which accompanies telling a story by the patient is a physical examination. Lisa Sanders enumerates the benefits of the examination. According to her findings, a thorough physical exam alters the patient's diagnosis and treatment in many cases. Studies suggest a careful physical exam can play a significant role in setting a timely diagnosis, and this role cannot be duplicated by freshly accessible sophisticated tests (p. 57). Additionally, a physical exam can also channel the doctor's thinking and narrow down the selection of tests to those more likely to supply useful answers, which save time, money, and at

times, lives (p. 58). In the case when a patient cannot distinguish which organ causes problems, the doctor must find a way of identifying the source of a disease. This is done independently of the patient's story, or sometimes the patient's subjective account. Then doctors turn to a physical exam. The diseases can be classified basing on changes that can be seen, felt, smelled, tasted or heard by the physicians (p. 137).

The author goes on to portray the image of what she sees in her medical environment, where the above mentioned mutuality in treatment process is present. The situation described by Sanders resembles the systemic–partnership model of communication on account of mutuality in discussion, but most of all because of a physician's introspection into the patient's lifestyle and background. In medicine, the patient presents the story of his illness to the doctor, whose role is reshaping its elements into a medical form, into a medical language. The doctor usually adds to the story by obtaining pieces of information through questions and from examination of the body and performed tests. The understanding between the doctor and the patient takes place when after making a diagnosis, the doctor has to reshape the story created by him into a story that can be given back to the patient. This story is translated back into the language and context of the patient's life so that s/he can make sense of what has occurred to him/her and incorporate it into the whole story of the patient's life. Only understanding by the patient of his/her disease and its causes, treatment and meaning enables the patient to take necessary measures to recover. The greater the patients' understanding of his illness and treatment, the higher the prospects of their carrying out their part in the treatment. Sanders refers to the research done in diabetic patients. Those who understand their illness are more likely to obey doctor's recommendations on how to modify their diet and take medicines than those who do not. Patients' better understanding of their illness has shown to dramatically improve compliance. Receiving a good history, which gives the doctor an insight into the patient and his feelings about illness, treatment and life can bring fruitful results (p. 14- 15). The doctor assesses the systemic–partnership model as successful and helpful in making a diagnosis and conducting treatment. The doctor's observations justify the opinion that it is worth teaching a proper doctor–patient communication to the medical staff, since it brings benefits and comfort to both sides.

Another feature of the systemic–partnership model is taking interest in the patient's family, which is based on the assumption that knowledge of the patient's family enables the doctor to adjust the form of support and gives a bigger chance of a positive treatment effect. This aspect of the model occurs in the following examples. The instances illustrate how the

power of telling a story works in particular patients' medical problems, regardless of the fact that these problems were different. The examples also indicate that the story does not have to be told by patients themselves, but by their families or relatives. This way of approaching the patient takes place in the case of Polly Murray, who experienced inexplicable problems (rashes, fever, pains in joints, fatigue). The systemic–partnership model is realized in this case; the doctor is interested in the patient's family. At first, Polly could not find appropriate help. Then she found Dr. Allen Steere, who asked Polly to come to his office and bring her notes. Unlike numerous doctors Polly had visited, Steere took a deep interest in her story. He collected the names of other sufferers Polly knew about. Steere contacted each family member on her list. The physician obtained additional names from those family members, which enabled her to compile a list of people with the same symptoms as Polly and her family had (p. 171- 2).

The systemic–partnership model can be observed in *The Real Doctor Will See You Shortly*, in which the doctor wishes to get to know the patient's family with a view to adjusting an appropriate treatment. In a doctor–patient confrontation, the doctor pays attention to the medical history of the patient's family. The previously mentioned Darryl landed in a hospital ICU due to an asthma attack. The physician wished to conduct an extensive medical interview with Darryl to obtain information about him and his family members in order to prevent similar attacks in the future. He learned that obesity did not run in Darryl's family (p. 249), and that in his adolescence he was diagnosed with Prader–Willi syndrome, a condition triggering a chronic feeling of hunger, which in turn is the reason for life-threatening obesity (p. 250). The doctor thought it would be difficult to intubate Darryl and he looked around to see his family and thought to himself: "Where was his family?" Was he someone like Benny, who would pass the hospital days in solitude?" (p. 250). The doctor's questions on his patient's family medical history gave him at least basic information on Darryl's situation and possible future action. The lack of family also served as information to him. This case shows how the doctor in this model is interested in the patient's environment, which in consequence allows for arriving at the information which would be unavailable without confrontation with the patient's family.

The next case from *The Real Doctor Will See You Shortly* exemplifies the author's interest in the patient's life and family background. It is also the reflection of the systemic–partnership model. The doctor also uses empathy and tries to understand the patient, a nineteen-year old teenager who swallowed 16 bags of heroin in the Dominican Republic, and took a flight to JFK. Ripping one of those bags would mean her death. The doctor attempts to visualize the life circumstances that would make a teenager swallow expensive drugs and board a plane.

The doctor is interested in his patient: "There was certainly a part of me that wanted to know more about her – her life, her family, why she swallowed drugs for money" (p. 182). The doctor is blocked in his relation to the patient, he wished he were like his colleague Jim O'Connell, however, the reality of connecting with patients was far more complicated than he had pictured. He wanted to avoid it, for the fear of inconvenience that could result from it. Emotional investment in the patient was crucial to him, but it was the last item among other tasks on his list. There was a time when connecting with patients was not his aim, but trying to keep them alive. When the thought of his patient's pain entered his mind, he thought of his pain, too (p. 183). The doctor recalls his colleague Diego's words: "Who are you looking out for? Yourself? Your reputation? Or the patient?" (p. 186). Caring about the patient is a challenge, and the doctor faces an internal struggle. The idea of emotional investment in a patient made the doctor anxious. Staying detached and living behind the wall seemed simpler. But despite his excuses, the urge to connect with patients was still present: "it was a fundamental quality of the doctor I wanted to be" (p.217).

The doctor fights with himself, he would not like to treat patients automatically, which is easier because he understands such treatment does not bring good results to anyone in the long run. He has certain ideals and images of a doctor in his mind and is careful to be faithful to them. Treating patients in a particular way is probably the matter of getting used to it, and with time, caring about the patient can become natural, although some medical workers learn it gradually, on condition that they are open to the lessons they get daily at work.

Cooperation with the patient's family in a treatment process belongs to the characteristics of the partnership model. There are examples of involving the family in the patient's matters. In *Do No Harm*, the doctor wants to talk to the patient's family in order to inquire about her recent condition, before the CT revealed a tumor in her head. The patient insisted on driving a car on her own. In a conversation with the family, the doctor set several questions, namely, if she had faced any difficulties in recent months. The surgeon had to read between the lines because her children were slightly reticent about confirming the existence of problems in her presence. The patient constantly interrupted and disputed what they had revealed, complaining that they did not permit her to drive. Despite the situation, between the three siblings, they gave the doctor to understand that their mother had become forgetful and confused, which they had attributed to her age. In the face of her deteriorating memory, their mother was seen by a geriatrician, who had prescribed a brain scan (p. 91). The information gave the doctor some clue on the duration of symptoms.

In the book *The Real Doctor Will See You Shortly*, the physician's mind was busy with analyzing the way he interacted with the hundreds of family members over the year. He remembers numerous cases. The doctor recognized family members as crucial participants in treating patients, which is the major feature of the systemic–partnership model. Family members were unpredictable and differed from each other, but they constituted a source of information about the patients. The doctor learned a great deal from them, for example, he found out that Carl Gladstone was a Yankees fan, that Denise Lundquist's best friend was her brother. The doctor appreciated patients' families because they were like invaluable windows into patients' lives "transforming two-dimensional stories about chest pain into three-dimensional experiences for them to analyze" (p. 298). Families, in some ways, became the doctor's second patients, who required time and attention, and things could deteriorate quickly if the doctor failed to ensure that. The doctor touches upon the way of communicating. He advocated using simple language in confrontation with a patient. He viewed medicine as complicated, which entailed a skill to simplify things by plainspoken language, which allowed for conveying what is actually taking place inside a person's body. The doctor made an effort to do it, and it was disappointing to him to see other doctors use medical jargon talking to families. The doctor wished to tell those doctors "just talk like a normal person" and "pretend you are not a doctor" (p. 299). The above examples show that one of the ways of finding by a doctor a common ground with the family, is to condescend by using a simpler language, rather than a complex, medical one, and that the doctor also needs to understand the family's emotions.

One case of engaging a family member into the patient's matters in this memoir took place post mortem. The doctor felt it was his responsibility to reveal medical information about the dead patient to his wife, since he felt it could bear relation to her health, too. Despite performing unsuccessful cardiopulmonary resuscitation (CPR) to the patient for almost half an hour, he still remained pulseless. It was the doctor's role to break the news about this patient's death to the family, since it was his patient. As the physician informed the patient's wife of her husband's death on the phone, she declared to come and find him as the doctor who was responsible for his treatment. Masterton's wife came to the hospital. The doctor was afraid that she might have a gun. No metal detector was installed at the front desk, only a security guard was employed. The doctor thought she would even get away with doing anything wrong, such as using the gun, since she would have the excuse of going insane at such bad news. Fearful though he was, he was ready to face the situation. However, she did not look like the aggressor, but like a victim (p. 299). The doctor was waiting for her, he thought she deserved some

explanation, at least a general one. He decided he had to get in there and talk to her. The doctor entered the room she was in. “We stood a few feet apart, two strangers inexplicably thrown together through catastrophe” (p. 300). He said he was sorry. Mrs. Masterton approached him and hugged him. The doctor added: “I’m sorry for your loss.” She cried for a few moments. The doctor was trying to imagine how she felt, but he could not. They were talking for a while, she said she loved her husband, and that he had made her laugh and smile when he came back home, but was “not a people person” with a lot of friends and was quirky and moody. He could sit locked in a room and surf the Internet for a long time (p. 301).

The doctor did not know if he should reveal her dead husband’s medical secret. The situation was more vague on account of the fact that the doctor could only base on circumstantial evidence. He thought she deserved the truth, but the doctor was not certain what the truth was. The information on hepatitis C – and the doctor was not sure if it could be sexually transmitted – was passed to him by another physician, but he himself did not see any medical records. On the other hand, it would be irresponsible to ignore this information. The dead patient’s wife did not know about this illness, so the doctor was going to make her a list of diseases she should be tested for, in case she had it (p. 303).

In the aforementioned examples, the medical staff communicate with the family member of their patients. These conversations have different functions. One of them can be obtaining valuable information, considering that family members may be more objective, as they look from a distance. Another function may be a therapeutic one, when the doctor comes to terms with his state of mind, as in the last case, when seeing that a family member accepted a hard situation, the physician stopped feeling guilty and felt better. Confrontation between a family member and the doctor allows for talking and sharing information or memories connected with the patient.

The systemic–partnership model is also visible in the nurse’s cooperation with the family, which takes place in *Critical Care*, in which the nurse opted to confront the family to settle the problem. This situation shows that a lot depends on individual medical staff, and their reaction may matter to the family, which feels at a loss and is in two minds about possible action. The nurse faced a dilemma; the doctor put the patient Mary a respiratory mask on her face and thought it is Mary’s family’s task to come and take it off if they considered it suitable. The nurse considered it cowardly and pathetic of the doctor. She was bearing it in mind, but left it to herself and decided to act. In her head the nurse only sets questions to herself: “Wasn’t it my job to help people face this? What kind of nurse would I be if I saw this family and this

patient and didn't offer any real help" (p. 36). She was not certain what the family wanted. She thought she should offer help, and talked to the family, who expected some directions from the medical staff that the time was right to remove the mask. The nurse dealt with the procedure (p. 35-6). The nurse's work was appreciated by the family member, Mary's mother, who thanked the nurse for everything and said that looking at the nurse gave her strength. The nurse was uncertain whether she should hug patients and their family, so she hugged only a couple of family members (p. 41).

In *Critical Care,* another example demonstrates a nurse's will to take part in a communication process. The nurse showed her need to be involved in the communication, and wanted to be present in the conversation between a patient and an attending doctor. Her role was supposed to be that of a listener. She was interested in what was said and especially in the family's reaction (p. 123). The nurse thought there were too few empty chairs to sit down and talk, since they were occupied by plenty of other people in the room. The doctor informed the patient of the return of his illness and offered three options of handling the disease, but the disease was incurable, anyway. The doctor communicated death in this way, but the patient's son was not able to face the truth. The nurse said that "however much I listened or cared, the pain would be theirs, not mine". No words could make the patient, Mr Barton's or his son Josh's pain go away. She wanted to be obliging and when the patient asked for the Bible, the nurse tried hard to find it (p. 125).

In *The Real Doctor Will See You Shortly*, the doctor's confrontation with the patient's family indicates various matters: interest in the patient's family background, truthful conversation and empathy which overwhelmed him (p. 232). This instance is a sign of how the doctor plays a role in facilitating the family's decision. The conversation informing Ms Hansen's daughter of her mother's death was difficult for the doctor. He did not find any way to offer her consolation because the medical staff did not see any hope. He practiced what he was going to say, imagining the way the dialogue would be played out. He was not to sure how to do it; he did not have a chance to hear these types of conversations in any sitcoms or drama (p. 234). The doctor tried to calibrate how close he should sit and how to conduct the conversation in a proper way. As in the case of many patients, he tried to picture what their home life was like. The doctor wondered how close to her mother the patient was, if they talked on the phone or fought. Did her daughter Ingrid understand what her mother wanted in case the situation took a turn for the worse? The doctor felt some part of him shattered when Ingrid's eyes welled with tears. He knew he needed to take some action, took Ingrid's hand in his and

tried to find words. In the face of Mr Hansen's daughter's anxiety (her lower lips were trembling, a tear was dripping down her cheek when she closed her eyes), the doctor fought a battle to stay empathetic and not cry himself. He was not certain whether he handled the conversation properly, but he did not feel anything was wrong, either. The doctor lost certainty, he realized that on his duty, he had not heard the patient's case discussed because he had to transport another patient to the adjacent ward. That is why the doctor did not hear the information about the patient at first hand. Another physician decided she did not need to be in an ICU any longer. The doctor based his conversation with Ingrid on the view of medical consultants he hardly knew. He considered deferring this conversation till morning when the rest of the team were accessible, and when he would have access to all notes from other physicians. When Ingrid was ready to do what the doctor wanted, he advised her to act according to her knowledge on her mother's will as to whether or not keep her alive at all costs for as long as possible, even if she was brain-dead (p. 236-7). It was difficult for the family to take a decision alone, and the doctor's consultation was helpful to them.

Although people must make decisions on their own, they feel at a loss in certain medical situations. This state of affairs may also be caused by the lack of medical knowledge and the fact that these situations happen to the families for the first time in their life. Often they do not have experience even in similar circumstances. In such cases, a doctor's or a nurse's intervention gives some direction and a clue for the action.

The partnership model can be exemplified by allowing a patient to decide about his matters on his own, thus giving him autonomy. In *Do No Harm* the reader can see an example of leaving a decision to a patient, who needs to consider certain information and presented facts: "I'm afraid it's your decision as to whether to have the op or not" (p.21). In the above utterance, the doctor informs the patient there's a risk of aneurysm rupturing, which may as well never happen. At four or five %, the operation my leave the patient disabled or dead. The doctor gives the patient bare facts and time to talk things over with his family. Apart from medical knowledge, some intuition is required to estimate when a doctor's intervention in a patient's matters is needed, and when patients are capable of deciding by themselves.

2.4.2. THE INTERPRETATIVE MODEL

A reflection of an interpretative model can be found in Lisa Sanders' book – *Every Patient Tells a Story*, in which she claims a patient's story is frequently the best place to find some indispensable clue in diagnosis making. It is also the oldest and the most reliable diagnostic tool. In the studies done in the 1960s and 70s to assess which tools matter most to help doctors set a diagnosis, the result was that in most cases doctors are capable of diagnosing an illness correctly by talking. A large number of medical diagnoses from the 1970s to the 90s were made on the basis of the patient's story alone. The patient's story included diagnostic tip-off up to 70% of the time. Physicians construct stories about patients that are arranged as scripts of illness. The doctor can use the patient's symptoms, his/her exam and tests results to match that story to an illness script for the purpose of making a diagnosis. A well-constructed story, which means a full one, and not only a fragment, might be helpful for the doctor in reaching the right diagnosis, even if the doctor has not seen a patient (p. 29). Telling a story by patients can be helpful in arriving at values important to them, which they may not have realized so far.

Although creating a story is supportive in a diagnosis, in the context of the discussed memoirs some doubts may arise. For one thing, it is difficult to check the credibility of stories reconstructed by doctors in their books because memoir literature is based on internal feelings of the author, who can interpret a given event in various ways, filtering it through their own cognitive system shaped by their experiences. Therefore, it cannot be clearly stated whether presented events are completely consistent with facts. What is more, the content revealed by patients may also be partly made up. It should be assumed, however, that while certain facts may be distorted, their essence remains intact. However, presented feelings and impressions accompanying the stories are authentic, although it cannot be ruled out that certain embellishments can be encountered. In any case, however, recalled stories bring closer the in-depth characteristics of a doctors' work, with its joys, dilemmas and insights related to it.

Sanders expands on her findings connected with telling a story by the patient and draws the reader's attention to some conclusions, including the observation that against common sense, neither the doctor nor the patient seems to appreciate the role of a patient's voice in making a diagnosis. Sanders points out, however, that an interview exceeds even the power of high-tech tests and the physical exam. Furthermore, what is learned from a simple interview often plays a crucial role in the patient's health also after the diagnosis is made. In fact, patients

are usually ready to answer the doctor's question: "What brought you today? They have a story to tell, and this story has usually been told to family and friends before. The trouble is that the patient may not have an opportunity to share that story with the doctor, who regards interrogation as the first step in diagnostic process. The doctor just wants to hear facts, the patient is compared to a passive crime witness, who should provide a narrow account of what happened. In this way, the patient's story is meaningful only as a "vehicle for the facts of the case". This "facts only" approach makes doctors interrupt patients, preventing them from telling their full story. The author enumerates certain figures, she refers to the study conducted by Deborah Świderski in 2005, "The effect of physician approaches on ability to identify patient concerns". This study analyzes doctors and patients' encounters, during which both sides were aware of being recorded. The doctors interrupted the patient in their initial presentation of symptoms more than 75% of the time (p. 6). Physicians managed to listen for sixteen seconds on average before they broke in (p. 7). This gave rise to a negative effect; when the story was interrupted, patients did not resume it. This state of affairs exposes contradictions in the perception and understanding of patients' visit and their illnesses. Sanders argues that surveys have shown that both sides disagreed on the patient's problem or purpose of the visit. She adds that in one study, which was described by Baker, O'Connell and Platt in the article: "What else? Setting the agenda for the clinical interview" in 2005 and aimed to measure patients' satisfaction with their visits at the doctor, more than half of the patients, interviewed after visiting the doctor, did not have the chance to describe their symptoms that worried them (259).

Another study revealed the patient's and the doctor's disagreement about the cause of patient's visit to the doctor. This study was conducted on patients at the Metropolitan Health (Care-First) Plan office, at the Baltimore City Hospitals and the Johns Hopkins University School of Medicine. Care–First is a prepaid Health Maintenance Organization plan, which provides preventive and comprehensive services to working-class families in Maryland and Baltimore. Patients were supposed to come back for an appointment for a follow-up visit and were interviewed. The results of the study showed that visits were so superficial or fast that a patient did not manage to reveal the true reason for coming, leaving the doctor mistaken about the cause. This happened 25 to 50% of the time. In other words, doctors often fail to obtain the information, which can only be provided by the patient. Sanders refers to the writer on this topic, Dr. George Balint, who does not approve of this type of superficial interview. He claims that if asked questions, one would only obtain answers, and nothing more. What is missing in this situation is the patient's story. When the patient is allowed to tell the story, s/he does not

limit himself/herself to the whats, wheres and whens, but can also inform of the whys and hows. The disadvantage of this interrogation model is that assumptions formed on the basis of certain symptoms may be adequate and true only in case of some individuals, but not in the case of all patients. Sanders detects that the distinction between the average patient and an individual may not be disclosed until the doctor asks, basing on the rule that one may be able to say what the average man will do, but one can never predict what any one will do (p. 6-7).

Sanders justifies her view that a patient's story brings benefits, by making a reference to the Canadian physician William Osler. In 1893, at Johns Hopkins Hospital in Baltimore, Maryland, Osler created the first residency program for specialty training of physicians, and he invented the idea of bringing medical students out of the lecture hall for bedside clinical training. He was regarded as the Father of Modern Medicine. Osler instructed his trainees that receiving a good story is a process that demands collaboration. It is more crucial to know what type of person has the disease than what kind of disease s/he suffers from. The collaborative process means that the patient brings something unique; namely, particular and private facts of their illness and life. The physician, on the other hand, brings knowledge and understanding, which are helpful in making sense both to the patient and the doctor. The doctor makes use of it to set a diagnosis and the patient needs to incorporate that subplot into the whole story of his life (p. 7-8).

The realization of the above conception of focusing on the story is present in the history of Randy from *Every Patient Tells a Story*. The interpretative model can be detected in the case of another doctor–patient interaction in this memoir. This example is used to point how by listening to the patient Randy, his doctor elucidates the patient's values and dreams and helps the patient choose medical interventions in agreement with his principles. A lot of physicians cared for Randy, but one stood out from them. It was Marc Wein, a medical student who was fascinated by Randy's illness and him as a patient. After reading voraciously about the disease, Marc Wein searched case reports of other patients with similar types of cancer, which enabled him to explain it all to Randy and Leslie, his fiancee. In collaboration with Randy the doctor created the story of this remarkable diagnosis that both of them regarded as reasonable. Randy liked the story that Wein reconstructed for him. The patient bore it in mind that he suffered from cancer and that curing it would let him restore his former strength. He was a conscious patient who understood his situation. He accepted the surgery and did not mind the pain caused by the incision down his chest. He even welcomed chemotherapy. When he watched the intravenous needle pierce his skin, he knew it meant he was closer to recovering. The author

observed the patient's optimism, which he never lost. The patient's life moved on, he resumed his work and later and got married. The author's conclusion is that chemotherapy may have cured Randy's body, but "his mind was healed by a story" (p. 21).

One more instance of discussing a patients' ailment with them can be found in the same book. This doctor–patient interaction belongs to an interpretative model, in which the power of listening and discussion is emphasized. The example shows how doctor – Wainapel implements the concept of this model of communication. He considers observation the most significant component of the physical exam. He also sees other ways of observation than with one's eyes. This doctor takes pride in his ability to listen with a view to getting the full history and let the patient tell what he has to tell. He is convinced he can perform his work with his hands, ears and what is most essential with his brain (p. 82).

A similar view is shared by the next physician who also practices interpretative model of communication and focuses on discussing a patient's medical problem with her. This example is adopted to illustrate the role of a story for diagnosing a medical problem. In *Every Patient Tells a Story* doctor, Walerstein is interested in hearing the patient's story. He did not read the chart on seeing the patient, not wishing to be influenced by other specialists' way of thinking. The patient was unwilling to repeat his story one more time, but the doctor found it essential to piece it together for himself. Knowing how to ask questions leading to an answer, with the help of the patient's mother, the doctor got to the core of the patient's problem, which was undetected by the team of doctors before. He diagnosed Wilson's disease, which was the combination of a liver failure and destruction of red blood cell (p. xvii- xviii).

All these example point to the conclusion that genuine power lies in creating a story by the doctor and the patient for the purpose of diagnosis and treatment. The above examples illustrate its bright sides, for example setting the patient in a positive way, which means acceptance of hard treatment with optimism. The doctor plays a crucial role; he serves as a trendsetter for the patient. However, there may be limitations to creating a story in the case of patients who do not want or just cannot talk too much, which results from their nature. Then, the doctor has to put more effort into eliciting the necessary information from the patient.

The interpretative model appears in the case of Darryl. This model is present when the doctor acts as counsellor who helps the patient understand the nature of his ailment, and involves him in a dialogue about the best possible solution. Assumptions of an interpretative model are fulfilled because the doctor facilitates the patient's interpretation by referring to his

own past mental health situation; namely, depression, thus finding a common ground with the patient. The patient has a chance to understand better who he is and how medical choices influence his/her identity. During a thorough medical interview, the doctor makes it possible for the patient to clarify his values and helps him reach a decision in accord with them.

2.4.3. THE PATERNALISTIC MODEL

The implementation of this model is conspicuous when physicians quickly and mechanically decide what to do, without listening to patients too much. At the same time, doctors treat each patients' case as a typical one, in which identical solutions apply.

An example of communication displayed in *Critical Care* resembles the paternalistic model, although the nurse's acting results from a great concern about her patient. This type of communication also contains an extreme form of the interpretative model when the nurse, who assumes that patients' values are not necessarily fixed and known to those patients, may be only partially understood by the patients. In its extreme form, when the doctor treats the patient's life as a whole, s/he helps specify the patient's values. In this case a medical specialist determines which tests and treatment reflect these values best. The following instance is used to show how a model regarded as a bad one is applied by the medical staff in good faith, and it brings the expected result, that is the performance of indispensable medical intervention. In her memoir, the nurse recalls the situation when she used empathy but also a trick in bargaining with the patient about refraining from eating until a surgical intervention is performed. The patient was stubborn and refused to wait for a meal any longer. The nurse knew that the medical intervention would have to be done without food. She assured the patient that he needed that line. Although the patient did not like what the nurse was saying, she did not give in: "I kept going, trying to put every bit of empathy I had into my voice, my voice, my face. I felt almost as if I were nothing but a voice, a disembodied voice in white scrubs" (p. 160). The nurse promised him food after the intervention, though she knew it may not be possible to keep that promise (p. 160). She was, however, bearing in mind his health.

In *Every Patient Tells a Story,* the author observes the phenomenon that doctors too often either reject patient's symptoms as unreal ("It's all in your head") or look superficially at some scanty evidence to get rid of uncertainty with a clear diagnosis. This behavior results from the doctor's intolerance of the state of not knowing. It deranges their ability to alleviate

suffering. Both attitudes do not do patients any good. To prove her point, Sanders uses the example of Will, who says that his doctors abandoned him by rejecting his symptoms. This is contrasted with other practitioners Will visited, listened with sympathy, offered explanation for his symptoms and a precise treatment plan. Dr. Gaito is one of them; she is one of the few doctors who listened to Will, validated his feelings and "offered him a compelling narrative of his symptoms" and then a solid diagnosis (p. 183).

Sander's book analyses other cases relating to the approach of not taking much notice of the patient. They are all characterized by the lack of communication. Examples recalled by Sanders are worth presenting in order to look at the results the paternalistic model brings. The author discusses the problem of David, who went to the emergency service. All doctors from the emergency room except for one, come up with a diagnosis and "close off thinking about possible alternative diagnoses before gathering all the data that would justify this choice" (p. 201). The author classifies it as a common diagnostic cognitive error, which she calls "premature closure". The doctor did not ask the most fundamental question: "What else could that be?" (p. 200). The doctor heard David describe the classic symptoms of a myocardial infarction – squeezing or pressure – like pain in the chest associated with shortness of breath, and began ordering tests and exams aimed at clarifying the suspected cardiac situation. The symptoms of weakness and numbness were noted in the chart in each of the visits, but were not considered on their own, even though they were not part of the typical chest pain presentation. David's complaint about his loss of strength was left behind. This type of dealing with the case was called by the physician Crosskerryan "intrusive approach", which worked by pattern of recognition. It was described as "a process of matching a new situation to one of many exemplars in one's memory which retrieved without effort" (p. 201). In other words, the patient was not treated as an individual.

The doctor (the author himself) recalls a situation which she considers her own mistake. She alludes to it to visualize what happens when a doctor does not talk to a patient or does not manifest much interest. When the patient came to her and at the end of the visit asked her about the lesion on her buttocks, the doctor was in a hurry, behind schedule and quickly looked at the lesion, and at her watch. The doctor did not ask any additional questions or do more thorough exams, and noticed that the girl seemed worried. Later the lesion reappeared turning out to be herpes (p. 10). By this Lisa Sanders shows how the lack of attention can lead to negligence and cause further medical problems.

Mistakes discerned above may result from the lack of awareness or just reflection or an ostensible lack of time during the visit. The physician also takes into account her own shortcomings and reflects on them, can reach the conclusion that she should be more attentive. Paying more attention can save time and effort in the future because it contributes to a better diagnosis of a patient's medical problem.

Analyzing numerous medical cases and talking to medical staff, Lisa Sanders detects some mistakes in the attitude of the medical staff. She makes reference to Dr. Nancy Angoff, who is a dean at the Yale Medical School, in whose view, medical education focuses students' attention too much on the disease and not enough on the patient (p. 33). She feels confused at hearing students refer to a patient by his/her disease and location. She fears the doctors will forget how to talk, listen to patients and feel for them. She is also worried that the excitement related to mastering the culture and language of medicine may make students lose the empathy that attracted them to the medical school (p. 33).

Apart from not having enough interest in a patient, Lisa Sanders reproaches doctors for not doing a medical examination and mechanical dealing with patients' problems. The charge of not listening to patients is similar to not detecting them by skipping an examination. She includes a few examples of such negligence as well.

The role of all the following examples is to prove that mechanical handling of the patient may delay or prevent a proper treatment or diagnosis. In the first example, Sanders cites a story of a man with a heart attack, who is brought to the hospital's Intensive Care Unit (ICU). His blood pressure starts to drop, to which doctors order intravenous fluids, but do not examine him. Then a cardiologist intervenes by draining the blood. The man dies on the table. The author claims that if the doctors in the ICU had examined the patient, rather than limiting themselves merely to observing monitors tracking his vital signs, they would have managed to diagnose these potentially reversible complications (p. 40). Relying only on the screen is not always enough.

Sanders supports her view by giving another story of a woman. Doctors overlook a loss of sensation and reflexes, which would have led them to the presence of the spinal cord lesion, if they had examined the patient. She was taken to hospital with a fever and breathing difficulties, which had been preceded by treatment for pneumonia. They decided to treat her with intravenous antibiotics without checking her condition. After further symptoms, such as

increase in white blood cells, doctors order a computer tomography (CT) scan of the chest, looking for a problem in her lungs. Only then do they see an abscess on her spinal cord (p. 40).

The third story concerns the patient Carol DeVries, who went to ER doctor, and was feeling pain and had a rash near the spine. After taking her temperature, the doctor glanced at the rash and briskly declared she had a Lyme disease. "An antibiotic will clear it up" – the doctor said scribbling a prescription. "One pill twice a day for two weeks" – he told the patient and headed out the door.

> Patient: "Wait a second" – Carol Ann called after him. Aren't you going to get a test to see if I have Lyme?
>
> Doctor: "You don't need it" – he told her, ticking off the items that supported his diagnosis (p. 167).

The doctor added that at such early stage, the Lyme test would not tell them anything. Then the doctor went out of the room to admit the next patient. Carol Ann was left with a prescription scrawled by the doctor and she felt uncertain. Frequently, doctors made diagnoses without a test, as Carol Ann's case showed that. Carol visited other specialists – a rheumatologist and an internist. The patient was crying while talking on the phone due to the pain. She said that she could not even sleep because of the acute pain. The doctor did not show much sympathy, which made Carol feel abandoned. Nor did the doctor know the cause of her pain. The patient resolved to take action on her own, which meant talking to friends and finding a Lyme specialist. The author concludes that the result of mechanical handling of the case is that a large number of patients are diagnosed with a "phantom" illness and undergo treatment for a medical ailment they do not actually suffer from (p. 169).

Further features of the paternalistic model can be traced in *Critical Care*. They include the lack of the doctor's cooperation with the family. The patient found out about her imminent death while watching TV in her hospital room. The family did not have enough information to consent to hospice care for their family member and wanted the doctor to communicate it to the patient. It became the nurse's role to communicate the family's wish by asking the doctor to come back (p. 132-3).The nurse told the doctor that the family did not understand what the options for their mother were. The doctor compensated for the earlier situation, his tone was apologetic for leaving the family confused, but he wished to talk to them the following day, since he was on the way to collect his daughter from school (p. 135).

Sanders also wishes to confront her own imperfections in the field of medicine and raises the matter, which in her view is desirable in a doctor–patient contact, but with which she herself has problems. Namely, the author means touch. She sees it a form of communication, which is

indicative of both affection and fellowship, concern and support. In her view, "this type of physical contact lies within our expectations of social intercourse". Although placing a hand upon the patient's body is a hallmark of the doctor, it is complicated. Medicine entails intimacy, but one featured by emotional and intellectual distance. Touch is different in a way that intimacy is not present like in the case of family and friends (p. 47). The author discusses a common phenomenon. Together with the development of modern and more advanced technologies: ultrasounds, MRI (magnetic resonance imaging) and mammograms, the doctors started doubting the power of their own hands: "Why deal with your own embarrassment, the possibility of patient embarrassment, and the difficulty of interpreting the fuzzy pictures generated by touch when a study can show you the inner structures of the body with more precision and accuracy?" (p. 52). The reader can see the doctor's reflection over her past career. She starts seeing things she did not spot before and she bases her understanding on analysis and reflection about confrontations with her own patients, but also relations of other medical staff, her colleagues, whom she is familiar with. This deep analysis of visits and patients' problems alters the doctor by helping her see a broader perspective in the light of her and other doctors' mistakes.

The author of *Every Patient Tells a Story* presents observations and some ways to correct the diagnosis, namely appreciating and incorporating by doctors at their work, senses like sight and touch. Lisa Sanders shares in this context her own experience. She thinks that the general impression of a patient is worthless without looking deeper and paying attention to the specific parameters of sickness or health that are hidden behind this impression. Studies in perception prove that the automatic use of one's eyes is the most effective way of collecting visual data (p. 90). However, careful observation and deduction can lead to the right diagnosis (p. 92).

Sanders stresses the role of a hand, since doctor's hand gives information that cannot be obtained from its technological counterpart. She exemplifies it by the issue of breast screening. Although machines like ultrasound, magnetic imaging and mammography are attributed with detecting breast cancers, an exam can pick up something that a machine cannot. The same takes place in case of abdominal pain. Many patients with pain in the belly land in the operating room (OR) and 20% of them face a negative appendix – unnecessary appendectomies (p. 110).

2.4.4.THE INSTRUMENTAL MODEL

In her memoir Lisa Sanders introduces the idea of drawing on electronic forms in medicine, for example for the purpose of diagnosis. This type of communication differs from a traditional one because speakers usually communicate through the screen, not necessarily seeing each other's faces and reactions, as in a live chat. This form of communication may be temporary, assuming that interlocutors will meet some day in the real, not virtual environment, in person. Sanders underlines the priority of human (personal) communication over communication with the computer. Although in the early 1980s there were attempts at creating artificial intelligence techniques that would help doctors make a diagnosis, it is now disapproved by them (p. 218). A feature which ranks humans higher than computers is that humans have a set of diagnostic tools: five independent and powerful sense organs. At a glance, a physician can understand and instantly process the information about a patient; their skin tone, posture, quality of eye contact, or quality of voice (p. 220). Moreover, Sanders argues that no one has managed to persuade doctors to use diagnostic software. They prefer to ask a colleague for help, instead. Therefore, the medical community has not embraced any computerized diagnostic support system, at least till the time Sanders analyzes this matter.

On the one hand, computers are limited, since they are deprived of the senses. In contrast, a computer is poorer, it only has at its disposal numbers and words, entered by a human, that are inadequately representative of a living and breathing, complicated patient (p. 220). Computers cannot draw conclusions or grasp subtle nuances or subliminal signals. That is why the idea of a computer system capable of thinking better, faster and more comprehensively than a human doctor has not been realized till Sander's day (p. 231).

On the other hand, despite limitations of computers, family and friends of the memoirist's patients admitted to using Google to investigate their own symptoms. Sanders cites a survey from 2005 conducted by the Pew Center, according to which 95 million Americans searched for health information on the Internet (p. 231). Sanders refers to a medical case where online intervention was successful. It also mirrors a true and rising trend among patients who either follow upon their doctor's diagnosis or diagnose themselves by using the Internet (p. 234). In this context, Sanders presents a conversation which is an instance of two-sided doctor–patient communication. This doctor–patient confrontation in Sander's memoir is selected to show that there are moments when the Internet can be helpful in diagnosis. The patient admitted

to having consulted the Internet and diagnosed his case as Rocky Mountain spotted fever. In the patient's confrontation with the doctor initially, the doctor did not agree with it, but the tests, which were done later, confirmed that the self-diagnosis was correct. The doctor admitted: "You are internist's dream. It really is Rocky Mountain spotted fever, and I would have completely missed it if I hadn't listened to you" (p. 234). This exchange is indicative of the doctor's openness.

On the whole, communication in medical memoirs selected for this dissertation resembles mainly the one present in the partnership and a systemic–partnership model. The interpretative model is conspicuous, too. Except for the above models, there is a mention of the instrumental model and a few examples described by authors fall into the category of the paternalistic model. *Every Patient Tells a Story* is the only of the four memoirs in which the instrumental model occurs and is noticed by communication via computer. The models of communication may vary, but all of them have ne common aim, which is to enhance the understanding of an illness by the patient and coping with this illness better by both sides: the medical staff and the patient. Medical specialists act according to the assumptions of those models, sometimes just by imitating a work mate, another time choosing a model of their own accord. Regardless of the selected model of communication, only with a progress of time do doctors see which one is worth practicing and proves rewarding to both sides. This realization happened to the memoirists who pinpointed a lack of attention or physical examination, characteristic of the paternalistic model, and insufficient cooperation with the family as obstacles to proper communication and treatment. Instead, traits like openness and contact with the patient were regarded as uplifting by them.

Undoubtedly, doctors created their memoirs because they felt such a need, but it also let them ponder over certain issues. It led to a change in their attitude or assessment of their professional reality; Sanders' view alters since she detects mistakes by analysing patients' stories. She looks at her and others' actions from a distance. She comes to realize that inclusion of physical observation of the patient is necessary, which means relying on senses in medical confrontation as a component of communication. Listening to the patient needs to be underlined with a great emphasis, too. All these things are helpful in reconstructing a story by both, which is essential in the interpretative model. Another memoirist, McCarthy is on the onset of his career, so his ways and attitudes are in the process of taking shape, which partly happens under the influence of his colleague, who serves as a role model to him. Namely, McCarthy learns to be more attentive and caring about patients' matters, which are the features of the partnership

and the systemic–partnership model. Theresa Brown assesses the partnership and the systemic–partnership models in a positive way. It brings satisfaction to both her and her patients when they exchange opinions and as a representative of the medical staff, she is in cooperation with the patient's family. Henry Marsh looks at the partnership model in a favorable way because when everything has been made clear by him to the patient, he also feels fulfilled. It must be noticed that all the medical staff remain themselves and have a strong sense of duty and professional purpose even in the crowded hospitals where they work.

During communication of the medical staff with patients and their families emotions may also appear. Emotions influence the communicating process and attitudes of the medical staff and patients to each other. In the following chapter I look into different emotions and circumstances, in which they are experienced in the medical context.

CHAPTER THREE

EMOTIONS: DEFINITIONS AND CLASSIFICATIONS

This chapter addresses the notion of emotions. They are the focus of attention in the context of research on medical memoirs. Like communication, discussed in Chapter Two of this dissertation, doctors' understanding of emotions and dealing with them also matter in confrontation with the patient during the treatment process. The chapter begins with definitions and classifications of emotions as well as a discussion of the role they play in human life and in literature according to researchers on emotions, such as Richard Lazarus and Nicholas Young. Starting with Theodore Kemper and his division of emotions into positive and negative ones, another psychologist Robert Pluchnik's Wheel of Emotion is incorporated to illustrate emotions experienced by people. Following his division of emotions into primary and secondary ones, primary emotions are characterized with a view to providing background for further analyses of selected memoirs. Secondary emotions, which constitute a mixture of primary emotions are also taken into account. Next, instances of both primary and secondary emotions occurring in the selected medical memoirs are traced and discussed. The focus of attention is on the way these emotions are felt by the medical staff and to a certain degree also by patients. A closer attention is given to how these emotions affect the staff and how they react to appearing emotions. In order to cope with daily challenges, the medical staff must get to know how to deal with their emotions, chiefly while being on duty. They can work out their own ways to do that basing on their own experience, but also on their observation of reactions of more experienced medical staff working with them. Tracing the occurrence of emotions in medical memoirs under consideration is supplemented by the research with the use of sketch engine, which permits for detection of the number of times a particular emotion, for example joy arises in each memoir. At the end of the chapter the literary aspect of medical memoirs is outlined, especially the way the memoirists construct the plot and create suspense.

In the context of the medical staff's ability to deal with emotions experienced during encounters with patients and their relatives, the question about the source of this competence arises. It seems that it is firstly the matter of education in medical schools. One would assume that medical institutions should equip students of medical professions, who are going to have contact with the ill during their professional work, with indispensable knowledge and skills in

this field, prepare them for participation in the trauma their patients and their relatives experience in connection with illness. Barry Jacobs claims that a crucial meaning ought to be attributed in the issue under consideration to mere practice, individual professional experience, which in each medic's awareness is a bit differently reflected as it has the features of his/her individual sensitivity, professed axiology and ethical position.[247] Eventually, each medic works out his/her own individual strategy of levelling in oneself emotions generated by potentially traumatizing experiences of their patients. Medics must not in this sense follow the patient or put themselves in the patient's shoes, but they must not reject patients' emotions completely and focus on their strictly professional duties. Professionalism entails reigning over one's emotions, the source of which are relations with patients and their relatives, and in which emotional nature is dominant. Nevertheless, situations happen in which a physician is not able to reign over emotions, although bearing in mind professionalism s/he ought to and reacts like any other human being involved in a disease.[248] Certainly, medical students can find guidebooks dedicated to them, which enable them to realize important things connected to managing their emotions, or just partly shape their emotional habits. *The Mindful Medical Student* offers these types of lessons to students of any medical field. It touches the matter of relations with other medical staff and patients, too. By presenting patients' exemplary predicament and posing questions ("Do you have empathy for her, what steps would you take to help her, and why?") for the reader to think, the book can potentially prepare the student for some future situations.[249]

The previously mentioned situation of being engaged in a patient's disease can take place when the doctor finds him/herself in a situation corresponding to the one of a patient or his relatives. In the second case, fear for life and health of a close person felt by the family – frequently regarded as exaggerated by doctors and seen as the source of their irritation – becomes part of the doctor's own experience. The surgeon from *Do No Harm* recalls the time when he feared for his little son's life when he was suddenly taken to hospital. He thus describes his own perception of the world in such a situation: "The outside world, the real world, becomes a ghost world, and the people in it remote and indistinct. The only reality is intense fear, a fear driven by helpless, overwhelming love" (p.108). Finding himself in the state of fear for his child's life, he is not able to look at this situation from the perspective of professional or scientific rationalism. Helplessness induced by fear wins over in a loving parent, who

247 Barry Jacobs, *The Emotional Survival Guide for Caregivers: Looking After Yourself and Your Family while Helping an Aging Patient*, New York: The Guliford Press, 2006, p.103.

248 Ibid. p. 103.
249 Jeremy Spiegel *The Mindful Medical Student*, Lebanon: University Press of New England, 2009, p. 130.

experiences the feeling of utter helplessness. What is more, he loses his faith that medicine is able to help him. His emotional state in this case does not differ much from that of his patients' family members whom he meets in his job. In the surgeon's case, this is a commonly occurring situation in connection with a scheduled operation when the fear of patient's family members increases. The surgeon who himself experiences a sense of helplessness, which in theory should be levelled due to possessed knowledge and medical experience, gains the chance of realizing what his patients' family members experience during the operation (p. 110). On this ground, the doctor comes to understand the state and strength of fright felt by a patient's family in the face of a threat to health and life.

3.1. DEFINING EMOTIONS

Since emotions are so powerful, it is crucial to understand what emotions are and what types of emotions appear in relations between the medical staff and patients and their relatives in the process of therapy. The term "emotion" derives from Latin (motere), and signifies 'to move".[250] Harold Sala defines an emotion as a psychological and mental state "associated with" a great diversity of thoughts, feelings and behaviors.[251] There are different ways of viewing emotions. Robert Zajonc gives a definition of emotions as "bodily feelings that reveal preferences".[252] According to Kwal Gamble, emotions are feelings experienced by people as a reaction to others and the surrounding.[253] Zeta Hill also perceives emotions as a reaction or a response and describes them as "inner personal experiences in reaction to the world". Contrary to what was deemed true in the past, that is that emotions were felt in one's heart, and similarly to two experts listed above (Young, Lazarus), Hill presents the view that nowadays emotions are visible through changes in people's body, particularly in a brain. Researchers vary in their perception of the functions of emotions. Whereas some (Young, Lazarus) claim that emotions disorganize and disrupt one's behavior and trigger problems, another specialist, Carroll Izard

250 Rush Dozier, *Fear Itself: The Origin and Nature of the Powerful Emotion that Shapes Our Lives and our World,* St. Martin's Publishing Group, 2015, p. 2.

251 Harold Sala , *Making Your Emotions Work for You: Coping with Stress, Avoiding Burnout, overcoming fear, lack of confidence, feeling inadequate and more*, Tennessee: B & H Publishing Group, 2014, p. 38.

252 Robert Zajonc. in Derek Croome, Creating the Productive Workplace, New York: Routledge, 2000, p. 58.

253 Teri Kwal Gamble, Michael Gamble, *Interpersonal Communication: Building Connections Together*, London: Sage Publications, Inc., 2014, p. 212.

is of the opinion that emotions have the potential of organizing and motivating behavior.[254] In Hill's view emotions have an important function, namely they direct people's attention to things which are significant. She exemplifies it by saying that when a person is frightened, emotions guide him/her into being more cautious and prevent the person from acting carelessly. For example, sadness is a signal to change the present state or situation since it is not proper. By contrast, joy signals that no change is necessary. Unlike sadness, joy is the state which one wishes to maintain. Emotions tell people what actions they could take next. Therefore, emotions can be seen as a bridge between the world and actions which should be taken.[255]

Emotions constitute a form of communication which uses a specific metalanguage. The example of the surgeon from *Do No Harm* who faces the anger of the dead patient's family, which is a common part in his job, may lead him to trivialize and treat it with a professional routine. However, from the available documentation it appears, that this anger is not unfounded, and it is an emotional reaction to the mistake made during treatment. The surgeon reads letters of complaints from patients' families or is confronted with lawyers. Once the surgeon analyzes medical documents concerning the dead man, he sees that the man died because of a further stroke, which the doctor misinterpreted as a tumor. Therefore, the biopsy operation was redundant and unsuccessful, but also irrelevant. After the surgeon's written explanation and apology, the patient's father is not pleased and demands a Complaints meeting. The family's anger is visible to the doctor: "The dead man's elderly parents sat opposite me, glaring with hatred and anger, convinced my incompetence had killed their son. I spoke to the parents, unnerved and frightened by their anger" (p. 158). The surgeon sits for a long time and listens to the man in bereavement pouring out his anger and grief (p. 159).

The father's regret and anger can be regarded as an emotional exponent of his knowledge of the reason for his son's death, expressed in the language of emotions, which due to the loss of a close person becomes a dominant feature of his behavior. The man expresses with a language of emotion, what he would say in a language of factual analysis, if this matter did not engage him emotionally. Emotions turn out to be corroboration of facts, rather than a sign of bad will on the part of the dead man's relatives. They result from the dominating sense of harm and are an expression of regret to those, whose negligence led to death of their close

254 Carroll Izard, *Human Emotions*, New York: University of Delaware, 2013, p. 1.

255 Zeta Hill, *Sadness (Causes & Effects of Emotions),* Mason Crest Publishers, 2014, p. 4.

relative, and not an expression of the lust for revenge on those who led to it. There is nothing else the surgeon, who understands it, could do, but listen to regrets of the grief-stricken man and let him show his anger. This storm has the strength of catharsis. The surgeon's attempt at opposing arguments expressed by the patient's family member would inevitably have to give rise to an escalation of negative emotions and worsening of the conflict. The experienced surgeon knows that he cannot equate his sense of dignity with the emotions of those who lost a close person as a result of medical error or negligence. In this case, the negligence was the misinterpretation of a stroke as tumor.

For an adequate and accurate description of emotions understood in this way and arising in relations between the medical staff and patients and their relatives, it is essential to accept the most appropriate classifying key, in the absence of one generally accepted classification. A conceptual grid of each science is arranged through diverse classifications due to criteria features of the designates of terms and the aim for which the classification is done. In classifying emotions, the most obvious division seems to be the one based on value of arousal and this division appears the most useful for further analysis.[256] Arousal can be positive, for instance joy or trust. This is the kind of arousal which one wishes to experience again, since it is the source of pleasant sensations and is associated with success. Negative arousal, for instance anger, is the kind one does not wish to feel again. Opposite emotions are the poles between which tension is generated, which shapes the nature of emotional relations between medical staff and patients with their relatives. If negative emotions dominate, the atmosphere of hostility and distrust prevails. The atmosphere of favor and trust starts dominating when the point of gravity shifts towards emotions triggering positive arousal. On this ground, a division of emotions into positive and negative ones is going to be discussed first to achieve the objectives of the following analysis. Other classifications, which are going to be discussed later, refer to other aspects of emotions and focus on explaining the mere nature of emotion.

The division into positive and negative emotions is the focus of the book *The Subtlety of Emotions* by Aaron Ben-Ze'ev. Positive emotion is indicative of a favorable assessment, a positive desire and an agreeable feeling, and negative emotion means "an unfavorable evaluation, a negative motivation and a disagreeable feeling".[257] Ben-Ze'ev classifies joy as a positive emotion and anger, shame, fear, sadness and disgust as negative emotions. It can be seen that negative emotions simultaneously belong to unpleasant ones. The classification of

256 Barbara Łukaszewicz, *Wyrażanie emocji negatywnych w polonistycznej praktyce glottodydaktycznej*, Warszawa: Uniwersytet Warszawski, 2019, s. 105.
257 Ibid. p. 94.

emotions into negative and positive ones presupposes that each negative emotion, for instance sadness, has a corresponding positive one, for example joy. The former ones are more strongly felt than the latter ones, since it is natural in one's behavior to focus on how to protect oneself from dangers, in which negative emotions are inseparable. People are more aware of events triggering negative emotions, they also think about such events longer than about occurrences inducing positive emotions.[258] People remember negative emotions better, since they derive knowledge about how to avoid events bringing threat. Those emotions give energy to change, but one should not dwell on them beyond measure, since then they reveal their destructive power, pose danger to mental health and disrupt relations with others.

The empirical basis for such a claim is provided by Trevor van Gorp and Edie Adams. According to their observation, experiences ensuing from negative events, among others in the form of pictures and sounds, are better remembered than those following pleasant events. It may result from the fact that negative impulses require more attention from people, and negative experiences and responses exert a greater influence on them.[259] An adventure of unintentional jumping through the glass door and being deeply wounded in a limb by a glass piece as a consequence of fun chase in the house can be better remembered by a casualty than joy caused by finding a few euros in an item of clothing in a fitting room of a second hand clothes shop. The first experience teaches more and fright warns against undertaking reckless fun in the future. Specific primacy of negative emotions over positive ones in the structure of human perception, reflected in a preference to derive energy from negative emotions seems to result from evolutionary experience, that following indications of negative emotions helps survival more than focusing on positive emotions, which weaken the chance for survival.[260] It is worth noticing that assumptions for proper shaping of interpersonal relations and network of social connections, which form social order are completely opposite.[261] People are expected to focus on positive emotions. The foundation of mental health of an individual is also viewed in that way. At the same time, attachment to negative emotions as a driving force in human acting is more deeply justified than it seems, and it is unrealistic to expect that the choice between those two can be made on a moral level, namely by accepting what is defined as good and rejecting

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258 Aaron Ben-Ze'ev, *The Subtlety of Emotions*, Cambridge: MIT Press, 2001, p. 99.

259Trevor van Gorp, Edie Adams, *Design for Emotion*, Walthman: Elsevier, 2012, p. 141

260 John Wade, Lawrence Marks, Roderick Hetzel, *Positive Psychology on the College Campus*, Oxford University Press, 2015, p. 61.

261 Timothy Owens, Jill Suitor, *Interpersonal Relations Across the Life Course*, New York: Elsevier, 2007, p. 41.

what is associated with evil. Referring to emotional relations of medical staff, their patients and relatives, which are frequently dominated by negative emotions, the evolutionary basis of this preference cannot be disregarded. In patients and their relatives, negative emotions dynamize the activities that aim at minimizing the risks whose source could be the doctor's inadequate performance. As mentioned earlier, trying to oppose the arguments of the patients' relatives is inadvisable for the doctor in such a situation, especially if the arguments were formulated in the language of negative emotions.

The assumption that emotions are divided into negative and positive ones remains valid in the concept of Paul Ekman and Karl Friesen, who distinguished six elementary, also known as basic, primary or fundamental emotions. However, in their classification Ekman and Friesen put emphasis not on affective designation, but on the source of emotions. They enumerate joy, surprise, anger, fear, sadness and disgust among elementary emotions. A visual indicator of each of them is a specific facial expression.[262] In the 1990s, this list was extended by two more emotions (trust and anticipation). The American psychologist Robert Plutchik, who is credited with inventing a psycho-evolutionary theory of emotion,[263] developed Plutchik's Wheel of Emotions. Basing on existing classification, he distinguished in it eight primary emotions, such as joy, trust, fear, surprise, sadness, disgust, anger and anticipation, which manifest strictly assigned emotional responses, and in many cases also manifest themselves behaviorally. On the basis of primary emotions, in the course of social practice, secondary emotions are formed, which have their mental, physiological and behavioral indicators. In general, therefore, basic emotions are of primary nature, while secondary emotions are learned, appearing in the course of social practice, related to showing primary emotions.[264] Therefore, certain secondary emotions are always attributed to particular, primary emotions. Their distinctive feature is also the fact that secondary emotions, contrary to primary ones, do not have a pattern of expression automatically activating at the moment of their occurrence. Therefore, their expressiveness may vary, or they may gain an expressive equivalent, which need not always be noticed.[265]

262 Nico Frijda, *The Emotions*, Cambridge University Press, 1986, p. 72.

263 Randi Fredrics, "Plutchik's Wheel of Emotions. Counselling, Emotions, Psychological Development, Relationships"available on http://drrandifredricks.com/plutchiks-wheel-of-emotions/, accessed on 27.01.2017. |

264 Darcy Ann Umphred, Rolando Lazaro, Margaret Roller, Gordon Burton, *Neurological Rehabilitation*, Elsevier-Health Sciences Division, 2013, p. 44.

265 Kemper, Theodore, "How Many Emotions Are There? Wedding the Social and the Autonomic Components.", *American Journal of Sociology*, vol. 93, no. 2, 1987, pp. 263–289. *JSTOR*, www.jstor.org/stable/2779585, accessed on 02.07. 2021.

To understand what each emotion is concerned with, eight primary ones are characterized below. In the following examples of experiencing emotions by the medical staff and sometimes by patients, it will be seen that doctors and nurses often feel variations of primary emotions, for example relief, which comes from joy. It is no wonder then that these derivative variations of emotions can often be found in medical memoirs.

3.2. PRIMARY EMOTIONS

Joy is one of the eight primary emotions enumerated by Plutchnik. It can be manifested by delight, enjoyment, bliss, pride, relief, happiness, thrill and ecstasy. Joy can be felt as a result of various activities, such as singing, cooking, working or not working. It is related to fulfilment of one's deep yearnings or desires.[266] Chris Meadows underlines transcendental nature of joy, which can be regarded by some as luxury and does not serve any function. He also proposes a contrary idea, and stresses that emotions, such as joy lead to "positive moods", sociability, feeling energetic and motivated to constructive behavior.[267] Joy is a useful emotion because it enables a person to appreciate positive things around him/her, such as peace.

Another emotion is trust, which can be described as behaviour which stems from the belief that the truster's vulnerability will not be exploited. Trust plays a basic role in both social and economic life; in love, friendship, family and economic transactions. Trust saves trouble and time; when contractors trust each other, drawing up of additional securing documents and paying for this service is redundant.[268] Trust is an expression of a sense of safety and expectation that things will happen according to one's anticipation. Trust is connected with a sense of community, closer relations and finding one's place in a group.[269] It is a risky emotion, if the other party is dishonest. Uncovering it, an individual feels disappointment. The fear of possible, negative consequences of shown trust may appear. A positive emotion can easily turn into a negative one, although reversing this vector seems hardly possible; rebuilding trust on foundations based on fear due to damaged trust seems difficult. Fear seems the most widespread negative emotion, though it can also appear prior to events not necessarily associated with fear,

266 https://www.jmu.edu/counselingctr/files/About%20Emotions.pdf, accessed on 19.06.2021.

267Chris Meadows, *A Psychological Perspective on Joy and Emotional Fulfilment*, London: Routledge, 2013, p. XIII, XV (intro).

268 David Sander, Klaus Scherer, *Oxford Companion to Emotion and the Affective Sciences*, Oxford, 2009, p. 392.

269 https://sentimenti.pl/blog/dlaczego-mierzymy-az-8-emocji-podstawowych, accessed on 11.10.2021.

for instance success or becoming rich, if uncertainty about bearing their burden or their negative impact on one's current life arises. Fear, as a strictly negative emotion assumes numerous forms of expression.[270]

Fear can appear in more than one form and it can be: anxiety, apprehension, nervousness, dread, fright, and panic.[271] Not only does fear trigger, but it also intensifies a sense of threat and is associated with a lack of control over the situation around. Someone overwhelmed by fear may not be able to think reasonably, and be blocked in their actions and alternative options.[272] Rush Dozier perceives positive aspects of facing and finally overcoming fear, which include growing mature and achieving full human potential. Fear can also determine one's choice of good or evil.[273] Fear, as other negative emotions, serves survival, since it is the source of energy for action. This truth is expressed through the saying: "If it does not kill you, it just makes you stronger". For this to take place, fear cannot paralyze vital and volitional power. Then, it would become destructive and would not allow for overcoming difficulties. Marian Estape states that and claims fear is fundamental for human internal balance and survival. People need to be afraid of certain things, in order to avoid taking up all enterprises, without moderation[274],[275].

The next primary emotion distinguished by Plutchnik is surprise. It is conspicuous through shock, astonishment, amazement, astound and wonder.[276] and it is recognizable by open mouth, raised eyebrows and wide eyes.[277] Surprise arises on encountering unexpected signals from the environment; visual, audible and situational ones (for example, the appearance of somebody or something). Paul Ekman emphasizes limited and fixed duration of this emotion in comparison with other remaining ones because it lasts several seconds at the maximum. Once surprise is over, it can merge into other negative emotion, for example fear, anger or relief that bad things have passed. The function of surprise is to focus one's attention on signals coming from the environment in order to evaluate them: such signals either do or do not announce peril. If they do, surprise evolves towards fear and the whole range of reactions derived from it, if

270 Jun Zhan, Jun Ren, Jin Fan and Jing Luo, Distinctive effects of fear and sadness induction on anger and aggressive behaviour, Front. Psychol., 15 June 2015, https://doi.org/10.3389/fpsyg.2015.00725, accessed on 14.09.2019.

271 https://www.jmu.edu/counselingctr/files/About%20Emotions.pdf, accessed **on** 13.07.2020.

272 Theresa Kelly, *Empathy: A Quantum Approach – The Psychical Influence of Emotion*, A Textbook of the University of Alternative Studies, 2012, p. 131.

273 Ibid. p. 2
274 Michael Bassey Eneyo, *Philosophy of Fear: A Move to Overcoming Negative Fear* Xlibris Corporation, 2018, p. 76.

275 Marian Rojas Estape, *Jak przyciągać dobre rzeczy*, Warszawa: Muza, 2020, s. 126.
276 Ibid.
277 http://wiecjestem.us.edu.pl/category/tagi/emocje-podstawowe, accessed on.24.01.2020.

they do not, relief appears. At on operational level, one deals with mobilization for action and its omission, respectively. Ultimately, the nature of excitation in case of surprise depends on the factor (s) caused by surprise.[278]

Sadness may also be perceptible in many ways. It may appear as grief, sorrow, gloom, melancholy, despair, loneliness, and depression**.**[279] Sadness means a sense of loss and feeling lonely. While experiencing sadness, a person may expect help from other members of the environment**.**[280] Hill looks at sadness from two perspectives, viewing it as either constructive or destructive. Sadness is constructive when a sad person becomes introspective, which involves wondering and analyzing what has led to sadness, what the person can do to improve their life and set oneself free from sadness. Grief of this type provides energy for a change, which will help combat it. Destructive sadness brings the opposite outcome. It appears when it has self-aggressive blade, which signifies sad people blame themselves for things that went wrong. Then, a person is losing his/self-confidence and their self-image suffers, which can lead to depression**.**[281] This one is an unequivocally destructive force.

Disgust is also a two-vector basic emotion; it can be directed towards oneself or towards others. The forms of its manifestation are: contempt, disdain, scorn, aversion, distaste, and revulsion.[282] Disgust is visible by distancing from an object, person or idea because of feeling repulsion for them. It informs an individual or a group of a need to change one's behavior or attitude, otherwise they run a risk of rejection.[283] It informs an individual of rejecting action repulsive to one's goals, which is considered to give rise to physical or psychological contamination.[284] A similar situation occurs when an individual is disgusted by oneself. Like auto-aggressive sadness, disgust can be a destructive emotion.

278 https://www.paulekman.com/universal-emotions/what-is-surprise, accessed on 18.03.2020.
279 Ibid.

280 Michael. Power, Mick Power, Tim Dalgleish, *Cognition and Emotion: From Order to Disorder Consultant Clinical Psychologist*, New York: Psychology Press, 2008, p. 261.

281 Z. B. Hill, *Sadness (Causes & Effects of Emotions),* Mason Crest, 2014, p. 36.

282 Ibid.

283 Theresa. Kelly, *Empathy: A Quantum Approach - The Psychical Influence of Emotion*, 2012, p. 132.

284 Michael Power, Mick Power, Tim Dalgleish, *Cognition and Emotion: From Order to Disorder*, New York: Psychology Press, 2008, p. 417.

Anger, which is also one of the basic emotions, is definitely qualified as negative and may take violent forms. It may convert into fury, outrage, wrath, irritability and hostility. Anger may be a manifestation of trauma or readiness for violence, and even an excuse to openly strike at the source of anger. Leonard Berkowitz argues that anger can be caused by "aversive sensory stimulations", such as rejection, threat, loud noise or heat. The presence of anger is accompanied by high arousal and displeasure. Anger is manifested through disturbances of biological and psychological functions, such as increased blood pressure and heart rate, higher temperature and hormonal changes. Readiness for aggression in anger is manifested through facial expressions, adopting belligerent poses or selecting aggressively marked vocabulary.[285]. An uncontrolled outburst of anger is destructive not only for the mental structures of the person who experiences it, but also for real determinants of being, for example professional or social position and positive image in others. The mastery of containing anger in patients by the medical staff is a useful ability, especially in Accident and Emergency department where casualties or their close ones sometimes seethe with anger. Teenagers who have taken designer drugs may also present aggressive behavior, filled with anger. This is indicated in the report on qualitative analysis of the lifestyle of seventeen- and eighteen-year-old users of psychoactive substances. In this report, among some of behaviors triggered by taking designer drugs, enumerated by teenagers themselves are: beatings with threats, inability to control one's emotions and thefts.[286]

The last basic emotion included in Plutchik's Wheel of Emotion is anticipation, which means looking forward to a certain prospective event, with the expectation of its positive course. Consequently, this expectation stimulates a pleasant feeling of what a person is going to experience or find. Anticipation denotes presentiment and prediction of this future occurrence and is based on models of the social world gained from past experiences. In addition, anticipation can also entail influencing the awaited event by planning or taking control over its course.[287] Anticipation may not always come true or realization of expected results or events may come in a completely different form. The effect of anticipation may be disappointment, which appears when it is not fulfilled at all or is fulfilled in a different form to an expected one.

285 Warren. Ten Houten, *Emotion and Reason: Mind, Brain, and the Social Domains of Work and Love*, New York: Routledge, 2013, p. 139.
286 Krzysztof Ostaszewski, Katarzyna Dąbrowska Jakub Greń Łukasz Wieczorek, „Analiza jakościowa stylu życia 17-18-letnich. użytkowników substancji psychoaktywnych, wzorów i motywów używania substancji oraz innych zachowań problemowych, w *Serwis Informacyjny Uzależnienia,* Warszawa: Instytut Psychiatrii i Neurologii, Nr 4 (88), 2019. 31-36.

287 Ibid. Warren Ten Houten, *Emotion and Reason: Mind, Brain, and the Social Domains of Work and Love*, New York: Routledge, 2013, p. 178.

It is worth noting that among primary emotions, the predominant ones are those which according to the most frequently applied classification can be described as negative ones. Fear, sadness, disgust and anger can fall into this category, whereas unequivocally positive are only joy and trust. The other two: surprise and anticipation, are contextual. Surprise can be positive and is manifested by joy, or negative, which results in disillusionment. One can anticipate rewarding events, for example, success, or undesired, though inevitable ones, for instance, failure. In the first case, anticipation is accompanied by hope, in the second one – fear dominates, which is one of the main negative emotions. This observation can be recognized as another premise for the evolutionary provenance of negative emotions. Emotions classified as positive are an indicator of an individual's participation in social life, and his/her opening up to the positive aspects of social life. Those emotions do not serve survival, but they reinforce social structure, which is the source of positive experiences. They are of secondary importance for the survival strategy of an individual.

As indicated previously, on the basis of primary emotions outlined so far, secondary emotions take shape. Secondary emotions include guilt, enthusiasm, depression, pride, vulnerability, regret, anxiety, contentment, disappointment, happiness, hope, jealousy, frustration, shame, confusion, satisfaction, peace, resentment, confidence, optimism. Todd Harvey points out that each basic emotion, for example joy, can occur in other forms, such as enjoyment, happiness, relief, bliss, delight, pride, thrill, and ecstasy.[288] Primary emotions classified as definitely positive, for example, joy and trust, can be assigned to certain secondary emotions as resulting in the same type of arousal. Joy combines with certainty, enthusiasm, pride, contentment, happiness, satisfaction, peace, self-confidence and optimism.[289] All of them describe positive effects of taken actions and constitute a specific emotional praise. A similar catalogue of secondary emotions can be attributed to trust, however, the praise of action expressed by these emotions refers to a strictly defined strategy of action, basing it on trust. If this strategy fails, a sense of regret, disappointment, frustration, shame, loss and trauma appears.[290] The nature of those secondary emotions that can be assigned to the primary negative emotions is opposite to those attributed to the primary positive emotions. Fear as mentioned previously, is expressed through a sense of guilt. A form of expressing fear can also be anxiety, frustration or trauma. Secondary emotions take violent forms in case of anger. Depression, guilt

288 http://toddharveymft.com/feelings, accessed on 26.03.2020.

289 https://www.spiral2grow.com/anger-as-a-primary-and-a-secondary-emotion/Posted by Moshe Ratson, accessed on 07.05. 2019.

290 Sara Algoe, Jonathan Haidt, "Witnessing excellence in action: the 'other-praising' emotions of elevation, gratitude, and admiration", in The journal of positive psychology, vol. 4, 2, 2009, 105-127.

and disorders are formed on the basis of sadness. Secondary emotions of positive or negative nature can turn, depending on the context, into surprise and anticipation. Surprise can be positive or negative. A similar effect can occur in case of anticipation.

Division of emotion into positive and negative is a starting point for other types of classification, such as Theodore Kemper's division of emotions into primary and secondary. The easily grasped thesis in his position is that preference for negative emotions, resulting from evolutionary premises prevail in people. He claimed that primary emotions, which are biologically primitive, are the ones which serve "evolutionary survival value" (for example, anger or fear trigger some responses in an individual in case of danger). This type of emotion arises during the earliest stages of human development, and emerges in all social relations. Secondary emotions are more "socially constructed" as they develop as a result of experiencing one or more of the primary emotions. For example, a child learns guilt (which is a secondary emotion) from the primary emotion of fear. It happens after committing a forbidden deed and facing the fear of punishment. Kemper agrees that secondary emotions are the result of combining different primary emotions. In practice, a combination of surprise and sadness leads to the feeling of disappointment. Fear and sadness give rise to despair.[291]

Thus all emotions that a human being succumbs to are entangled in the evolutionary context. Primary emotions are characterized by negative arousal as survival depends on them. They are also the matrix of secondary emotions developing in the course of social practice, which limits the freedom of choice of human emotional expression. In order to survive as a social individual, a person must accept an action based in fact on primary emotions. As even a cursory observation of social life shows, too overt preferences for positive emotions can be read as violation of principles of social life. Kemper's concept seems to contain the premise that human emotionality is based on emotions which can be defined either as equivocally negative (for example, fear), or conditionally negative, despite being socially constructive (for example, a sense of guilt). The furthest-reaching conclusion that can be drawn from Kemper's theory for the purposes of this dissertation is putting in question the division of emotions into negative and positive. This, however, does not seem justified because it would mean questioning empirical validity of colloquial and scientifically confirmed observations that humans also experience positive emotions and derive from them energy to act. It does not change the fact that negative emotions indisputably prevail in this respect. What matters for the analysis of the

291 Jonathan Turner, Jan Stets, *The Sociology of Emotions*, The New York: CUP, 2005, p. 19.

raised issues is not so much their genesis, mechanism of their appearance, whether they are primary or secondary, but above all, whether emotions stem from negative or positive stimulation. Therefore, this division will be most often referred to in the following analysis. This classification will apply to both primary and secondary emotions.

The above-outlined range of primary and secondary emotions, defined as negative or positive due to the nature of arousal, may be experienced by people of all age groups, including children, without their even realizing it. In daily life, people may not even be aware of the emotions they experience. States resulting from experiencing emotions are more easily visible to the surrounding. It is people around who more often combine shouting with anger, fear or envy, than the shouting person does. Medical environment is especially prone to generating more frequently negative rather than positive emotions; in particular hospitals and other healthcare institutions, where innumerable interactions between medical staff and patients along with relationships streaked with strong emotion take place. It can be especially felt when GP surgeries are crowded and queues to specialists or registration desk are long and negligence or mistakes occur. However, positive emotions can also be felt by patients when patients or family members recover. Heterogeneous emotions are experienced by doctors and patients, consciously or unconsciously, and these emotions influence their subsequent behavior. Emotional swing that can be experienced in medical places may lead to untypical and unpredictable behavior patterns. This is reflected in the medical memoirs referred to in this study.

3.3. COPING WITH EMOTIONS

According to Edda Weigand, emotions cannot be completely controlled by means of reason. This is possible only to some extent.[292] Thus people happen to act uncontrollably in many situations, especially in the face of unexpected or difficult situations and do not think about emotions or how they affect them. Specialists know and recommend certain ways of coping with emotions, although having the knowledge of such means may not amount to applying them when necessary. Definitely, the ability to hold back one's emotions and think of a constructive solution instead saves people from troubles and allows them to achieve their aims.

292 Edda Weigand, *Emotion in Dialogic Interaction: Advances in the Complex*, Philadelphia: John Benjamins Publishing Company, 2004, p. 10.

One of the researchers who have outlined ways of coping with one's emotions is Beata Master. First of all, she proposes being conscious of what one feels, and in consequence being able to name one's emotion. Other ideas involve meditation, relaxation and concentration, which are connected with stopping and listening to oneself. Writing an event anew is another way of dealing with strong emotions. After an unfortunate event in life, for instance unsuccessful performance, which prevents a person from further acting, a person can think of an alternative ending. That opens up a new chance or possibility of success in the future and sets the person free from feeling blocked. Master suggests that one should stop comparing oneself with others and avoid judging them and oneself. A method which entails somebody else's interference relies on contacting a coach or a therapist.[293]

Numerous strategies of coping with difficult emotions and stress accompanying them are recommended by Agata Orzechowska, Marlena Zajączkowska, Monika Talarowska and Piotr Gałecki. These strategies form elements of four general styles: concentrating on the problem, avoidance behavior, seeking support, and focusing on emotions. The first one is called active coping, and means endeavoring to eliminate or minimize the "stressor" or its effects. The authors also outline planning, that is, considering ways to tackle the problem. This can be done by addressing somebody else either by asking for advice, information or help, or searching emotional support, understanding and sympathy, which is known as seeking social support. This strategy, which is also discussed by Matthew McKay and co-authors, is called interpersonal coping. This concept involves turning to family members and friends for support.[294] Emotional support is also supposed to be achieved by turning to religion. In this context, positive growth and reinterpretation are mentioned, which could lead to personal development due to a certain experience, for example, a spiritual breakthrough. Another strategy of dealing with emotions, discussed in literature is handling a problem by suppression of rival "activities", that is, putting aside for the time being activities not connected to a given problem with a view to coping with it more effectively in the future. This is called "restraint coping". A strategy, which does not require much action is regarding the state of affairs as irreversible and accepting it by getting used to it and learning to live with it. An efficient strategy of coping with emotions emphasized by the above mentioned researchers on this topic

293 https://be-master.pl/9-sposobow-na-radzenie-sobie-z-emocjami, accessed on 21.04.2020.
294 Agata Orzechowska, Marlena Zajączkowska, Monika Talarowska, Piotr Gałecki, Deppression and ways of coping with stress: a preliminary study. Med Sci Monit. 2013 Nov 25;19:1050-6.
292 Matthew McKay, Patrick Fanning, Patricia E. Zurita Ona, Mind and Emotions: A Universal Treatment for Emotional Disorders, New Harbinger Publications, Icn, 2011, p. 19.

can rely on venting of emotions also by expressing them. Other ways of dealing with emotions include withdrawal, which is visible by denial in a form of ignoring and not recognizing the problem. A typical withdrawal syndrome consists in getting involved in activities such as watching TV and sleep, which are classified as "mental disengagement" and are undertaken in order to avoid consequences of problems. Behavioral disengagement is characterized by minimizing activity, resignation from attempts to achieve goals and helplessness. Turning to alcohol or drugs in order not to feel or be aware of unpleasant emotions is called "alcohol-drug disengagement". One more way to relieve negative emotions is a sense of humor.[295]

Whenever people face hard times as a result of certain events, different emotions for example anger appear. However, some people do not try to take any means described above, but just withdraw or wait for troubles to pass. Each of the memoirists discussed in this dissertation encountered bad or good emotions at work and depicted them in their book. It was not always possible for memoirists to draw the line between professional and personal life. The situations discussed on the following pages present the emotions of the memoirists' but they also give an insight into the ways of dealing with emotions, consciously, subconsciously, or just viscerally.

3.4. EXAMPLES OF EMOTIONS EXPERIENCED BY THE MEDICAL STAFF AND PATIENTS IN MEDICAL MEMOIRS

In this part of the chapter, numerous examples of emotions of one type, for instance, fear or joy are traced, grouped together and presented as they occur in those memoirs. Some emotions are experienced sporadically, whereas others repeatedly. Memoirists chiefly focus on their own confrontations with emotions in professional life. Emphasis on emotions faced by patients is marginal in comparison with that of the medical staff, and does not appear in all four memoirs. This can be easily explained by the fact that in their memoirs, the authors depict the ambient reality from their own perspective, in particular they focus on how they felt or what they thought as a result of certain confrontations with their patients. The patients' perception of treatment and communication with medical specialists is portrayed in *Every Patient Tells a*

Story. In it, the author compiled patients' stories of diseases, medical conditions and her own reflections based on the stories she heard. Focusing more on the patient's side sets this book apart from the remaining medical memories. The patients' point of view is included in *Do No Harm* to a lesser extent than in *Every Patient Tells a Story*, but it is also present there. The initial analysis of medical memoirs leads to the following thesis: in the case of emotions experienced by the staff and patients, negative emotions dominate over positive ones. Along with descriptions of emotions that surface in the discussed memoirs, the research by means of sketch engine has been done, which helps trace the number of times a particular emotion, for example joy, occurs in a particular memoir. Only some emotions have been analyzed in this way, namely those that appear in all medical memoirs in abundance (especially fear and anger) and those whose occurrence in all memoirs is slight, such as joy, disgust and anticipation (see Table 1).

3.4.1. SATISFACTION AND JOY

The examples below serve to prove that experiencing emotions, such as joy and contentment enriches the life of medical staff and corroborates the claim that satisfaction helps enjoy life. These emotions allow doctors to see the fruit of their work. In *The Real Doctor Will See You Shortly*, a patient's recovery after his serious medical state becomes later a source of joy and satisfaction for doctors. Before that takes place, doctors experienced the states of tension and uncertainty, since they did not know if the patient's therapy was going to end in a success. In the work of the medical staff, the swing of moods is frequent, the doctor even compares his professional life to an emotional roller-coaster (p. 267). In this particular case, a positive feeling, that is Dr. McCarthy's joy and satisfaction with rescuing a ninety-five-year-old patient prevails. Together with his workmate Baio, the doctor, is doing compressions to a female patient's chest, whose heart is not beating. After a successful action, both doctors feel pleased. The surgeon expresses his joy and satisfaction in the following way:

> After years of preparation, I just helped bring someone back from the dead. My heart raced, and I could feel my own pulse pounding through my neck. This was the sensation I had been seeking, the one that was missing for me in surgery. (p. 35)

His colleague shares this joy and appreciates Matt's achievement by saying: "There is nothing more rewarding than bringing a ninety-five year old demented woman with widely metastatic lung cancer back to life. Well done" (p. 35). The source of the physician's joy is also the awareness that due to their effort, the rescued patient will be able to face another day with her

spouse, children and friends. The physician's joy is so great that his twenty-one-hour shift elapses in the twinkling of an eye. He feels he saw and did more during that night than he had over months spent in the medical school (p. 35). The way the doctor feels is in accord with what Chris Meadows says about joy; namely, it leads to positive moods and, for example, feeling energetic. The doctor feels lively despite the long shift.[296] This situation is a heart-warming experience for the intern Matt McCarthy, who does not feel very secure or self-confident at that stage of his professional life, when not all secrets of practical knowledge are known to him. Baio supervises interns and doctors and he is there to instruct McCarthy or just tell him which medical activity to take up, in this case breaking the patient's ribs to achieve the desired result. The young doctor is prompted what to do, but he manages to do something important at the outset of his career; he performs medical actions on his own, and what is more crucial, he has learned how to perform this action in practice, which brings him joy (p. 35). In the face of activating theories of emotions, the emotions marked with positive affect may also provide energy for further efforts in the field of professional development and improvement, and become a predictor of future professional achievements. It can be assumed that this mechanism could have triggered McCarthy's participation in the miraculous resuscitation of a very age-advanced patient.

An episodic mention of joy is made in *Do No Harm.* It is felt by the doctor on the way from the hospital, after an operation of an aneurysm, but his joy is muffled in comparison with the "intense exhilaration" felt in the past after successful operations of this type. The surgeon compares his state after those operations to feeling like the "conquering general after a great battle" (p. 33). In the light of mistakes committed by the surgeon in his job, the surgeon experiences joy as a result of a successful aneurysm operation: "I still felt pleased with the way operation had gone […]. It was a deep and profound feeling which I suspect few people other than surgeons ever get to experience" (p. 33). The surgeon feels satisfaction after an aneurysm operation, at which he manages to reposition the clip properly at his third attempt (p. 33). The joy of a novice doctor, McCarthy, who was mentioned earlier, resembles a breath of fresh air because he has a feeling of achieving his first professional success, performing a new activity in his career and learning new skills. The surgeon's joy in *Do No Harm* is moderate by comparison. The difference may result from the fact that he performs a successful aneurysm operation for the umpteenth time, in accordance with procedures familiar to him. He applies them in his job again, but he does not do anything new, nor does he learn new things during the

296 Chris Meadows, *A Psychological Perspective on Joy and Emotional Fulfilment*, New York: Routledge, 2014, p. 51.

surgery. Clearly, acquiring new skills can bring more joy to an inexperienced doctor than to an older colleague in a stable position. This is certainly the case of Matt McCarthy. The surgeon from *Do No Harm* looks at his success differently, with less enthusiasm, but can still enjoy his job. That is why his joy is different, too.

On the basis of the examples discussed above, it can be seen that physicians can derive pleasure from daily duties, such as life-saving operation. This joy motivates them to take further actions and fulfil their vocation. In their attitude to their professional duties, doctors go beyond thinking about patients through the prism of their biology and physiology. Physicians do not reduce performing their duties to earning salaries They perceive the patient holistically, as an individual, who ought to be supported in suffering and whose life ought to be saved even in hopeless situations. The source of joy in the situations outlined above amounts to satisfaction with well performed duties towards patients. This joy may be diversified in its intensity, which does not change the fact that it meets the criteria of emotions attributed to it by science. An emotion close to joy is contentment, and it occurs in *The Real Doctor Will See You Shortly*. In the doctor's case, contentment is an effect of going through both easier and less pleasant emotions such as sadness and fear. He describes his stance on duties in the following way:

> Medicine was a job and I was now comfortable doing it. I didn't need a script to follow […]. I was still trying to work out a reasonable work-life balance, and through that struggle I had come to view my job like a new family member, an unpredictable stepbrother whom I mostly adored but, on occasion couldn't stand. (p. 306-7)

The doctor finds the point and meaning in his job. He realizes that medicine has become his life, everything else that is not a matter of life and death, has become secondary. Ambivalence is clearly perceptible in quoted arguments. The doctor expresses his contentment (general satisfaction) with the fact that he has become a doctor, finds himself in this profession and is able to separate the professional side from the private one. Decidedly, it is satisfaction with his life status, achieved due to medical profession, on which with a flow of time, cracks frustrating him start appearing. He puts his job first, but treats it as "an unpredictable stepbrother whom he couldn't stand". The work itself is not the source of joy to the doctor, but the signs of material success achieved at work. They are chiefly the source of his contentment. The doctor recollects his work-mate's words that everyone breaks, and the doctor thinks to himself that although he had broken many times, he later feels reassembled, "patched back together" (p. 307). The doctor's malaise is visible in his doubts whether he would make a good doctor and if he would be able to treat patients because of sticking himself with a needle. The doctor also feels

incompetent when he is neglected by his ex-patient Dre, who had resigned from treatment by escaping from hospital and was not willing to talk to him. These are not the only unpleasant situations for the doctor. When his other patient dies directly after the operation, the doctor feels he disappointed that patient's wife and family. He feels "whole again" despite the cracks thanks to people around him – his colleagues, friends and family – who want him to succeed. The doctor is also relieved to observe that mental anguish and sleep curtailment have not caused a long-lasting damage to his health. He thinks that things that are taking place in the hospital where he is working are incredible (p. 307).

The emotion of joy is also described in *Critical Care* in reference to a patient. When the nurse passes the patient whom she knows in a hospital corridor and asks him how he is getting on, he radiates with joy: "He turned to me and smiled an amazing smile, a smile so full of light and happiness and even joy" (p. 164). Although the patient is hospitalized, he still finds the reason to feel joyful, and this emotion spreads to the nurse, which is seen through her response: "I'm so glad" (p. 164). In this case, contentment is triggered by the sight of a pleased patient, and not any particular achievement. In the above situation, the patient feels happy because he has been noticed by the nurse, which shows that she remembers him and takes interest in him. This circumstance makes him experience joy, and this joy is shared by the nurse. Karen Rodham describes this process, called a chain reaction, in which a particular attitude leads to a similar one in another person.[297]

A moment of happiness as a positive emotion secondary to contentment is captured in *Critical Care* when the nurse derives pleasure from working in a medical team. She refers to one of her working days, when the surgeon informs her on the phone that he is on his way to the hospital. The nurse with other medical specialists is supposed to open the wound and remove a patient's dressing just in time to operate on it. The nurse feels happy to be part of a team sharing the same goals. This in turn gives her hope that one day she will be able to do her work with more confidence than she had at the beginning of her employment (p.104). The nurse is aware of what she feels, and she formulates her thoughts as follows: "I felt really happy" (p. 103). She also recalls that the information on the doctor's imminent arrival at hospital fills her

297 Karen Rodham, *Health Psychology*, London: Palgrave Macmillan, 2010, p. 34.

and the team of medical staff with hope and relief (p. 104), the latter of which is a derivative of joy, included among secondary emotions. The nurse experiences time at work consciously. Her deductions indicate that happiness felt by her in connection with a situation described by her has the value of a predictor of her future involvement in work, and thus of professional development and success.

In both cases, belonging to a certain professional group is for representatives of the medical staff a source of agency and leads to the emergence of positive emotions. The surgeon and the scrub nurse from two different memoirs feel exceptional, indispensable and appreciated. They identify themselves with their professional group and it helps them gain confidence. Each of them is at a different stage of their career, each has a different social status and performs a distinct function, yet emotions felt by them at work are similar.

Relief, a secondary emotion to contentment, is felt by the surgeon in *Do No Harm.* He experiences it two days after the patient's death, when he realizes that if the patient had survived, he would have been left disabled with an extremely limited ability to maintain contact with the environment. The surgeon settles the matter of guilt in his own favor: the patient perished because of the operation, not as a consequence of any obvious mistake on the doctor's part: "I do not know why the stroke had happened or what I could have done to avoid it. So, just for once, I felt, or at least on theory, innocent" (p. 185). The doctor's considerations about his patient's predicament are indicative of his emotional and ethical involvement in the dilemmas of his profession. However, he does not see any other possible development of the situation in which the patient found himself. Nor does the surgeon see in any moment premises to change his way of acting in order to stop the development of his patient's illness. Hence, relief appears, which allows the doctor to keep his faith in himself, although it is also a difficult feeling because it makes him aware that dilemmas of the type he describes cannot always be solved in a way beneficial to the patient.

Gratitude is described in *Do no Harm*. After a vitreous hemorrhage and retinal tear in his eye, the surgeon returns to work within several days, which makes him grateful to his colleagues. He is thankful to his workmates, who have contributed to it. He realizes that this thankfulness is comparable to the one patients have for their doctors when things go well. The surgeon is thankful because his treatment has gone well and he feels gratitude when he thinks that not all his patients are lucky to undergo operations with success (p. 230). On that occasion the surgeon has a chance to feel a pleasant emotion, but from the patient's perspective. The

switching of roles, when he turns from a doctor into a patient becomes a source of his emotions, and this situation is new to him.

Henry Marsh touches on the matter of patients' gratitude from the patient's perspective. In *Do No Harm*, he notices that patients are highly thankful immediately after an efficient operation. Patients' gratitude, lined with self-interest, is instrumental, and demonstrated to earn surgeons' favor in case of possible future contact. The stoppage of gratitude may, they believe, be a lack of gratitude. Gratitude is therefore treated as kind of compulsion, lined with fear of consequences of stopping to show it. That is why, as Marsh puts it, patients are inclined to view surgeons as "angry gods", who have to be placated by presents or thank-you cards. Henry Marsh also expresses a viewpoint of surgeons who feel happy when patients put them behind and go home without the need to see the surgeons again (p. 34). It can be seen that patients' positive emotions such as gratitude happen to be lined with negative ones, for example with fear. The context of showing positive emotions is not always purely positive. In the background, emotions classified as negative ones occur, most commonly, fear. Therefore, some attention is going to be devoted to the reflections of the latter in the medical memoirs selected for analysis.

3.4.2. FEAR AND ANGER

A lot of attention in the memoirs discussed in this dissertation is paid to primary negative emotions, such as fear. It is one of the most often occurring emotions and frequently combined with other feelings, especially anxiety. Examples illustrating fear are selected to indicate the effect fear has on people who experience it. On the one hand, it blocks them, but, on the other, it can lead to an analysis of the situation and it can motivate people to make an attempt at a better performance in the future.

One of the memoirs in which fear figures prominently is *The Real Doctor Will See You Shortly*. The author who is an internist faces fear after sticking himself while drawing blood, which could lead to getting infected with HIV. Directly afterwards fear paralyzes him and is conspicuous through bodily reactions: feeling as if he was going to faint and vomit, a strange sense of time speeding up and slowing down in turns, the inability to move, and the feeling of being trapped as if in rolling dunes (p. 125): "My teeth felt heavy; my lips were numb. I felt

like a small child, wanting to run, to disappear, and unable to formulate words" (p. 126). His feeling reflects what Theresa Kelly notices about fear when she claims that it evokes a sense of threat and lack of control over the situation. His apprehension is visible in the questions which later bother him and concern his cooperation with the medical staff and looking after the patients. Fear merges with embarrassment at walking back into the hospital and facing his work mates: David, Ashley and a student doing an internship with him. This is because the doctor considers himself a burden and peril to himself and those surrounding him. He is afraid if his patients – Ariel, Lalithia and Megan – could trust him to perform his job right, and will not put them at risk of getting infected. He wonders how he is going to face all of those AIDS patients, and what are the prospects that they would trust a doctor who accidentally joined their fate by his own carelessness. His fear is connected with anxiety about having to wait for his test result (p. 139).

However, this is not the end of the story; his fear keeps escalating. Now the doctor's fear and worry are about the influence his possible infection might have on his reputation and career progress in the long run. In his intern group, everyone is under pressure to make progress every day: to be able to diagnose more quickly, to take notes in more competent way, and to have a more thorough knowledge about their patients and illnesses than other hospital staff. He cultivates anonymity among doctors since in his view, anonymity allows for better patient care because the staff can bend the rules by quietly violating strict work hour regulations. The physician is fearful that his anonymity will be shattered because of his needle stick; he will become "that guy", a doctor people know about and keep an eye on. He also faces the fear of gossip about him in the workplace:

> I considered how far word of my needle stick might have travelled in our insular hospital world. Although we didn't have much time to socialize, we had time to gossip. I knew who was screwing, who was pregnant, and who was trying to become pregnant […]. I could only imagine what would be said about me. (p. 140)

The internist is also apprehensive about the way other doctors, Ashley and Carleton and the medical student, intend to spread the news about his situation to others. This student is in the same medical team as the doctor because he undergoes practice, thanks to which he observes the medical staff at work. During their training, medical students are close to doctors for a while and they participate in hospital life to some extent. The internist is concerned about the lessons he will learn from his recklessness and how he will describe his case to others. The internist wonders: Did the student

describe the incident in detail to his classmates?, Did he state the doctor handled the situation properly or did he admit the truth – that the doctor was frightened and unable to function as the consequence of his mistake became visible? (p. 140). The intensifying fear described above is destructive, undermining not only his trust in his own competence, but also the security of continuing to stay in his profession. He finds himself in a situation of losing his credibility both as a doctor and a person on whom others could rely. The intern is troubled by uncertainty whether he will be able to feel safe and count on co-workers in his workplace.

In both memoirs *Do no Harm* and *The Real Doctor Will See You Shortly*, the doctors become patients and see the opposite perspective, however, in one case it is pleasant (gratitude), and in the other gloomy (fear). The intern faces dilemmas of common people; he is not sure of the reactions and behaviors of co-workers around him.

Even an experienced doctor feels fear in confrontation with his work and it is visible in *Do No Harm*. Fear is, however, manifested in him in a completely different way than it is in an intern, whose case was discussed above. The surgeon comes back in his thoughts to the operation on a young woman, which left her paralyzed down the right side of the body. Although the surgery was uneventful, the doctor thought he had been insufficiently cautious and must have had too much self-confidence. He thinks he probably endeavored to remove too much of the tumor. He longs for the next operation – on the pineal tumor in the future. The surgeon wishes it would go and end well, and then he would feel at peace with himself again. He knows that as time goes by, his grief about the damage done to the young woman will fade. The recollection of her lying in a hospital bed, with paralyzed leg and arm, will turn from a painful wound into a scar : "She would be added to the list of my disasters – another headstone in that cemetery which the French surgeon Leriche once said all surgeons carry with themselves as soon as an operation starts, the surgeon usually finds that his fears disappear" (p. 5). The mere presence of the surgeon's reflection may surprise the reader because the surgeon does not attribute an unfortunate effect of the operation to a chance or bad luck, but stops to think and draw conclusions. He wants to track down the reason of unsuccessful operation just for himself, not for others. He does not let fear paralyze him gradually, but inevitably, as it was in the case of the intern. He sees the cause of failure not in objects or external circumstances, but in his own attitude, which is an intangible thing. He suspects that his lack of humility and too much self-confidence was to blame for the damage. The doctor longs for a chance to correct or amend for this disaster in the future, although, if such an opportunity ever appears, it will not concern the same patient. In other words, the damage done is irreversible. Finally, significant

characteristics of any doctor's work emerges in this case, namely the consequences of doctors' mistakes, although sometimes unavoidable and not resulting from negligence, are graver than in other professions because those mistakes affect health and life. The surgeon's ability to accept this failure allows him to carry on with other duties and not break down. One way of coping with the emotion of fear and gloom described in this case consists in listening to oneself and analyzing what has happened.

Exaggeration with carefulness in two opposite directions leads both doctors to failure and becomes the reason for their deliberation. Excessive caution in the case of the surgeon from *Do No Harm* and the internist's nonchalance in the previous memoir *The Real Doctor Will See You Shortly* activate in both doctors the mechanism of self-analysis, which will enable them to get at the source of their failure. However, it works differently in both of them. In the surgeon, self-analysis leads to a conviction that his exaggerated caution becomes the source of the patient's tragic health situation. In the internist, fear triggers a deep crisis of faith in the sense of continuing to be a doctor, uncertainty about his own health state and personal life. In order to avoid failure in the future, he needs to be careful. Fear becomes for him an opportunity to avoid mistakes in the future. This is an illustration of the evolutionary role of negative emotions, which have the potential of protecting a person from dangers.

Fear, expressed through dread and anxiety caused by involuntary carelessness, will be discussed below. Such a case is presented in *The Real Doctor Will See You Shortly* and concerns McCarthy, who was still an intern at that time. He overlooks a patient's internal bleeding and does not report it in a medical note. Another doctor, his superior Scothscott, reproaches him for this in a phone conversation, and points out that on account of his oversight, McCarthy's note is misleading, which could have killed the patient. McCarthy feels truly awkward:

> I wanted to hide. I wanted to disappear. I wanted to run away, but there was nowhere to go. I was terrified to think of what I had done to Carl Gladstone […]. My knees buckled and I crouched toward the tiled floor, gasping for air as my eyes welled up. (p. 47)

His physical symptoms accompanying his emotions may or may not be exaggerated. It is hardly possible that overwhelmed by such strong emotions, he could register exactly how his body reacted. His description, including also biting his bottom lip, are stereotypical, but they are nevertheless meant to convey the strong emotions of fear mixed with shame. It is not only his fear concerning the patient's health, but also the awareness that his supervisor knows about his misstep that together lead to fear and anxiety. The next morning his anxiety comes flooding back. He does not know how to face the day. His conscience is bombarded with questions. The internist marvels what has happened to that patient, Carl Gladstone, after his leaving the unit.

The doctor wonders how he would report this sequence of events to his work mate Baio, and if he should not inform him of the phone call and act as if nothing had happened. His other concern is whether the team of doctors are at risk of being sued in case that matter comes out. He visualizes the necessity of telling people that he was a physician for several days but then he inadvertently killed someone. He is overwhelmed with guilt (p. 51). Instead of explaining, the doctor bottles up his feelings, which is tormenting to him. He wonders if there will be fears and repercussions, and what will happen to him and the patient. He feels he will not find many people he could talk to about it, and not many people who would understand this matter. Fortunately he could turn to his wife (p. 70).

The intern chooses to hide his feelings because he feels, until the conversation with his wife, that he cannot share his situation with anyone from work, which is sad, but true. He starts feeling more and more uncertain about his future and his environment, which he cannot influence. The doctor can only wait for the development of events. Paralyzed by fear, the doctor is not capable of adopting any strategy of dealing with it, besides waiting: he is thinking about his situation, but does not take any action. In the light of uncertainty and doubts about his future professional situation, he is waiting for the events to unfold. The support of his wife is a breakthrough, which makes him feel, he is not alone with his problem, and has someone to talk to.

In connection to anxiety and fear, powerlessness appears in the doctor. He needs help. He does not feel prepared for extreme emotions that medicine provides and wishes he would find some guidance to lead him through meanders of hospital life. By this guidance the doctor means a mood stabilizer or a moral compass. He wishes someone could offer some hints to him, which would show him which direction he should follow in his career (p. 52). Eventually, he finds balance. With the course of time, without having to account for his previous patient Gladstone, he finds it easier to get by. After analyzing his situation, he begins to feel numb about it. The doctor thinks he needs to stop worrying or else he will never come to terms with his work, and his stomach will suffer because of upset (p. 73). The doctor ostensibly overcame his negative emotions thanks to the support of his wife. As a result, he can look at his situation with a greater optimism and notice that not all is lost. This lets him eliminate his fears about his future in the medical profession to a great extent. He feels more comfortable in his job and becomes more favorably disposed to it. However, in the long run, this oversight still haunts him. Whenever he feels he was starting to be a real doctor, he remembers his oversight and that he needs supervision. He thinks what would happen if he were the supervisor (p. 123). His oversight

from his internship has left a lasting mark on his psyche and the state of his mind. It turns out to be instructive, and the fear it causes, after proper processing, strengthens him.

Fear is, however unavoidable in doctors' work and it may not result from their carelessness or oversight, but from a patient's unstable medical state. The memoirist Lisa Sanders in *Every Patient Tells a Story* recalls a young patient with a fever and yellow skin, whose pulse is rapid. Although doctors have done everything they thought reasonable, they fear that they may have missed some important clue that can make the difference between life and death of this patient (p. xii).

There is yet another situation when fear surfaces in *Do No Harm*, this time in the doctor's mind. It is an experienced surgeon's fear of the causative power of his opinions that in a given case the patient cannot be saved and must die, as a result of which he or any other doctor does not undertake operations that the patient believes will be successful. The doctor fears that maybe the patient is right in hoping against hope, hoping for a miracle, maybe the surgeon ought to operate just once more. The surgeon calls this situation "madness for two", in which both the patient and the doctor cannot stand reality (p. 151). Again, the surgeon is confronted with a hard dilemma, he is often considered an authority in medical matters, but he does not have the power to be infallible. This example shows how the doctor and the patient can share identical emotions, although their situation is different; one of them treats, the other is treated. Both sides do not know what the correct solution or action is in a common case, and this becomes the source of fear and uncertainty. The difference is that the surgeon puts at risk just his professional reputation, whereas patients – their lives. This illustrates the seriousness of dilemmas that must often be resolved in a doctor–patient relationship.

The following example from *Do No Harm* also illustrates the similarity of emotions felt by the doctor and the patient. In this case, anxiety and fear are subject under consideration. The doctor Henry Marsh reveals to his patient medical information concerning his prospective operation (the risk of death or a major stroke), which makes the patient anxious. The patient's anxiety and the physician's feeling of failure about previously performed operation join together and lead to the surgeon's further dread of operating (p. 3). This situation shows how doctor and patient can form a team, and emotions or feelings of one of them can influence the other side. Therefore, clarity of the doctor's explanation is important, together with his/her courage to admit to one's fallibility and to the fact that there is a limit marking the end of his competence.

In the same memoir, the surgeon stresses how anxiety is part of his work. This is because surgical operations carry certain unpredictability and each brain tumor is different. Doctors find out about the situation only after they cut the patient's brain. They never know for certain from a brain scan exactly how a tumor will behave until they begin to remove it. The doctor writes that when he approaches a tumor, he needs to know which blood vessel can be sacrificed and which cannot. However, it is complicated: "Every time I divided a blood vessel I shook a little with fright, but as a surgeon you know at an early stage of your career to accept intense anxiety as a normal part of the day's work and carry on despite it" (p. 8). Once he informed the patient's family of the impossibility to predict from the scan the risk scale of making her worse, since it depended on how much the tumor surface was stuck to the brain surface (p. 91). The situation is not clear at the moment: "Until you operate you cannot tell how easy or difficult it will be to separate the tumor away from the underlying brain. If it is stuck, the brain will be damaged and she could be left paralyzed down the right side of her body and unable to communicate" (p. 91). This risk results from the fact that language competence is controlled by the left side of the brain (p. 91). Unfortunately, some anxiety is inevitable in medical profession, which leads doctors to living under stress, if they worry about the patient.

Fear expressed by anxiety is also experienced by the author of the above memoir when he faces ophthalmic problems, and is reliant on medical help of his colleagues, when he becomes their patient. Initially, the surgeon feels fearful, when he thinks about the prospect of being a patient himself soon. He shares his reflections then, and talks about apprehension in a broader context. In the course of this analysis, he notices that anxiety was also felt by all surgeons when they treated their own colleagues. This anxiety stemmed from the fact that the common rules of detachment had stopped applying and the treating doctor felt painfully exposed because such a doctor was aware that his patient – also a physician – knew about his fallibility (p. 218). Anxiety caused by treating another doctor probably takes place occasionally, since physicians in the role of patients constitute only a fraction of all the patients. However, doctors who treat other ones may feel natural anxiety assuming that such patients are more demanding because their medical knowledge is wider than a usual patient's and may try to intervene in treatment or are more vigilant. Paradoxically, in the doctor-patient relationships such as the one quoted above, anxiety about the successful course of treatment appears instead of trust.

The memoirist in *Do No Harm* points out that anxiety is also felt when medical staff climb a career ladder and the responsibility increases, and so does anxiety about making a

mistake and causing the patient's suffering. Then, doctors feel both fear and sympathy as a result of confrontation with their patients. Doctors may feel sympathetic when their patients' condition requires undertaking unpleasant and frightening procedures, which include inserting drips and even cutting people's body. The doctors' fear can arise from uncertainty about the outcome of these interventions, and sympathy appears when the physician see suffering. Medical staff can also be afraid of patients and their families' negative reactions to the effect of treatment and being blamed for the treatment consequences. The memoirist suggests detachment from the patient, without which doing the job would be impossible. If doctors internalized the patients' fear and suffered themselves, they would be unable to help anyone (p. 215-16): "Most medical students go through a brief period when they develop all manner of imaginary illnesses – I myself had leukemia for at least four days – until they learn, as a matter of self-preservation, that illnesses happen to patients, not to doctors" (p. 215). Imaginary illnesses the doctor talks about derive from too much fear about the patient and this apprehension may be transferred onto the doctor himself. The need to get rid of fear and cope with stress is important.

The emotion of fear is also exposed in *Critical Care,* with the difference that all the examples refer to patients or their families, in whom certain situations evoke fear. In one situation while talking to the patient's children, the nurse observes the phenomenon she was taught during her medical studies. Sometimes patients' families may dread hearing a true answer from the medical staff about the patient's health to such an extent that they prefer not to ask precise questions, but general ones (p. 23). In another case, the nurse recalls a patient's fearful reaction to medical procedures. She thinks it is natural that patients experience fear in the face of all the activities performed on them such as having tubes stuck to "every possible" body orifices or having their bowel movement counted. Such situations are beyond the understanding of people living outside hospitals and leading normal lives (p. 127). The nurse thus comments on it: "The level of vulnerability, dependence, and fear experienced by patients in the hospital remains far outside the realm of normal, everyday life, and none of us want to imagine ourselves in that position" (p. 127). The nurse thinks of her role in confrontation with her patient's fear. Whereas the surgeon in *Do No Harm* advocates the doctor's detachment from his patient's problem, when the patient causes fear in a doctor, the nurse from *Critical Care* is convinced that a nurse's role is to get involved in the patient's matters: "Doctors are concerned with other things [...]. Probably they don't do Bibles, either. But nurses have to get to the heart

of the matter, whatever that may be" (p. 127). That is the difference she spots in the job of a nurse and that of a doctor, and in their respective reactions to fear.

Anger, the second next to fear primary negative emotion, can be considered the exact opposite of joy, which has already been mentioned above, due to its opposite affective signification. Anger, which also accompanies a doctor's work occurs together with an episode of surprise in *The Real Doctor Will See You Shortly* in the situation referred to beforehand – of the doctor sticking himself. The doctor is thinking about his new situation; how a moment of carelessness could have changed the trajectory of his life. This is where his angry reaction immediately after sticking himself occurs. The doctor describes his anger as follows: "Suddenly I was on fire. Rage rippled through my entire body like a shock wave. I looked into Dr Chanel's aqua eyes and screamed" (p. 130). He also faces surprise and says: "I can't fucking believe this" (p. 131). He wishes to overturn Chanel's desk and break a window and direct all his rage into some other object than himself. This conduct illustrates what Berkowitz argues about expressing anger through belligerent poses, in which readiness for aggression is visible. He feels as though he had just climbed up ten flights of stairs and been kicked in the face: "Eventually I paused to catch my breath, aware that I had rather successfully transitioned from the first stage of grief (denial) to the second (anger)" (p. 131). This example illustrates how fear or any other emotion can turn into anger, which may be perilous. In these circumstances, the ability to control one's emotions is indispensable. Taking out his anger brings a positive result of achieving balance. In this case, the method of handling negative emotions is to vent the emotions by screaming. However, he does not put his idea of destroying objects into practice.

Uncertainty is another emotion felt by the doctor in connection with the above situation. He thinks that in retrospect he will not able to recall the state his body is in at the moment. His colleague said the matter was not clear; the doctor just has to swallow the tablets and wait. Blood tests results will not be known for long time. He endeavors to distract his attention from the situation he is in, but he does not manage to do that. The image of a priest reading his last passages to him as he lay in bed comes to his head, followed by pills and syringes. What he lacks is scientific reality of viral transmission, which remains elusive. All of a sudden blood cells, enzymes and biochemical reactions become vague to the doctor. He misses clarity, but instead he can only imagine a huge question mark blinking at the top of his head (p. 129). "If the virus didn't destroy me, the uncertainty might" (p. 135). As for coping with uncertainty, this example reveals that the doctor takes an unsuccessful attempt at withdrawal syndrome when he wishes to occupy his mind with anything that will take his mind off his state. He may

lack ideas what he could turn to. The temptation to escapism appears. The doctor does not want to see or touch anyone. He does not wish to tell anyone, but prefers to be completely alone and wants an answer as to whether he is infected with HIV or not. His work mate and his attending doctor Banderas make him realize he will not find it out for weeks. Other questions bother him, too, for example, if he can have kids with HIV. He is not sure what his wife Heather's reaction is going to be and what she is going to say. Intuition tells him she will be supportive, but he cannot be sure (p. 135).

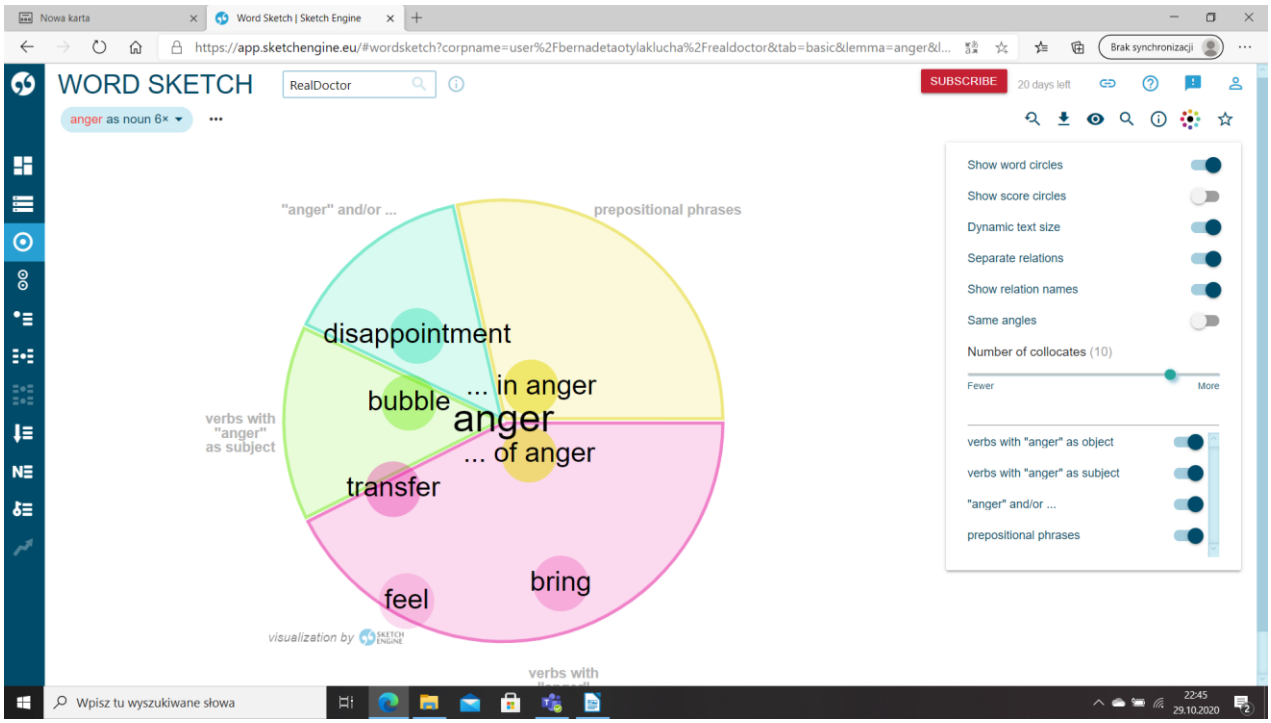
At that stage, the doctor is secretly expecting emotional support from his wife, which is his form of tackling his uncertainty. His intuition appears to be accurate. When he discloses what has happened to him, the wife answers: "Whatever happens, I want you to know that I'm here" (p. 137). She adds she loves him and the doctor feels dumbfounded because it is the most wonderful thing he has ever heard (p. 137). When the doctor is waiting for his test result, he thinks he has never felt worse. Even his colleagues' concern does not raise his spirits. His life is filled with pain, he is approaching a sentence on his future health (p. 203). As a means of acting, he takes up reflection in order to look for ways out of the situation. Whenever he looks back on what has happened, he thinks about a terrible mistake that has led him to the position he is in. He has improved at many aspects of being a doctor, but it is not sufficient, neither for him, nor for his patients, and people around him (p. 203). After his blood samples have been taken for tests, he cannot sleep or concentrate on rounds. The doctor dry-heaves when he thinks about the likelihood of living with HIV. He considers this time the most frustrating in his life (p. 219). The vision of himself on a waiting list for a new organ, after his own one stopped functioning as a result of HIV, appears in his head (p. 142). He aims at accepting his situation and living with it, but in his case it is not reasonable because at that point, he cannot do much more. He switches from one type of emotion to another. Finally, the doctor finds out that he is not infected with HIV. When he stopped taking HIV medicines, the feeling of normalcy recurs, which helps him tackle "the emotional roller coaster" of being a doctor. Home is the place he can relax, where his wife is happy to see him calm again, and the doctor feels the same, too. Now that the episode with a needle stick is over, they are beginning to talk more explicitly about that period (p. 267). The doctor's situation is another example of experiencing patients' emotions, this time – uncertainty. This emotion paralyzes the doctor, but eventually – thanks to the support of others – he overcomes its destructive effects and regains his previous mental and professional balance.

In *The Real Doctor Will See You Shortly*, anger is also present in the doctor in connection with his patient's medical situation, which renders the doctor powerless. When the patient Benny needs heart transplantation, and there is no heart for him, the doctor experiences both anger and sadness. The doctor feels terrible about the patient's situation: "When a patient yelled at me, or some error was made, it was easier to think of something else – to think of Benny and transfer the anger or disappointment in my own moment to the faceless system that had wronged him" (p. 263). In difficult moments like these, the doctor prefers to take his anger away from himself. He does it by turning his thoughts from such situations and focusing on the patient, instead: "No one could be blamed for the lack of a transplant organ, not doctors, nurses or organ donors" (p. 263). This time the doctor consciously avoids venting his anger in an aggressive way, but stays calm.

Sketch engine has been used in this dissertation as assistance in determining the appearance of emotions in the selected medical memoirs. Sketch engine serves as a tool for exploring how language works in a given text or texts. It does that through processing texts of billions of words and finding examples of the word, phrase or phenomenon. It presents the results as word sketches, concordances and word lists. Its algorithms make it possible to analyze authentic texts (text corpora) in order to identify typical, rare, unusual or emerging characteristics in the language. Sketch engine is designed to analyze the text and text mining applications. That is why it is used by linguists, lexicographers, translators, students and teachers, but also publishers and national language institutes[298]. It can show how a particular word is distributed throughout a book (evenly or sporadically) and how frequently it occurs in it. Presentations occur in the form of circles or bar charts. In the same way, sketch engine detects instances of emotions, for example, anger, when they have been overlooked by the researcher in his/her own study. The circles from sketch engine below present the emotion of anger in particular memoirs. The circles also visualize other words or prepositions accompanying the emotion of anger. Looking at visualization from *The Real Doctor Will See You Shortly*, it can be seen that anger binds with, for instance, disappointment. Prepositions collocating with anger are: in anger, of anger, which indicate that the source of anger is a person who does it, in this case the doctor, who is governed by anger. It is shown by concordances: "I'd hit anything in anger, I felt a swirl of anger when his eyes met mine, I felt an anger bubbling up inside of me".

298 Create and search a text corpus | Sketch Engine, http://www.sketchengine.eu, accessed on 13.01.2020.

Fig. 1. Anger in *The Real Doctor Will See You Shortly*



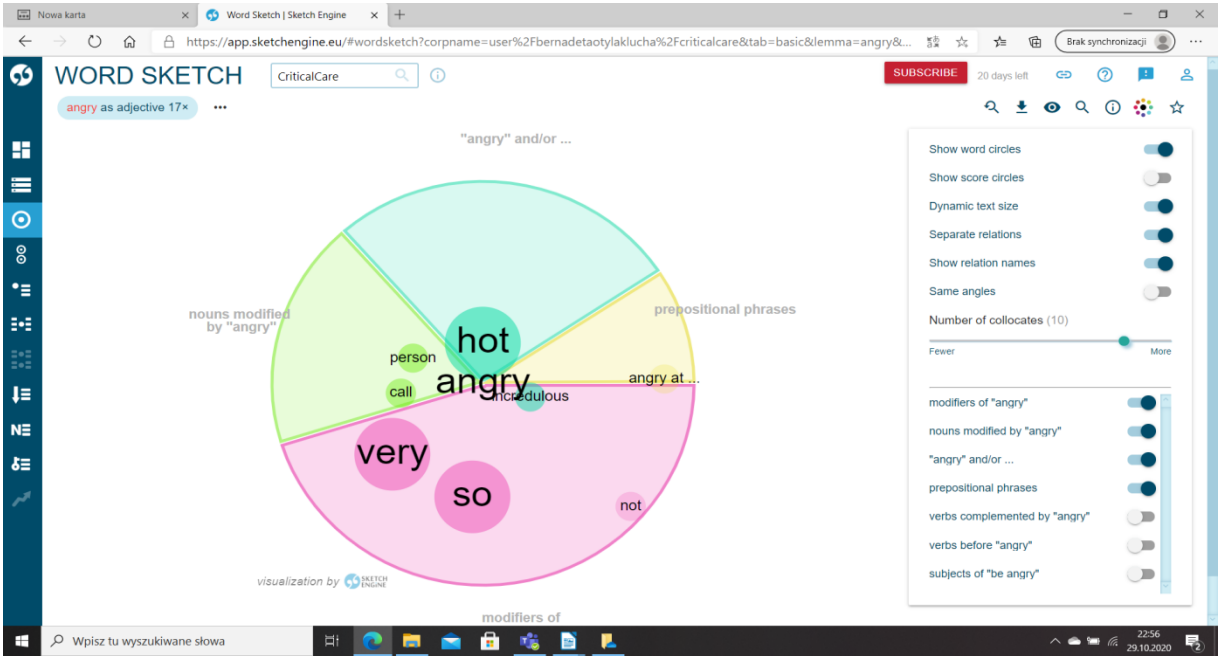
Similar situation to the one in *The Real Doctor Will See You Shortly*, where the patient requires immediate medical help, and its lack makes the nurse angry is described in *Critical Care*. Nevertheless, the nurse is not overwhelmed by anger, but acts quickly to counteract the misfortune and anger. When the nurse wants the patient to be given FFP (Fresh Frozen Plasma), another nurse is unwilling to do that and says that they do not have the staff, which in practice, means the patient cannot be treated. The nurse thinks this state of affairs is not right, and on the spur of the moment puts her colleague, another nurse through to M. D., a superior worker, to confront her refusal to treat the patient. The nurse realizes she can make her co-worker angry by this (p. 157). She expresses her attitude towards treatment in reference to this and other patients: "I keep my feet pointed toward the greatest need. I do not have time to chatter with rage, and no one else would have time to listen, but I have felt my eyes get hot and angry when my patients are not treated as I would like, and I will fight to make things better" (p. 163).

The following visualization of a nurse's anger in *Critical Care* (Fig. 2) illustrates how various reasons for this emotion can be and that anger in the medical environment is not only directly caused by a patient's unstable health state. The nurse is angry when she and her co-workers face an unpleasant atmosphere at work caused by bullying. She dreads coming to work because two clinicians shout at the staff. One night followed by another terrible ending of her

working day, the nurse runs out of patience and decides to make an online application for another job within her hospital (p. 140): “I returned to my computer flushed and angry” (p. 140). The nurse confronts her anger by taking an action. To put a stop to her anger and prevent herself from facing stress in the future, she hopes to change her workplace. This situation with shouting does not happen only once, the nurse consciously opts to avoid anger, although she could have the reason for it. Her patient needs more blood platelets for the surgery. It turns out that a bag of platelets ordered by her for the patient does not contain sufficient amount of the product. The number of blood platelets provided by blood bank is not in accord with what the nurse imagined it to be, which means the patient is left without supply. The nurse chooses not to get angry but act instead: “I could waste time being angry and incredulous, or I can roll up my sleeves and get down to work” (p. 152). She calls the blood bank and clears the situation. Another instance of anger in *Critical Care* concerns the patient who does not show his anger. The nurse gives the example of her patient with incontinence, which is the cause of his anger: ‘’It made him angry that he shitted all over himself, he did not take it out on me” (p. 115).

As for analysis of circles with emotion of anger in *Critical Care*, they reveal that anger often occurs on its own, with fewer intensifying or accompanying emotions, but with words: “so” or “very”. Although in *Critical Care*, the emotion of anger is omnipresent, it is frequently mentioned in the context of resigning from feeling it. Anger or the absence of it refers to both the patient and the nurse herself: for example, “And then in a rush of anger I blurted out” (p. 141) or “His anger was deep and real. We talked about his anger that he had been a responsible home buyer” (p. 135).

Fig. 2. Anger in *Critical Care*



The situation of resigning from anger looks different in *Do No Harm*, in which the surgeon cannot always suppress his anger, which is visible in the form of nervousness caused by the process of operating. The surgeon has the possibility of entering the situation of the patient's family, which frequently emotionally and thus far from just assessment, demonstrates its dissatisfaction with the care taken of this patient. When the surgeon's three-month-old son is diagnosed with a brain tumor, the surgeon leaves his wife as he is unable to stand the situation in which he cannot find the consultant in a hospital corridor. The surgeon goes home and because of anger smashes a kitchen chair and swears to sue the hospital if any harm is done to his son (p. 109). Thanks to this personal experience, the surgeon comes to understand that relatives seething with anger and anxiety are a burden to the medical staff, which they must endure (p. 110). In other words, he has a chance to see desperation of his own patients, visible in extreme emotions, through the eyes of his patients' relatives who may have blamed him for negligence. When he finds himself in the position of a parent stricken with overwhelming fright for his child's life, the fact that he is a doctor who should try to understand the limits of treatment processes stops counting. However, fright dominates over reason. The surgeon smashes the chair at home because of helpless anger induced by fright, instead of searching a rational explanation why a consultant could not be found. As a doctor, he is a part of the system. He is far better acquainted with the functioning of the system than a common patient's family. The surgeon, after all, positively works through his outburst of helplessness. The same surgeon recalls the situation when after the operation a patient's daughter apologizes to him for losing

her temper with the registrar when delays in performing the operation appear. The surgeon understands her then, since he remembers feeling anger himself when he was in a relative's position (p. 106). The effect of entering the patient's position by the doctor and working through this experience may also be an understanding of a moderative role of the doctor in the therapy process. The doctor does not underestimate, or skip as unessential, the circumstance that patients feel fright in the face of recognition of a serious illness and pain, suffering and death. Influenced by his own experiences, mediated by life confrontation with emotions of patients and their relatives, he starts taking the patient's side in his struggle with the heartlessness of the system. The doctor feels anger when the manager is angry because the surgeon should not have admitted patients or operated on them in the absence of beds. The surgeon answers that he makes decisions and it is not the manager's business. He emphasizes the physiological signals of his strong emotion: "My hands were starting to shake with anger and I had to make a conscious effort to calm down and get on with the operation" (p. 138).

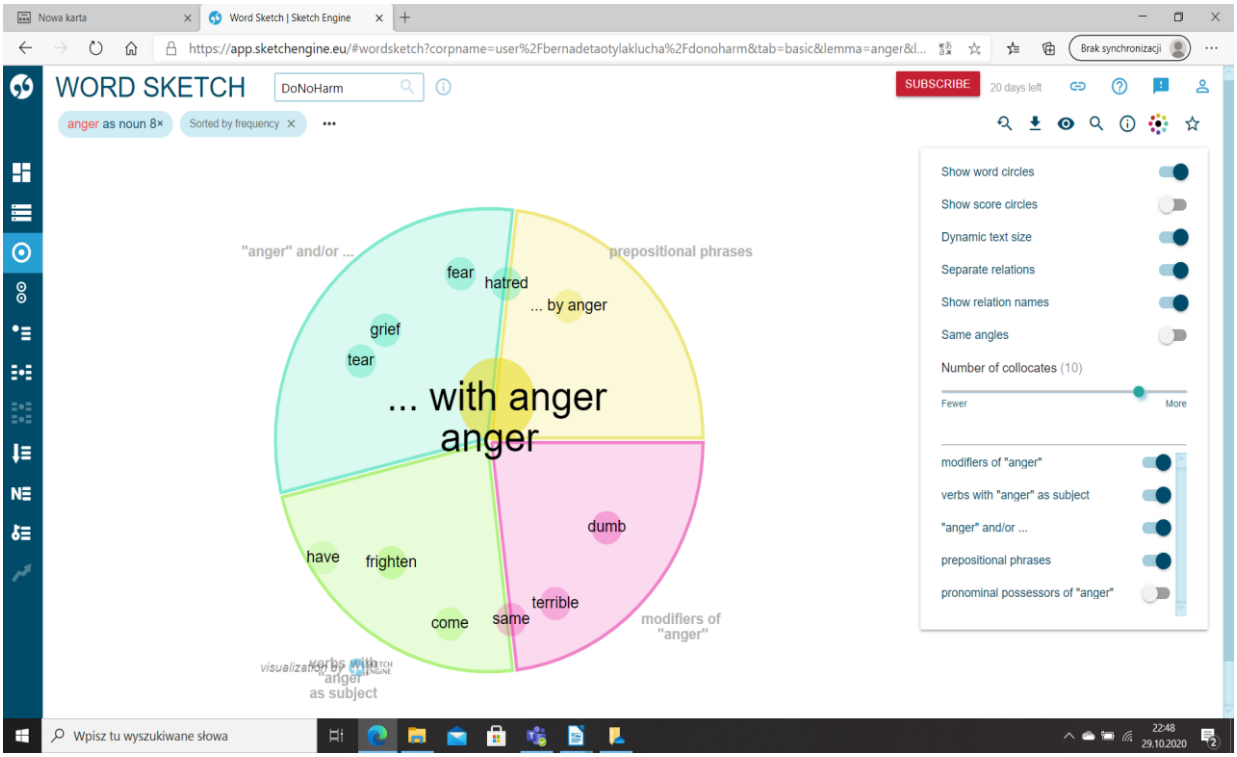
Being in an emotional situation similar or identical to his patient or/and his relatives, the doctor gains the unique possibility of looking at emotions of the latter from their perspective, entering their mental state, conditioned by existential circumstances in which they found themselves as a result of illness. The experience, which ought to help him build his own strategy of coping with his and his patients' emotions, becomes available to him. The surgeon can look at patients and their relatives from more empathetic perspective, but without crossing the border, which separates understanding the feelings of patients and their relatives from identifying with them. Crossing this border can even put the capacity to practice a medical profession at risk. In a therapeutic process, the doctor is first of all supposed to provide professional help in accordance with medical knowledge, which in numerous cases excludes looking at this process from the patient's perspective. Sanchez-Reilly stresses the role of emotional detachment by saying it allows a physician to remain composed in the face of emotionally difficult situations. Furthermore, it guides and supports the patient through this situation. A physician who "crumbles and cries in front of a patient cannot fulfil this role". This in turn puts the patient in the clumsy position, in which they may feel obliged to support and comfort the physician, rather than vice versa. Doctors also need to maintain an emotional detachment to protect themselves from stressful situations faced by them at work. Lack of ability to manage emotions in medical practice is frequently perceived as lack of

professionalism.[299] The doctor cannot share the patients' anxiety about, for example, too slow progress in treatment because it would amount to doubting not only about his own competence, but also about medical knowledge and experience. At the same time, s/he must not reject humanistic perspective, since the alternative is the attitude of a technocrat, for whom a patient is a mere recipient of treatment. Then, emotions in the doctor's relations with patients and their relatives would stop having any meaning.

Henry Marsh makes a brief reference to anger felt by patients who additionally become disappointed when he cancels visits in an out-patient clinic because he is offered to go to Kiev to deliver lectures on brain surgery. In cases like these, his secretary answers phone calls from angry patients, who rearrange their appointments (p. 64). The patients' anger is limited to verbal reactions, and no details of what they think or feel are provided. Visualization of a patient's anger occurs in *Do No Harm,* but it is marginal. This happens when the surgeon tells the patient that he cannot bend his left leg because the foot nerve has been damaged during an operation. The doctor expects this news is likely to cause anger in this patient later: "The anger and tears, I thought as I went away, and dutifully squirted alcohol gel on my hands from a bottle on the wall, will come later" (p. 25). In fact, the patient's angry reaction is only the surgeon's anticipation, the doctor expects this type of emotion from the patient, it may be the surgeon's experience with patients, which tells him to expect anger. In the circle below (Fig.3) presenting visually references to anger in *Do No Harm,* words: hatred and disappointment are among the ones, which accompany anger. These words constitute enlargement of the emotion of anger. In *Do No Harm,* anger refers to the description of particular cases, not the permanent existence of anger in a doctor's work in general. The circle indicates that anger is accompanied by other emotions, associated with anger, such as hatred, fear, greed and also the noun "tear", and modifying adjectives, such as terrible. Anger is expressed through the prism of other emotions, which are intensive. The examples of those accompanying words are illustrated in the phrases from this memoir: "the same terrible dumb anger and fear, glaring with hatred and anger". The words: "dumb" and "glaring" show that anger is temporary, but intensive and visible, it appears on the spur of the moment and does not stay for long, but passes after a while (dumb as opposed to serious, for example).

299 Sanchez-Reilly S, Morrison LJ, Carey E, Bernacki R, O'Neill L, Kapo J, et al. Caring for oneself to care for others: physicians and their self-care. *The journal of supportive oncology.* 2013;11(2):75.

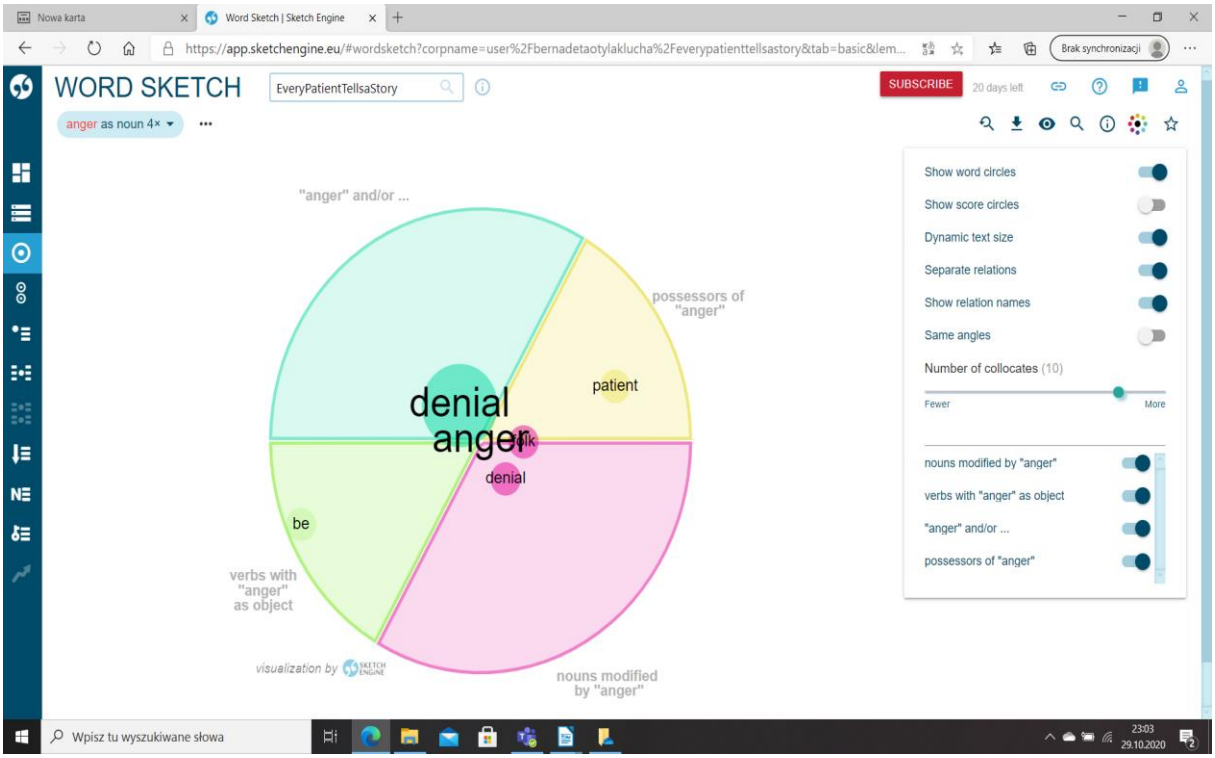
Fig. 3. Anger in *Do No Harm*



In *Every Patient Tells a Story* circles from the sketch engine (Fig. 4) present a small number of words accompanying the emotion of anger (the words are: denial, verb – be and patient), which is narrowed to the patient and once refers to fourth-year medical students, in connection with their attitude towards their poor performance in a practical test results at university: "The anger and denial had evolved into deep, deep depression" (p. 153). "It was anger, denial and bargaining rolled up in one" (p. 152). Another episode of anger occurs when a female patient, who suffers from nausea, is given an explanation by her doctor that she ought to stop smoking marijuana, which causes her problem and the fact that her condition has improved in hospital without smoking it, corroborates this claim. The patient is not convinced by this idea and answers angrily: "That's a total bullshit. I don't buy it" (p. 13). That anger surprises the doctor, who wonders why the patient is so angry. The reason for the patient's anger in this case seems trivial in comparison with the anger of doctors from previously discussed memoirs, whose emotion of anger is triggered by the threat hanging above them; either to personal health and future career or to a patient's life, when the surgeon knows that one wrong action during an aneurysm operation may lead to the patient's death. The book *Every Patient Tells a Story* contains the fewest examples of anger of all four memoirs; its author focuses more

on solutions how to improve erroneous attitudes to treatment, rather than on the emotion of anger.

Fig. 4. Anger in *Every Patient Tells a Story*



3.4.3. SADNESS

In *The Real Doctor Will See You Shortly*, negative emotions of sadness and helplessness are highlighted, too. McCarthy's patient Dan Masterton has flat-lined en route to the ICU. CPR is performed for twenty-two minutes, but to no avail. A team of doctors decide to stop doing chest compressions. McCarthy is not willing to stop the action, although they have done CPR for almost twice as long as it is usually performed (p. 291). It was probably because fear governs the doctor. On the following morning's round, he will be accountable for describing the state of every patient wheeled into the ICU on his shift, and in that case he will have to report that the medical team could not rescue the patient. The doctor pictures the physicians, who attend ICU exchange condescending glances while he is formulating an explanation of the reason for unsuccessful resuscitation. The doctor imagines the whispers: "Does McCarthy know what he's doing?" (p. 291). The doctor drops his head. His first patient died several minutes after the doctor had met him. He did not manage to help him. He wonders what it says about him as a doctor. Detecting his nervousness, Dr. Jang assures they did everything they could. Tears welled up the doctor's eyes: "I couldn't quite explain why I was so emotional" (p. 293). In fact

the doctor has been witness to the death of many patients – at times it can occur daily and he seldom "got choked up" (p. 293). The doctor has not reacted in this way so far. Why does he react in such a way this time? The reason is that this patient was introduced to the doctor at the beginning of his shift and it was the first patient he cared about alone. His death moves the doctor. Reacting in this way, the doctor expresses his sadness after the death of a person he was related to in some way. This situation seems more dramatic to the doctor, since he only knew this patient for about half an hour. However, behind this sadness, there is also fear of losing reputation. He cannot do anything about the patient's death, but fears someone might judge it badly. The medical environment and patients who meet him are probably unaware of his emotions, which however overwhelm the doctor. The question is whether the doctor will ever be able to free himself from those emotions. It takes time until McCarthy sees that the year of internship has fundamentally altered him, bringing changes to the way he perceives himself and the world. Prepared for making decisions faster, he finds more time for empathizing with his patients and looking at different matters from their perspective. Now the doctor can also explore things that usually remained unsaid because of short visits in his clinic or in the hospital. This deeper exposure and dedication to medicine allows him respond to Diego's question: "Who are you looking out for? Yourself? Your reputation? Or the patient?" (p. 186). "I was looking out for my patients, not myself" (p. 307).

Sadness and fear experienced in connection with ineffective resuscitation of the patient increase McCarthy's self-awareness and accelerate his professional maturity. The feeling of sadness makes the intern think about himself and his professional environment. It corresponds with Hill's view of constructive sadness, which can result in self-reflection and changing one's attitudes (p. 4).[300]

3.4.4. SHAME AND EMBARRASSMENT

Shame is exposed in several memoirs, one of which is *The Real Doctor Will See You Shortly*. The doctor is capable of bearing recurrent thoughts of Gladstone and embarrassing remarks from his supervisor Scothscott's phone call in a busy Critical Care Unit (CCU), but he finds it more difficult to cope with those remarks, when they are made in the presence of all

[300] Zeta Hill, *Sadness (Causes & Effects of Emotions),* Mason Crest Publishers, 2014, p. 4.

ward colleagues. The doctor treats this state of affairs as a kind of punishment, which in general is severe to him (p. 78). Whenever he thinks about the ambient environment, he feels bad and awkward about it. Shame makes him feel stigmatized, the end of which is impossible to predict. For shame is not a formal but a moral punishment. There is no procedure to cancel it. The doctor's shame is related to workplace bullying and this problem is also tackled by the nurse from *Critical Care,* who writes a lot about it. She actually uses the term ''bullying" in her memoir. To illustrate this matter, the nurse talks about floor nurses, who have the role of clinicians and regard themselves as disciplinarians; those who know the principles and ascertain that they are obeyed. The nurse refers to them as bullies: "Both of them seemed to enjoy telling people off, and they rarely offered help when it was needed. Their criticism and rebukes most often fell on the newest and most inexperienced nurses" (p. 137). The nurse herself feels touched by bullying, visible in a form of reproaching, which she finds demeaning and infuriating. The nurse considers certain policies and procedures enforced by those floor nurses irrelevant in specific situations. She adds that bullying takes place because other workers are silent about it, although they witness it. "Public humiliation by senior staff, and especially the two clinicians, was so common it was considered normal" (p. 138). In the light of this state of affairs, the only solution the nurse sees is for her to leave, which she finally does and is satisfied afterwards in a new workplace. It could be concluded the problem of lack of proper communication underlies bullying.

Shame is a broad theme. On the one hand, there is a matter of public shaming and, on the other, feeling shame in private, when the environment may not be aware or may only suspect that a person feels shame. The case of private shame triggered by professional activities included in the medical profession is presented in the book *Every Patient Tells a Story.* It concerns shame about touching a patient. The doctor refers to the point of her training, when she has not had a chance to examine any patient yet: "Until that moment I hadn't really envisaged how strange and unnatural it would be to violate the zone of privacy each of us occupies. I couldn't touch sister-in-law. In fact, I wasn't sure I could touch anyone" (p. 47). She goes on that although touching the patient lies within the competence of some medical specialists, it is filled with intricacies. Normally when people touch the loved ones, they let them enter an intimate space in physical and emotional terms, because they are aware that they are seen by each other through a filter of love, which is absent in the medical context. This intimacy of physical exam does not resemble the one that occurs between family and friends. Physicians and patients are frequently strangers to each other, which may make touch

inconvenient for both sides (p. 48). Nancy Ainsworth-Vaughn argues that "The physician and patient usually do not know one another and do not expect to have a continuing relationship".[301] Thomasine Kusher and David Thomasma include their observations about patients who are new to doctors. They say that when patients visit the doctor in order to obtain help with their problem, they need to reveal details from their personal life, which are not shared with many or any other people. Patients also talk about their living habits for example related to taking medicines. Despite the feeling of strangeness, as trust develops, patients agree on palpation, which may sometimes trigger pain. Trust may also make patients follow the doctor's recommendations regarding a change in a lifestyle or consent to diagnostic tests or medical procedures, which entail being unconscious or having some vital organ removed.[302] It may be natural that the patient is afraid and ashamed of a visit or being touched, especially while coming to a consultant such as ENT specialist or neurologist for the first time, and it is the doctor's role to explain the procedure in order to prevent shock or reduce shame or fear. It can be done by announcing the intention of using a probe or pressing some organ for a while or even hitting a part of an arm with a neurological hammer. However, doctors happen to feel shame, too.

Sandy Miles argues that medical training fails to provide physicians with sufficient guidance on how to deal emotionally with the unavoidable crises they are exposed to at work. It is related to shame, which is the emotion that is least discussed, and most feared. The author encourages teachers to share difficulties encountered by them in their practice with learners. This allows discussing challenges and fears[303]. Overcoming shame by some doctors would be of benefit to patients, since shame in confrontation with the patient limits both professional development, and providing patients with help in accordance with the doctor's competence. Touching the patient, breaching not only his/her privacy, but also intimacy is part of the medical profession. What is more, a lack of examining by touch can be interpreted as either negligence or lack of competence, since some important signals or symptoms may go unnoticed by an attitude of shame and not touching. Experiencing a feeling of shame can also be motivating. Its variety – embarrassment is also tackled in *Every Patient Tells a Story*. The author is of the opinion that during examination with the inclusion of touch, the doctor needs to deal with

301 Nancy Ainsworth-Vaughn, *Claiming Power in Doctor-Patient Talk*, Oxford University Press, 1998, p. 7.

302 Thomasine Kimbrough Kushner, David Thomasma, *Ward Ethics: Dilemmas for Medical Students and Doctors in Training*, Cambridge University Press, 2001, p. 101.

303 Sandy Miles, "Addressing shame: what role does shame play in the formation of a modern medical professional identity", In: BJ Psych Bulletin, Volume 44, Issue 1, February 2020, p. 1 – 5.

his/her own embarrassment a possible emotion of this kind from the patient (p. 52). Without it, full therapeutic contact between the doctor and the patient is impossible.

One can read about a doctor's embarrassment in a different context in *Do No Harm*. Although the surgeon in *Do No Harm* performs his work right, he happens to feel embarrassment evoked by other factors. After an eye operation, his left eye is blind and covered with a black patch, and therefore his glimpse of the world is narrowed. For the time being, he is incapable of operating, but performs medical services in an outpatient clinic and feels embarrassment because of the fact that his patients see his health is not ideal (p. 221). The doctor talks to an epileptic patient, whose business went bankrupt after losing his driving license. He lost weight due to treatment, but is overjoyed to have survived. In confrontation with this, the nature of the surgeon's dilemma seems trivial and fretting about his own troubles makes the surgeon feel disappointment and shame (p. 275). Shame triggered by it eventually turns out a purifying factor for the surgeon. The role of this emotion is showing him that when others have existential problems, he is bothered by problems related to his own professional reputation.

3.4.5. ANTICIPATION

Anticipation and its lack are particularly interesting in *Critical Care.* Anticipation is encountered in the memoir when the nurse is wheeled into the triage department, and is asked a multitude of questions concerning the circumstances of her fall while working, and her health state by the triage nurse. All those questions were anticipated by the nurse, among them the one: "On a scale of 1 to 10, how would you describe your level of pain?" (p. 45). The nurse finds it difficult to assess the intensity of her pain, and realizes how misleading a numerical scale is in reference to the pain felt. In the same memoir, the nurse also mentions the lack of anticipation; namely, she has not anticipated that being initiated into the process of giving chemotherapy treatment to the patient will give her such power and at the same time terrify her to such an extent (p. 171). Only at the time of performing this procedure does the nurse realize a sense of amazement it invokes in her because of the trust shown by patients to the nurse to let her inject the substance into their veins. This amazement has its source in the responsibility she feels on herself (p. 171). In both cases mentioned above, anticipation does not influence the nurse's reaction to a particular event, which the theorist Warren Ten Houten stressed in his

book while discussing the emotion of anticipation.[304] The nurse acts spontaneously, and suddenly realizes certain facts about medical procedures and her own reactions to them, both as a nurse and a patient. For example, she discovers that estimating one's pain by means of a scale is difficult, or that the responsibility of providing chemotherapy is immense.

In *Every Patient Tells a Story*, the doctor makes only a slight reference to anticipation, while discussing her first impressions at the physicians' conference, seeing the auditorium gathered at the designated ballroom. She talks about "a sense of giddy anticipation" felt among the conference guests, which she compares to the feeling experienced at concerts during her college years. At this conference, hundreds of doctors anticipate the doctor in charge of leading this conference to figure out the diagnosis of complex and challenging cases submitted by them. This doctor is a genuine version of a TV's Dr. House, and the participants' anticipation of being provided with diagnoses is likely to stimulate a pleasant feeling in them, about which Warren wrote describing the emotion of anticipation (p. 22). In the doctors' case, it can be the hope of finding a solution to medical problems at their work.

3.4.6. OTHER NEGATIVE EMOTIONS

A feeling of gloom appears in *Do No Harm*. The doctor admits that generally deaths during an operation are not frequent. He has experienced them four times in the course of his work and they were followed by a dreary atmosphere in the operating theatre. The nurses could not hold back their tears, and the surgeon was close to tears, especially if that was a child (p. 131). Death is a hard part of a doctor's work. It triggers different emotions, but usually negative ones.

Sadness and disillusionment are emotions felt by the memoirist in *The Real Doctor Will See You Shortly.* The doctor experiences this when one day he finds out that Dre left the hospital in the middle of the night. He realizes that Dre was not reciprocating the feelings he was showing to her. He recalls his state after Dre's escape in the following way: "My arms went limp. I felt like I'd been kicked in the stomach. I hadn't been aware until just that moment how emotionally sucked into Dre's life I had become. The face touching, the playful nicknames, the agreement to take pills" (p. 177). It is obvious from this account that he has put a lot of heart

[304] Warren. Ten Houten, *Emotion and Reason: Mind, Brain, and the Social Domains of Work and Love*, New York: Routledge, 2013, p. 138.

into treating Dre, and when she escaped secretly from the hospital, he feels deeply disillusioned. This is also indicated by the following words: "We were connecting. At least I had thought we were […]. What if that was just how she was with everyone? I had assumed I was special when I wasn't and it hurt" (p. 177). Afterwards, trying to investigate Dre's motives for leaving the hospital, he wonders if the fact that he mentioned the possibility of his having HIV seemed manipulation to Dre. She is poor and homeless. He suspects that she saw through it and lost trust in him because of raising this fact in order to use it to play on her sympathy. Later the doctor feels ill at ease and guilty about it. He was responsible for Dre (p. 178). It turns out that the doctor did not know the patient so well, although they had talked a lot. The doctor deals with his emotions by analyzing past events and his own emotions, trying to understand them.

The following example gives a clue on how to face depression, whose source is work. In *Critical Care,* depression with nervousness is visible in a nurse when the death of a patient takes its toll on her. The nurse talks about her state directly after this event: "Somehow I got through the rest of my twelve-hour shift and did another […] shift the next day as well, but I felt jumpy at work and depressed at home" (p. 87). Her boss, a nurse anesthetist, tells her that nurses with similar experiences manage to proceed with their work if they find a way to transfer those experiences into positive things in their lives, such as family, home and children. However, after several days, the nurse still feels miserable (p. 87). Events at work can affect mood of the medical staff, that is why coping with emotions of this type is helpful. The nurse deals with her negative emotions by revealing them to her supervising nurse, and after the conversation with her, the nurse feels less dejected and notices she does not need to feel helpless about it.

Two ways of handling negative emotions emerge in the above book: obtaining advice from the boss and planning to see the movie *The Counterfeiters* with her friend as a consolation and distraction. The nurse finds solace after watching it, realizing that violence in a concentration camp seen in that movie is worse than a patient who bleeds out. Thanks to that film, the nurse comes to positive conclusions about her and everyone's role (p. 88): "What comforted me while one prisoner beat another to death in *The Counterfeiters* was the realization that with so much cruelty in the world, all any of us can do is try to make our own piece of it better" (p. 88). The nurse in *Critical Care* has other reasons to be nervous, too, and it is caused by the nature of her work. When she gives the patient Bill his treatment, the majority of particulars connected with the procedure of drug administration are hazy to her. Although the nurse is familiar with the basics of administering medicines, drip with chemotherapy still makes

her jittery. That is why the nurse remains awkwardly silent while sitting in the room in the chair. She devotes all her attention to performing her activities, thinking that maybe the patient feels awkward, too. She is sorry that she does not manage to focus on Bill, and things that may be going through his head (p. 172). The procedure is so complicated to the nurse that she has to put her whole heart and soul in it, and does it a bit nervously and tightly, not being able to think about the patient himself. Her nervousness limits her, though it is not her intention to ignore the patient. Not only does the nurse feel nervous because she is a beginner in her profession, but an inexperienced doctor faces nervousness and fear, too.

In *Do No Harm*, the doctor feels annoyance when three applicators turn out to be faulty (they have stiff hinges, or the instrument refuses to release the clip). That causes delay and discomfort in operating. The surgeon flings himself back in his chair, swearing even more vehemently, and throws an applicator onto the floor: "This aneurysm looks relatively easy but my nerves are too frayed to let my assistant take over again and so, with yet another applicator, I clip the aneurysm" (p. 31). In his own view, the surgeon lacks strong nerves and at a certain point of an aneurysm operation, he has to struggle against an overwhelming wish to get the operation over with, and leave the clip in place, even if it is not quite perfectly placed:

> I struggle against my urge to finish the operation and escape the fear of causing a catastrophic hemorrhage, I decide at some unconscious place within myself, where all the ghosts have assembled to watch me, whether to re-position the clip yet again or not. Compassion and horror are balanced against cold, technical precision. (p. 32)

The surgeon has to fight his nervousness, but he comes out victorious from that surgery because composure, which is acquired through practice, saves him. He sees the difference between himself and younger specialists: "I have become bolder with experience. Inexperienced surgeons are too cautious – only with endless practice do you learn that you can often get away with things that at first seemed far too frightening and difficult" (p. 32).

The author of *Critical Care* refers to the matter of fatigue of the medical staff. After the patient's death, the nurse feels tiredness and is too weary to cherish the vivacity of her her children and the environment. She wants to crawl under a rock and come out it once she is sure that there will be no danger to people she knows at least for a some time (p. 106). A moment of despair appears in *Do No Harm.* The surgeon has a recollection of numerous awful defeats and he adds that most neurosurgeons' lives are filled with the times of great despair (p. 33). By this despair he might mean depressing moments during an operation, when the surgeon is unsure of its success. He recalls this type of operation. The patient is complaining of minor problems following the operation, which the doctor neglects in the light of the operation which is close

to a disaster. The surgeon thinks about other patients: "Perhaps they never quite realized just how dangerous the operation had been and how lucky they were to have recovered so well. Whereas the surgeon, for a while, has known heaven, having come very close to hell" (p. 34). It can be concluded that doctors feel desperate during many operations, and they leave those moments of despair to themselves, but patients usually only find out that the operation was effective and have no idea of the danger that existed. In *Do No Harm,* among the surgeon's reflections there is one mention of the period of his life when he felt unhappy, namely, the period after graduation from the medical university when he started his professional career. The doctor was lonely then and was working in a hospital, that is a place full of suffering, illnesses and unhappiness. He himself experienced adolescent anxieties for his future and suffered from unrequited love (p. 76). By activating the mechanism of self-reflection, the doctor manages to turn what he believes to be his weakness into his strength. He begins to think of the profession of surgeon as a profession of "altruistic violence". He feels excited about it and decides to firmly tie his future to the surgical profession. The remedy for the doctor's unhappiness is his work, in other words, turning to something that lets him forget about loneliness and find his calling.

The case of a woman with Lyme disease from *Every Patient Tells a Story* portrays the patient's emotions. This instance of uncertainty and feeling abandoned is crucial because it shows the effect that doctors' reactions have on the patient in a doctor–patient relation. The patient feels uncertain when the doctor excludes the patient's suspicion of Lyme disease, saying the Lyme test is not necessary and goes to the next room. The patient feels this as a disregard for her ailments and continues her visits to various medical specialists with her medical problem: at first her internist, then a rheumatologist, and next she comes back to the previous doctor, who in turn sends her to his assistant: "Her doctor was a nice guy, […], but he clearly didn't know what was causing her pain or what to do about it" (p. 168). The patient decides to take matters into her own hands and finds a Lyme specialist. The lack of empathy in the doctor is strongly felt by patients, of which, as the cited case proves, the former ones often do not realize.

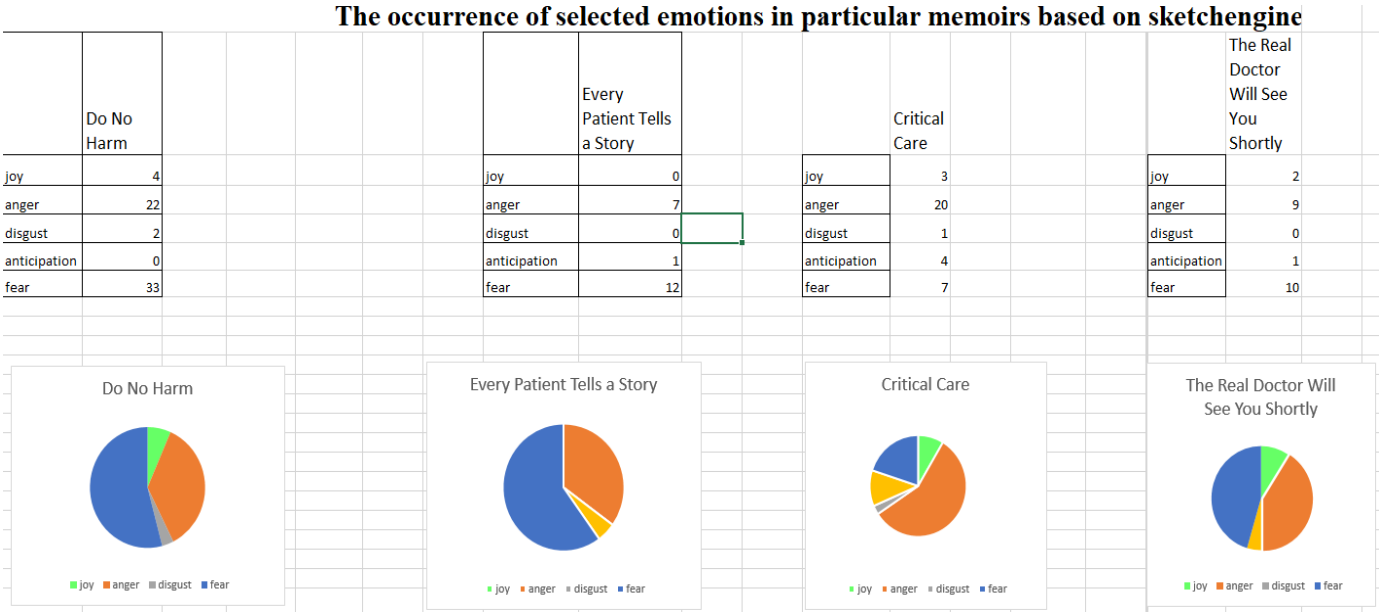
Abandonment is also described in the above memoir, in case of another patient whose symptoms are dismissed as imaginary, that is, existing only in his mind. In this way, doctors leaves him, which makes the patient search other traditional and alternative practitioners (p. 183). After patient has been put through the medical tests, and returns with satisfactory tests results, doctors wonder why the patient is still there. They think it is in his head, but the patient feels tired and confused. He needs help with the situation and finally finds the right doctor (p.

183). In the above situation, the patient's emotions become clearly visible to the doctor. The patient feels rejected because previously consulted doctors disbelieved his symptoms and words.

3.5. SKETCH-ENGINE RESULTS

An analysis of how frequently each emotion is mentioned in a given medical memoir is possible by searching it in the sketch engine. The occurrence of five emotions from Plutchnik's Wheel of Emotion has been analysed by means of it. The analysis is limited to those five emotions, which either appear in a large or small number, namely: joy, anger, disgust, anticipation and fear. Their occurrence is presented in the following tables:

Table 1 The occurrence of selected emotions in particular memoirs based on sketchenine



Emotion	Do No Harm	Every Patient Tells a Story	Critical Care	A Real Doctor Will See You Shortly
joy	4	0	3	2
anger	22	7	20	9
disgust	2	0	1	0
anticipation	0	1	4	1
fear	33	12	7	10

Upon looking over emotion in medical memoirs and data in the sketch engine, it can be inferred that the emotion which is referred to most often in almost all medical memoirs, with the exception of *Critical Care*, is fear. It may be surprising that it is the older surgeon in *Do No Harm* who describes fear in his memoir with the highest frequency. Although data from the sketch engine give evidence of the highest number of the use of the word " fear" by the surgeon, it is worth noting that many of those uses refer to patients' and not the surgeon's fear. After an analysis of situations described in his memoir *Do No Harm* and concordances from the sketch engine, it can be seen that the author often talks about fear in the context of his patient's feelings (for example he "tries to lessen the patient's fear", or "'detects fear in patient"). However, despite his extensive surgical experience, he still faces fear in his professional life. The surgeon looks with fear at the consequence of the operation performed by himself. The nurse from *Critical Care* writes about fear least often of all, and when she does, she almost always refers to the patients' fear, which she perceives in them during medical confrontation ("fear in patient's eyes"). It is interesting that the nurse, who is new to her nursing profession does not feel fear, which is in opposition to the intern from *The Real Doctor Will See You Shortly*, who is also an adept in his profession. The reason for this may be attributed to a difference in personality type, but the intern's younger age may also be a factor. The nurse has just started her nursing job, but she had a previous professional life in a different field; she used to be a teacher. This could have helped her gain resistance to fear. The intern writes about fear nearly as often as the middle-aged doctor in *Every Patient Tells a Story*, with the distinction that he usually does it in reference to himself ("I feared that […], pure […] fear coursed through me"). Numerous occurrences of situations in which the intern's fear appears and the data from the sketch engine corroborate that the experience of fear by the intern is high. In the case of the middle-aged doctor, fear is present in her memoir, both in the physician and the patient (for example, in the doctor's case, it is the fear of getting the diagnosis wrong, but the doctor also senses the patient's fear).[305]

Anger is another, most common emotion if one looks at all the memoirs, again most frequently referred to by the older doctor in reference to the patient's family, patients and himself (for example, "anxious and angry relatives", ''I remembered how angry I had been", "I had seen her tearful, angry face" p. 110). In *Critical Care,* the nurse expresses anger, and also writes about angry patients (for example, "I said sounding angry", "He was very angry at his primary oncologist" p. 163). The middle-aged physician in *Every Patient Tells a Story* often

305 https://app.sketchengine.eu/#concordance?corpname, accessed on 24.01.2020.

concentrates on anger felt by patients or wonders what the cause of their anger is (for example, "Hsia was taken aback by the patient's anger", Why was she so angry?" p. 13). It is the intern who almost always feels anger at finding himself in a terrible situation, that is, when a risk to his health and professional life arises, and at being powerless about the patients' situation.

What binds all four memoirists discussed in this analysis is that none of them feels joy to a great extent. The medical staff in all four memoirs rarely talk about joy, and the middle-aged doctor in *Every Patient Tells a Story* completely resigns from making reference to joy. The older surgeon recalls the time when the operation brought him joy, but it only happened once. In the intern's case, joy results from the sense of acquiring practical skills. This occurs when the intern learns how to interpret an EKG and state a lab value (p. 40). Although the nurse mentions joy in her memoir, seldom is she the one who experiences its variety, that is, satisfaction. She mostly focuses on patients' joy (a patient is in a good mood while staying in hospital, and once she concentrates on her husband, in whom joy is triggered by playing the piano). Laconic emphasis of the medical staff on joy leads to the conclusion that the doctors and the nurse are so overwhelmed by patients' medical problems and their work that there is little room for joy there.

Anticipation and disgust are almost absent from medical memoirs, too. Disgust occurs only sporadically in certain memoirs and so does anticipation. Both disgust and anticipation do not appear in some of memoirs at all (anticipation is absent from *Do No Harm*, whereas disgust is not to be encountered in *Every Patient Tells a Story* and *The Real Doctor Will See You Shortly).* The emotion of anticipation is felt mainly by the medical staff. Sporadic examples of anticipation can be detected in *Critical Care*, in which the nurse talks about anticipation referring to herself (the nurse has anticipated the question she is asked about her health when she becomes a patient herself). The intern from *The Real Doctor Will See You Shortly* also describes anticipation in reference to himself when he hopes his pain will wear off when he is disillusioned with his patient's reaction, who ignores her doctor. The middle-aged doctor recalls a sense of anticipation before the conference.

As for coping with emotions, in the light of the conducted analyses, the medical staff are good at dealing with positive emotions. They accept those emotions and they do not have a detrimental effect on them or their work. In the case of negative emotions, doctors adopt the following strategies: listening to themselves (for example, Henry Marsh), planning by considering ways to tackle the problem through seeking support by consulting somebody else (a work mate or a family member; for example, the nurse in *Critical Care*). Other means of handling emotions selected by doctors include: relaxation, focusing on one's emotions, naming

them and waiting until difficulties get solved. It may also happen that the medical worker feels powerless in taking any action in response to the surrounding events and, therefore, resigns from taking any steps. Sometimes they accept the surrounding situation and live with it. None of the staff in the four memoirs decided to consult a specialist who could help them solve their problems. Nor did they resort to alcohol or stimulants; at least they do not admit it in their memoirs. However, despite fear and discomfort, none of them avoids facing the problem that caused negative emotions.

3.6. THE LITERARY ASPECT

One reads memoirs in order to get to know the memoirist's thoughts, experiences and views, but the form of writing also matters. In fact, the more interesting the plot is, the more readable the memoir becomes and the more it attracts readers. This part of the chapter is going to be devoted to the literary aspect of medical memoirs; how memoirists construct the plot and suspense. There are principles of constructing the plot and building suspense, and these processes coexist. Certain ways of constructing both of them are visible in discussed medical memoirs. The authors of those memoirs employ different techniques to build the plot and keep the reader's interest. Since none of them aspires to write a literary work of art, but rather popular texts that would appeal to readers who include both medical staff and patients, the best way to approach the writing techniques employed by the four memoirists is through the lens of popular how-to-write guidelines, which abound on the Internet.

Jan Rozpisany points out that a story usually starts with presentation of the characters and their background, and this forms elements of the plot.[306] Jane Cleland underlines the importance of relatable characters in creating the plot; characters with whom readers easily connect, on the one hand, and, on the other, a gripping story, which contribute to readers' interest in the story.[307] According to Joanna Wrycza-Bekier, a character ought to acquaint the reader with his/her wish or desire. Then, the reader will start worrying whether the character is going to achieve what s/he wants, and due to this, the reader is closer to identifying with the protagonist.[308] This principle is exemplified in *The Real Doctor Will See You Shortly,* in which the intern reveals to the reader his wish to be like his superior workmate, a doctor. He is particularly interested in developing a better relationship with his patients. While reading the

306 http://www.rozpisani.pl/blog/konstrukcja-fabuly---kilka-porad, 27.01.2020.
307Jane Cleland, *Mastering Suspense, Structure, and Plot: How to Write Gripping Stories That keep readers on the edge of their seats*, Writer's Digest Books, 2016, p. 43.
308 Joanna Wrycza-Bekier, http://poradnikpisania.pl/jak-zwiekszyc-napiecie-w-opowiesci-poznaj-4-sekrety/#more-2431

book, the reader can observe with curiosity whether the intern manages to achieve that goal, and follows the story of the intern's professional life cheering him on. Joanna Salak argues that there is a close co-relation between the character's background (friends, family and relations with them, the people the character loves and likes) and the fact that the reader identifies with this character.[309] In *Critical Care,* the main character, who is a nurse, does not present the achievement to which she is aspiring, but makes references to her fulfilled dreams; one of them was a contract to write a memoir on how she became a nurse. The surgeon from *Do No Harm* recollects coming to terms with his unhappiness and claims that the period of working in a hospital helped him find his professional way. The fact that he shows his dilemmas makes him a relatable character, with whom the reader can find a thread of understanding. In all four memoirs the main characters, who belong to the medical staff, encourage the reader to identify with them. Those characters – doctors and in one case a nurse – have their fears and doubts. They do not know if they are right or not, and they sometimes admit to their medical mistakes.

Jan Rozpisany claims that another element in creating a plot which attracts the reader's attention is a conflict in which a character or several of them are involved. Then, some stimulus triggers the action and provokes reaction. In crime stories or novels, this stimulus can be in finding a corpse and starting an investigation. It can also be in entrusting some mission to an agent. The event, which triggers all the other events and actions should be included relatively quickly in a book to appeal to the reader.[310]

Medical memoirists choose and follow some of the above ways of plot construction. Certain means, such as conflict between characters, is present in just one memoir, *Critical Care*, and not in remaining ones. Except for relatable characters, which appear in each memoir, the memoirs contain their own specific element of plot construction, which is distinctive in each particular book. In *Every Patient Tells a Story* by Lisa Sanders, the idea of a direct conflict is skipped, but a stimulus is present and takes form of an illness or intractable medical condition triggering a diagnosis rather than investigation. Instead of a traditional investigation like in crime stories, in this medical memoir, the role of a detective is performed by the doctor and the medical staff. Lisa Sanders was acclaimed as a detective story teller and writer of suspense by some writers and editors. This is a metaphorical reference, which is used because her books frequently contain, for example, unsolved (undiagnosed) medical problems, which she manages to diagnose in her book through her "investigation". Pauline Chen claims that *Every Patient*

309 https://www.maszynadopisania.pl/praca-nad-powiescia-pierwsze-kroki-bohater, accessed on 28.01.2020.
310 Ibid.

Tells a Story contains "intriguing diagnostic dilemmas that draw you in".[311] Those dilemmas are fascinating patient stories. Atul Gawande considers Lisa Sanders a role model of the modern medical detective storyteller. Her stories are filled with suspense, that is, moments when health of patients from stories presented by her is unstable.[312] Her writing is compared to sleuthing, which is the core of medical diagnosis. The reader is encouraged to solve the unfolding mystery.

Lisa Sanders presents many medical cases of patients, which include an elusive diagnosis. Those medical conditions require unravelling mysteries by the physician. The doctor in her memoir resembles a detective who must piece together all available information on her patient's illness. This demands deciding by the doctor which tests must be done and gathering stories from patients and their families. One example of the patient who suffers from a mysterious illness, which is unexplained for a long time, is Crystal Lessing, who develops abnormalities, such as uncontrolled bleeding, lack of blood-clotting or yellow skin color. The ER doctors have found no signs of hepatitis and bloody diarrhea, which they interpret as a case of Clostridium. Sanders keeps her readers in uncertainty about the patient's situation. Clarification of this condition comes only after a long time: "Like in a classic mystery novel, the doctor asked the victim to go over the crime once more" (p. xvii). Finally, after considering various possible diagnoses, the doctor finds the answer. Crystal suffers from liver failure and destruction of red blood cells, which the doctor diagnoses as an inherited illness, Wilson's disease. The story is mysterious since many other physicians have failed to make a diagnosis. The story may be gripping to the reader, as the female patient's life is endangered, and she has to be transported by helicopter for liver transplantation, as the diagnosis has been made at the last possible moment (p. xxi). Sanders has collected plenty of similar stories which involve mystery.

A way of constructing a plot by putting the character into a conflict is visible in *Critical Care*. Jan Rozpisany notices that normally events follow, side plots appear and everything aims at the culminating point, which brings solution to the conflict.[313] The nurse is in a temporary conflict and takes actions to move to another floor within the same ward in order to escape mistreatment by her colleagues. The nurse feels baffled, which she expresses as follows: "I told HR I won't work where staff yell at and humiliate other staff and I can't work with people who would rather criticize others than do their jobs" (p. 143). A solution to this conflict comes after

311 Pauline Chen, M.D.: Healthcare & Medicine Author, Speaker | PRH Speakers Bureau, accessed on 23.02.2020.
312 For 'Diagnosis' Show, Dr. Lisa Sanders Lets Times Readers Around the World Join in the Detective Work - The New York Times (nytimes.com)
313 Ibid.

the whole procedure of applying for other jobs within her hospital which include: the sister unit, the emergency department and the ICU. The nurse faces hospital bureaucracy and job interviews. After going through all these stages, she finally reveals that she finds some relief:

> Right away I noticed a startling difference between the two floors. On this floor, no one yelled at anyone. Never. The tension that hovered in the air like a miasma was absent. It was still high-stakes inpatient health care, so the nurses had stress [...] but there was none of the meanness and just plain spite that was inescapable in my present job. (p. 140)

Rozpisany claims further that when the character runs into serious troubles and faces an insoluble situation, the reader is interested in how it will end.[314] In *The Real Doctor Will See You Shortly*, the internist is in a hopeless situation, in which he fears he may be seriously ill and his professional and personal life are at risk. At the same time, the final outcome of his worrying, when it turns out that the internist is not HIV positive, may strike the reader as surprising in the light of his previous persistent torments of the mind.

Jane Cleland stresses the role of suspense in keeping readers involved in a book.[315] Bekier explains that the best way of constructing suspense is to make the reader ask him/herself: "Will the character jump?". Then, postponement of the answer to that question follows, and building suspense during the time which is left before the answer comes.[316] In the case of medical memoirs, the questions do not concern jumping, but making a recovery, instead. Although in *Do No Harm*, the suspense is short-term because each chapter makes a different, concise and separate story, the memoirist, Henry Marsh, manages to build suspense by sowing a seed of anxiety or even terror when he tells about his small son's dangerous medical condition. The surgeon recalls his son's admission to hospital on account a brain problem. The doctor keeps the reader in suspense about what happens next. He describes his own emotions that accompanied him, such as anxiety and fear, and recollects the torment he underwent on his way from the workplace to the local hospital his son was in. The surgeon also describes behavior of the medical staff and his wife's reaction to that situation. Only after having faced all these dilemmas with the protagonist, is the reader informed of the positive result of the boy's operation. In this memoir, another technique of building suspense listed by Bekier is present, which is limiting the time of action. This means medical activities and procedures have to occur instantly, decisions have to be taken immediately.

In *The Real Doctor Will See You Shortly,* Matt McCarthy describes the medical staff

314 Ibid.
315 Jane Cleland, *Mastering Suspense, Structure, and Plot: How to Write Gripping Stories That keep readers on the edge of their seats*, Writer's Digest Books, 2016, p. 43.
316 Ibid.

who must work under the pressure of time because a female patient's survival depends on whether they manage to restore her pulse. The author includes numerous descriptions of how he feels or what he does, by which he also builds tension: "My heart felt like it was going to jump out of my chest" (p. 206), or ''I reached for the central line kit and took a deep breath" (p. 204). ''My heart was racing, my breathing ragged. Sweat pooled under my arms" (p. 205). The writer arouses anxiety in readers and involves them in uncertainty, informing them that he would like the procedure to be successful. The readers wait with anxiety for the result of this medical intervention.

Jan Rozpisany mentions engaging the element of surprise as a way of intensifying suspense.[317] Taking the reader by surprise occurs in *The Real Doctor Will See You Shortly*. The memoirist seems to prepare the reader for a risky situation, which the reader can expect to take place. On the phone, the physician advises his patient's wife of her husband's death. The character prepares the reader for something perilous by quoting the woman's response to him: "I am coming in now to find you" (p. 296) and by his subsequent utterance to himself while waiting for her: "What if she had a gun? And if she used it, would she even be guilty of anything?" (p. 297). The memoirist goes on to reveal his fears about this woman, which may imply to the reader that she intends to do him some physical harm. The writer devotes four pages to his dilemmas related to her imminent arrival. This plot could very well be encountered in a criminal novel. However, the memoirist creates this type of tension only once. The reader may be in two minds about what to think about this situation and consider the possibility of a desperate woman attacking the doctor. The reader may also wonder, how dangerous the doctor's job can sometimes be. Finally and unexpectedly to the reader, it turns out this woman comes not to take her anger out on the doctor, but with a view to talking about her dead husband and nothing jeopardous happens (p. 300).

Although the authors of the four medical memoirs hold medical professions, they build the plot and suspense in their books, as writers do in works of fiction. The content of those memoirs is serious and thanks to the inclusion of mystery or surprise, they read like novels. The reader is not only limited to medical facts, but s/he experiences uncertainty about the patient's life or curiosity about how the doctor will resolve a medical problem. The memoirs are authentic because they are documents rather than literary fiction. This is visible by the inclusion of

317 https://www.rozpisani.pl/blog/konstrukcja-fabuly---kilka-porad, accessed on 29.01.2020.

medical details in the form of precise or complicated medical problems. For example, in *Critical Care* the nurse reports an emergency, in which the patient is struggling for breath and this is indicative of tachycardia. The form of a document is achieved by providing descriptions of processes inside the human body and names of the smallest internal organs. The nurse provides meticulous symptoms of the condition of tachycardia; the upper heart chambers "do not have time to fill up with enough blood for the ventricles to pump sufficient volume out to the rest of the body" (p. 29).

To sum up, medical memoirs contain a multitude of emotions, most of which are experienced by the medical staff. Both positive and negative emotions are visible, but the number of situations with negative emotions, such as fear and anxiety, dominate over positive ones. Emotions exert different influence on those who experience them; they help doctors feel better at work in case of joy and contentment, but also block them in the event of fear and anxiety. They may also have destructive effects, if a person experiencing them does not find emotional support in their problems. In other words, negative emotions may inspire changes and provide energy for them, but they can also ruin a medic's professional life. After experiencing a lot of emotions, the medical staff become more resistant: "I have become bolder with experience […]. Compassion and horror are balanced against cold, technical precision" (p. 32).[318]

[318] Henry Marsh, *Do No Harm: Stories of Life, Death and Brain Surgery.* London: CPI Group, 2014, p.32.

CHAPTER FOUR

MEDICAL MEMOIRS AS A RESOURCE IN TEACHING MEDICAL STAFF

This chapter focuses on teaching the medical staff. This issue shall be discussed through the prism of how British and American authors of medical memoirs; namely doctors and nurses themselves, perceive their process of education during studies and after graduation, especially, learning on the job and learning from their patients, through which they broaden their professional experience. Medical specialists in the memoirs discussed in previous chapters refer to their past medical education, sometimes compare it with teaching at present time. This leads them to conclusions and reflections of a more general nature. The question of the usefulness of medical memoirs and diaries[319] in training physicians and other medical personnel constitutes the essence of reflections in this chapter. "Self-writing" is an overarching term for the memoir and the diary, which will therefore be applied throughout the chapter whenever the discussion comprises both cases. The order of the topics discussed in this chapter corresponds with the stages of memoirists' professional development they undergo. At first they gain experience and observe the surroundings, after which they are ready to analyze their progress and draw conclusions from their experiences.

The first part of the chapter addresses the question of usefulness of medical memoirs in the process of training doctors and shaping their attitudes towards their future professional and deontological duties. Training with the use of medical self-writing comprises a wide spectrum. It ought to be borne in mind that the works of self-writing are created not only by medical specialists, but also by patients themselves. Moreover, the authors of self-writing can also be medical specialists, who happened to be patients. In this case, a professional viewpoint and the patient's perspective overlap, and they do not necessarily have to be convergent. In three memoirs discussed in the dissertation this situation takes place; that is, doctors turn into patients. One of these books, *The Real Doctor Will See You Shortly*, presents the case of a doctor who fears he may have got infected with HIV and is about to undergo laboratory tests (p. 136). In another memoir, *Critical Care,* following her injury, a nurse becomes a patient and is hospitalized (p. 58), and in *Do No Harm,* a surgeon undergoes an eye surgery (p. 229). Later in this chapter, reflections of the medical staff concerning their learning at work and the way they see their own professional progress are discussed. In the final part of the chapter doctors'

[319] Memoirs are written some time after an illness and its treatment, whereas diaries are written day by day, in the course of treatment.

remarks on their own or others' mistakes are recalled and analyzed from the point of view of their meaning for the medical education of physicians and the medical staff. In accordance with one of general educational guidelines on learning from mistakes, medical specialists try to indicate how these guidelines can be used in medical education and improve current medical practice.

4.1. ENHANCEMENT OF THE SYSTEMIC–PARTNERSHIP MODEL THROUGH MEMOIRS

Teaching medical staff consists of two stages. The first one is the time of medical studies, during which future medics acquire competence necessary to achieve learning outcomes and obtain a diploma, and within practice in medical centers gain the first experiences which verify theoretical knowledge gained under the curriculum of the studies. The author of *The Real Doctor Will See you Shortly* underlines that the second phase of medical education is more difficult and longer; it lasts as long as the medical specialist's professional activity within the acquired medical profession. During that time medical workers are obliged to provide help to patients with their health problems, which results from their duties specified in medical deontology. As Matt McCarthy argues, the first years of medical school are spent on quiet studying in lecture halls, libraries and laboratories, and sleep is a dominant need. This state of affairs changes when clinical practice begins and students have to face real medical cases. Then one's own experience plays a key role. In that moment true selection for the profession begins. Education does not cease with graduation, but as McCarthy observes, it only begins at that point. Competence gained during studies and his own experience are the basis for his action as a certified doctor (p. 1).

4.1.1. KEEPING TRACK

The experience gained by doctors and medical specialists throughout their own medical practice constitutes their main resource. Its importance and usefulness for medical education increases when it is written down. The need and readiness of physicians and other medical staff to record their medical experience in the form of medical self-writing has been more and more appreciated by the medical environment in Anglophone countries. However, the habit of

keeping this type of specific documentation and encouraging patients to capture their thoughts, feelings and emotional states experienced during therapy has so far been merely a matter of good medical practice, and has not been covered by formal medical training.[320] It is changing, since the documentation of this type, created by both physicians and patients can not only serve as a useful tool, aiding daily medical practice of its keeper, but it also supports education of doctors and adepts of other medical professions. One example of a medical record kept by a British nurse and writer is Christie Watson's *The Language of Kindness: A Nurse's Story.* Andy Alaszewski describes in a convincing and inspiring way the role diaries played in the work of community nurses studied by him. Namely, the nurses record various observations concerning their work, and describe their attitudes both towards their tasks and charges. He defines a diary as: "a document created by an individual who has maintained a regular, personal and contemporaneous record".[321] Such is the nature of diaries, written by community midwives and analyzed by this researcher. Those diaries usually contain a record of specific events from their practice, followed by personal comments. In a survey preceding his research, Alaszewski encourages nurses to give their diaries more extensive structure and enrich their content. In this manner, he gains research material that opens up new vistas on the work of community nurses, and stimulates reflection on it. This material inspires discussion among nurses about the profession itself.[322] That leads to the thesis that the significance of documentation of this type goes beyond the mere technical act of recording the course of one's work, and may become a resource of generalized experience that can be useful both in educating new apprentices as well as in professional development of active medical staff.

The above observation on the usefulness of diaries written by community nurses in professional education and development can be juxtaposed with medical memoirs written by doctors and patients. Unlike diaries, memoirs look back to past experiences and they can constitute a highly useful tool in registering the course of therapy, and medical development in the broadest sense of the term. On the other hand, patients' diaries can have an essential meaning in monitoring how patients obey medical recommendations. As noted in the literature, the effectiveness of medical therapy is not only dependent on the doctor's competence, but on whether the patient obeys medical recommendations. The matter of patients' adherence to those recommendations is widely debated in science and has interdisciplinary nature. It can be viewed from the perspective of social psychology, health education, clinical science, the psychology of

320At the Membranes of Care: Stories in Narrative Medicine, Acad Med. 2012 Mar; 87(3): 342–347.
321 Andy Alaszewski, *Using Diaries for Social Research*, London: Sage Publications, 2006, p.1.
322 Shalva Weil, "Andy Alaszewski. Using Diaries for Social Research." In: *Forum Qualitative Sozialforschung / Forum: Qualitative Social Research*. 2006. 7(4), art. 25.

decision-taking or medical sociology. Empirical data show that the scale of a lack of adherence to therapeutic recommendations by patients ranges from 30 to 40% of all cases. In current medical care, the category of patient's obedience to medical recommendations is used.[323] The physician formulates assessment in this regard basing on the current patient's operation. By effectively persuading the patient to keep a diary of his own disease, the doctor is likely to obtain an empirical tool to control the patient's adherence to medical recommendations. This is an additional argument for keeping diaries as an integral component of both successful therapy and a doctor's workshop. Only in the United States and Great Britain is the scale of medical self-writing so huge that there are real premises to use it for widely understood medical education and therapeutic practice.

Works of medical self-writing, included into the so-called narrative medicine, in particular those which are created by patients, also allow one for the course of therapy from a humanistic perspective, that is, from the perspective of patients themselves. This is closely connected to the matter mentioned before, that of the patient's compliance with medical recommendations. Therapy is the domain of medical science, and is based on scientific evidence defined and clinically verified and on a deeply humanistic need of providing help to the patient according to the best achievements of science. At the same time, for the patient, an illness is a traumatic experience, completely disrupting their current life activity. Patients try to conform to the doctor's instructions, but when the therapy fails to bring results they subjectively expect, they can search for other ways to get out of illness, under the influence of their own reflections or inspiration from the family environment. Keeping one's own diary, the patient can give the doctor an insight into his/her own experiences related to an illness and course of therapy and reflect the thinking mechanisms of a person who found themselves in a situation of danger. This type of knowledge permits seeing medical therapy based on scientific evidence also from the perspective of the patient's experiences and emotions, and thus modify the therapy itself in such a way as to minimize the risk of the patient's "disobedience" to medical recommendations. The importance of this attitude to medical therapy is being increasingly emphasized in the literature.[324] Works of self-writing become the media, through which patient's voice is heard and taken seriously.

In the context of the above comments, the question arises about the source of doctors' and patients' competence to create works of self-writing in such a manner that they contain not

323 M.T.H. van Berge Henegouwen, H.F. van Driel, D.G.A Kasteleijn-NolstTrenité, "A patient diary as a tool to improve medicine compliance", In: Pharm World Sci **21,** 21–24 (1999). https://doi.org/10.1023/A:1008627824731, accessed on 23.04.2021.
324 Giulia Marini, *Narrative Medicine: Bridging the Gap between Evidence-Based Care and Medical Humanities*, Springer: Milan, 2015, p. 143.

only a simple reflection of reality, but also a research and cognitive potential useful to others.[325] Thomas Couser points out that the fundamental role in this respect seems to be played by the doctor who is able to create works of self-writing documenting his/her work, but also inspire patients to do so, and provide them with skills necessary for it.[326] The conception of including the issue of self-writing into medical curricula and recommendations of medical organizations is worth taking into consideration in the light of the above remarks. Sidone Smith notices that this entails broadening the scope of doctors' professional education and development by widely understood literary competence, thanks to which physicians will create their own self-writing in a clear, linguistically effective manner, and make an insightful analysis of somebody else's works of this kind. In order for the work of self-writing to be communicative, it must be properly constructed and have an adequate language form. In other words, an educated doctor needs to be prepared to keep a work of medical self-writing with the above mentioned characteristics, and also to read and interpret the works of others. This is connected with certain literary preparation, both at the level of creation and critical analysis of narrative statements of an autobiographical nature.[327] An educated physician also needs to be equipped with skills and instruments to inspire patients to take notes of the course of their own illness and therapy and pass to them skills required in this field. In this way, doctors can provide themselves with auxiliary source of knowledge necessary for improvement of their own medical practice.

It seems that in connection with a growing role of medical self-writing, the above mentioned issues ought to be included in the process of educating doctors. Some attention shall be paid in this chapter to the matter of the extent to which the types of competence in question are currently present, both in the process of general education (medical studies) and a specialist one, and what postulated state ought to be like, in reference to a growing role of medical self-writing as therapeutic practice. Rowena Cullen says that in view of this phenomenon, the doctor needs to be equipped with the following skills: literary preparation for independent creating and reading the works of others (both other physicians and patients) and inspiring patients to write their own self-writing works. The skills of blog-keeping and giving feedback on the Internet are also useful in doctors' case.[328] Therefore, equally crucial is the way doctors currently acquire competence in creating the works of medical self-writing describing their widely understood professional experiences, that is, including not only matters of therapy, but also their relations

325 Rita. Charon, *The Principles and Practice of Narrative Medicine*, New York: Oxford University Press, 2017, p. 234.
326 Thomas Couser, *Memoir: An Introduction*, Oxford: Oxford University Press, 2012, p. 29.
327 Sidone Smith, Julia Watson, *Reading Autobiography: A Guide for Interpreting Life Narrative*, Minneapolis: University of Minnesota Press, 2012, p. 356.
328Rowena Cullen, *Health Information on the Internet. A Study of Providers, Quality, and Users*, London: Praeger, 2008, p. 269.

with the patients, reflection on their attitudes or more general reflection in the field of ethics and deontology of the medical profession. It is closely connected to the issue of what role the works of medical self-writing play in doctors' professional development, what place they occupy in a doctor's workshop, when it comes to their own and the patient's self-writing that they inspired in the course of their therapy.

4.1.2. MASTERING LANUAGES

As it was argued in Chapter Two, narrative medicine helps doctors have a better understanding of their patients' situation and well-being. It can be noted that the role of works of narrative medicine in the process of therapy is growing in the age of globalization, which creates premises and conditions for the internationalization of medical activity and the exchange of experiences in this field. For this to happen, there is the need of including to a greater extent doctors' language competences in their education and professional development. The point is not only to increase in this field the role of so called conference languages having a global range, but also the role of regional and local languages, spoken in multi-ethnic countries, although fulfilment of the second aim may be burdened with numerous difficulties. In the age of globalization, which opens the previously mentioned perspective of internationalization of therapy and exchange of medical experiences, it is crucial that the doctor have the command of different languages at an advanced level. In this event, s/he will be able to read more thoroughly and accurately the contents of narrative medicine in the original language.

Janina Wiertlewska spots that too excessive formalization of language education in the process of medical education and professional development of active medical staff can be a trap which can be avoided by adopting a glottodidactic approach. It consists of building motivation to learn foreign languages and collecting instruments necessary for this, basing on the learner's individual needs and aspirations of the medical student or an active medic. A theoretical basis for this approach to learning foreign languages is the English for Specific Purpose language didactics formula recognized in the English linguistic literature.

This variation meets the aforementioned criterion of developing linguistic competence of medical students and already active physicians towards multilingualism, based on their individual needs, aspirations and goals that language education is to serve. This approach is mirrored in didactics and didactic materials of ESP. In the literature, ESP is treated as "an approach to a foreign language teaching, in which all the decisions concerning the contents and

teaching methods are based upon the reasons for which every person is learning the foreign language".[329] That implies that within a formal education and professional development in doctors taking part in an international exchange or functioning in the multi-ethical area, one should build awareness of the importance of multilingualism for their effective professional functioning in such conditions, based on premises derived from ESP. The arguments in favor of developing language competence by both medical students and active medics is among others obtaining a direct access to works of narrative medicine in the original language.

According to Magdalena Steciąg, the glottodidactic attitude ought to take into consideration the postulate of ecolinguistic approaches to multilingualism. The glottodidactic attitude becomes more and more subject to criticism as an instrument of establishing a simplified, patchwork version of English in global space as "lingua franca", behind which there is a hidden, though legible idea of cultural colonization of the world by English-speaking nations. This version of English is said to function as "lingua frankensteinia", Frankenstein language, which alters the user's identity into a monstrous patchwork of incompatible elements.[330] At the same time, glottodidactics viewed through the perspective of ecolinguistic approach serves to promote multilingualism not only in "language acquisition" without a clear purpose and need, but also to "design the desired relationships in a given linguistic environment".[331] In its very idea, it influences the change in the perception of the role of language, both dominant in the community and taught as the second or third one. One starts to treat them as factors intensifying mutual cultural exchange by expanding the common language space. The languages that co-create this space are changing themselves under the influence of this transformation.

It is clear from the ecolinguistic approach that, people learn the language functioning in their environment in order to meet the standards of this environment and to participate in its matters.[332] In a globalizing world a command of the language of one's native environment is no longer sufficient, which also concerns people exercising a medical profession. This is the context in which the postulate of multilingualism raised here is situated as an element of the education and professional development of doctors, and thus an integral component of their professional skills.

329 Janina Wiertlewska, "Doctor-patient communication: towards an outline of medical English didactics", In: *Scripta Neophilologica Posnaniensia*, 2017, Tom XVII, 423-434.
330Magdalena Steciąg, „Glottodydaktyka w ujęciu ekolingwistycznym." In: *Kształcenie Polnistyczne Cudzoziemców, Łódź: Acta Universitatis Lodziensis*„ nr 21 2014. 53-62.
331 M. Steciąg, *Glottodydaktyka*, p.55.
332 M. Steciąg, *Glottodydaktyka*, p.55.

Language competence acquired by doctors basing on ESP seems an indispensable tool in the era of internationalization of the exchange of medical knowledge and experience. With this competence, the medical worker will be capable of establishing an effective communication not only with patients speaking in the same language as they do. The quality of medical care given to patients by doctors depends on the quality of relations with those patients. The doctor's competence in this area is regarded by Jennifer Fong and Nancy Longneckert as "the heart and art of medicine".[333] As emphasized in literature, ineffectiveness of therapy or its poor effectiveness is the result of a lack of understanding between the doctor and the patient, which largely stems from overestimation by doctors of their own communication skills, on the one hand, and, on the other, underestimation of the importance of messages addressed to the patient and the meaning of messages directed by the patient.[334]

Marion Rojas Estape elaborates on this topic by talking about a university researcher from Miami, Elizabeth Losin, who claims that a sense of social, cultural and educational connectivity with the doctor felt during consultation helps reduce the pain felt by the patient. It is related to the sense of trust to the doctor. This trust is also built by careful listening to what patients want to tell the doctor, which gives hope and relief in suffering. Thoughts concerning relief and hope lead the brain to release chemical substances such as endorphins, which alleviate pain.[335] WenGang Hu, Xiao Zhong and JiaYu Feng indicate that healing process is reinforced due to careful listening and affects patient's satisfaction with treatment. Proper communication between medical staff and the patient influences results of therapy in a positive way, although paradoxically little attention has been paid to communication in medical education.[336] However, this situation is changing. Efforts are being made to work out tools for the best possible understanding between the doctor and the patient. These attempts are reflected, among others, in the evolution of the model of these relations towards a model based on partnership and deliberation, which will be discussed in this chapter. Medical self-writing seems to be one of the tools in optimizing this model. Positive and close relations with the doctor improve the quality of the patient's life and satisfaction with treatment. Self-writing from the course of

333Jennifer Fong, Nancy Longnecker, "Doctor-Patient Communication: A Review", In: *Spring*, 2010. 38–43.
334 Katarzyna Jankowska, Tomasz Pasierski, „Medicalcommunication: a coremedicalcompetence," In: *Polskie Archiwum Medycyny Wewnętrznej,* 2014. 350-351.
335Marion Rojas Estape, *Jak przyciągać dobre rzeczy*, Warszawa: MUZA SA, 2020, s. 32.
336 WenGang Hu, Xiao Zhong, JiaYu Feng, "Improving doctor-patient communication: content validity examination of a novel urinary system-simulating physical model,"In: *Patient Prefer Adherence*, 2016;10:2519-2529.

illness give patients an excellent opportunity to express both challenges and achievements experienced during therapy. It is helpful when doctors are conscious of that. In the light of the raised issues, the postulate that awareness in this field should be built as early as at the stage of formal medical education and form an inherent element of doctors' training programs and professional development, seems to be particularly important.

Comments made so far justify the conclusion that the effect of therapy largely depends on a proper doctor–patient communication. Moreover, communication competence ought to be treated as an inherent component of a doctor's professional skills. As it is stated by Jankowska and Pasierski, "Communication skills are not something additional to medical practice but are a core clinical competence of a physician".[337] In educating doctors and in their professional training, the shaping of communication competence currently belongs to key issues. Works of narrative medicine seem to be some of the key tools in establishing this model of medical education. Through their narrative statements, both doctors, among them also those who were patients, and patients can freely express their judgements and views on the course of therapy, expectations connected with it and emotions, which that therapy arouses. The above expression may be marked by subjectivity, which does not seem to be a disadvantage in this case. Therefore, the ability to define and adequately read messages contained in them is increasingly classified as an essential medical competence in Anglophone countries and could be taken into account in the process of medical education at all of its levels as a tool for building proper doctor-patient relations in terms of the effectiveness of therapy. This postulate also considers the patient's relations with other medics.

Medical self-writing can serve as a useful means for consolidating experiences, whose source is a widely understood medical practice, and reception of these experiences, despite language barriers, but also for shaping a new communication model between the doctor and the patient. This aspect of usefulness of medical self-writing is worth considering in the context of the training process and professional development of doctors. The case in point lies in an effective use of educational potential included in self-writing for the purpose of passing the knowledge to medics and building an appropriate model of relations between medical staff and patients. Appreciating the importance of these relations, recorded among others due to medical self-writing, alongside systematically improved doctors' language competence will allow medics move efficiently in international space, successfully participate not only in international professional exchange, but also effectively treat patients outside doctors' home country or

337 Katarzyna Jankowska, Tomasz Pasierski, *Medical communicatio*n, p. 351.

foreign patients in a doctor's country. The main determinants of these relations are its goals: the patient's welfare, the doctor's deontological duties (which include making use of one's best knowledge and means), respecting patients' rights and choices made by them during the therapy and not imposing on the patient solutions considered as best by the doctor.[338] A number of doctor–patient models of interaction, worked out and described by researchers, was already discussed in Chapter Two. Currently partnership–systemic model is the most preferred model of doctor–patient interaction. This change happened under the influence of consumer movements and advocacy for patients' rights. Activities of these movements, however, cannot be considered in isolation from the model of social order based on the subjectivity of the individual and the supremacy of his/her rights and freedoms. The patient, despite his/her specific life situation is the most important point of reference in his relationship with the doctor. The limitations to which the patient is subject in the therapy process do not mean consent to the violation of his ontological and legal subjectivity. Physicians are expected to fully respect it.

In general, therefore, the currently preferred model of the relationship between the patient and the doctor reflects the current state of social relations as well as the social destiny of medicine and the physician's position in the society.[339] In the model under consideration, the doctor's ability to listen to the patient gains particular importance. For the doctor, this means a radical status change. This change indicates, difficult for psychological reasons, departure from the conviction of the doctor's advantage over the patient for professional reasons in his/her relationship with the patient. However, practice suggests that the model of the systemic-partnership relationship is worth developing and deepening. As Danielle Ofri argues, basing on her experiences of partnership relations with patients, both patients and doctors benefit from them. Contrary to popular beliefs, the doctor can learn a lot from the patient if s/he learns how to listen and acknowledges that this ability is indispensable for the purpose of improving the quality of these relations. Patients themselves, gain more and more confidence in the doctor if they notice that the doctors listen to them carefully. Patients' self-awareness of their organisms during illness increases, too. The doctor's empathetic attitude towards the patient enhances in a peculiar way defensive powers of the patient's organism. Feeling support from the doctor, the patient gains conviction that s/he is not alone in their plight, and that the doctor does not treat them as a professional challenge and object of influence, but is their partner and ally in a fight with an illness.[340]

338 Ezekiel and Linda Emanuel, "Four Models of the Physician-Patient Relationship.", In: *JAMA*, 1992, No 16, 2221.

339Roman Lewandowski, Marcin Kautsch, „Przekształcenia strukturalne i społeczne w ochronie zdrowia.", In: *Przedsiębiorczość i Zarządzanie,* 2012, nr 5, 221-230.

340Danielle Ofri, *What Patients Say, What Doctors Hear*, Boston: Beacon Press, 2017, p. 42.

4.1.3. MEMOIRS AND THE SYSTEMIC-PARTNERSHIP MODEL

For the reasons outlined above, in professional training and developing of doctors, the contribution of self-writing to creating and promoting the systemic-partnership model of doctor–patient relations should not be underestimated. The premises for such a contribution are not only created by the content included in the works of self-writing, but also by the mere fact that they may be written during the process of treatment by doctors and patients alike. From the patient's diary, the doctor can find out if and to what extent the patient is observing the doctor's advice, which can be recorded in the patient's work. Doctor-patient relationship is then built on a partnership basis, and not based on voluntarist and hence sometimes misleading declarations. In this context, it is worth noting that the systemic-partnership model may contribute to minimizing the negative effects of the more and more common phenomenon of self-diagnosis and self-treatment by patients. Practice of this kind not only lessens the effectiveness of professional medical care, but in extreme cases results in a decision to stop treatment under the doctor's supervision and take up treatment on one's own.

A growing dynamics of the indicated phenomenon of self-diagnosis by the patients themselves is the effect of a stormy development of the Internet and social media. Their catalyst is the poor level of social capital, which is manifested among others through a low level of trust in the public healthcare.[341] On this account, the phenomenon of self-diagnosis largely concerns countries less advanced in a social development, but with a widespread access to the Internet and social media.[342] The study described in 2014 by Aleksandra Czerw reveals that the phenomenon of self-medication is widely practiced among students of the Medical University of Warsaw. Almost 94% of them practiced this form of treatment. Drugs without prescription were most frequently bought for personal use (43%) or family (41%). While purchasing OTC drugs, 85% of respondents followed the pharmacist's advice, and 79% of them others' tips. Cold and influenza belonged to most common ailments treated in this way, and they accounted for 68%, headaches constituted 67% of cases, abdominal pain was also listed among them.[343]

Another study, narrowed to self-diagnosis of a specific medical condition, that is cellulitis, is an analysis conducted in the U K by Patel Mitesh and other researchers. It aims at exploring the experience of self-diagnosis among adults of all ethnicities, who can speak

341 Mohabbat Mohseni, Martin Lindstrom, "Social capital, trust in the health-care system and self-rated health: the role of access to health care in a population-based study.", In: *SocSci Med*, 2007, No 7 (April), 1373-138.
342 National Library of Medicine, https://pubmed.ncbi.nlm.nih.gov/21796954.
343Aleksandra Czerw, Urszula Religioni, Angelika Kunda, Anna Augustynowicz, „Samoleczenie jako problem zdrowia publicznego w Polsce.", In: *Journal of Health Science*, 2014, nr 4, 249-256.

English. The interview included those with suspected episode of lower-limb cellulitis in the last twelve months, or those with a history of recurrent cellulitis. The research results show that interviewees were confident about self-diagnosing; they considered themselves knowledgeable about their own cellulitis episodes. One of the reasons for this situation is a similarity of the clinical features of cellulitis when experiencing recurrent episodes. These features included: flu-like symptoms and fatigue, which were later followed by inflammatory features of pain, warmth, and erythema. Self-diagnosis was visible by starting emergency antibiotics provided to patients in advance by the GP. In some cases, patients only sought medical advice, if those antibiotics did not bring results. Family members were also engaged in the process of self-diagnosis; they either relied on recurrent patterns of the disease in their identification of cellulitis or even detected additional changes unnoticed by their relatives such as: paleness and glassy eyes. Feeling experts in making a self-diagnosis before seeing a healthcare practitioner, cellulitis sufferers were sure of their diagnosis prior to a healthcare practitioner. Patients were able to predict the symptoms, namely breaks in the skin, triggered by gardening or walking barefoot. A factor encouraging self-diagnosis was the fact that patients' self-diagnosis met with doctors' approval, which was visible by interviewees' statement that medical specialists in primary care and in the emergency department trusted their self-diagnosis and intuition. Patients chose to make a self-diagnosis to avoid waiting long to be admitted by a healthcare professional. Patients stressed the role of their own self-diagnosis in a further diagnosis made by the physician; this doctor-patient cooperation led to a successful diagnosis. It may be surprising that interviewees did not regard healthcare professionals as the highest authority, but were convinced of their own rightness, which was conspicuous by consulting another specialist, who would confirm the patient's self-diagnosis, after visiting the first doctor, who did not agree with the patient's speculations. Some did not even look for another specialist, but stood by their conviction. This type of behavior was governed by practical reasons; patients feared that delayed diagnosis might affect their workplace, social activities and lead to hospital admission for treatment. Different attitude to self-diagnosis was also shown by respondents, who wanted to be diagnosed quickly and sought medical advice as soon as the first symptom appeared.[344]

It is difficult to find parallel American research; American doctors seem reluctant to present data on self-diagnosis. Rita Charon's emphasis on listening to patients' stories

344 Mitesh, Patel. Siang, Lee. Levell, Nick. Smart, Peter. Kai, Joe. Kim, Thomas. Leighton, Paul. "Confidence of recurrent cellulitis self-diagnosis among people with lymphoedema: a qualitative interview study." In*:* British Journal of General Practice. 2020 Jan 30;70(691):e130-e137.

contributes to finding a cause of an ailment by the doctor. Taking into account the circumstance that self-medication as a form of solving one's health problems is largely opted for by future doctors, it seems reasonable to conclude that this phenomenon is strongly widespread and comprises many social environments, including doctors themselves. Self-medication in itself is not negatively assessed. What awakes anxiety is the fact that self-medication is not always conducted properly. Therefore, shaping correct habits and patterns of behavior in this field ought to constitute an essential element of a long-term policy within state healthcare sector. Aleksandra Czerw, Urszula Religioni, Angelika Kunda and Anna Augustynowicz are convinced that promoting aware self-medication is going to contribute both to a rise in responsibility for the citizens' health, and to a fall in health expenses of the state.[345] An element of doctors' professional competence could, within the systemic-partnership model of doctor–patient relation, support patients in self-diagnosis and self-medication and include this task in the area of ethical and deontological obligations of doctors. The doctor's competence should also comprise the skills of using modern tools, based on advanced IT technologies, as well as interpersonal communication tools in order to minimize negative consequences of exuberant self-diagnosing among patients on the basis of the information derived from social media and the Internet. Doctors should also teach patients the skills of organizing, critical receiving and interpreting information provided in these media. The doctor who is prepared to use modern technologies in communicating with patients and shows understanding for patients' search can contribute to decreasing an information chaos, faced by patients who seek information essential for solving health problems bothering them. Doctors can in this regard resort to such forms as keeping a blog on self-diagnosing and self-medication or giving feedback to those interested on their social media accounts.

Not only can works of self-writing serve as an element of therapy, but they are useful in the teaching process. The issues outlined above related to the use of medical self-writing in educating the medical staff will be expanded on later in this chapter. In reference to the USA and Great Britain, they will be presented from diagnostic, prognostic and postulative perspectives. The diagnostic perspective is the one whose concern is to see to what extent medical works of self-writing are used in the process of educating doctors, the prognostic one is interested in the trends exist in the use of medical self-writing and how they are going to develop in the future, and the postulative perspective is concerned with the direction the use of medical works of self-writing should aim at in terms of training medics. It is assumed that the

345 Ibid. Aleksandra Czerw, Urszula Religioni, Angelika Kunda, Anna Augustynowicz, "*Samoleczenie jako problem zdrowia publicznego w Polsce* =Self-healing as a problem of public health in Poland", In: *Journal of Health Sciences*, Nr 4(9), 2014. 249-258.

ability to create the works of self-writing, edit them, and thoroughly analyze the contents of works of this kind created by others (also in foreign languages) as well as inspire patients to create their own diaries, over the course of their illness and treatment, ought to constitute the elements of the doctor's workshop covered by the standards of educating doctors both at the stage of formal education and in the process of updating and developing professional competence of practicing doctors. Memoirs are written some time after an illness and its treatment, whereas diaries are written day by day, in the course of treatment. The indicated works of narrative medicine are a valuable source of knowledge supplementing scientific knowledge and a record of medical experience or opinions, reflections and patients' emotions from the period of lasting therapy. Finally, these works can be regarded as a crucial instrument in disseminating the optimal model of doctor-patient relations, defined as the systemic-partnership one. Effective use of this instrument is only possible if its application is the element of doctors' formal training and process of their professional retraining and development.

4.2. LEARNING ON THE JOB

The rest of the chapter focuses on the process of learning by the medical staff as described in the memoirs by Matt McCarthy and Theresa Brown. Learning takes place mainly on the job, but some medical specialists look back on their medical education during studies, too. The topic of learning or training constitutes a great part of each memoir written by the medical staff. Their memoirs containing a record of their experiences and reflections are the source of education and development to themselves, and also their readers, who may be engaged in medical careers, too. The intern in *The Real Doctor Will See You Shortly* and the nurse in *The Critical Care* make similar points. For example, they depict what their learning on the job is like, describe their tasks and admit that they learn from other medical staff at work. The surgeon in *Do No Harm* writes about the learning process from a different perspective; that of a teacher. He dedicates and recommends his writing and experience to younger doctors.

The Real Doctor Will See You Shortly refers to the doctor's self-education on the job. The intern's practical education comprises being guided by a more experienced doctor. The learning process he describes begins when he comes to the clinic on the first day of his work in this place. The intern comes under the care of the physician Moranis, whose experience – as the intern instantly notices – exceeds his own. The newly met physician becomes an authority to the intern, who notices in this physician a different attitude to performance of tasks: "I tried

to absorb it all but caught myself zoning out, watching his lips move while wondering if a lifetime spent memorizing journal articles and acronyms would turn me into someone like him" (p. 63). The intern starts to perceive Moranis as the one, whose knowledge of his patient is greater than the intern's, although Moranis has not examined the patient. The intern is not sure how to reach the state of being a good doctor, since even diligent studying medical literature may not be sufficient. The intern is also afraid of being preoccupied with minute details to such an extent that fear arises in him whether he would be capable of merging with patients even at a primary level. He feels the advantage the older doctor has over him all the time. The intern wonders whether he would achieve the state, in which he would derive pleasure from doing his job and feel in his element like those whom he considered his mentors: Moranis and Baio (p. 64). These types of thoughts continuously enter the intern's mind. In this context, the intern goes on to present an episode when his mentor is more appreciated by the patient than he is. He discerns it the moment the patient asks the physician to become his permanent doctor. This patient does not want to be treated by a different doctor every time he visits hospital. The intern thinks that by making this request, the patient means him and agrees:

> Doctor: "Of course I can be your permanent doctor. I'm here for the next –"
>
> Patient: "No", Sam said, motioning towards Moranis, "him" (p. 65).

The patient unequivocally chooses Moranis as his permanent doctor, not the intern. The reason for this seems evident; the patient knows what the status of both of them is in a medical team and opts for the doctor with experience, who is able to establish and maintain close relations with the patient, awaking his/her trust, and not the intern, who lacks such advantages. As can be deduced, in order not to make the intern feel humiliated, Moranis ensures the patient that he and the intern form the team which takes care of the patient and that he is in good hands (p. 65).

The intern tries to fulfil his duties and perform tasks entrusted to him as best as he can. He realizes that although theoretical knowledge is useful, since it constitutes a "framework" for the knowledge acquired during studies (p. 37), it is not sufficient to achieve professional success. Therefore, the intern knows that he has to develop his competence through practice, under the supervision of experienced doctors. He describes his process of gaining practical knowledge, which means learning on the job, and in his case, this often occurs while he is working in the medical team. The supervising doctor has designated the intern for a three-year residency training with three other doctors. It means that each of them works shifts thirty-hours every fourth day during the year. Each of them also works with second-year doctors to acquire

practical skills. Every four weeks during the year, four of them are transferred to a different rotation: general medicine, infectious diseases, geriatrics, medical intensive care and oncology. During the second year, that circle is repeated and extended by the task of supervising an intern (p. 38). The intern stresses the trust on which their team work was based: "If my colleagues could not rely on me, if they could not be sure that I would take care of their patients as well as they could, our group would be dysfunctional. No amount of kindness or humor or empathy could overcome that. Without a shared sense of trust, we would have nothing" (p. 39). During his placement, the intern learns what is important in his job; apart from medical qualifications non-medical issues also matter; especially the aforementioned trust. It results from the fact that team members are dependent on each other, so they must be sure that none of them will fail. Teamwork also gives doctors a chance to use medical information acquired at the university and practice new skills. There are also times when doctors face an individual work for some time, but the intern does not stop feeling part of a group. The intern recalls circumstances when his task is to present the situation of individual patients as his team of doctors do a hospital round within the unit: "Most of it I got right, some of it I got wrong" (p. 40). He feels secure because the team is there to kindly step in if he misinterprets an ECG finding or misstates a lab value (p. 40). By these examples, the intern shows in his memoir what is the essence of cooperation in a medical team.

Other examples of teaching relate to the concept of at least five minutes of education every day. One of the lessons concerns chest X-ray. The intern is instructed how to read a chest X-ray systematically (p. 43). This description of the intern's feelings about learning in a team is corroborated in Polish context by Jakub Lickiewicz, who argues that while working in a team, participants share their knowledge and are involved in teaching each other. That lets group members acquire knowledge effectively, develop it, apply it in practice and verify its adequacy.[346]

The Real Doctor Will See You Shortly shows that obtaining feedback from the patient is an integral element of the process of learning on the job. This situation occurs when the patient shares with intern his observation that whenever he meets the intern, he is continuously in a rush, and that the intern treats talking to anyone like "another box to check". That direct

346 Jakub Lickiewicz, Patricia Paulsen Hughes, Marta Makara-Studzińska, "*The use of board games in healthcare teaching.",* In: *Nursing Problems,* 28 (2) 2020. 71-74.

criticism from the patient is hard for the intern to take. The intern is not willing to find out why, in his patients' opinion, he does not care about them, but he admits to feeling completely overpowered (p. 72). All of the intern's remarks and doubts concerning his professional situation, for example, the fear about his inadequate abilities may be useful to a potential reader. In particular, it applies to physicians who can thus find confirmation of their own feelings and observations from the time of their internship. This is helpful in realizing that one is not alone in certain circumstances, that other workers have faced certain dilemmas, too, and that feeling awkward at work may happen and it may be natural.

4.2.1. REFLECTION ON ONESELF AND COMPARING TO OTHERS

In his memoir, the intern is reflective about the importance of his internship, the next phase of gaining knowledge and medical competence in the course of medical practice. He realizes it is not a single act, but a process. At the same time, the intern finds out how crucial this stage is in educating a doctor. This is the second phase of learning; the one which takes place during one's professional practice. He realizes that one is not highly competent at once. The intern cannot imagine that his colleague was in his position just one year earlier, and he was not doing very well in that role. The intern finds out that the colleague Baio, whom he considers a role model was unsuccessful at the time. It comes out during a conversation with him and another doctor when this colleague himself admits he was a mess and a disaster. The intern attempts to envision what his colleague's incompetence would look like. Was he racing with fear in his eyes instead of assurance? Within a year, Baio, once unsuccessful, is capable of instructing other medical staff: "And now you're telling an intern, another doctor, what to do? Amazing". "Circle of life, Baio said flatly" (p. 81).

In the further course of his narrative, the intern puts himself in Baio's position as an adept and discerns a similarity. He realizes that this doctor, now acclaimed and respected by patients and inferiors was not always as competent as today. Besides, the intern wonders what his internship should be like to bring the results visible in Baio. He estimates that he himself is learning approximately forty new facts and a new procedure every day, which forms an extensive knowledge over the period of a year. However, for him it is still not enough; he expects "the learning curve to flatten" and therefore he thinks he will forget certain things (p. 77). The intern feels at a loss: "I look forward to the day when I will actually feel like I know

what I'm doing around here" (p. 79). The reader of the intern's memoir can easily notice that he analyzes his own process of learning during internship and making progress at work, and is not satisfied with his abilities yet, but hopes to improve them at work. It can be seen that the intern is aware of his mistakes, to which he admits openly in his memoir.

The intern tries to imagine how he will behave if his previous patient, in whose case he overlooked bleeding, comes up. He thinks he will be regretful, and will not try to defend himself. He will admit to his mistake, accepting uneasiness and punishment caused by it (p. 80). The memoir discussed above also includes the intern's honest perceptions of his acting in particular situations. One situation with a patient and her husband Peter makes the intern feel low. The patient's husband asks about the possibility of a heart transplant for his wife. The intern is not certain about it, and when he notices further thirteen questions, he feels competent to respond to only about four of them. That evokes disillusionment in Peter, which leads him into a state of even deeper confusion. The intern feels paralyzed. As the intern's clenches his teeth, he catches himself moving almost inconspicuously away from the patient's husband, heading for the door. Then he automatically sits in his chair and feels that his legs are becoming tense, his body wants to retreat. It is at this moment that the intern sees the reflection of words his patient Benny uttered about the intern's not caring enough and being in a rush. The intern looks at himself through that patient's eyes: "I could imagine what Benny saw: a doctor who was so afraid he might be wrong that he couldn't properly care for his patients. I caught myself and leaned forward, looking Peter in the eyes" (p. 84). On this impulse, the intern corrects his behaviour and declares to the patient he is going to get to know if there is a possibility of a heart transplant (p. 84). This is an example of how his patient helps him see his flaws, which he would not see by himself. As a result, the intern becomes more sensitive to his patients' needs. This circumstance proves the intern's ability to acquire practical skills independently. He finds a way to change his attitude; from being in a hurry, and hence not caring sufficiently, to being more mindful of his patients' needs.

During his internship, he also gets accustomed to various medical procedures and treatments as well as resistance to different situations and events related to them. At this point, he evokes the process of becoming familiar with the sight of blood. It takes the intern more than a month of his work in the Critical Care Unit (CCU) to reach the point when he is not terrified by the sight of blood "flying across a room didn't freak me out, but this still seemed like a lot" (p. 118). He detects a change in his attitude to blood; he used to cringe if he had encountered blood on a television or computer screen several months before, even though it was not real

blood. As his internship progresses, he realizes that the sight of blood has gradually become natural to him, as it was to other doctors (p. 118).

However, the intern does not get used to all the daily tasks of a doctor's work as easily as to the sight of blood. Once he has come to terms with one daily situation, other difficult tasks emerge. In his memoir, the intern refers to another situation which overwhelms him, which takes place during the procedure of pericardiocentesis (plunging a needle under the patient's chest and into the heart lining to obtain fluid). In fact, he is not the only doctor to feel uneasy about it. Other doctors look around with anxiety thinking who ought to try the procedure. The risk is putting in the needle too far, which could be fatal. The intern holds his breath during the procedure when an Asian doctor performs it, and admits that he would not be able to do that himself because it terrifies him and he feels nauseous (p. 119). The above record of the intern's practical education shows that in the course of practice, he acquires medical knowledge and competence both by being exposed to certain sights and by observation of other specialists, who perform the role of superiors during his internship. He is aware that he would not be able to conduct certain medical procedures at the early stage of his medical career.

4.2.2. DIFFERENT SKILLS ACQUIRED AT WORK

The intern endeavors to look holistically at his education process by analyzing his skills and abilities acquired so far and the ways he can make use of them in the most effective way in his professional activity, both for his self-improvement and for the benefit of patients. He recalls how difficult it is to learn medicine, and compares this process to "being thrown into the fire". He describes it as "learning on the fly", and mentions different faces of medicine; the one the intern learned working in the CCU differed from the one practiced in the infectious diseases ward. Patients there did require critical care learned by him beforehand (p. 204). Training a doctor, as the intern points out in his memoir, does not only entail acquiring strictly medical competence, but to a significant extent also the quantum of non-medical competences, which he calls "connecting with patients and performing procedures" (p. 218). The intern reflects on the essence of medical profession. He thinks a doctor can feel s/he is bad at any or all of the areas of exercising this profession. The intern implies that strength is necessary to save one from quitting that profession, especially when he notices that there are better doctors than himself around (p. 218).

In his memoir, he encourages other adepts of medical profession to this type of reflection as an important element of professional experience. Thanks to that reflection, professional self-awareness leading to identification of specialty which suits them is shaped. At the end of this part of his considerations, the intern states that work in the ICU demands "an advanced grasp of physiology" (p. 223), and being able to stay self-possessed, but also assertiveness, due to which the doctor to deal with seriously ill patients in particularly difficult for them position of immediate threat to life. The intern decides that this type of job is not suitable for him, although his workmate likes it. While defining his reason for rejecting the Intensive Care Unit (ICU), the intern discovers that for himself medicine is meaningful insofar as it allows him to establish a personal connection with patients. The ICU does not offer such a possibility because the doctors' role there is to stabilize the patient's condition, and not to cure the patient or explain anything to him/her (p. 223). The intern considers all these matters before he chooses his future path.

The nurse from *Critical Care* by Theresa Brown also learns the nature of her profession, including its practical aspects. She sees that holding a nursing profession requires not only specialist knowledge, but also constant practice. The author of this memoir realizes it when she is away from work for a month due to a fall and the resulting injury. After a month of not performing her nursing duties, the nurse feels she is losing her knowledge and fears that after two months, she will have to start learning from scratch. Her own indisposition lets her realize that nursing also involves physical skills such as bending, squatting, lifting, carrying, pushing and pulling (p. 57). After coming back to work, the nurse has to complete the two-weeks orientation with the support of her preceptor in order to remember everything. Another week needs to pass before she can start working independently (p. 58). Analyzing her own example, she learns the importance of caring about one's own safety. Each physical indisposition resulting from an accident or disease leads to exclusion from this type of work. In this way, the nurse gains the possibility of putting herself in her patients' shoes, for whom illness means a break from normal life activities (p. 59). She describes learning from her patients when she has found herself with a walking disability. Patients inspire her in the sense that their fight with cancer and trying to stay alive motivate her to overcome difficulties and weaknesses. She feels privileged to support them in this struggle (p. 192). Similarly to the intern from *The Real Doctor Will See You Shortly*, she also learns from a patient.

4.2.3. DISCREPANCY BETWEEN THEORY AND PRACTICE

All three memoirs: *The Real Doctor Will See You Shortly*, *Critical Care* and *Every Patient Tells a Story*, show that the medical staff frequently doubt whether they have sufficient skills to face certain situations, which they encounter at work. In such cases, the medical staff must learn performing duties on their own, and solve problem by trial and error. This type of case appears in *The Real Doctor Will See You Shortly*, in which the intern describes the Allen ICU in the community hospital near the northern tip of Manhattan, where he works and a shift there lasts thirty hours. The intern sees it as a place where he can practice the ability to make tough decisions on his own, with no interference from a senior resident. In his memoir, he recalls a situation when the whole Allen ICU medical team leaves hospital at 8 p.m. according to the schedule and he is supposed to "hold the fort" at night. Previously, he could depend on support, namely of an overnight attending doctor, who is now busy admitting his patients in the other hospital part. At eight o'clock in the evening, though, his attending physician finishes his duty, leaving the intern completely alone. Left to his own devices, the intern is bound to make mistakes and their consequences in the form of improper diagnosis or choice of a wrong medicine are felt by patients. The necessity to preside over an ICU without assistance leads some interns to burst into tears (p. 283).

Despite it, the author of the memoir copes well, although patients' health and life is at stake, and it may be surprising that the intern should cope on his own. In his memoir, Matt McCarthy shares his doubts as to whether he acts correctly as a doctor, and these doubts may be reflective of other representatives of his profession as well. That may result from a lack of faith in oneself, or fear of critical evaluation by more experienced staff. The pressure of great responsibility in the absence of support deepens the intern's dilemmas rather than give him self-confidence and faith in his abilities, although he manages to deal with his night shifts. The intern feels satisfaction because of it; however, this satisfaction is lined with fear about whether they will make good doctors. These appearing fears are analogous to those fears which took place in the aforementioned doctors in McCarthy's memoir. Doctors have reservations as to whether they are worthy of being doctors and whether they can be trusted to hold patients' life in their hands or wonder if they are appropriate partners for other physicians to have complicated discussions about patients' conditions. It is indispensable to find ways to avoid these types of feelings at the stage of residency; that is, the time when decisions about doctors' future professional choices are made (p. 240).

Doubts about their competence are experienced by the doctor in McCarthy's memoir and the nurse from *Critical Care.* They do not only mean strictly professional competence, but also competence to communicate with patients and their families smoothly. In *The Real Doctor Will See You Shortly*, the intern comes to realize that he is not sufficiently prepared for his medical service, especially in practical terms. This thought strikes him when he is shown by his more experienced colleague, Baio the way in which an ECG should be read, an arterial blood report interpreted and the data generated on individual patients every few hours processed. Demonstrating these tasks takes two hours and a half and the intern regrets he had not been shown that in his medical school. Theoretical knowledge, which was passed on to him as a student did not equip a future medical doctor with all the necessary skills:

> Countless anatomy or pharmacology lectures had armed me with volumes of critical information and yet no way to translate it into the actual practice of being a doctor. Dealing with life-or-death situations required not just body chemistry and practical science but how to assess a patient's condition correctly and make quick decisions. (p. 37)

This is the gap he must fill in himself. The intern feels he lacks not only clinical, but also interpersonal skills. When he finds himself at the Associates in Internal Medicine clinic in the Columbia University Medical Center, which is plagued by a shortage of regular doctors, it becomes his role to provide primary care for the community, which is poor. This proves to be a major challenge for him: "It was clear that primary care would draw on a unique set of clinical and interpersonal skills, ones that I had most certainly not yet fully acquired" (p. 53). At some point, the intern notices that he participates in a lesson, that he should have taken during his medical studies. A conversation with the husband of a seriously ill patient gave the intern an opportunity to make this finding. The husband asks the intern whether his wife is dying. Contrary to what the intern knows, he denies that and assures the husband that his wife is well. He wants to withdraw his words the moment he utters them, as if seeing that the husband seems to have come to terms with the imminence of his wife's death. The intern only says with embarrassment: "It all got to me just now. I am sorry" (p. 86). Then, the patient's husband hastens with consolation. He pats the intern's shoulder and says: "We have all been through a lot" (p. 86). The intern comments it in the following way: "Here was another tip they had omitted at medical school: when you can't comfort the patient, make the patient comfort you" (p. 86). The intern feels strong enough to reveal to the patient's husband the truth about his wife's health state. Thanks to him, the intern plucks up courage and sets himself free from frustration. The intern comes to realize that relations between doctor, patients and their relatives are full of paradoxes. It seems that it is the doctor who ought to bring them consolation. However, the situation can also be different: a patient or his/her relative becomes a source of

comfort and relief. From this situation, the intern learns that when one cannot comfort patients, one can let them comfort you. It will prevent emotionally destructive mood swings. As the intern himself admits, he is not prepared for them, he even suspects it is a matter of emotional disorders. He even wonders: "How did senior physicians build emotional calluses to avoid bawling without becoming automatons?" (p. 68). Maybe in this way, the doctors are not slavishly attached to the role of comforters for their patients and their relatives. Thus they do not experience frustration when they themselves expect consolation from those who are supposed to be comforted, and agree to accept this comfort. In this way, they avoid dehumanizing automatism. It is easier for the doctor not only to be familiar with paradoxes of his/her relations with patients and their relatives, but also be ready to accept them as an inseparable part of their profession.

During her adaptation period, the nurse from *Critical Care* also detects discrepancy between the content she was taught during nursing studies and what she is confronted with in her job: "A confused jumble of things she had learned in school, sometimes complementing, but often contrasting with, the reality of inpatient health care" (p. 18). She admits she does not understand all the orders, nor does she know all the drugs. She confesses she has never heard of some. Similarly to the intern from *The Real Doctor Will See You Shortly*, the nurse from *Critical Care* must compensate for gaps in her studies in the course of professional work; in her case, they concern arrears in oncology and chemotherapy. She attends classes at work, which however provide merely the basics. It is only there that she gets acquainted with interchangeable names of drugs used in chemotherapy. For example, Cytarabine is also called are-C and vincristine is VP-16. Regimens also have various names. She justifies the need to learn the names as those terms cannot be deduced instinctively. The same applies to recommendations on how to adjust individual drugs to age, weight, past medical history, cytogenetics and what their risks are in connection with administering them in wrong doses. These matters are supplemented only at the stage of professional training and development. The nurse is sent to a training on oncology and chemotherapy. Completion of this several-week training on the job brings her a measurable effect in the form of certificates confirming her competence to work in oncology and in the field of chemotherapy, which is her additional responsibility to the regimen (p. 169). The nurse also emphasizes that it takes a year to prepare for the profession. She views this year as a hard one, the first weeks are the most difficult.

The nurse also discusses what learning on the job entails; she has to put a lot of effort into learning the names of the medical staff by whom she means: other nurses, people from IV team,

doctors, senior staff (cardiologists and surgeons) and inexperienced staff (residents and interns). In addition, she also needs to learn patients' names. What is especially problematic are unexpected situations when all of a sudden a patient's flawless skin cracks and its content spills out, or a patient suddenly has difficulties in breathing (p. 18-19). More than once, the nurse faces a clash between what she sees on the job and what she learned at school. She spots that in the situation when she begins her encounter with a patient and her husband with a traditional introduction she was taught at school: "Do you have any questions for me?", she expects to be able to answer their questions with ease. The patient and her family member surprise her when they ask more complicated queries than those concerning the length or time of starting the treatment. She is not prepared or cannot answer on the nature of illness or its prognosis. Their questions differ from those posed in a nursing school by other students, who were in touch with patients during practical classes. In her memoir, the nurse calls those questions softballs. No one had told her that while conducting a conversation, she must deduce what patients or family members want to know, rather than just respond to their questions (p. 22). In the situation outlined above, the nurse feels confused and has no idea what to do or tell the patients. Then, the nurse hopes the same patient and her husband will not ask her many questions because she does not know anything about chemo at that point. The nurse is in the process of learning which tests need to be taken to see if patients' heart or kidney can tolerate the medicine (p. 21). Besides, she mentions other skills that need to be acquired, and are not obtained before entering the floor by the nurse. She talks about patience and attention necessary to hear the questions behind the question. Another skill indicated by the nurse is the courage to answer patients' questions honestly. The nurse calls these skills nursing practice and also stresses its importance. She argues that performing these skills requires physical, emotional and mental demands that nurses are not ready for (p. 25). Nursing duties also mean emptying bedpans and studying their content, sometimes even pouring it into a plastic container and sending it to the laboratory (p. 122). Performing other tasks involves the nurse's participation in medical procedures, which consist of sticking tubes into patients' orifices, and filling their veins with chemical substance. The nurse's tasks comprise simple or basic things, such as bringing the Bible, which she calls getting to the heart of the matter (p. 127). She tries to cover all those duties with her mind, but the list of responsibilities is unpredictable. Her work entails constant readiness for new challenges and ability to learn new duties quickly. The nurse finds out how important these skills are when she decides to call the blood bank once more when the content ordered by her turns out to be insufficient (p. 152).

Searching the essence of a nursing profession, the nurse refers to Florence Nightingale's words, who compared nursing to artistic professions, such as a sculptor or a painter. The nurse's masterpiece is the patient who is feeling less physical or emotional distress than at the time prior to seeing the nurse (p. 26). The nurse goes on to show that in her profession, studies will not prepare undergraduates for all the situations which appear at work. The characteristics of those situations is unpredictability, which also accompanies death, referred to in her hospital as Condition A. Whereas some nurses never face it in their career, it has happened to the nurse twice within three months. This illustrates that nursing can be a shot in the dark, since the outset of a shift does not indicate what will occur during the day (p. 82). This is the nature of a nursing job, which cannot be grasped during nursing studies.

Another difficulty expressed and experienced by the nurse and the intern from the two discussed memoirs and stemming from shortcomings in formal education process is passing bad news to patients' families. The nurse from *The Critical Care* realizes that she was not trained on how to inform the patients' family member of their death: "I received no training on talking about death to anyone, and this situation taxed me" (p. 91). The nurse finds it problematic to tell the patient's spouse about the patient's sudden death on the corridor when he goes for radiation. The patient dies during the spouse's brief absence when she leaves for a moment. The nurse wonders how she ought to start a conversation and inform the family member. She decides to begin by asking about the spouse's name (p. 91). This example indicates that the nurse is at the stage of working out the ways of conducting difficult conversations with patients and their relatives. The doctor from *The Real Doctor Will See You Shortly* is in a similar situation. He is also at a loss when he has to inform the patient's family member of this patient's death. He realizes he must find his own way to do that, since: "These are the tasks – the heinous duties of being a doctor – that were never fully fleshed out in medical school, the awful moments you might never be comfortable with no matter how long you practice" (p. 294). Although the physician remembers practicing how to deliver bad news to patients or their families, this practice did not entail the ways of conveying the news about the patient's death. This situation is new to the doctor. What makes the circumstance still more complex is that he is supposed to convey this shocking message on the phone. He tries to put himself in a family member's shoes and imagine what he would wish to hear in that moment and thinks he would probably hang up and lose his reason. The doctor is not at ease, he wants to disappear and glances at another doctor after he has dialed the number. A reflection appears that in these situations he experiences deglamorizing of the doctor's profession; that is, he perceives his profession as it truly is, stripped of beauty and sublimity. He fights with his

thoughts, does not know what to say and wonders if he ought to deliver the news quickly or slowly. The doctor does not know how to solve this matter, since he realizes that he is unprepared to pass the medical information to patients and their relatives. He develops involuntary stress reactions; he observes body changes in himself, such as faster pulse as well as rapid and irregular breathing (p. 294). Both the doctor and the nurse from the two memoirs discussed above come to the same conclusions; namely, they need to work out their own ways to talk about death to patients, no one will teach them that. Difficulty also lies in the fact that each situation is different and so may be a particular family member's reaction to the news, for whom the message can be unexpected. That is why each act of providing the information is not a routine, but a separate experience.

Both memoirs show that the intern and the nurse have a lot of practical skills to learn through their own cognitive activity. In the intern's case, it is interpreting tests and performing medical procedures, whereas the nurse needs to memorize intricate medical terminology and get used to reacting appropriately to unpredictability at work. The situations discussed above indicate that the medical staff think their profession is full of new, unpredictable situations and they need to use their abilities, observations of other medical staff to cope with those circumstances. Within the staff self-education, sometimes certain taught patterns of behaviour are modified and altered by them on the job. The nurse shares the following reflection about not opening up to her patients: "My job flipped […] those assumptions on their heads" (p. 111). She resigns from being a saintly nurse with business-like manners (p. 104). As a result, the nurse talks to patients about her background, not sticking to learned patterns of establishing and maintaining relationship with them. Against the rules, she tells patients that she has got three kids, about her teaching past and the place she lives in (p. 110). The nurse's attitude shows how she switches on her own thinking in performance of duties, tries out her own independent ways of functioning at work and makes use of gained experience. Thanks to that, she adds a more humane dimension to her nursing job. This is a paradoxical but positive consequence of insufficient formal preparation for the profession.

There are plenty of similarities between examples presented above and situations described by the internist from *Every Patient Tells a Story*. In her memoir, she recalls her student days when she also felt the lack of knowledge about medicine, despite knowing a lot about anatomy, genetics and cell biology. Being already a doctor, she realizes she does not know how to touch the patient, since she was not taught. Nor did she learn how "to occupy the permitted space between physical intimacy and intellectual distance". This type of knowledge

was not included in the curriculum of the studies, nor were there any lectures on it in the medical school she studied. The internist thinks that it is impossible to be a doctor without learning how to approach this area. She has no doubt it needs to be learned, since she views medicine as a sensual science, in which the medical staff use not only intellect at work, but also senses, including touch, which are essential in collecting data about a patient and setting a diagnosis. The importance of touch in medicine is noticed by patients and doctors. The doctor from *Every Patient Tells a Story* realizes one needs to learn it to become a fully qualified physician (48).

Medical education begins with anatomy classes, in which students are told to perceive human body by disassembling its parts, one by one. In students' minds, the process of objectifying the body takes place, which leads into the habit of treating the body as – in a sense – an object (p. 48). This way of viewing the body is not conducive to its humanization, that is perceiving the body as a sentient organism and the empowerment of the patient. During medical studies, the aspect of empowerment of the patient could be taken into account to a much greater extent than it is at present.

4.2.4. LEARNING BY OBSERVATION

Apart from learning on one's own by following one's intuition, medical staff can learn by following an example. The intern from *The Real Doctor Will See You Shortly* devotes some attention to learning skills by imitating his colleagues. In the memoir, he admits that some knowledge concerning physiology and pharmacology has been passed on to him by his colleague Jim O'Connell, however what he values to a great extent are the life lessons he learns from him (p. 308). He develops this thought by recollecting the time when he was in the ICU and found himself among sick patients with complicated conditions. The intern had to cope with them on his own. His strategy was to recall doctors he had previously known and to ask himself how they would act in this situation. This was the proper way of acting in the face of complicated medical challenges on his duty, such as profound electrolyte disturbances, fibrillating hearts and pneumonia in a Vietnamese. The intern felt the presence of "a silent partner" near him. That partner was his colleague, whose advice from the past he remembered. That and one more colleague in his head "reminded" the intern what to do. One of them "reminded" the doctor to palpate for lymph nodes, and another one reminded him how to perform an abdominal examination correctly. He also "told" him to take further steps on this

basis: “As I scribbled my findings and the voices bounced around my brain, I felt less alone. I knew that if my judgement failed me, memory would not. I had diagnosed and treated pneumonia so many times that I just needed to draw on prior experience to guide me” (p. 285). The intern attributes his ability of making medical decisions to the advice of experienced doctors, whose previous advice has stayed in his memory. In his memoir, he recollects treating pneumonia with another colleague. The fact that that colleague pulled back then and left the intern to make a diagnosis, order a test and devise a treatment plan allowed the intern to develop professionally. He feels can control his self-dependence and feels at ease about taking crucial decisions, while the colleague is there to check his work and detect his errors (p. 285). From then on, every time he approaches a new patient, he thinks about recommendations of one or two colleagues from the past. The intern realizes that a great deal of his medical knowledge comes from rounds while he is listening to what his work mates and representatives of the medical staff are saying (285). The strategy of following in his colleague’s footsteps is a useful way of approaching new situations in his practice. It is especially effective at the stage when the doctor himself has not gained plenty of experience. In the future, he may work out his own methods of solving problems and compare them with those he observed in his colleagues. Although the intern is supposed to work alone, he feels he can count on other medical staff by asking them questions and seeking their advice. Thanks to that, he can develop professionally and avoid mistakes, which could ruin his medical career (p. 284).

Being embedded in a team is also important for the intern from *The Real Doctor Will See You Shortly* for his professional development. Apart from acquiring practical professional skills needed in his job, this is conductive to developing a holistic view of oneself as a future doctor, but also as a human being, who functions in a particular social environment, with which he builds his relations. The intern analyzes his way of becoming a doctor. He does not hide his mixed feelings. On the one hand, he wishes to be a marvelous physician, but on the other, he misses the state of not being a doctor, but an ordinary man whose mind is clutter-free who takes a stroll or carries groceries. He wants to go back to the time when he did not have to act decisively and quickly and was capable of making eye contact without ophthalmological connotations. He wonders whether it is possible to stay an average person and be a physician at the same time. He hopes he will not have to make a choice between the two states, but at times he feels he has already chosen (p. 282). “I no longer experienced life like a normal person. I couldn’t watch a movie or read a magazine without drifting off to the hospital – to a procedure

or an ambiguous diagnosis or a patient encounter – to relieve the moment again and again, until something shook me out of the moment" (p. 282).

It is difficult for him not to refer to the hospital while having a conversation with his family and friends. The intern notices that he becomes so obsessed with his work that, without his wish or plan, he looks at the world from the perspective of medicine. For example, when he sees someone limping, he wonders what caused it –a fractured bone or a stroke. He considers various diagnoses and keeps thinking until he formulates a hypothesis (p. 282). He sees medical challenges everywhere around and all the stimuli constitute an object of refining his medical knowledge and practicing his skills.

Pointing to his own example, the intern shows the way of developing certain habits over a long period of medical practice. He recalls events from his work and seeing his imperfection, he draws conclusions for the future. For example, he develops a belief that when he touched a patient, then he becomes professionally responsible for that patient. The doctor recalls the situation of a female patient, whom he calls the drug mule (she swallowed drugs). Analyzing her plight, he admits with self-criticism that his own attitude was wrong since he treated that patient as a medical case, but did not show empathy and was unmoved by her plight. He does not want to be like that any more. That is why next time he examines the other patient's chest he puts himself in his shoes (p. 290). It indicates that the intern analyzes things that happen to him in the course of his professional practice and draws conclusions. The doctor cannot only treat the patient, but also show empathy. He still bears in mind his earlier patient's remark about not being sufficiently present when he talks to the patient.

Similarly, the matter of learning on the job is also the topic of the memoir by Theresa Brown, *Critical Care*. However, unlike the intern from *The Real Doctor Will See You Shortly*, the nurse feels secure about her knowledge and ability to perform her tasks. After taking up a job, her education does not end, but is continued and seen by the nurse a natural, though an energy-consuming, process. The nurse treats her memoir as the story telling about how she learned to perform her job that is an object of both her love and hatred (p. 11). The nurse specifies what the process of learning on the job looks like in her position. She calls this process orientation, and says it lasts eight weeks in the case of a new nurse. During that stage, a nurse on orientation works together with a more experienced nurse, who is her preceptor. This system of working is comparable with the one of the intern, who is also supervised by an experienced doctor. This learning system permits the nurse to observe nursing procedures and then adopt her practical skills at work. It allows her to gain self-confidence and independence. The main

challenge for the nurse is to figure out things she is not familiar with and the ways in which she could learn them effectively (p. 19). By this she means information of practical importance, such asf getting to know what is the fastest allowable rate of potassium IV that can be given to a patient. Another piece of information to be learned by the nurse is where to make a chart of a patient's swollen feet or what color of a tube she needs for a vancomycin trough. This type of practical knowledge is part and parcel of caring about the patient. These skills can be learned by the nurse through constant repetition under the guidance of her preceptor. Gradually, the nurse reaches the state in which she conducts her professional activities automatically (p. 20). In addition to being able to perform routine activities, the nurse highlights the significance of skills that nursing professors call critical thinking. She bases her concept of caring about the patient on this indication. The nurse explains how her concept of caring about the patient developed over time, using as an example the case of a patient whose back cracks. In the face of that medical condition in the past, the nurse was only able to call the code. Practice has taught her she can also call a doctor. She also mentions the importance of intuition:

> Over time a good nurse will learn when to listen to that funny feeling in her gut and have some idea what to do about it. Should I put my patient on oxygen? Give some hydralazine IV? Suction the blood clots out of her throat? Insist that a doctor see the patient right away? Or call the code?. (p. 20)

According to the author of the discussed memoir, intuition constitutes the basis for any practice. In nursing, intuition must be based on knowledge and then intuition becomes an invaluable common sense. Technical skills without intuition are not sufficient to conduct a nursing profession properly. The nurse learns the technique during an eight-week adaptation period, which also requires learning nursing from a human perspective (p. 20). During her adaptation period the nurse from *Critical Care* combines fulfilling her nursing duties with learning. She gains professional competence through practice, which constitutes the dominant form of vocational training for nurses. Following her adaptation period, the nurse returns to an oncological ward, where a more experienced nurse continues her practical training in the chemotherapy administration procedure.

The situation when the medical worker is trained by another specialist is, as can be inferred from previous analyses, common to both nurses and interns. The nurse from *Critical Care* describes this matter on the basis of her own path to being initiated into oncology nursing and the first chemotherapy. When she is not considered qualified yet, she assists a qualified nurse in this procedure by checking the order together with that nurse. When the nurse introduces herself to the patient, she explains that she is being trained on how to give

chemotherapy. The patient is unabashed, his knowledge of the drug he is given exceeds that of the nurse, and the patient knows more about his diagnosis and prognosis than the nurse does; she just gives the patient a life-saving medication. Both nurses follow the instructions when providing treatment: they check whether the patient's name on the chemo is in agreement with the one on his wristband, ascertain that the lumen for administering the drug is open and perform a set of further required activities (p. 170). The role of the learning nurse is only auxiliary. She gets to know a nursing job from the technical side (the mode of administering a drug), and a formal one (dealing with requirements of the procedure). The patient seems to be an object, to whom a life-saving medicine is given. Emotional closeness with him and empathy are not required. A humanistic dimension of nursing is thus missing. However, this issue finally appears, but in the context of the matter of death. The nurse addresses this matter in reference with elderly patients: "They reached the end of the line, those deaths do not raise concerns about lost potential or what might have been and often come as relief to everyone" (p. 185). However, the nurse is even more touched by deaths of younger patients. She mourns over them. She has two such deaths roughly at the same time on the floor. After having those patients in her mind, full of life and energetic on admission and then in an instant irrevocably dead, the nurse formulates the message: "Don't wait, listen when you can, tell the people in your life you love them" (p. 189). Facing death at work is a difficult situation through which she learns to make use of every moment in life.

The neurosurgeon from *Do No Harm* is another doctor who in his memoir proves that learning takes place through observation of performed activities and being exposed to the observation of one's own activities by others. While presenting one of the past stages of his medical career, namely that of a junior doctor, the surgeon recalls that it inseparably involved practice of learning on the job. Since he wanted to be a surgeon, he managed to find a job in his teaching hospital. He performed his tasks while working from Monday to Friday, and additionally was on duty on every alternate night and every other weekend, which amounted to being in hospital 120 hours a week. As a young surgeon, he had to acquire a lot of abilities in the workplace. He recalls being handed by his predecessors the bleep with tips on how to keep the boss satisfied and how to help dying patients. This information was new to him (then a junior doctor), as it was not covered in the textbooks or lectures. His day and night duties also included clerking in patients, filling up forms and blood-taking. He also assisted in the operating theatre and had to hold patients' abdomens open with retractors while his seniors were operating (p. 80). Although he enjoyed being among junior doctors in hospital, after a few months, he became more uncertain about which direction his medical career should follow. His superficial

impressions of the surgery he saw when he was a theatre porter were completely different from the ones he saw at the moment. He noticed that surgery is connected with "unpleasant, smelly body parts, sphincters and bodily fluids". He thought it was unattractive and repulsive (p. 80). The surgeon underlines the impact of several surgical teachers in the hospital without whom he would not have decided to become a surgeon. What he finds inspiring is their kindness to patients and technical proficiency (p. 80).

The surgeon emphasizes an inspiring value of visual impressions. When he saw the neurosurgery ward for the first time, he realized he would like to work there. He had not had the chance to see it as a medical student or a houseman: "The neurosurgical operating theatre was out of bounds, and people spoke of it with awe, almost alarm" (p. 80). He stresses the significance of just watching. The surgeon spends six months watching surgeons operating. This activity of observing leads him to becoming a surgeon later on (p. 76). The surgeon writes about the nature of operating: "I found its controlled and altruistic violence deeply appealing. It seemed to involve excitement and job security, a combination of manual and mental skills, and power and social status as well" (p. 76). The process of growing mature enough to become a neurosurgeon took a long time: "Nevertheless, it was not until eight years later when as a junior doctor I saw that first aneurysm operation that I discovered my vocation" (p. 76). Like the intern from *The Real Doctor Will See You Shortly*, the young surgeon gains practical knowledge from observation of his workmates and his superiors. The surgeon develops a passion for neurosurgery, and this passion originated from observation. Recapitulating his own experience in this field, the neurosurgeon draws the reader's attention to the importance of observation of medical procedures when they are performed. He moves from the description of his own observation to how he is subsequently subject to observation by young generations of prospective doctors. The surgeon approaches this issue from both a student's and later a teacher's perspective. He mentions briefly that the surgical team watches him operating on a video monitor attached to the microscope (p. 25).

Many fragments of his memoir are aimed at training young medical specialists on the job. Thus, his memoir offers a different, didactic perspective. His concept of practical training in the profession entails engaging trainees in parts of operations and enabling them to see their course. During those operations, an experienced surgeon also explains to young adepts what he is doing. He argues that supervising and instructing the novice staff requires effort, involvement and responsibility from the surgeon. He admits that operating on his own would be much simpler than supervising the novices in addition to his regular work. Despite this, the

neurosurgeon is strongly attached to his didactic activity and approaches it with great responsibility. Therefore, he does not even think of leaving the operating theatre for the juniors to perform even the simplest surgical procedures. He feels compelled to be present in the room. As a result, the surgeon's work also entails wandering in and out of the theatre, watching with a slight jealousy juniors performing activities and only scrubbing up in case they reach the patient's brain and the operation becomes more perilous or intricate (p. 119). Only when the operation enters a decisive stage does the surgeon become directly involved in its course. The surgeon explains why being a trainee is more comfortable than training others. He thinks about it when he becomes a consultant and years of being trained come to his mind as almost carefree ones. The responsibility for mistakes made by a trainee is taken by his/her consultant, rather than by trainees themselves. The viewpoint changes when the doctor becomes a consultant and considers the self-confidence of his trainees, for whose mistakes he is liable, irritating despite his awareness that he was also once a trainee like them (p. 181).

To illustrate the training process, the surgeon brings readers closer to details of operations, his role in training and trainee's acting. The early stages of operation are performed by a junior neurosurgeon. If aneurysms are operated on, his assistants must give way to the surgeon quickly. The majority of aneurysms are coiled rather than clipped, which makes it impossible to train junior surgeons appropriately and the surgeon can only enable them to perform the simplest parts of an occasional operation, under surveillance (p. 29). In the phase when a junior surgeon replaces the surgeon, s/he is handed the loaded clip applicator, which s/he moves towards the aneurysm, but nothing happens. The surgeon observes the activity. Taking responsibility by the surgeon for trainees' actions can be stressful: "I nervously watch the clip wobble uncertainly around the aneurysm. It is a hundred times more difficult and nerve-taking to train a junior surgeon than it is to operate oneself" (p. 29). During the surgeon's surveillance, he makes sure that everything is all right by asking how it is going. As he enters the operating theatre, he puts on his glasses and a face mask to look at the wound. His trainee answers that it is fine, and the surgeon feels the trainee wants him to leave being aware that the surgeon would like to elbow him away and replace him in the operation. Then, the surgeon only asks hopefully if the trainee is sure he does not need him, to which he is usually assured that the situation is under control. The surgeon returns to the sitting room (p. 120).

The attitude of trainees presented in *Do No Harm* differs from this of the intern from *The Real Doctor Will See You Shortly*, who is very anxious and reluctant to perform procedures on his own. However, despite the trainees' self-confidence, in certain situations, the surgeon

must intervene in the operation. Those circumstances include either medically complicated conditions or moments when the surgeon does not want to risk waiting for trainee's further performance, and urgent surgical action is necessary: "The point at which I will take over will depend on the experience of the trainee and the difficulty of the case" (p. 119). The surgeon finds the situation vague: "After a while – probably only a few seconds though it feels much longer – I can stand it no longer. You're fumbling. I'm sorry but I'll have to take over" (p. 29). As can be seen, the surgeon needs to be cautious all the time, observe and know better than trainees whether or not they can cope with medical tasks by themselves. The surgeon presents the operation in which trainees participate partially because it looks too serious to the surgeon. The pregnant woman is about to have a tumor removed, and therefore she is subjected to the same general anesthetic as her unborn child. The surgeon's trainee carries out commands up to a certain point, for example, placing the retractor under the patient's front lobe, and sucking away the fluid by means of a sucker in another hand. The right nerve looks stretched, so the surgeon decides to take an action on his own: "I think I'd better take over now," I said. "I'm sorry, but what with the baby and her eyesight being so bad it it's not really a training case" (p. 55). After the whole procedure, the trainee rejoins and they close the patient's head together (p. 55).

All these examples reveal that the medical staff largely acquire practical skills on the job. This training takes place in a team. Working in a team, also emphasized by the intern from *The Real Doctor Will See You Shortly*, is described by the neurosurgeon in his memoir *Do No Harm*. Trainees learn by observing more experienced doctors in order to gradually become self-dependent and take responsibility for tasks entrusted to them. In this team, the surgeon plays a major role, but trainees also have important tasks to perform. They mainly watch or do parts of operations, whereas the surgeon takes over some procedures, and demonstrates or explains. The surgeon recalls the operation when the nurse informs him of having anaesthetized the patient. This is the time when the surgeon sends a junior doctor off to begin the operating procedures. The junior doctors do not work long hours, so they are willing to perform surgical tasks: "They are desperate for even the most basic surgical experience and I feel obliged to leave all of the opening and closing to them as this is a simple and relatively safe part of brain surgery, even though I would much prefer to do it myself" (p. 119). The surgeon also shows to the trainee how some procedures need to be performed in practice. They start the surgery together by making a curving incision near the patient's forehead. On this occasion, the surgeon talks to the trainee Patrik during the initial stages of the procedure. The doctor avoids leaving too big

cosmetic mark after the surgery: “I showed him how to make a single burr hole in the skull just out of sight behind the orbit and then use a wire saw called a Gigli saw […] the power tools we usually use– to make a very small opening in the skull” (p. 52-3). The surgeon explains the function of the applied device, although operating the Gilgi looks violent, as hands are used to pull the saw forwards and backwards and causing the fly of blood and an unpleasant screeching sound, it enables to make a smooth and ideal cut (p. 53). The above examples from *Do No Harm* and *The Real Doctor Will See You Shortly* show that learning how to do things in practice occurs through observing colleagues at work and one’s superior, and both those types of learning belong to valuable educational experiences. They enable seeing practical dimension and characteristics of the work.

4.3. SELF-ANALYSIS

Practical abilities are gained by an inexperienced medical specialist by seeing what other medical staff is doing. Being cautious is useful. The intern includes his observation of his workmates. Sometimes he compares himself to them, and wonders at which stage of professional development he is in comparison with them. He distinguishes between different kinds of interns: the ones who went to a medical school for internship directly after college and those who did not. The intern is convinced that those who did not opt for medical schools immediately after graduation are more comfortable about interacting with patients. He thinks so looking at his colleague who passes the diagnosis of HIV to the patient skilfully in a “less frantic and forced” way than he would have done. The intern acknowledges that he would not manage to do it so well (p. 159). He is preoccupied with his medical skills, which he reveals in his conversation with a female colleague Ariel. Both of them discuss their attitudes to work and share their doubts and dilemmas. They are full of doubts about their abilities. The male intern states that the activities they perform are strange. Ariel agrees and adds that at times she worries she is a danger to herself and patients (p. 160). The intern continues: “I feel like I’m a wall that needs to get painted” (p.160). Comparing himself to the unpainted wall indicates that the intern looks at himself critically and can admit to himself that he has not acquired all the necessary skills yet. What is more, his utterance signifies anxiety that his lack of practical skills may harm patients. That may be a source of stress to the intern. However, on the whole, the intern feels he is gaining skills, and describes that as follows: “every day a bit of paint gets splattered on

me" (p. 160). He explains that that paint is splattered whenever he is confronted with a new patient or a medical problem (p. 161). He stresses the significance of the practical aspect of learning medical skills.

Interestingly enough, he does not find reading about medical cases helpful, he even says he drops off before he reads the whole page. The intern appreciates the possibility of seeing some medical problems in person. This means making use of every opportunity to hear and see what a patient's condition involves. His colleague shares his powerlessness of facing a patient, who suffers from symptoms unseen by her so far. She states that one cannot learn medicine from one's sofa. Sofa is a metaphorical use for passive learning. The intern feels his colleague Ariel is also searching a way of learning on her own. The intern is curious to know if his colleague has similar dilemmas connected with mastering of medical profession. These are some of the questions he finds puzzling: "Had she made mistakes? Been talked down to? Or yelled at? Was she befriending patients like Benny?" (p. 161). The intern feels the need to find out how his colleague tackles the above issues. That would let him confront his professional situation and maybe would introduce some valuable tip into his professional life. Unfortunately, these matters may seem personal ones, and one needs to be on really close terms with another person to be able to discuss them. The intern realizes he has been occupied with his own world to such an extent that he did not see what it was like in his colleague's situation. His aim was to get through every single exhausting day. However, he does not find out about her way of dealing with challenges at work, and does not know how much he should elicit from her. He does not know if her reticence results from her wish to keep things for herself or letting him speak (p. 161). Finally, the intern is left to his own observation and analysis of his progress. He has a wish to become a better doctor: he arrives early, stays up late and cares about his job (p. 165). The intern is reflective about his work abilities. He thinks of his work mates, who rejoice practicing medicine. The secret of their joy intrigues the intern. He realizes a lot of interns, including himself, sometimes only pretend to derive pleasure from treating patients. The doctor may smile when in fact s/he is exhausted. The doctor may show enthusiasm when s/he offers to transport patients or collect blood when s/he in fact feels like leaving for home to eat a meal. All these are mere pretence (p. 172). By analyzing other medical workers' abilities and attitudes to healing, the intern is better able to define his own position and stage of development as a fully-fledged doctor.

Apart from describing how his trainees learn their profession, the surgeon from *Do No Harm* also talks about learning things in practice in reference to himself. He recalls his next

position at work, that is, how learning practical things at work was like when he was a junior doctor. The surgeon views this job as work involving more responsibility and less surveillance than the previous one as a house surgeon, when he was at the bottom of the hierarchy in his hospital. At that time he acquired a lot of skills in practical medicine in a short time span, though these lessons were not always pleasurable. His task was to see the patients, mostly admitted as emergencies through the casualty department after they arrived, and to care about those who were already in hospital units. The surgeon learned not to call the senior doctors about patients without prior to seeing them himself. The surgeon remembered being rebuked by his registrar when he asked him for advice before going and seeing the patient himself. Following this event, he would try to decide what action to take, and reserved ringing his seniors up only in such cases when he was truly uncertain (p. 82). In sum, there are moments at work when the doctor must learn or deduce what action to take on his own, without anybody's assistance.

Another more advanced stage of his training on the way to become a surgeon proves that the doctor's learning on the job is a process occurring all the time. That stage is when he completes his year as a houseman, comes back to his teaching hospital in London and works as a senior house officer on the Intensive Care Unit. The doctor thinks that working there is the first useful step in training as a surgeon. The tasks performed by him involve: filling in forms, taking blood, putting up drips, and also procedures that excite the doctor more, that is, the invasive ones, including inserting IVs or chest drains into the veins of the neck. The aspect of teaching comes in the form of practical instructions provided to him by junior doctors with broader experience. This matter of gaining practical skills by following other specialist's example is a binding feature in this memoir and *The Real Doctor Will See You Shortly.* The process of becoming involved in the field of surgery occurs at that time: "It was while working on the Information Technology Unit (ITU) that I had gone to the operating theatres and seen the aneurysm operation that prompted my surgical epiphany" (p. 84). The surgeon shows again that he becomes interested in surgery because he has seen others operating. Like in the case of the intern in *The Real Doctor Will See You Shortly*, reflections concerning his own professional skills and his progress at work appear in the doctor's mind in *Do No Harm*. The doctor also sees that it is a long process. That is a reflection that may be valuable to the reader of his memoir. The surgeon notices that in neurosurgery, one becomes good at performing complicated operations after gaining a great deal of practice. Unfortunately, this entails making plenty of mistakes at the outset and leaving a group of injured patients behind him/her (p. 210).

The surgeon states that doctors of his field need to have a thick skin to continue this profession or that they must be crazy. Regrettably, the commercial US healthcare system makes it difficult for surgeons to admit to their mistakes because it would be hardly affordable (p. 211). The surgeon from this memoir admits to his mistakes. At certain moments, especially when his patient's state improves, the intern feels he has acquired the necessary skills for being a doctor. He feels that by degrees, he is gaining confidence and becoming more efficient (p. 183). The surgeon claims that doctors think of medicine as the art of science, but he views things done in his job as a practical craft. This craft needs to be learned, and he makes this claim on the basis of the activity of clipping aneurysms, He says that learning that skill takes years. Even if the aneurysm can easily take the clip because it is exposed, plenty of conditions must be obeyed, the clip must be placed across the aneurysm and its neck needs to be clipped with no damage to an artery (p. 31). During his work, the doctor draws conclusions. Apart from technical skills, such as clipping the aneurysm, through years of operating he has also learned not to undertake pediatric cases. This tendency is caused by parents who did not accept the surgeon's refusal to operate on their child again and found another surgeon willing to do that and later sued him for negligence. The surgeon's lenient attitude towards parents turned against him, and he does not wish to repeat that mistake in the future (p. 136).

He discusses the role of experience in gaining courage, both of which come with time. That is the case with him, he has become braver with experience. Through practice, the surgeon has learned to cope with things which seemed terrifying and complex at first. Surgeons without experience are too cautious (p. 32). Both the surgeon in *Do No Harm* and the doctor in *The Real Doctor Will See You Shortly* see their progress. McCarthy finally reaches the point when he feels he has gained experience. This happens when another doctor tells McCarthy that he is now prepared for having interns to guide them, since miserable days are over and he is evaluated in a positive way. The doctor thinks to himself that he must have jumped into the body of a gifted physician and he does not know the circumstances, under which it happened. He recalls the time when his superiors had reservations about his acting, and he does not remember when the turning point was. The doctor wonders if it is due to some patient that he has earned his reputation (p. 273). The intern brings to his mind a problem with his progress. He wonders what his superior's opinion of him is. Does his superior think that the intern is making progress as a doctor? Does he think about the time spent together in the CCU (p. 174). The intern feels ready to be unassisted. He knows that in order to avoid making a mistake during the night, he would have to stay completely focused. The intern can observe his own progress from the time

perspective. He assesses himself as a person who values challenges. The episode with the patient Gladstone (in whose case in the past the intern overlooked bleeding and did not make a proper note) undermined his confidence for some time. However, afterwards he copes with a poor image of himself caused by this situation, and is evaluated in a a positive way by his supervisors due to his skillful performance of procedures and ability to present intricate cases in a concise way (p. 286).

He also spots that providing care to patients does not tighten his stomach any longer. He feels at ease looking at the patient with a problem and listing things which account for the trouble. He can also narrow down this list, and prioritize problems as well as consult other specialists – a neurosurgeon or an ophthalmologist – in order to gain dismissal or confirmations of his suspicion: "I felt different now because I was different" (p. 286). After almost the whole year of being an intern, he eventually feels like nearly a real doctor (p. 286). He also remembers the situation while working in a team, and the responsibility of caring about the patient alone does not scare him any more. It is what he wants to do (p. 287). Working for weeks in the ICU allows the intern to develop as an "autonomous physician". He feels it let him acquire medical knowledge along with technical skills and tactful empathy. After two weeks, he also stops hearing voices in his head. While examining a patient, the doctor no longer thinks of other colleagues in the context of help, he simply does not desperately need them. He knows he can cope on his own. Whenever he trips, he knows how to seek help and find a response. After almost a year of being an apprentice, he is also prepared for supervising other physicians, those with less experience (p. 305). He can see his transition, which took some time and effort. Things were not always so bright until he reaches that stage of his profession. The professional path presented by him in this memoir is clearly meant as a lesson and support to generations of young doctors or medical students who may be reading his memoir.

4.3.1. PROGRESS AND MISTAKES

All three medical specialists: the intern, the nurse and the surgeon devote a vast amount of attention to medical mistakes and their consequences. They present patients' medical problems resulting from doctors' mistakes and analyze those mistakes. All three memoirists believe in the educational power of mistakes. Some of them try to work out means of preventing mistakes in the future. Addressing the issue of learning from mistakes, the surgeon points to the following dilemma: although it is generally accepted that everybody makes mistakes and learns

from them, in the case of doctors, mistakes may be catastrophic for both doctors and patients. Mistakes leave in surgeons a sense of shame. It is difficult to admit having made a mistake to oneself and to others. According to the surgeon's observation, as a result, doctors choose to disguise their mistakes or try to blame someone or something else. To confirm that the surgeon says lying is easy when something went wrong during an operation:

> You can invent plausible excuses – besides, patients are always warned that the nerve damage can happen with this operation, even though I have scarcely ever seen it happen […]. I know of at least one famous neurosurgeon, now retired, who covered up an even more major mistake on a very eminent patient with a dishonest operating note. (p. 173)

Going against the tide, the surgeon feels obliged to reveal his past mistakes in his memoir (p.154). He claims that writing about his mistakes in his memoir is dictated by the hope that his trainees will learn not to repeat the same mistakes. He mentions surgeons attending Morbidity and Mortality meetings held to discuss their preventable mistakes and learn lessons from them. The surgeon feels that if he had not written them down immediately, he would have forgotten them completely (p. 155).

He recalls one of his mistakes he presented at the Morbidity and Mortality meeting. That mistake resulted from his carelessness. It concerned a young man admitted to the hospital. Being late for his outpatient clinic, the surgeon just looked quickly at the scan, and agreed with his registrar that it was probably an inoperable tumor, in which case a biopsy operation was a solution. Now the surgeon sees that he ought to have inquired more about the patient's history and after obtaining information, he should have analyzed the scans more critically or consulted a neuro-radiologist for an opinion. After performing a biopsy operation, the analysis indicated an infarct, not a tumor: "In retrospect it was rather obvious that this was what the scan had shown and I had misinterpreted it" (p. 157). The surgeon did not think much about that case, but two years later he received a letter written to the Complaint Office, in which the patient's father accused the doctor of his son's death. The doctor's conclusion is that despite his mistake and redundant operation, the patient's death was caused by a stroke, not by any surgical error (p. 158).

The surgeon recalls another situation from his professional life, which taught him medical humility. After operating on a patient, he learns that removal of all of the tumor is wrong when he sees the operation can take extremely long. He is not likely to allow an operation to last longer than seven hours. He realizes that then he will be more efficient with this type of tumors. One more lesson is that he should not perform an operation which a surgeon with greater experience did not wish to undertake (p. 213). That lesson comes after the event when

he starts removing the last fragment of the tumor: “I should have stopped at that point, and left the last piece of tumor behind, but I wanted to be able to say that I had removed all of the tumor” (p. 211).While removing the last fragment of the tumor, he tears a branch of the basilar artery. Arterial blood begins to pump upwards, which results in damage to the brainstem. The patient does not manage to ever wake up and the surgeon sees him unconscious after seven years in a nursing home, which is painful to him (p. 212). The surgeon’s actions during the operation are also an effect of what he saw at open lectures for doctors. During these lectures famous specialists showed the post-operative scans, but they never presented residual tumor, so the surgeon inferred total removal was proper. That is why the surgeon’s lesson was to treat keynote lectures with a dose of skepticism (p. 211).

The surgeon attempts to trace the reasons for his mistakes. He recalls yet another mistake caused by unconscious carelessness. After an operation, a patient develops a streptococcal infection, which is initially missed by the surgeon. The patient’s husband calls him while the surgeon is occupied with an emergency. The surgeon does not fully understand what the family member says and misdiagnoses the affliction considering it a harmless inflammation. Since the surgery went successfully, he does not expect any complications and dismisses the signs of condition, which subsequently seem to him self-evident. The doctor’s delayed diagnosis leads to the patient’s paralysis. The surgeon regrets diagnosing the problem on the basis of a phone call. He can only say he was distracted and preoccupied and no grave complications had occurred previously with that type of operation (p. 188). The surgeon’s unpleasant memory shows that sometimes it is safer to ask the patient for a check-up visit to ascertain if his/her problem is trivial or serious. This step makes it easier to alleviate medical complications. This is what any trainee can infer from the surgeon’s mistakes.

It must be difficult for the surgeon to list his professional mistakes, but he bears a higher goal in his mind: the hope that his mistakes can be a lesson for other medical specialists. He also stresses that being a neurosurgeon involves the possibility of inadvertently making mistakes and putting people’s lives at risk. He describes the surgeons’ mental pain connected with confrontations during rounds, the patients whose lives they destroyed and facing those patients’ families (p. 190): “You can’t stay pleased with yourself for long in neurosurgery. There’s always another disaster waiting round the corner” (p. 191). The surgeon extends the topic of mistakes by writing about mistakes committed not directly by himself, but which occur in the process of teaching the medical staff. He is weary of training juniors, which is conspicuous in his thoughts: “Why don’t I just stop training juniors? Why don’t I just do all the

operating myself?" (p. 174). Training juniors is a burden, and deciding whether juniors can operate or not is a particular challenge because their skills and aptitude cannot always be properly assessed. He thinks training others is not safe for the patient, whose health may suffer, and for the surgeon if a mistake is conducted under his guidance (p. 174-5). These thoughts come to his mind in the context of the mistake made by a registrar, not a junior doctor. Only after the operation started, does the surgeon see that the registrar severed the nerve root: "It became apparent that my registrar had completely misunderstood the anatomy and opened the spine at the outer rather the inner edge of the spinal canal and hence immediately encountered a nerve root, which [...] he had severed" (p. 171-2). The surgeon finds this mistake incomprehensible since the registrar has had the chance to observe numerous operations of this type conducted before and performed them by himself. The effect of this mistake will be ankle paralysis and a limp for the rest of his life. The registrar proves to have less experience than the surgeon had thought (p. 172) and the surgeon's misjudgment of his skills has consequences for him as well, in fact, mainly for him as the patient puts the blame on the surgeon, whom he trusted (p. 174). Although these situations took place in the past, the doctor still remembers and shares his memories with his readers as an explanation and a warning to prospective doctors. He stresses the doctor's role as a teacher and points to the responsibility resulting from it. The surgeon conveys the message that mistakes can frequently be avoided by cautiousness, but at times they are inevitable in the medical environment. Writing openly about mistakes results from the memoirists' conviction that by sharing those situations, they can learn a lesson and teach others, too. In this way, they make use of their unfortunate experiences.

Like in Marsh's memoir, Lisa Sanders in her one *Every Patient Tells a Story* also tackles medical errors, but their nature differs from those performed in surgery because those specialties differ. She shows that in internal medicine, mistakes can result from negligence or incompetence. She claims that each single component of gathering medical data (taking an improper history or carrying out an unsuccessful examination or complete resignation from it) can lead to diagnostic mistakes. Furthermore, misinterpreting or misreading the test can give rise to derailment of a diagnostic process (p. 198). By a diagnostic error, she means a wrong diagnosis, which is delayed or missed. Diagnostic errors are reasons for malpractice lawsuits filed against healthcare institutions (p. 197). These suits lead to dishonor and discomfort to the those medical centers and doctors themselves. Awareness of how to diagnose correctly could alter the plan of treatment. Sanders presents a survey analyzed by Berner, which indicates that a third of patients taken to an emergency room express their fear about medical errors, the

greatest number of which concerned the risk of being misdiagnosed. The data analysis reveals that a diagnostic error rate range from 2 to 10% in primary care doctors. Improper diagnosis occurred in up to one in ten patients who consulted the doctor.[347]

Sometimes errors are the result of both types of mistakes: errors related to the medical system and cognitive errors (p. 199). The doctor and researcher at the VA Hospital on New York's Long Island distinguished the most common error, a cognitive one, by which he meant errors caused by physicians themselves (p. 199). The author illustrates errors by including patients' medical stories. In one of them, she presents a cognitive error combined with a system-related error through an example of a patient, who is admitted to an ER to two different emergency rooms. Since obtaining the patient's records from one room is time-consuming, his second visit is a repetition of the first one. The patient's assurance that myocardial infarction was excluded is not taken seriously without medical documentation and doctors' focus of attention does not go beyond that area for fear of missing the diagnosis. A lack of his records results in delayed diagnosis, which is a system-related error (p. 200). In this way medical specialists fail to reach the diagnosis of pernicious anemia because they do not bother to ask "What else could that be?" and disregard abnormal symptoms during his physical exam or the history of numbness and weakness (p. 203). In the aforementioned example, the doctor advocates a bigger mindfulness in dealing with the patient. Doctors could just focus more on the patient by listening to what he tells them and asking him more questions which could lead doctors to helpful ideas.

In the discussed memoir *Every Patient Tells a Story*, the attitude to errors is scientific and didactics-oriented. Another kind of cognitive error Sanders discusses is what is referred to as diagnostic momentum in cognitive literature. It means that a diagnosis once labelled to a patient stays there forever. In a medical school, students are instructed simply not to accept a diagnosis made in case of some patient without re-evaluation of the data for themselves and only then accept or reject this diagnosis. According to Lisa Sanders, doctors ought to start anew and think things through for themselves. She is aware that this is not an easy thing to do when the doctor is tired or in a rush. Thinking it over requires analyzing all available test results and evidence related to the diagnosis. Even if the physician puts effort into starting fresh, it may not be easy to follow the same "well-defined pattern of disease", either mistaken or not, previously defined by those who have examined the patient before. The memoirist's conclusion is that this

347 Berner ES, et al. "Overconfidence as a cause of diagnostic error in medicine." In: *Ann J Med*., 2008, 121(5A): 2-23.

effort is worth trying (p. 209). Sanders makes an identical point to Marsh about learning from one's mistakes, which is possible after having performed one's job for an extended period of time. She starts by presenting an insightful diagnostician who manages to get at the reason for the patient's autoimmune disorder. The patient visits the diagnostician to consult the diagnosis and obtain treatment. This diagnostician decides that although the patient comes to him with a diagnosis, he must examine the matter from scratch. After a series of blood tests, a lung biopsy, CT scans, he solves the problem by diagnosing it as sarcoidosis and applying anti-inflammatory medicine, after which she can breathe more easily and her cough disappears. Sanders claims that the diagnostician has not always been so successful with his skills. He learns to check and double-check other medical specialists' work:

> He learned this and many other invaluable lessons about diagnosis over the course of a long career. And that […] is why we can be hopeful that doctors and other health care providers can avoid or even eliminate the types of cognitive errors we have encountered in this chapter. (p. 213)

The internist develops her thought and continues that although doctors as human beings are inclined to be biased and distort the perspective, they are capable of learning from their mistakes and overcoming prejudices rooted in them. For this purpose, she also recalls her past failure, which has been a part of her learning process. The internist includes her own story from the past. In the third year of medical school, she was supposed to intubate a patient who was unconscious. Even though intubation is a basic technique in medicine, she did it wrong. She slid the tube for breathing into the esophagus instead of placing it in the trachea. When lungs were silent, she realized her mistake and felt embarrassed in the presence of her supervising doctor. The doctor was not angry and announced that what was shameful was not intubating the esophagus, but omitting to check the procedure and see the error (p. 214). According to supervising doctor's message, mistakes are inevitable, they will always occur in the form of technical or cognitive ones. Her supervising doctor advocates working out and adopting one's own ways to eliminate mistakes: "The key is designing our systems, our procedures, our protocols, and our own thinking processes to minimize mistakes as much as possible and then to catch mistakes when they are made" (p. 214). Arguing that alertness in an important part of a doctor's work, in her memoir, Sanders provides examples known to her, which she finds useful for explaining her point. She writes about a national attempt to eliminate medical errors by implementing the notion of checks and double checks to catch errors before they occur. She expands on this concept and refers to numerous strategies that were developed by the airline industry and have been applied in hospitals and operating rooms in the United States. In practice, surgeons are obliged to follow a pre-surgical checklist along with the surgical team

members. Team members gather prior to the operation and this meeting is a chance for them to raise any anticipated or visible problems (p. 214).

Sanders presented the results of the study in an article published by the *New England Journal of Medicine*. In it, she indicates that applying a nineteen-item surgical safety checklist contributed to a drop in mortality by almost 50% and the number of complications by a third[348]. Another study shows that adopting a checklist before particular procedures in the ICU can save lives and minimize medical errors by 80%.[349] Diagnostic errors, which constitute a certain part of all the mistakes are connected with cognitive limitations that physicians must struggle with, namely the limited capacity of human brains. Regardless of a doctor's experience and the number of patients seen by this doctor and textbooks read, a single human cannot know it all because medical knowledge has significantly expanded. This problem could be solved by augmentation of one's "personal neural computer with actual computer", which does not feel weary or confused and whose memory capacities are unusual (p. 215). Being aware of one's fallibility and mistakes made by other medical specialist is the first step any doctor can take to avoid errors.

The doctor from *The Real Doctor Will See You Shortly* also detects his own professional mistakes, and realization of them makes him wiser. He reveals his past way of seeing things and his attitudes, which he considers wrong at present. The conclusions he draws from his oversight of patient's bleeding are visible in his daily work. Afterwards, he orders repeating potentially redundant head scans a few times a week as well as consultations with a neurologist. The intern also realizes that some of his attitudes need modifying; namely, he sees the need of becoming more independent at work and wonders what will happen when he becomes a supervisor himself. He notices that so far, he has been surrounded by his colleagues, who signaled to him whenever his behavior or attitude was improper; for example. that he was not cautious enough. The intern is aware that one day he would have to "cut the safety net" (p.123). He analyzes his attitudes and behaviors in retrospect, which leads to fruitful observations. It happens when the doctor himself is a second-year resident, and four enthusiastic and anxious interns stand in front of him and are waiting for rounds. During the final weeks of his intern year, he turns back in thoughts, analyzes his initial time and comes to the conclusion that he did not focus on patients' matters sufficiently: "I simply hadn't had the capacity to fully immerse

348 Haynes AB et al. "A surgical safety checklist to reduce morbidity and mortality in a global population." In: *New England Journal of Medicine*, 2009. 491-499.
349 Pronovost Petal, "An intervention to decrease catheter-related bloodstream infections in the ICU." In: *New England Journal of Medicine*, 2006. 2725-2732.

myself in my patients' realities" (p. 313). These thoughts constitute the doctor's self-education. He realizes certain facts of which he was not aware before, such as not giving the patient enough attention. However, this lack of sufficient focus on patients was determined by the will to get on with his studies. This is how he explains that to himself: "I was so busy trying to master the medicine – to listen for a murmur or a wheeze rather than a note of despair – that I'd missed out on crucial opportunities to intervene in my patients' lives" (p. 313).

The doctor develops his point that in his clinic of primary care he cared about patients' strictly medical needs, such as ascertaining whether they had proper medicines. While handing a prescription, he did not notice the signs of distress or the wrinkled eyebrow. However, it took him a year to develop his ability to see more than just diagnosis and cure for a disease: "I developed the ability to think outside the diagnosis, beyond the science of medicine to the art of medicine. I discovered that there is so much more to being a doctor than ordering tests and dispensing medications" (p. 313). He concludes this ability cannot be taught in any way; it is acquired with time and by repetition (p. 313). The doctor wonders to what extent he can guide his students (p. 313). He casts his mind back to the situations which took place on the hospital floor; moments with the patient Dre and other ones. He is eager to get to know more of her story, which is probably connected to her medical problems (p. 319). The doctor feels his erroneous attitudes were inevitable, and they constitute the process of learning.

4.3.2. THE ROAD TO BECOMING A DOCTOR

Medical specialists portrayed in the memoirs make observations about their past university education, and sometimes compare past and present trends in medical education. They also divulge what is important to them as far as their own medical education is concerned. The surgeon from *Do No Harm* juxtaposes his entrance exams with the present ones. The very first stage remembered by the surgeon dated to the 1970s, marking the beginning of his education, was a five-minute interview with the Medical School Registrar. The surgeon remarks that since then, the procedure of selecting students for medical schools has become more rigorous. For example, the Medical School at the London hospital, which is his workplace, apart from other procedures, adopts role-playing with actors to shortlist candidates for future doctors. Applicants are expected to show how they can break sad news by informing an actor that his/her pet has had a fatal car accident. The doctor does not argue, however, that this concept is better

than the previously practiced process he underwent (p. 77). Although the surgeon does not have evidence how effective these interviewing techniques are, asking candidates to enact a role may be a way of making them realize that skills connected with empathizing or communicating certain things to others also matter. The surgeon stresses the need of learning in an authentic way, and he refers especially to teaching anatomy. To explain the importance of learning from autopsy, he describes his first stage of education, which was joining the MB course, that is, a traditional course lasting five years and offering medical training at an undergraduate level. He recalls that within classes, students spent time titrating chemicals for chemistry and "dissecting and disassembling" rabbits for biology. They also attended physics lectures. He remembers the anxious atmosphere which resulted from the fact that although students wanted to become doctors, the majority of them felt inadequate and unsuccessful (p. 78).

The surgeon comments on each stage of his education. Pre-clinical studies in a medical school took him two years, during which he learned physiology, anatomy, pharmacology and biochemistry. After this education three years of clinical studies in the hospital ensued. In anatomy classes, students were divided into small groups, and each group slowly took an embalmed cadaver apart during the year. Marsh looks back on the first day of the course, when students were holding their new dissection manuals containing several instruments and queued nervously on the stairs in front of the Long Room, which is a huge and high attic space with trolleys containing "sinister shapes covered by green tarpaulins" (p. 78). The room attendant presented intact corpses to new students. Marsh emphasizes that this way of learning was a part of traditional education practiced for hundreds of years, which – as he adds – has now been abandoned to a large extent. The surgeon stresses the need to learn real anatomy anew and points to the difference between the anatomy of the body that lives and bleeds and that of the grey, greasy flesh of cadavers embalmed for an autopsy. He is aware that the anatomy students learned from dissection was of limited value, but it constituted a crucial initiation rite, enabling students to pass from the lay world to that of death and disease. He views that way of learning as a sociable process because it meant sitting with a group of classmates around their cadaver, scratching away and picking at dead tissue. He says it also meant learning a multitude of names for veins and arteries, parts of bones and organs.

On this occasion, he expatiates upon his personal fascination with the anatomy of a hand. The surgeon recollects the anatomy department where students were given a plastic bag with hands inside in different dissection stages from which he liked to make colorful and elaborate drawings (p. 79). He derived satisfaction from that type of learning. The surgeon also

compares practical training at the time of writing his memoir and in the past. He seems to perceive the contemporary learning process as simplified or condensed. This also applies to interpersonal relations. When he worked as a consultant about twenty five years before, he used to know all of the registrars as individuals and was interested in their careers. At present, they appear and leave as quickly as patients do (p. 17). This speed also refers to certain actions that are done almost automatically, such as informing the patient of risks connected with the operation prior to its performance and how those risks outnumber the reasons for not taking any action (p. 36).

The internist from *Every Patient Tells a Story* is another figure to look back on his education. She detects both the perennial aspects of educational process and traces certain differences in teaching the medical staff, too. She has not observed changes in medical training since the end of the nineteenth century. It was at that time that residency system in hospital was developed by William Osler as a means of institutionalizing and standardizing medical internship. The memoirist continues that it takes some time for doctors to embrace the modifications:

> Medicine has held on to the paper chart long after virtually every other profession has made room for electronic efficiency. Physicians are so reluctant to change the way they practice medicine that it takes on average seventeen years for techniques well established by research – such as giving an aspirin to a patient having a heart attack – to be adopted by even half of those in practice. (p. 75)

The internist shows that although it usually takes the whole generation of doctors before a new practice becomes routine and a part of medical tradition (p. 75), the situation is different in the case of a physical exam. Doctors have seemed willing and enthusiastic to resign from the physical exam, which was conscientiously developed over the past two centuries, although over the years, there has been a rising conviction that a physical exam can greatly contribute to the doctors' understanding of patients and their illness. The view that the physical exam plays a crucial part in treating patients has an impact on the education of new doctors. In reference to the importance of physical exam, the following questions arise: Which elements of the physical exam should be retained and which ones should be disposed of? (p. 76).

The doctor focuses on the order in which prospective doctors are taught to perform those elements of the exam, which include observation/sight, touching and listening (p. 76). As the memoirist sees the point in the physical examination and observation as an essential component of the physical exam, she devotes many pages of her book to a discussion of the way relying on senses is taught. Sight is crucial for prompt assessment and action. During the internist's studies and residency training, she was taught about the need to learn what "sick" looks like. It

gives an idea of how ill a patient is (p. 83). She refers to listening and spots a difference in an attitude taught at medical schools now and when she was a student. She points to a new generation of doctors who reject a patient's story as the main source of information. Instead, they classify a disease basing on changes that they see, hear, feel, smell or hear, in other words, on the doctors' objective observations, rather than the patient's subjective account. The internist remarks that emphasis in the curriculum nowadays is not often put on the ways in which information on a patient's symptoms should be obtained (p. 137).

4.3.3. PROBLEMS WITH THE PHYSICAL EXAMINATION

The internist wonders how it is possible for generations of doctors who work as residents and sometimes undergo subspecialty training not to improve their skills in the physical exam. She takes a closer look at a researcher and physician Salvatore Mangione, who on surveying programs of medical training concludes that structured teaching of primary physical skills could be found in just one in four programs. Rarely are trainees performing the physical exam under observation. Mangione's finding is that maybe doctors do not acquire these skills, since programs do not aim to teach them.[350] A similar point is made by Patricia Thomas, David Kern, Mark Hughes and Belinda Chen, who claim that in the course of history, residency programs seldom taught such abilities directly, as a separate course. The teaching of this type took place informally, while looking after patients. A resident lived in a hospital, which enabled him to acquire his skills through immersion. Then, residents could learn the skills of performing physical exams from older doctors as they watched them at work. Each day teaching physicians, residents, interns and students saw patients who were admitted. Their task was to review the patient's story, examine him/her and review essential physical findings noted by the team. Moreover, the attending doctor gathered with medical students and residents for a teaching session, during which he incorporated instruction in the physical exam at the patient's bed.[351] The internist notices that this practice of unstructured, informal educational sessions constituted main methods of instructing about patient care and the physical exam (p. 44). She observes that

350 Vulkanovic-Criley Jasminka, Criley S, et al. "Competency in cardiac examination skills in medical students, trainees, physicians and faculty." In: *Arch Int Med*, 2006, 166: 610-616.

351 Patricia Thomas, David Kern, Mark Hughes, Belinda Chen, *Curriculum Development for Medical Education: A Six-Step Approach*, Baltimore: Johns Hopkins University Press, 2016, p. 8-81.

the situation looks different now, and that this type of teaching has become extinct due to a number of factors. One of them is the will to reduce the costs of hospitalization, which led to shortening the patients' stay in hospital:

> Those with significant hear murmurs, the kind that make good teaching cases, are in and out of the hospital within days. […]. So there is less opportunity to do bedside teaching – a triumph of medical economy that only slowly has been recognized to have come at the expense of education. Patients zip in and out of the hospital too quickly for residents to learn from their exams. (p. 44)

The memoirist Lisa Sanders describes the same state of affairs as Henry Marsh does; namely, that practicing doctors appear in the hospital for a shorter period than it was in the past system. Nowadays, residents taking care of patients come and go from the hospital. The eighty-hour working week – introduced in 2004 in Chicago by the organization supervising medical education, the Accreditation Council of Graduate Medical Education (ACGME) – limits the amount of time spent in hospital by doctors, who undergo training. They spend little time with their patients because during shorter time spent at work, the amount of workload has not decreased. The internist compares the situation of present doctors-in-training to her own from the past:

> As in intern, I used to allow two hours to see my patients first thing in the morning, before work rounds when I presented the patient to my resident and the attending. This gave me plenty of time to talk with the patient, examine him, check his labs. With the eighty-hour workweek, interns in our program are not permitted to come into the hospital any earlier than one hour before work rounds. Given the dual demands of patient care and education – which are, after all, the purpose of residency – something had to give. Unfortunately, what's given up is the time doctors spend with the patient. (p. 44)

By this juxtaposition of two approaches, she reveals the contrast. The internist regrets that the time of confrontation with the patient has been reduced. She explains that today numerous diseases are routinely treated ahead of time, frequently before there is a need for patients to visit the hospital. This state of affairs is beneficial for patients, but in terms of education, it lessens the chance of patients' encounters with doctors or trainees and the chance for their education. In the past, informal teaching occurred; it depended on learning "at the bedside", which is no longer practiced. Today's concept of one-day surgery means that a patient comes only for a surgery, and is not hospitalized, but leaves the health care institution as quickly as possible to make room for the next patient. In this case, a trainee sees each patient for a short while and does not have much chance to attend to that patient. In this situation, medical education has not worked out substitute ways to educate doctors in terms of important skills useful for a physical exam. Disappearance of skills has led to a loss of faith in the benefits of this exam. Although officially a physical exam in crucial, in reality it is considered redundant (p. 45). The doctor deplores the fact that the value of a physical exam is no longer appreciated. Students are taught that crucial questions to ask are those concerning the content of the newest high-tech test or the

recent research on a certain therapy. These questions are substitutes for traditional ones such as "What did you see when you looked at the patient? What did you hear […] and feel"? (p. 46). Sanders recollects that during her medical education, she learned that "the physical exam feels primitive, intimate – even intrusive" (p. 46), in contrast to solutions offered by technology. She also realized that conducting this exam is psychologically daunting for the doctor. All these factors led to the loss of chief role that the exam once had (p. 46). The doctor confronts the attitude she was taught during her studies with stories she hears from doctors and patients today.

Sanders also discusses her own formal education, that is the way she was educated when she was a student. She focuses on the physical exam, which was taught both during the second year of studies and prior to starting students' clinical apprenticeship. Teaching lasted twelve weeks and consisted of lectures on the physiology of the organ system and the technique of the exam, which was sometimes not only explained, but also demonstrated. She seems not to be satisfied with the way she was taught: "I got a brief, very nonspecific chat and a book. And did I have any questions? No. Great. The end. All the real info I was left to gather on my own" (p. 153). The doctor managed to figure things out by spending hours walking through the hospital halls in search of medical students who were doing their apprenticeship and requesting them to demonstrate to her intriguing results of physical exam. She learned how to do a physical exam on her own by seeing patients, reading books and consulting older students. Her colleagues followed a similar self-education pattern (p. 153). The internist learned how to perform this examination by practicing it. The doctor juxtaposes this way of training with the present one in the Medical School of Yale University, where students are taught from the first day on methods of examination and interviewing. Every week during the first two years, students practice and analyze these methods in small groups to, at first on each other, next on patients in doctor's surgeries and in the hospital. Those medical students are accepted in hospital for their practice in the third year with rudiments of data-collecting tools: "They are ready to build on a sound foundation. However, it does not mean success. Unfortunately, there is frequently no one there to help them start construction" (p. 153).

She sees some progress in teaching the physical examination. Although it is now taught earlier, she still sees imperfections. The doctor goes on to evaluate her skills in performing physical exam after graduation from her medical school. She assesses her skills in this area as idiosyncratic and spotty, she even thinks that if she had been observed by the doctors she worked with at that time, they would have found her skills unacceptable. This, however did not worry her, as she hoped to learn the appropriate way of patient examination during her

residency. She was mistaken; time showed that although residency training ended, her skills did not improve. The doctor blames the lack of progress on the underlying negative attitude to the physical exam. The internist recalls the meeting with medical school directors and residency schemes launched by the American Board of Internal Medicine Pittsburgh (ABIM) with a view to talking about a new initiative to improve physicians' clinical skills in training. At this gathering Dr. Raquel Burananosky from the University of Pittsburgh expressed a complaint that residents did not have time for physical examination of the patient and no one cared about it. This was also corroborated by the student who participated in this meeting (p. 154). It seems that the medical staff is eager to find ways to improve their practical skills in treating patients. They are aware of the need to change the status quo, but overwork or lack of belief in their own abilities are still obstacles to recognizing examination as a preventative factor. Their professional meetings, like the one mentioned by the internist, give doctors a chance to face problems and come to conclusions.

The internist reveals how negligence in medical examination influences patient treatment. She claims that she learned about mitral stenosis from her own mistake, and that is how she has learned much of medicine. The internist realizes that she has yet to learn how to perform a proper heart examination, she lacks this skill in spite of practice and training. She admits to being among other doctors, who – like her – cannot recognize some principal heart abnormalities (p. 141). This inability to perform the examination properly leads to missing a diagnosis. She explains that her own and other doctors' oversight in the case of a patient with hypertension led her to develop asthma. Only later does the internist on the faculty of didactics, Dr. Eric Holmboe, manage to diagnose this patient while performing an examination. While listening to her heart, this internist hears a murmur overlooked by other specialists. After listening to the heart intently, the internist hears the murmur, too: "It was a quiet sound and I hadn't done the kind of thorough exam I had been taught to do, so I hadn't heard it" (p.145). The internist realizes she has missed an important symptom in her diagnosis:

> She was getting worse right in front of my eyes as the aperture of the mitral valve approached a critical stage. It distressed me to know I could have figured it out too, if only I had done a proper exam. How many diagnoses have we all missed, because, most of us don't have a clue about an adequate heart exam. (p.145)

The internist repeatedly focuses on the importance of practical skills in doctors' job and shows how they can be taught. She gives examples of ideas which were implemented in the American College of Physicians, where refresher course in clinical skills was started in 1995. Then, the college extended its offer by classes in suturing and skin biopsies, which are surgical procedures

done by internists so rarely that they tend to forget them. With time, it appeared that what doctors need most are common skills which they practice on a daily basis. They focused on the ways to examine different body parts, such as the joints and muscles, eyes or thyroid gland. The syllabus was diversified in answer to evidence that doctors started practice with gaps in their clinical skills, and these gaps could not be filled merely by reading textbooks. The first course showed that there was a demand for "hands-on learning". Doctors in their thirties and forties, who attended the course, realized that after completing their training, they needed to acquire practical skills they may have missed or learned insufficiently in a medical school. Sanders describes in detail the challenge of teaching the heart examination. Finally, the electronic dummy Harvey – invented in 2001 by the lab director, Doctor Patrick Alguire – became a solution. During the conference that year, a few classes were offered, which was excellent for physicians who needed assistance with heart examination. It allowed for refreshing skills for the basic cardiac exam. The device (Harvey) is a life-sized mannequin capable of simulating various heart conditions, imitating high-quality digital sound recordings of the abnormal heart and showing the arterial pulse. These features of the device are useful for clinical diagnosing of different heart diseases (p. 132). It can be concluded that the internist advocates application of technology in teaching medical specialists, but there are areas such as physical examination where human abilities predominate over technology.

Like Henry Marsh and Matt McCarthy, Lisa Sander reminisces about the time of her studies. Once again, she stresses the practical aspect of educating current medical students. She observes that since 2000, the final exam has been based on simulations. During those simulations, students are currently exposed to situations in which apart from recognizing the patient's problem, they also need to communicate with patients, just as in real life. In particular, she looks back on end-of-the-year final exam, at which there were no desks, and the exam consisted of six simulated patient encounters. The patients seen by students were actors trained to pretend any of the 320 medical conditions on which students in the U.S. are tested (p. 147). The test aims to simulate doctor's outpatients practice, each student is scheduled to visit six rooms. After seeing the list with the patient's complaints, students enter the room and collect information on each patient, which involves obtaining the patient's history, performing a physical examination and informing the patient what they think the problem may be. To perform the task included in scenarios students usually have to recognize a common illness and propose a suitable treatment. The example of a medical problem is a man's chest pain after exertion, to which a diagnosis could be unstable angina. It ends with writing a brief medical

note on the patient's state. Students have medical devices at their disposal, for example, a blood pressure cuff or a thermometer. These student/patient confrontations are videotaped and the teacher reviews them afterwards. This concept of simulation also allows for evaluation of the student. There is a form with yes/no questions for the teacher to mark. The exemplary questions are: Has the student introduced herself/himself?, Has s/he used simple language? And so on. The teacher also asks the patient about the encounter with the student. The teacher's remarks while discussing student's performance include such aspects as: empathy towards the patient, which is visible, for example, through stopping pressure on the pain spot as soon as the student has found out where it hurts. The skills checked during this test-simulation are useful in the future regardless of which area of patient's care the student will select. Nowadays, this model of simulation is repeated at the end of students' four years of medical school (p. 150). It can be inferred that the internist praises the form of examining students that consolidates theoretical and practical skills. She indicates how practical abilities are included in qualifying exams, together with theoretical knowledge.

In 2004 to get licensed, medical students were obliged to pass an exam in which they were tested on their clinical skills, such as the ability to take a history, do a proper physical exam, collect data necessary for diagnosis and treating a patient. In most states, doctors must pass the test called The United States Medical Licensing Examination, known as USMILE. The test comprises two parts, the first of which tests what knowledge students have as far as sciences of medicine are concerned, such as physiology, anatomy, pharmacology and genetics. The second part checks whether students understand primary patient care concepts (ability to interpret the data provided by the patient and ability to formulate a proper diagnosis). The internist analyzes the changes in testing students' practical skills over the years (p. 151). In 2005 the National Board of Medical Examiners, which supervises USMIE introduced evaluation of a real patient with observation by an experienced physician. This idea of a new test was not accepted with enthusiasm by medical schools. The American Medical Association and the American Academy of Family Physicians opposed to it. They complained about the costs connected with the requirement that students travel to one of the appointed centres across the country. Finally, despite these objections, students have to take this type of exam if they want to become doctors. Sanders considers the benefits of this test and the difference it made to what doctors do. In her medical school at Yale University, it has an enormous influence on doctors' training (p. 152). The change concerns already mentioned teaching of the physical exam earlier than it was previously, that is during the first year. Students are taught the

techniques of examining and interviewing the patient as early as on the first day of their medical education (p. 153). Then, they feel more comfortable in confrontation with the patient.

4.3.4. THE USE OF COMPUTER TECHNOLOGY IN MEDICINE

No matter how effective the system of education is, Lisa Sanders recommends gaining abilities on one's own. The doctor refers to the concept of broadening professional horizons beyond the university curriculum by lifelong learning. She also focuses on the need to acquire computer-aided procedures. She acknowledges the work done in this respect by Peter Szolovits of the Massachusetts Institute of Technology, who since 2006 has chaired a group of graduate students researching the uses of computers for biomedical decision support. The memoirist recalls attending his student seminar called Biomedical Decision Support. Sanders analyzes the vision of the future proposed by Peter Szolovits, who is fascinated by the abilities of computers, which could hold a substantial amount of data and thus meet the needs of medicine, especially the requirements of medical diagnosis (p. 216). Szolovits presented the idea of designing a computer for doctors to let them type patient's symptoms into a computer to obtain a set of probable diagnoses, but it did not appeal to the doctors who were present at the seminar and refuted it: "these are the hands of surgeon, not a typist" (p. 217)". Szolovits' idea from many years ago of creating a system that makes diagnosis easier and faster and delivers it to physicians via a computer, turns out to be impossible. Physicians wish to get to the core of patients' medical problem basing on their own abilities, not on the machine. However, were such a means available, maybe the doctors would start relying on it. Equally unacceptable to doctors are the techniques of artificial intelligence that assign the computer the main role as an expert consultant to the doctor. There is no market for it, as doctors are not interested in such a solution. They hold out their hope for their own inventiveness and do not believe computers could substitute them:

> Rather than trying to bring the average doctors up to a level of being super-diagnosticians, the emphasis and attention has shifted toward bringing below-average doctors up to current standards and helping even good doctors avoid doing really stupid things. That turns out to provide greater benefits to patients. (p. 218)

Sanders claims that a wide majority of physicians prefer to depend on their own or their colleague's brain in making a diagnosis rather than on a computerized diagnostic aid. Their argument is that computers lack satisfactory language skills to make sense of the patient's

symptoms. What is more, hospitals and laboratories do not use one universal computer software, which makes it impossible for any system to interface with the diversity of software used for keeping the patient data. The doctor would have to provide the data once more to have them considered. This software also means a financial investment. Medical specialists find it simpler to consult another colleague than base their diagnosis on a blurring clinical image. In sum, in medicine "The dream of a computer system that can think better, faster, and more comprehensively than any human beings has not been realized" (p. 219). The dominance of humans over computers at diagnosing results from the fact that computers are devoid of five senses which allow doctors to instantly process medical data about the patient, such as their posture, voice quality, skin tone and clues that are difficult to verbalize. Computers remain on the losing side, having at their disposal only numbers typed in by a human and are incapable of representing a complex living and breathing patient (p. 220). Despite these reservations, Sanders depicts how a doctor's openness to a digital brain, by which she means a computer, can be effective. She proves the usefulness of this device by presenting the problem of a patient with schistosomiasis, which is an infrequent affliction in the United States. It was originally missed and wrongly diagnosed. She talks about the doctor who admitted to his own limits and decided to rely on a digital brain:

> If you don't know about a particular disease or a particular region, you can miss something. This program helps you narrow down the differential. You can look at diseases in certain countries. If someone has a fever and a rash, and they are just back from Ecuador, you can put in the symptoms and the country and it will come up with a list of possible infections. (p. 225)

The internist presents a vision of the future in which medical digital brain – or a computer assistant – is considered an ideal tool in saving doctors' time and patients' lives. A nurse or a doctor who sees the patient for the first time may be at a loss. After entering lab results into a computer program, which is trained to track down anomalies, it generates an alert on the screen, urging the nurse to take into account, for example, a parasitic infection. With the increase of the Internet, advances in memory capacity and computer speed, and the spread of computers in the medical system invented in the U.S., there is a prospect of achieving a more perfect network (p. 226). Sanders writes about the web as an aid for doctors. The site will presumably support clinicians in a better way than the lay society. This results from doctors' more advanced knowledge, which they can use in searching for a diagnosis. Physicians use more specific terms, for example a myocardial infarction instead of a heart attack, and those terms will help them find more precise results. Clinicians stand better chances of identifying tips from the websites on medical conditions because of their pre-existing knowledge. Apart from the medical knowledge, one problem lies in a specialist language which may be applied in reference with

medical assistance offered by the Internet site. Patients can be at a loss in confrontation with the medical language and can find hints obscure (p. 236). Not understanding medical terms (for example, formal names of illnesses) encountered while consulting the Internet, the patient may not be sure what the computer exactly means or may misinterpret the content. One instance is myocardial infarction, which stands for a heart attack. It may take some time for a patient to establish or check the meaning of this medical condition, whereas the doctor will probably grasp its meaning immediately because of learning about it during studies.

The internist mentions in this context a Health Advisory Panel launched by Google and its organization – the National Library of Medicine for medical search (p. 236). Whereas self-diagnosis made by patients by using the Internet may be misleading, the web resources can assist doctors in the process of diagnosis. For example, a patient with a fever, increased heartbeat and rash, which constitute only part of all the symptoms, is admitted to hospital. Doctors are not sure about her problem suspecting either allergy, a viral illness – Coxsackie or West Nile. The patient decides to explore the problem on her own and resorts to Google. After entering a brief description of her problem, among several diagnoses provided by the browser, the patient focuses on the first result – Rocky Mountain spotted fever, mentioned by the physician. During another doctor's visit, the patient suggests this disease and admits to searching the information about her state on the Internet. The doctor takes it into consideration. Later on, this prediction is confirmed by the results. The above case shows how the doctor's diagnosis may be followed up by the patient and this action may in turn give clues to the doctor. Sanders admits that computers have transformed diagnostic abilities, the CT scanner being a meaningful digital tool as well. She reflects on the role of computers in the work of medical specialists and wonders whether a computer can eliminate diagnostic challenges and substitute doctors. She doubts it. Computer system can only facilitate and speed up the process of diagnosis. Nevertheless, medical specialists will always have to choose between probable diagnoses, treatment methods and tests to do. These decisions cannot be made by computers, but by knowledgeable and experienced people. Treatment is not all that patients need, which also includes explanation, reassurance, compassion and encouragement, that is, a full scope of emotional support constituting part of the overall treatment (p. 238).

All in all, apart from an extensive formal training at medical universities, medical specialists undergo further training, which takes place at their workplaces, such as hospital or a doctor's surgery. This stage of education will differ for every member of the medical staff, depending on their specialty. Doctors can also obtain a valuable feedback from their patients,

which is possible due to systemic–partnership model. This kind of partnership is described in Matt McCarthy and Lisa Sanders' memoirs. Additionally, medical memoirs can also be a lesson for medical specialists of any age or type; those with a longer work experience have a chance to confront and compare their experiences, and young ones are given ideas on how to approach, for example, an unwilling patient or convince him/her to undergo a vital medical test. Finally, memoirs can raise the readers' spirits when they see the memoirist's daily professional struggles, thoughts and reflections described in memoirs. Through memoirs, the medical staff may stop feeling alone in their experiences, which so far may have seemed strange to themselves, when they did not have anyone to share them with. Doctors depict their transition from the one who learns from others or on their own to the one who teaches other medical personnel (as in the case of the surgeon or the intern). Some doctors, especially Henry Marsh, prove that education arises from mistakes; either one's own (when the specialist sees them later), or somebody else's (when a young or older specialist reads about them in the memoir). The internist from *Every Patient Tells a Story* and the intern in *The Real Doctor Will See You Shortly* also learn from mistakes. The nurse is the only one who does not concentrate on her own mistakes, but is fully aware of how much she has yet to learn within her profession. Writing about mistakes definitely requires courage from the medical staff, but it serves others. A precious lesson is also gained from observing how medical activities are performed. Especially in one memoir – *Every Patient Tells a Story* – the doctor persuades that the Internet can be of help in diagnosis-making, on condition that it is only an extension of a specialist's skills.

CONCLUSIONS

Medicine is in a constant progress; along with the invention of new treatment methods and medicines, new approaches to patients are developed. As Maria Nowina Konopka notices, the outcome of social changes occurring after World War II can be observed in such fields as sociology of medicine and medical science. The reason for abandonment of bio-medical understanding of health and disease after World War II, and assuming a socio-medical and psycho-medical model was the conviction that a narrow model of phenomena analysis was no longer effective.[352] The past model was substituted by interdisciplinary and hybrid approach to a human being. In the 1970s, a holistic method of explaining ailments was developed and undertaking any type of therapeutic actions began to be focused on patients, that is, their generally understood psycho-social determinants, emotions and behavior. A holistic paradigm also needs to be bound with the conviction that experiencing any type of disease by the patient, is frequently not merely connected to his/her organism. Even if a disease is of somatic nature, it may be characterized by a non-empirical basis. Besides, it needs to be underlined that such a disease refers to numerous areas of human existence. Therefore, applying terms "a sick organism" or "untypical clinical case" is today viewed as a case of negligence. A disease evolves on many levels, and striving to cure it needs to take into account this multidimensionality. Undoubtedly, the efforts to treat problems related to patients and their wellbeing in a comprehensive way and to adopt an interdisciplinary approach as its foundation pose a significant challenge for the medical environment. An ability to approach one's profession in a holistic way has become a measurement of a professional approach to one's job. It concerns both medical knowledge consisting of preclinical, clinical and basic disciplines, as well as social competence, whose basis constitutes information derived from the field of communication and psychology.[353]

There is a greater demand for increasing competences, due to which satisfactory doctor-patient relations will be formed. It is essential, especially at present reality, distinguished by, among others, development of such processes as media saturation, namely, saturation of all social groups with instruments passing diverse data. Due to the existing common tendency to verify all judgements and views, today's patients frequently check and evaluate diagnoses and

[352] Maria Nowina Konopka, *Komunikacja lekarz-pacjent. Teoria i Praktyka*, Kraków: Uniwersytet Jagielloński, Instytut Dziennikarstwa, Mediów i Komunikacji Społecznej, 2016, p. 8.
353 Ibid. p. 8.

decisions made by their physicians. This action does not always influence relations with the medics positively. On this ground, using all the accessible methods can be used in order to lead to normalization of relations in this matter. According to one of the assumptions of this dissertation, one way is to reach for medical memoirs, which form a part of autobiographical literature. Conclusions formed on their basis give a greater chance of building harmonious doctor–patient relations and analyzing the quality of doctors‘ involvement into the particular patients' situation. Some medical staff bear it in mind and decide to record their daily professional experiences, which arises from their internal need. That is also an unmistakable sign of a growing humanization of the medical profession. This deserves attention, since it constitutes the answer to the danger of increasing treatment of a patient more like an object than a human being. Added to this is commercialization and commodification of medical services, whose consequence is pragmatic and utilitarian thinking, demanding attitudes expressed by the medics and disappearance of empathetic attitudes. The stoppage of the above mentioned tendencies can, among others, be achieved by implementing modifications to standard doctor–patient relations, and these actions are motivated by physicians' intensive autobiographical reflection.

This dissertation aims to indicate that there is something more to memoiristics than just a description of events and facts from private and professional life of the medical staff, their actions and reactions. Apart from the fact that memoirs comprise medical knowledge in the form of medical terms and descriptions of medical procedures (this is especially visible in the case of Theresa Brown), they above all involve the memoirist's reflections, feelings and emotions (exemplification of this state of affairs is the memoir by Matt McCarthy). They are a certificate of internal experiences of writers-doctors. An analysis of the experiences of doctors gives a valuable insight into the process of communication between the medical staff and patients, the emotions they feel, and their perception of the usefulness of theoretical knowledge in their professional lives. Therefore, the present dissertation argues that memoirs serve as an educational tool for the benefit of currently employed and prospective medical staff, who can compare their own attitudes towards patients to the ones described in memoirs .

This dissertation shows that keeping memoirs also concerns patients, who sometimes belong to the circle of medical staff at the same time. In autobiographical writing the memoirists – Matt McCarthy, Henry Marsh and Theresa Brown – assume the patients' viewpoint. This is the result of realizing by memoirs the idea of narrative medicine, whose aim is to contribute to a better understanding of the perspective of patients on certain events and phenomena and,

consequently, to implement more effective treatment methods. Narrative medicine accepts patients' thoughts, feelings and reflections, without distorting or rejecting them as false or inappropriate. Applying assumptions of narrative medicine in practical clinical activities, apart from the informative aspect, gives rise to treating the patient as a multidimensional unity interacting with the cultural and social environment. In short, the patient is perceived as a human being, not as a sum of bio-medical phenomena or disease entities. Narrative medicine also has a crucial educational meaning, since owing to it, critical thinking and interdisciplinary cooperation in a therapeutic team are improved, which in turn enable the medical staff to get to know their patients better and take appropriate actions to meet their needs.

Professional experiences described in memoirs kept by the medics may enhance professional development of active medical staff. Readers have an opportunity to explore attitudes and behaviors of authors, who offer analyses of committed mistakes. The sources of memoirists' research material are manifold. This can be examination of patients' stories, which is the case of Lisa Sanders, or invoking one's own patients, whom doctors treated during their professional path (this variant can be found in Henry Marsh, Theresa Brown and Matt McCarthy). For the author, recording his/her own experiences is a kind of return to the past, but the adopted perspective of a cool observer allows for elimination of excessive emotionality. For example, Lisa Sanders emphasizes the importance of the patient's physical observation, which amounts to relying on one's senses during the medical confrontation. She also stresses the need to listen carefully to the patient. Analogous conclusions are reached by another memoirist, Matt McCarthy, who in the summary of his professional career, confesses that he was not attentive enough to his patients, pointing out, however, that this was not intentional. It resulted from being engrossed mainly in the medical aspects of the patient's case.

Medical memoirs also become an inspiration for verifying the quality of education of future medical staff. By analyzing a multitude of patients and doctors stories, Lisa Sanders tries to find methods to optimize therapy. She argues that medical students during their educational path ought to gain practical skills that would enable them to perform a physical examination. She is also in favour of starting interviewing patients as early as possible. She is not an advocate of the view that contemporary technological solutions can completely be substituted for the doctor's observance of the patient and his/her reliance on such senses as sight, hearing or touch. A more holistic approach is advocated by this memoirist, assuming a possibility of getting to know the general background of a given patient and his/her lifestyle, by adopting an

individualistic approach that consists of asking questions concerning the patient's medical history.

Henry Marsh emphasizes the need to reveal his mistakes to his readers, which is supposed to serve didactic purposes. He is convinced that introducing students to medical memoirs, even in a fragmentary form, could be a part of the curriculum, for example independent reading as a form of self-education. From his standpoint, that would contribute to making students aware of the presence of some problems and would be a component building students' sense of safety, which is so significant while conducting professional duties in a healthcare sector. Referring to reflections present in medical memoirs, conclusions can be drawn, which concur with the basic assumptions of already mentioned narrative medicine. The main finding is that scientific progress ought to be accompanied by a humanistic one. This means that experience in creating appropriate relations with the patients gained by the medical staff, understanding the burden of illness which patients face and paying attention to patients' words and attitudes belong to factors, which enhance treatment effectiveness. All these abilities are the essence of doctors' attitude. They are more important than, for example, efforts to ensure that the profession is perceived as prestigious (it is stated by Matt McCarthy). In turn, Lisa Sanders presents the possibility of harmonious cooperation of a humanistic approach and technological support by exemplifying the Internet (computer aided) diagnosis, which however is realized through face to face confrontation with the attending doctor. The conviction that those models are beneficial for both sides – the doctor and the patient, is especially visible in memoirists such as: Theresa Brown, Matt McCarthy and Henry Marsh.

Medical memoirs also touch the matter of doctor–patient relations and relations within the environment of medical specialists (*Critical Care)*. Reflections included in medical memoirs contribute to working out or reinforcing of the partnership and the systemic–partnership models of doctor–patient relations in terms of communication. A distinguishing feature of the partnership models is that the patient participates in the treatment process and is jointly responsible for its effects, not only fulfilling medical orders, but also being the central link of the described relationship. In this relation, the physician is regarded as a counsellor, whose role is to present all accessible methods of diagnostics and therapy to the patient. As for the systemic-partnership model, the presence of partnership relations between the doctor, the patient and the patient's family is distinctive. They are a component of cooperating systems having a medical, family and social dimension. What matters is the impact of the environment, family relations and emotional problems. A close cooperation between the physician, the patient

and the family is observed in terms of formulating a diagnosis and planning therapeutic measures. Particular stages of treatment are related to both the patient's health and health conditions of his/her family members. The doctor's duty is to pay attention to the problems and health dangers that may run in the family. These include lifestyle, conflicts and disorders. Having the knowledge not only of the patient, but also of his/her family background gives the doctor a chance to work out a better supportive system and enhances the probability of a satisfactory final therapy outcome.

In doctors' memoirs, the reader can also find information on the course of mental transformation that takes place in medical specialists, who at the outset of their career acquire essential knowledge, and in the further stages of their professional practice, gain the status of mentors passing their knowledge to medical adepts. Observation of this kind indicates the priority value of patience as a particularly useful attribute in the medical profession. A careful analysis of doctors' reflections is visible in memoirs, such as *Critical Care* and The *Real Doctor Will See You Shortly*. One can claim that these books teach humility, since they prove that apart from acquiring practical skills from the staff with richer experience, learning from patients is also extremely valuable. For this to take place, the above mentioned art of listening to dependants is necessary.

Referring to an emotional component, it needs to be stressed that keeping memoirs is helpful for their authors in understanding and analyzing their feelings appearing while performing professional duties. To examine emotions experienced by the medical staff and patients, the research by means of sketch engine was adopted in this dissertation to measure the frequency of occurring emotions. This research shows that negative emotions, such as fear and anxiety, appear most often in this group of medical specialists. It needs to be added that the presence of positive emotions, such as joy, is also found both in patients and the medical staff. Its existence is especially emphasized by the nurse Theresa Brown and the neurosurgeon Henry Marsh. The above results prove that the medical staff, aware of their own and other people's emotions, is characterized by a better understanding of the specificity of their work, a greater sense of fulfilment and more grounded thoughts related to the quality of their profession.

Summing up the whole material gathered in the dissertation it can be stated that the theses formulated at the beginning of this dissertation have been corroborated both at the theoretical and the empirical levels. It can be hoped that the issues raised in the present study may well lead to further scientific activities, due to which analysis can be broadened and existing knowledge extended. This state of affairs is desirable owing to a constant progress in

medical sciences, which – as it was argued throughout this dissertation – ought to follow two paths: not only the technological but also the parallel humanistic one.

BIBLIOGRAPHY

Primary sources:

Brown, Theresa. *Critical Care: A New Nurse Faces Death, Life and Everything In Between.* New York: Harper Collins Publishers, 2010.

Marsh, Henry. *Do No Harm: Stories of Life, Death and Brain Surgery.* London: CPI Group, 2014.

McCarthy, Matt. *The Real Doctor Will See You Shortly: A Physician's First Year.* New York: Broadway Books, 2015.

Sanders, Lisa. *Every Patient Tells a Story: Medical Mysteries and the Art of Diagnosis.* New York: Broadway Books, 2009.

Secondary sources:

Abramson, Ann. *Who Was Anne Frank?* New York: the Penguin Group, 2007.

Agarwal, Renu. Selen, Willem. Roos, Göran, Green, Roy. *The Handbook of Service Innovation.* Sydney: Springer, 2015.

Ainsworth-Vaughn, Nancy. *Claiming Power in Doctor-Patient Talk.* Oxford University Press, 1998.

Alaszewski, Andy. *Using Diaries for Social Research.* London: Sage Publications, 2006.

Aleksander, Michael. *A short History of English Literature*. London: Palgrave Macmillan, 2007.

Allen, Lewis. *The Big Change: America Transforms Itself, 1900-50*. New York: Routledge, 2017.

Anderson, Linda. *Creative Writing: A Workbook with Readings*. London: Routledge, 2006.

Angrosino, Michael. *Exploring Oral History: A Window on the Past.* Illinois: Waveland Press Inc, 2008.

Awdish, Rana. *In Shock. My Journey from Death to Recovery and the Redemptive Power of Hope.* New York: St. Martin's Press, 2017.

Baggerman, Arianne. Dekker, Rudolf. Mascuch, Michael. *Controlling time and Shaping the Self: Developments in Autobiographical Writing since the Sixteenth Century.* Boston: Brill, 2011.

Barrington, Judith. "Writing the Memoir". In: *The Handbook of Creative Writing*, ed. Earnshaw Steven, Edinburgh: The University of Edinburgh Press, 2007. 109-15.

Ben-Ze'ev, Aaron. *The Subtlety of Emotions*. Cambridge: MIT Press, 2001.

Berner, Graber. "Overconfidence as a cause of diagnostic error in medicine." In: *The American Journal of Medicine*, 2008. 121(5A): 2-23.

Bleakley, Alan. *Medical Humanities and Medical Education: How the medical humanities can shape better doctors.* London: Routledge, 2015.

Bolander, Brook. *Language and Power in Blogs: Interaction, disagreements and agreements.* Amsterdam: University of Zurich, 2010.

Borofka, Deb Everson. *Memory, muses, memoir*. New York: Universe, Inc., 2010.

Boswell**,** James. *Boswell's Life of Johnson - Including Boswell's Journal of a Tour to the Hebrides and Johnson's Diary of a Journey Into North Wales*. London: LULU Press, 2010.

Boufis, Christina. *The Complete Idiot's Guide to Writing Nonfiction*. New York: Penguin Group, 2012.

Bowen, James. *A Street Cat Named Bob.* London: Hodder &Stoughton, 2012.

Bunyan, John. *Grace Abounding to the Chief of Sinners.* Destiny Image Inc., 2007.

Castro, Joy. *Memoirists on the Hazards and Rewards of the Family Revealing.*London: University of Nebraska Press, 2013.

Charon, Rita. *Narrative Medicine: Honouring the Stories of Illness.* Oxford University Press, 2008.

Charon, Rita. *Narrative Medicine: Honouring the Stories of Illness.* New York: Oxford University Press, 2006.

Charon, Rita. *The Principles and Practice of Narrative Medicine*, New York: Oxford University Press, 2017.

Chen, Wei-Ti. Starks, Helene. Shiu, Cheng. et al. "Chinese HIV-positive patients and their healthcare providers: contrasting Confucian versus Western notions of secrecy and support." In: ANS Adv Nurse Sci. 2007. 30((4)): 329–342. [PubMed] [Google Scholar]

Cieński, Andrzej. *Z dziejów pamiętnika w Polsce.* Opole: Wyd. Uniwersytetu Opolskiego, 2002.

Cleland, Jane. *Mastering Suspense, Structure, and Plot: How to Write Gripping Stories That Keep Readers on the Edge of their Seats.* Writer's Digest Books, 2016.

Couser, Thomas. *Memoir: An Introduction.* Oxford: Oxford University Press, 2012.

Crawford, Paul. et al. *Health Humanities.* New York: Palgrave Mcmillan, 2015.

Cullen, Rowena. *Health Information on the Internet. A Study of Providers, Quality, and Users*, London: Praeger, 2008.

Czermińska, Małgorzata, “O autobiografii i autobiograficzności.” In: *Autobiografia*, ed. Małgorzata Czermińska. Gdańsk, 2009. 9-16.

Czermińska, Małgorzata. *Autobiograficzny trójkąt. Świadectwo, wyznanie, wyzwanie.* Kraków: PWN, 2004.

Czerw, Aleksandra. Religioni, Urszula. Kunda, Angelika. Augustynowicz, Anna. „Samoleczenie jako problem zdrowia publicznego w Polsce=Self-healing as a problem of public health in Poland.” In: *Journal of Health Sciences*, Nr 4(9), 2014. 249-258.

Davies, Michael. Owen, W. R, *The Oxford Handbook of John Bunyan.* Oxford University Press, 2018.

De Quincey, Thomas. *Confessions of an English Opium Eater*. London: Macmillan, 2019.

Delany, Paul. *British Autobiography in the Seventeenth Century.* London: Routledge, 2016.

Dickenson, Donna. Richard, Huxtable. Michael, Parker. *The Cambridge Medical Ethics Workbook.* Cambridge University Press, 2010.

Domański, Henryk, and Antonina, Ostrowska, Paweł, Sztabiński. “Paternalizm czy partnerstwo? Relacje między pacjentami a lekarzami w Europie.” (red.), W środku Europy? Wyniki Europejskiego Sondażu Społecznego. Warszawa: Wydawn. IFIS PAN, 2006. 185-200.

Douglas, Kate. Poletti, Anna. *Life Narratives and Youth Culture: Representation, Agency and Participation.* Palgrave Macmillan: London, 2016.

Dozier, Rush. *Fear Itself: The Origin and Nature of the Powerful Emotion that Shapes Our Family while Helping an Aging Patient.* New York: The Guliford Press, 2006**.**

Einstein, Albert. Shaw, George Bernard. *Einstein on Cosmic Religion and Other Opinions and Aphorisms.* New York: Dover Publications Inc., 2009.

Einstein, Albert. *The World as I See It.* Snowball Publishing, 2018.

Eneyo, Michael Bassey. *Philosophy of Fear: A Move to Overcoming Negative Fear*. Xlibris AU, 2018.

Estape, Marion Rojas. *Jak przyciągać dobre rzeczy.* Warszawa: Muza, 2020.

Ezekiel, Emmanuel. Linda, Emanuel. "Four Models of the Physician-Patient Relationship", Jama, April 22/29, 1992-Vol 267, No. 16. 2221-2226.

Fong, Haennifer. Longnecker, Nancy, "Doctor-Patient Communication: A Review", Spring 10(1), 2010. 38–43.

Frank, Anne. *The Biography, Melissa Müller*. New York: Bloomsbury, 2013.

Frank, Anne. *The Diary of a Young Girl.* General Press, 2012.

Franklin, Benjamin. *The Autobiography of Benjamin Franklin.* Philadelphia: University of Pennsylvania Press, 2005.

Frijda, Nico. *The Emotions*. Cambridge University Press, 1986.

Gale, Cengage Learning. *A Study Guide for Mary Karr's The Liar's Club.* Gale, Penguin Group Inc., 2017.

Gamble, Teri. Kwal. Susan. *Interpersonal Communication: Building Connections Together.* London: Sage Publications, Inc. 2014.

Ganczar, Maciej. Wilczek, Piotr. *Literatura Piękna i Medycyna.* Wydawnictwo Benedyktynów: Kraków, 2015.

Giulia, Maria. *Narrative Medicine: Bridging the Gap between Evidence-Based Care and Medical Humanities.* Springer: Milan, 2015.

Gutkind, Lee. *The best creative nonfiction.* New York: Norton, 2007.

Hampl, Patricia. *The Florist's Daughter.* Florida: Mariner Books, 2007.

Hart, Tom. *The Art of the Graphic Memoir: Tell Your Story, Change Your Life.* St. Martin's Griffin, 2018.

Haynes, Alex. “A surgical safety checklist to reduce morbidity and mortality in a global population.” In: *New England Journal of Medicine,* 360(5), 2009. 491-499.

Herron, Rachael. *Fast-Draft Your Memoir: Write Your Life Story in 45 Hours.* HGA Publishing, 2018.

Hilger, Stephanie. *New Directions in Literature and Medicine Studies.* Pelgrave Macmillan: Urbana, 2017.

Hill, Zeta. *Sadness (Causes & Effects of Emotions).* Mason Crest, 2014.

Hofmeyr, Isabel. *The Portable Bunyan: A Transnational History of The Pilgrim's Progress. Oxford:* Princeton University Press, 2004.

Hossain, Munir Talukder. *Nature and Life: Essays on Deep Ecology and Applied Ethics.* Cambridge Scholar Publishing, 2018.

Hu, WenGang. Zhong, Xiao. Feng, JiaYu. “Improving doctor-patient communication: content validity examination of a novel urinary system-simulating physical model.” In: *Patient Prefer Adherence,* 2016. 2519-2529.

Hunt, Dixon John. *John Evelyn: A Life of Domesticity.* London: Reaktion books Ltd, 2017.

Imiela, Jacek. *Medycyna, moja miłość.* Kraków: Wydawnictwo Literackie, 2012.

Izard, Carroll. *Human Emotions.* New York: University of Delaware, 2013.

Jacobs, Barry. *The Emotional Survival Guide for Caregivers: Looking After Yourself While Helping Your Aging Parent. New York: The Guilford Press, 2006.*

Jankowska, Katarzyna. Pasierski, Tomasz. “Medical communication: a core medical competence.” In: Polish Archives of Internal Medicine, 2014. 350-351.

Jarosz, Mirosław. Kawczyńska-Butrym. Zofia Włoszczak-Szubzda, Anna., ‘’Modele komunikacyjne relacji lekarz-pacjent-rodzina.” In: Medycyna Ogólna i Nauki o Zdrowiu, 2012, Tom 18, Nr 3, 212–218.

Jolly, Margaretta. *Encyclopedia of Life Writing: Autobiographical and Biographical Forms.* London: Fitzroy Dearborn Publishers, 2013.

Kaplan, Arie. *Blogs: Finding Your Voice, Finding Your Audience.* New York: The Rosen Publishing Group, 2012.

Keller, Helen. *The Story of My Life*. New Delhi: General Press, 2018.

Kelly, Theresa. *Empathy: A Quantum Approach – The Psychical Influence of Emotion.* A Textbook of the Univeristy of Alternative Studies, 2012.

Kemper, Theodore. “How Many Emotions Are There? Wedding the Social and the Autonomic Components.” In: American Journal of Sociology, Vol. 93(2), 1987. 263–289.

Kephart, Beth. *Handling the Truth: On the Writing of Memoir.* New York: Penguin Group, 2013.

Klarer, Mario. *A Short Literary History of the United States.* London: Routledge, 2013.

Kushner, Thomasine Kimbrough. Thomasine, David. *Ward Ethics: Dilemmas for Medical Students and Doctors in Training.* Cambridge University Press, 2001.

Larson, Thomas. *The Memoir and the Memoirist: Reading and Writing Personal Narrative.* Athens: Ohio University Press, 2007.

Lesser, Harry. *Justice for Older People*, New York: Editions Rodopi, 2012.

Lewandowski, Roman. Kautsch, Marcin. “Przekształcenia strukturalne i społeczne w ochronie zdrowia.” *Przedsiębiorczość i Zarządzanie*, tom XIII, zeszyt 5, Łódź 2012.221-230.

Lickiewicz, Jakub. Hughes, Patricia. Makara-Studzińska, Marta. “The use of board games in healthcare teaching.” In: *Nursing Problems,* 28 (2) 2020. 71-74.

Lubas-Bartoszyńska, Regina. „Pisanie autobiograficzne w kontekstach europejskich.” W: Pamiętnik Literacki, Warszawa: Instytut Badań Literackich Polskiej Akademii Nauk, 2003. 278-83.

Łukaszewicz, Barbara. „Wyrażanie emocji negatywnych w polonistycznej praktyce glottodydaktycznej.” W: Wydział Polonistyki Centrum Języka Polskiego i Kultury Polskiej dla Cudzoziemców POLONICUM, Warszawa: Uniwersytet Warszawski, 2019. https://depotuw.ceon.pl/handle/item/3710

Marini, Maria Giulia. *Narrative Medicine: Bridging the Gap between Evidence-Based Care and Medical Humanities*. Milan: Springer International Publishing, 2016.

Martin, Mike. *Memoir Ethics: Good Lives and the Virtues.* London: Lexicon Books, 2016.

Maryl, Maciej. „Blog jako dziennik elektroniczny. Analiza genealogiczna blogów pisarzy.” W: *Zagadnienia Rodzajów Literackich*, Łódź: Łódzkie Towarzystwo Naukowe, nr 55/109, zeszyt 1, 2012. 95-111.

McKay, Matthew. Fanning, Patrick. Zurita, Patricia. *Mind and Emotions: A Universal Treatment for Emotional Disorders. New Harbinger Publications, Inc. 2011.*

Meadows, Chris. *A Psychological Perspective on Joy and Emotional Fulfilment.* New York: Routledge, 2014.

Mendelsohn, Daniel. “But Enough about me: What Does the Popularity of Memoirs Tell Us About Ourselves.” In: Augustine and the Environment, eds. John Doody, Kim Paffenroth, Mark Smillie. London: Lexington books, 2016.

Mike, Martin. *Memoir Ethics: Good Lives and the Virtues.* London: Lexicon Books, 2016.

Mitesh, Patel. Siang, Lee. Levell, Nick. Smart, Peter. Kai, Joe. Kim, Thomas. Leighton, Paul. ‘’Confidence of recurrent cellulitis self-diagnosis among people with lymphoedema: a qualitative interview study.” In*: British Journal of General Practice,* 2020 Jan 30;70(691):130-137.

Mohseni, Mohabbat. Lindstrom, Martin. “Social capital, trust in the health-care system and self-rated health: the role of access to health care in a population-based study.” In: *SocSci Med,* No 7 (April), 2007.1373-83.

Morrill, Dan. *Boom and Bust in the Blogosphere: Case Studies of the Blogging Industry*. BookSurge Publishing, 2009.

Mstowska, Joanna. “Various aspects of Mimesis in Selected Sea novels of Frideric Marryat, James Cooper and Richard Dana”, Toruń: 2013. 108-118.

O'Connor, Maureen. *Life Stories: A Guide to Reading Interests in Memoirs, Autobiographies, and Dieries.* Denver: Libraries Unlimited, 2011.

Ofri, Danielle. *What Patients Say, what Doctors Hear.* Boston: Beacon Press, 2017.

Orzechowska, Agata. Zajączkowska, Marlena. Talarowska, Monika. Gałecki, Piotr. “Depression and ways of coping with stress: a preliminary study.” In: *Med Sci Monit,* Nov 25;19, 2013. 1050-6.

Ostaszewski, Krzysztof. Dąbrowska, Katarzyna. Greń, Jakub. Wieczorek, Łukasz. „Analiza jakościowa stylu życia 17-18-letnich użytkowników substancji psychoaktywnych, wzorów i motywów używania substancji oraz innych zachowań problemowych.” W: *Serwis Informacyjny Uzależnienia*. Warszawa: Instytut Psychiatrii i Neurologii, Nr 4 (88), 2019. 31-36.

Owens, Timothy. Suitor, Jill. *Interpersonal Relations Across the Life Course*. New York: Oxford University Press, 2009.

Pascal, Roy. *Design and Truth in Autobiography.* New York: Routledge, 2016.

Pedersen, Sarah. *Why blog? Motivations for blogging.* Oxford: Chandos Publishing, 2010.

Platt, F. Keating, K, “Differences in physician and patient perceptions of uncomplicated UTI symptom severity: understanding the communication gap.” [PubMed] [Google Scholar] 2007. 61(2):303–308.

Poirier, Suzanne. *Doctors in the Making: Memoirs and Medical Education.* Iowa: University of Iowa Press, 2009.

Power, Michael. Power, Mick. Dalgleish, Tim. *Cognition and Emotion: From Order to disorder.* London: Psychology Press, 2016.

Pronovost, Petal. Needham, Dale. “An intervention to decrease catheter-related bloodstream infections in the ICU.” In: *New England Journal of Medicine*, 2006. 2725-32.

Rimondini, Michela. *Communication in Cognitive Behavioural Therapy.* New York: Springer, 2010.

Robinson, Peter. "Jean-Jacques Rousseau and history: moral truth at the expense of facticity, Rethinking History.” In: *The Journal of Theory and Practice*, Vol. 12, 3/ 2008. 417-431.

Rodham, Karen. *Health Psychology*. London: Palgrave Macmillan, 2010.

Rousseau, Jean-Jacques. *A Friend of Virtue By Joseph R. Reiser*. London: Cornell University Press, 2003.

Rousseau, Jean-Jacques. *The Confessions of Jean-Jacques Rousseau* Complete. The Floating Press, 2012.

Sala, Harold. *Making Your Emotions Work for You: Coping with Stress,* Avoiding Burnout. Nashville: Publishing Group, 2013.

Sanchez-Reilly, Sandra. Morrison Laura, Carey Elise. Bernacki Rachelle. O'Neill, Lynn. "Caring for oneself to care for others: physicians and their self-care." In: *The journal of supportive oncology,* 11(2), 2013. 75-81.

Sander, David. Scherer, Klaus. *Oxford Companion to Emotion and the Affective Sciences.* Oxford University Press, 2014.

Sandy, Miles. "Addressing shame: what role does shame play in the formation of a modern medical professional identity." In: *BJPsych Bulletin*, Vol. 44, 1/2020. 1 –5.

Sara, Algoe. Jonathan, Haidt. "Witnessing excellence in action: the other praising emotions of elevation, gratitude and admiration." In: PubMed, 4(2), 2009. 105–127.

Saver, Cynthia. *Anatomy of Writing for Publication for Nurses*. Indianapolis: Honour Society of Nursing, 2017.

Schenker, Yael. et al., "Interventions to Improve Patient Comprehension," [PMC free article] [PubMed] [Google Scholar] 2011. 151–73.

Scotland, Nigel. *Christianity Outside the Box: Learning from Those Who Rocked the Boat.* Oregon: Cascade Books, 2012.

Scott, John. *Jean-Jacques Rousseau: Politics, art, and autobiography*. New York: Routledge, 2006.

Serfaty, Viviane. *The Mirror and the Veil: An Overview of American Online Diaries and Blogs*. Amsterdam: Rodopi, 2003.

Shaw, Peter. *The Autobiography and Other Writings* by *Benjamin Franklin*. New York: Bantam, Classis, 2008.

Singer, Margot. Walker, Nicole. *Bending Genre: Essays on Creative Nonfiction*. New York: Bloomsbury, 2013.

Slattery, Dennis Patrick. Corbett. Lionel. *Depth psychology: Meditations in the Field.* Carpinteria: Pacifica Graduate Institute, 2004.

Ślusarska, Barbara. Dobrowolska, Beata. Zarzycka, Danuta. **‘’**Meta-teoretyczny kontekst zachowań zdrowotnych w paradygmatach zdrowia. Problemy Higieny i Epidemiologii.” In: *Elementy psychologii* ***zdrowia,*** ed. Grażyna Dolińska-Zygmunt. 2013, nr 94 (4), 667–674.

Smith, Sidonie and Julia Watson. *Reading Autobiography: A Guide for Interpreting Life Narrative.* Minneapolis: University of Minnesota Press, 2012.

Sowińska, Agnieszka. “I must do everything to eliminate my negative attitude: Polish general practitioners’ emotions toward patients with medically unexplained symptoms.”In: *Linguistic approaches to emotions in context,* eds. Florence Baider and Gordon Cislaru. Amsterdam: John Benjamins, 2014. 309–30.

Spiegel, Jeremy. *The Mindful Medical Student*. Lebanon: University Press of New England, Springer International Publishing, *2018.*

Steciąg, Magdalena. „Glottodydaktyka w ujęciu ekolingwistycznym.” W: *Kształcenie*

Polnistyczne Cudzoziemców, Łódź: *Acta Universitatis Lodziensis.* nr 21, 2014. 53-62.

Streissguth, Thomas. *Franklin Benjamin*. Minneapolis: Learner Publication Company, 2002.

Szasz, Thomas. Hollender, Marc. "A Contribution to the Philosophy of Medicine: The Basic Model of the Doctor-Patient Relationship." W: *Encounters between Patients and Doctors: an Anthology*, ed. J. D. Stoeckle, Cambridge, 1987. 165–177.

Talukder, Munir Hossain. *Nature and Life: Essays on Deep Ecology and Applied Ethic.* Cambridge Scholar Publishing, 2018.

Thomas, Patricia. Kern, David. Hughes, Mark. Chen, Belinda. *Curriculum Development for medical education: A six-step approach.* Baltimore: Johns Hopkins University Press, 2016.

Turner, Jonathan. Stets, Jan. *The Sociology of Emotions*. New York: CUP, 2005.

Twain, Mark, *Autobiography of Mark Twain*: Volume 1. London: University of California Press, 2012.

Umphred, Darcy Ann. Lazaro, Rolando. Roller, Margaret. Burton, Gordon. *Neurological Rehabilitation.* Oxford University Press, 2017.

Van Gorp, Trevor. Adams, Edie. *Design for Emotion.* Walthman: Elsevier, 2012.

Van, Marcel. *Autobiography of Brother Marcel Van*. Gloucester: Action Publishing Technology Ltd, 2006.

Vulkanovic-Criley, Jasminka. Criley, Stuart. et al. "Competency in cardiac examination skills in medical students, trainees, physicians and faculty." In: *Arch Int Med*. 2006. 610-6.

Wade, John. Marks, Lawrence. Hetze, Roderick. *Positive Psychology on the College Campus.* Oxford University Press: Oxford, 2015.

Warren, D. Houten, Ten. *Emotion and Reason: Mind, Brain, and the Social Domains of Work* and Love. London: Routledge, 2013.

Watson, Christie. *The Language of Kindness: A Nurse's Story.* London: Tim Duggan Books, 2018.

Weigand, Edda. *Emotion in Dialogic Interaction: Advances in the Complex*. Amsterdam: University of Munster, 2002.

Weil, Shalva. "Review: Andy Alaszewski (2006). Using Diaries for Social Research." In: *Forum Qualitative Sozialforschung / Forum: Qualitative Social Research.* 2006. 7(4), art. 25

Wiertlewska, Janina. "Doctor-patient communication: towards an outline of medical English didactics." In: Scripta Neophilologica Posnaniensia. Tom XVII, Poznań: Wydział Neofilologii, Uniwersytet im. Adama Mickiewicza, 2017. 423–434.

Wiertlewska, Janina. "Ekolingwistyczne podejście do nauczania języków obcych na przykładzie języka angielskiego – wyzwaniem dla glottodydaktyki XXI wieku." In: Glottodidactica. An International Journal of Applied Linguistics. Toruń/Bydgoszcz: UMK w Toruniu, Collegium Medicum im. L. Rydygiera w Bydgoszczy, 2014. 195-206.

Wilkinson, Dominic, and Julian Savulescu, Tony Hope, Judith Hendrick. *Medical Ethics and Law: The Core Curriculum*. University of Oxford: Oxford, 2008.

Willes, Margaret. *The Curious World of Samuel Pepys and John Evelyn*. Yale University Press, 2017.

Windover, Amy. Boissy, Adrienne. “The REDE Model of Healthcare Communication: Optimizing Relationship as a Therapeutic Agent.” In: J Patient Exp. 2014 May; 1(1): 8–13. Published online 2014 May 1.

Yagoda, Ben. *Memoir: A History.* New York: Penguin Group Inc., 2009.

Zaidi, Zareen. *Contemporary Challenges in Medical Education: From Theory to Practice.* University of Florida Press, 2019.

Zembała, Anna.‘’Modele komunikacyjne w relacjach lekarz – pacjent.” W: Zeszyty Naukowe Towarzystwa Doktorantów UJ Nauki Ścisłe, Uniwersytet Jagielloński, Nr 11, 2/2015. 35-50.

Internet sources:

https://www.ateneum.edu.pl/assets/Uploads/003-baczkowska.pdf
https://danielleofri.com/medical-memoirs
https://wAhcitypaper.com/pittsburgh/author-and-nurse-theresa-brown-discusses-hospitals-nursing-and-her-new-book-the-shift/Content?oid=1857103
Christy Duan, Q&A with Physician-Author Dr Matt McCarthy,
https://www.studentdoctor.net/2016/05/04/qa-physician-author-dr-matt-mccarthy/

https://scribepublications.com.au/books-authors/books/superbugs
http://www.drmattmccarthy.com/bios/matt-mccarthy
https://www.nytimes.com/2019/08/16/reader-center/diagnosis-tv-netflix.html
https://www.enotes.com/homework-help/why-does-writer-writer-autobiography-what-try-405935

http://literarydevices.net/autobiography.
https://www.britannica.com/art/journal-literature
“Literary Devices, Definition and Examples of Literary Terms”,
http://literarydevices.net/memoirs, accessed 08.05.2019.

https://www.enotes.com/homework-help/why-does-writer-writer-autobiography-what-try-405935. Accessed 12 Feb. 2020.

Florentz Christopher, Can Crowdsourcing Solve Medical Mysteries?, More heads are better than one, 28 Jun 2018, https://www.cslbehring.com/vita/2018/crowdsourcing-and-medical-mysteries-0628

Matthew Matheny, ‘’The Autobiography Of Benjamin Franklin”, available on https://www.bartleby.com/essay/The-Autobiography-Of-Benjamin-Franklin-F36ZT9LJPLLX, 23 November 2014.

https://theboar.org/2016/04/i-think-autobiographies-important/ Katie Sewell, Apr. 8, 2016
https://www.10ofthose.com/uk/products/2579/richard-baxter-autobiography
https://www.ccel.org/ccel/bunyan/holy_war.html
https://www.goodreads.com/book/show/6527849-journey-to-hell
https://www.goodreads.com/book/show/770451.How to Pray in the Spirit
Parry Julie, “Meet Yale Internal Medicine: Lisa Sanders, MD, FACP, Associate Professor of Medicine (General Internal Medicine)”
https://medicine.yale.edu/intmed/people/lisa sanders._ profile

Urama, Kelechi, https://www.pghcitypaper.com/pittsburgh/author-and-nurse-theresa-brown-discusses-hospitals-nursing-and-her-new-book-the-shift/Content?oid=1857103

Create and search a text corpus | Sketch Engine, http://www.sketchengine.eu

http://drrandifredricks.com/plutchiks-wheel-of-emotions/ Randi Fredrics, Plutchik’s Wheel of Emotions, Jan 27, 2017 | Counselling, Emotions, Psychological Development, Relationships

http://toddharveymft.com/feelings

http://www.rozpisani.pl/blog/konstrukcja-fabuly---kilka-porad
https://app.sketchengine.eu/#concordance?corpname

https://be-master.pl/9-sposobow-na-radzenie-sobie-z-emocjami

https://sentimenti.pl/blog/dlaczego-mierzymy-az-8-emocji-podstawowych
https://www.jmu.edu/counselingctr/files/About%20Emotions.pdf
https://www.maszynadopisania.pl/praca-nad-powiescia-pierwsze-kroki-bohater/

https://www.paulekman.com/universal-emotions/what-is-surprise/

https://www.spiral2grow.com/anger-as-a-primary-and-a-secondary-emotion/

Joanna Wrycza-Bekier, http://poradnikpisania.pl/jak-zwiekszyc-napiecie-w-opowiesci-poznaj-4-sekrety/#more-2431

Jun Zhan, Jun Ren, Jin Fan and Jing Luo, Distinctive effects of fear and sadness induction on anger and aggressive behaviour, Front. Psychol.,15 June 2015, https://doi.org/10.3389/fpsyg.2015.00725

M.T.H. van Berge Henegouwen, H.F. van Driel, D.G.A Kasteleijn-NolstTrenité, *A patient diary as a tool to improve medicine compliance*. *Pharm World Sci* 21, 21–24 (1999). https://doi.org/10.1023/A:1008627824731

National Library of Medicine, https://pubmed.ncbi.nlm.nih.gov/21796954

http:// www.researchgate.net/profiles/sarah-pedersen

Stanton E, Noble D. Emotional intelligence. BMJ Careers. 2010. http://careers.bmj.com/careers/advice/view-article.html?id=20001646.

https://www.newyorker.com/magazine/2015/05/18/anatomy-of-error# Anatomy of Error, A *surgeon remembers his mistakes.* Joshua Rothman, May 18, 2015

https://www.theguardian.com/books/2019/nov/24/how-to-save-the-nhs-by-five-medical-memoirists-henry-marsh-adam-kay

https://www.townandcountrymag.com/society/tradition/g25574123/celebrities-with-royal-honors-knights-dames/

Dr. Matt McCarthy Bio–Wiki, Age, Books, Superbugs and Net Worth. - Wiki

Parry, Julie. “Meet Yale Internal Medicine: Lisa Sanders, MD, FACP, Associate Professor of Medicine (General Internal Medicine).”, https://medicine.yale.edu/intmed/people/lisa sanders._ profile

https://www.nytimes.com/2019/08/16/reader-center/diagnosis-tv-netflix.html

Saver, Cynthia. Anatomy of Writing for Publication for Nurses, Indianapolis: Honour Society of Nursing, 2017, p. 357.

Kelechi Urama, https://www.pghcitypaper.com/pittsburgh/author-and-nurse-theresa-brown-discusses-hospitals-nursing-and-her-new-book-the-shift/Content?oid=1857103

Rojann R. Alpers (2010) A Review of "Critical care: A new nurse faces death, life and everything in between", Health Care for Women International, 32:1, p. 96.
https://www.pghcitypaper.com/pittsburgh/author-and-nurse-theresa-brown-discusses-hospitals-nursing-and-her-new-book-the-shift/Content?oid=1857103
Christy Duan, Q&A with Physician-Author Dr. Matt McCarthy,
https://www.studentdoctor.net/2016/05/04/qa-physician-author-dr-matt-mccarthy/

https://scribepublications.com.au/books-authors/books/superbugs
http://www.drmattmccarthy.com/bios/matt-mccarthy
Christy Duan, Q&A with Physician-Author Dr. Matt McCarthy,
https://www.studentdoctor.net/2016/05/04/qa-physician-author-dr-matt-mccarthy/

Elborough, Travis, Travis Elborough's top 10 diarists, 1 Jan 2014, accessed on 08.05.2019, https://www.theguardian.com/books/2014/jan/01/travis-elboroughs-top-10-literary-diarists

Matheny, Matthew ''The Autobiography Of Benjamin Franklin", available on https://www.bartleby.com/essay/The-Autobiography-Of-Benjamin-Franklin-F36ZT9LJPLLX, 23 November 2014

Shandler, Jeffrey "Anne, from Diarist to Icon", https://www.annefrank.org/en

Think Like a Doctor: The Painter's Headaches – The New York Times (nytimes.com)

SUMMARY

This dissertation tackles the topic of doctor–patient relations which occur in the context of undergoing treatment. These relations become apparent in medical memoirs, referred to in the dissertation, which constitute a segment of autobiographical literature, whose forms and functions are discussed in Chapter One. In particular, the focus of attention is on selected medical memoirs of the 21st century, written by American and British medical staff. In the initial part of this study, roles of memoirs are discussed. It is argued that a self-analysis of memoirists who recall and work through their experiences is the main role of memoirs. Other functions of memoirs include leaving legacy to readers, sharing one's failures and successes (for example, Henry Marsh) or drawing conclusion for oneself (for example, Henry Marsh, Matt McCarthy). Moreover, memoirs remain a source of medical and non-medical information. Next, the dissertation takes a closer look at memoirists writing in the past and in the 21st century.

Chapter Two of the dissertation defines the concept of communication, which is a key term in doctor–patient relations. Benefits of proper communication in the context of medical environment are presented in order to illustrate how they can contribute to more fruitful treatment and mutual satisfaction. While discussing the role of communication, I incorporate the term of narrative medicine, which serves the purpose of indicating its essential role in understanding patients' needs. The notion of narrative medicine is relatively new and assumes the inclusion in the treatment process of the art of story-telling or/and listening to the patient's stories. Narratives – which build on the participation of a teller, a listener, plot and content – are not only helpful to doctors, nurses and social workers, but also to patients. Narrative skills (that is, skills indispensable for listening and understanding narration about an illness, obtaining accurate interpretation of these stories and capturing the patient's complex situation) enable the addressee's comprehension of the story told by the addressor. These skills are of great significance, since only in the situation when the physician understands his/her patient's stance, can medical care be provided with respect. By narrative medicine, Rita Charon means medicine practiced with the kind of narrative skills that permit recognizing, interpreting and navigating through patients' stories about their illnesses. Narrative medicine gives hope that medical care system may become more effective in treatment by showing respect and appreciation to the ill.

This dissertation quotes examples of specialists from the medical world, such as Jennifer Fong Ha, Nancy Longnecker, Katarzyna Jankowska, Tomasz Pasierski, or linguistics, for

example, Janina Wiertlewska, who detect certain shortcomings in doctor–patient communication and at the same time agree with the assumption of narrative medicine that improvement in this area will contribute to more effective treatment and satisfaction of both sides. Advocates of this view prove that complaints about doctors more frequently concern a lack in communication rather than clinical incompetence. They also claim that efficient doctor–patient communication amounts to fewer court trials, even in case of an unsuccessful result of therapy. A more satisfied patient is likely to follow the therapy more willingly, and less often opts for trials. Improvement in communication is a source of motivation, encouragement, support and comfort. Smooth doctor–patient relations can stimulate patients and lead to their self-confidence, positive perception of their health state, which may influence their health. Physicians who can skillfully diagnose and treat illnesses and communicate effectively are precious to patients.

Part of this dissertation is devoted to models of communication between the doctor and the patient, developed in the history of medicine and to examining reflection of these models in medical memoirs, selected for the purpose of the study. Communication in these memoirs mostly resembles the one present in the partnership and the systemic–partnership models. The interpretative model is also apparent. Beyond these models, there is a mention of the instrumental model, visible through communication by means of a computer, and several examples described by the author fall into the paternalistic model.

Apart from the matter of communication, emotions accompanying both doctors and patients during a treatment process have been explored. This is done in Chapter Three by defining and classifying emotions and discussing their role in human life and in literature. Robert Pluchnik's Wheel of Emotions becomes a reference point for a detailed study of the feelings experienced by doctors and patients. Primary emotions are characterized first as a background to further analyses of the selected memoirs. Secondary emotions, which constitute a mixture of primary emotions, are taken into account, too. Instances of primary and secondary emotions are traced in the medical memoirs. How those emotions are experienced by the medical staff and to some extent by patients is given a center of interest. A closer attention is paid to how these emotions influence the staff and how they react to emotions. In order to cope with daily challenges, the medical staff need to learn how to deal with emotions faced on duty. It is possible due to working out one's own ways basing on experiences, and also observing reactions of more experienced medical staff, with whom one cooperates.

Together with descriptions of emotions appearing in the analyzed memoirs, research by means of sketch engine has been conducted. Sketch engine is a tool serving to explore how

language works. It helps trace the number of times a particular emotion – for example, joy – occurred in a given memoir. Sketch engine is used in the dissertation as an aid to obtain findings on the appearance of emotions in memoirs. Sketch engine does it through processing texts that contain billions of words and searching examples of a word or a phrase. It shows results in the form of word sketches, concordances and wordlists.

Finally, Chapter Four raises the matter of training the medical staff and of the usefulness of medical memoirs in the process of educating doctors and other medical staff, shaping their attitudes towards future professional and deontological duties. Training with the use of medical memoirs constitutes a broad issue. Not only are memoirs written by medical specialists, but also by patients themselves, and authors of memoirs can be doctors who were also patients. Examples presented in memoirs indicate that professional viewpoint and perspective overlap and do not have to converge. The matter of training the medical staff is discussed through the prism of how British and American authors of medical memoirs – doctors and nurses – perceive their training process during and after graduation from studies; namely, learning at work from their patients, through which the medical staff broaden their experience. In the analyzed memoirs, medical specialists refer to their past medical education, sometimes comparing it with currently conducted didactics and formulating conclusions and reflections flowing from these comparisons. Memoirists undergo stages of professional development. At first, they gain experience and observe the surrounding environment, then they are ready to analyze their progress and draw conclusions from their experiences.

STRESZCZENIE

Niniejsza rozprawa podejmuje tematykę relacji zachodzących między lekarzem a pacjentem w kontekście odbywania leczenia. Relacje te uwidoczniają się w memuarach medycznych, do których sięgnięto w pracy, a które stanowią segment literatury autobiograficznej. W szczególności, oparto się na wybranych medycznych memuarach XXI wieku, tworzonych przez amerykański i brytyjski personel medyczny. W Rozdziale I pracy omówione zostały formy i role memuarów. Należą do nich: analiza własnych doświadczeń dokonywana przez autorów poprzez ich przytoczenie i przepracowanie. Inną z funkcji stanowi pozostawienie spuścizny czytelnikom, dzielenie się swoimi porażkami i sukcesami (np. Henry Marsh) lub wyciągniecie wniosków dla siebie (np. Henry Marsh, Matt McCarthy). Poza tym, memuary stanowią źródło informacji medycznej i pozamedycznej. Następnie, praca przybliża pamiętnikarzy tworzących w przeszłości oraz w XXI wieku.

Rozdział II pracy definiuje pojęcie komunikacji, będące kluczowym terminem w relacjach lekarz–pacjent. Przedstawione zostają korzyści płynące z właściwej komunikacji w kontekście środowiska medycznego, aby zilustrować, w jaki sposób mogą one przyczynić się do lepszego leczenia i obopólnej satysfakcji. Przy okazji omawiania roli komunikacji w medycynie, autorka pracy przybliża pojęcie medycyny narracyjnej, aby wskazać jej istotną rolę w zrozumieniu pacjentów i ich potrzeb. Koncepcja medycyny narracyjnej jest stosunkowo nowa i zakłada włączenie do procesu leczenia sztuki opowiadania historii lub/i słuchania historii pacjenta. Narracje – czyli historie z udziałem osoby opowiadającej, słuchaczem, fabułą i treścią – są pomocne nie tylko dla lekarzy, pielęgniarek i pracowników socjalnych, ale także dla samych pacjentów. Umiejętności narracyjne (tj. umiejętności niezbędne do słuchania i rozumienia narracji o chorobie, uzyskiwania trafnych interpretacji tych historii i uchwycenia trudnej sytuacji pacjenta), umożliwiają odbiorcy zrozumienie historii opowiedzianej przez adresującego. Umiejętności te mają kluczowe znaczenie, ponieważ tylko w sytuacji, gdy lekarz rozumie sytuację swojego pacjenta, opieka medyczna może być zapewniona z szacunkiem. Przez medycynę narracyjną Rita Charon rozumie medycynę praktykowaną z wykorzystaniem takich umiejętności narracyjnych, które pozwalają na rozpoznawanie, interpretowanie i swobodne poruszanie się w opowieściach pacjentów o ich chorobach. Medycyna narracyjna daje nadzieję, na to że system opieki zdrowotnej może stać się skuteczniejszy w leczeniu choroby poprzez okazywanie szacunku i uznania chorym.

W pracy przytoczone zostają przykłady postaci ze świata medycyny, np. Jennifer Fong Ha, Nancy Longnecker, Katarzyna Jankowska, Tomasz Pasierski, lub językoznawstwa, np. Janina Wiertlewska, dostrzegających niedosyt w obszarze komunikacji między lekarzem a pacjentem, a tym samym zgadzających się z założeniem medycyny narracyjnej, że poprawa w tej sferze przyczyni się do efektywniejszego leczenia i zadowolenia obydwu ze stron. Zwolennicy tego przekonania dowodzą, że skargi na lekarzy zwykle dotyczą w większości raczej braku komunikacji niż ich kompetencji klinicznych. Twierdzą również, że skuteczna komunikacja pomiędzy lekarzem a pacjentem oznacza mniej procesów sądowych, nawet w przypadku niekorzystnego wyniku terapii. Pacjent jest bardziej zadowolony, chętniej stosuje terapię, a co ważne, rzadziej składa pozwy. Poprawna komunikacja jest źródłem motywacji, zachęty, wsparcia i otuchy. Właściwa relacja lekarza z pacjentem może motywować pacjentów i prowadzić do ich większej pewności siebie, pozytywnego postrzegania stanu ich zdrowia, co może istotnie wpływać na rzeczywisty stan zdrowia pacjenta. Lekarze, którzy potrafią umiejętnie diagnozować i leczyć choroby oraz skutecznie komunikować się, są cenni dla pacjentów.

Rozdział II poświęcony jest modelom komunikacji między lekarzem a pacjentem wypracowanym w dziejach medycyny, oraz zbadaniu ich odzwierciedlenia w memuarach medycznych. Komunikacja w wybranych do tej pracy pamiętnikach medycznych przypomina przede wszystkim tę obecną w modelu partnerskim i systemowo–partnerskim. Widoczny jest również model interpretacyjny. Poza powyższymi modelami wspomina się o modelu instrumentalnym, widocznym poprzez komunikację za pośrednictwem komputera, a kilka przykładów opisanych przez autorów zalicza się do kategorii modelu paternalistycznego.

Poza kwestią komunikacji, w Rozdziale III zagłębiono się w emocje towarzyszące zarówno lekarzowi jak i pacjentowi w procesie leczenia. Dzieje się to poprzez zdefiniowanie i klasyfikacje emocji oraz omówienie ich roli w życiu człowieka i literaturze. Koło Emocji Roberta Pluchnika staje się punktem wyjścia do przedstawienia emocji. Charakteryzowane są emocje pierwotne, co stanowi tło do dalszych analiz wybranych wspomnień. Pod uwagę brane są również emocje wtórne, będące mieszanką emocji pierwotnych. Zaobserwować można przykłady emocji pierwotnych i wtórnych występujących w wybranych pamiętnikach medycznych. W centrum uwagi jest sposób, w jaki te emocje są odczuwane przez personel medyczny, a do pewnego stopnia także przez pacjentów. Uwagę zwraca się na to, jak te emocje wpływają na personel i jak reaguje on na pojawiające się emocje. Aby poradzić sobie z codziennymi wyzwaniami, personel medyczny musi nauczyć się radzić sobie z emocjami

podczas dyżuru. Jest to możliwe dzięki wypracowaniu własnych sposobów na podstawie swoich doświadczeń, ale także obserwacji reakcji bardziej doświadczonego personelu medycznego, z którym się współpracuje.

Wraz z opisami emocji, które pojawiają się w omawianych pamiętnikach, przeprowadzono badania za pomocą sketch engine – narzędzia służącego do eksploracji działania języka, które pozwala prześledzić, ile razy w danym pamiętniku pojawia się określona emocja, np. radość. Sketch engine zostało wykorzystane w rozprawie jako pomoc w uzyskaniu ustaleń dotyczących pojawiania się emocji w pamiętnikach medycznych. Sketch engine czyni to poprzez przetwarzanie tekstów zawierających miliardy słów i znajdowanie przykładów słowa lub frazy. Przedstawia wyniki w postaci szkiców słów, konkordancji i list słów.

Wreszcie Rozdział IV porusza kwestię nauczania personelu medycznego oraz przydatności pamiętników medycznych w procesie kształcenia lekarzy i innego personelu medycznego, kształtowania ich postaw wobec przyszłych obowiązków zawodowych i deontologicznych. Szkolenie z wykorzystaniem pamiętników medycznych stanowi obszerny aspekt. Piszą je nie tylko lekarze specjaliści, ale sami pacjenci, a autorami pamiętników mogą być także lekarze, którzy byli pacjentami. Przykłady przedstawione w pamiętnikach pokazują, że zawodowy punkt widzenia i perspektywa pacjenta nakładają się na siebie i niekoniecznie muszą być zbieżne. Kwestia nauczania personelu medycznego jest omawiana przez pryzmat tego, jak brytyjscy i amerykańscy autorzy pamiętników medycznych; czyli sami lekarze i pielęgniarki postrzegają swój proces kształcenia na studiach i po ich ukończeniu; a mianowicie uczenie się w pracy i od swoich pacjentów, dzięki czemu poszerzają oni swoje doświadczenie. Specjaliści medyczni w omawianych pamiętnikach odwołują się do swojej przeszłej edukacji medycznej, niekiedy porównują ją z prowadzoną obecnie dydaktyką, formułując wnioski i refleksje wyłaniające się z tych porównań. Pamiętnikarze przechodzą etapy rozwoju zawodowego. Na początku zdobywają doświadczenie i obserwują swoje otoczenie, po czym są gotowi analizować swoje postępy i wyciągać wnioski ze swoich doświadczeń.